# Jigsaw Independent Hospital

## Quality Report

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

## Ratings

| | |
|---|---|
| **Overall rating for this location** | **Requires improvement** |
| Are services safe? | **Requires improvement** |
| Are services effective? | **Good** |
| Are services caring? | **Good** |
| Are services responsive? | **Good** |
| Are services well-led? | **Requires improvement** |

### 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.

# Summary of findings

## Overall summary

**We rated Jigsaw Independent Hospital as requires improvement because**:

We inspected Jigsaw Independent Hospital to see whether improvements had been made following a comprehensive inspection in March 2016. At that inspection, we had issued requirement notices for breaches of regulations relating to person centred care, good governance, staffing and duty of candour.

A warning notice had been served for a breach of regulation 12 of the Health and Social Care Act (2014) and an inspection visit in August 2016 confirmed that issues had been addressed and this warning notice was met.

At this current inspection, we found improvements and changes had been made throughout the hospital.

There had been a review of blanket restrictions throughout the hospital and many of the restrictions that had been in place had been altered. There was a collaborative multidisciplinary approach to delivering care. There had been a review of patient pathways throughout the service and evidence of discharge planning was apparent from talking to patients and reviewing records. The hospital now had a clear admission process.

In terms of good governance, we found records were well maintained and comprehensive. Physical health information was included in health passports. A new governance structure had been established and this ensured information was communicated up to board level and back down to ward level. A duty of candour policy had been developed and staff were aware of this. We found that although overall governance had improved, there were still areas which lacked sufficient oversight, for example, training levels, policies, ligature audits and out of date clinical stocks. There were also still issues with the Mental Health Act policies despite these being reviewed.

# Summary of findings

## Contents

Requires improvement

# Jigsaw Independent Hospital

**Services we looked at**

Long stay/rehabilitation mental health wards for working-age adults

# Summary of this inspection

## Background to Jigsaw Independent Hospital

Jigsaw Independent Hospital provides care and treatment for up to 36 patients. At the time of our inspection there were 30 patients at the hospital, all of whom were detained under the Mental Health Act.

The provider was registered to provide the following regulated activities :

• Diagnostic and screening procedures

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

• Treatment of disease, disorder or injury

The wards we visited were:

Montrose ward – female rehabilitation ward with eight beds

Linden ward – male rehabilitation with 10 beds

Cavendish ward – female rehabilitation with 10 beds

Oriel ward – This ward had recently re-opened for intensive support for male service users with a diagnosis of mental illness and/or learning disability (mild to moderate) with complex needs. The ward had nine beds.

CQC previously inspected the hospital in March 2016. At that inspection, there had been concerns about medicines management, environmental risk assessments, Mental Health Act policies, staff supervision and appraisal rates, access to psychological therapies and governance systems. An action plan was developed by the provider to address these issues.

The service had a registered manager and a controlled drugs accountable officer.

## Our inspection team

Team leader: Andrea Tipping

The team that inspected the service comprised 3 CQC inspectors, an inspection manager, a clinical pharmacist and an expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer. A Mental Health Act reviewer attended for one day to carry out a Mental Health Act monitoring visit on Montrose ward.

## Why we carried out this inspection

We inspected this service to review whether the requirement notices from the inspection in March 2016 had been met. This was an unannounced, comprehensive inspection to check whether improvements had been made.

We had issued requirement notices which related to person centred care, good governance, staffing and duty of candour. The provider had sent an action plan which stated they would be compliant by December 2016.

We had inspected the service in August 2016 to assess whether improvements had been made following a warning notice being issued and we were satisfied that this had been met.

# Summary of this inspection

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- 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.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 20 patients who were using the service
- spoke with the registered manager and general manager
- spoke with 23 other staff members; including doctors, nurses, occupational therapists, psychologists, domestic staff and the Mental Health Act administrator
- spoke with an independent advocate
- spoke with four carers
- attended and observed one multi-disciplinary meeting and one therapeutic group
- undertook two short observations using the short observation for inspection tool
- looked at 15 care and treatment records of patients
- reviewed the admission process including two recent admission records
- carried out a specific check of the medication management on all four wards
- reviewed 28 medication cards
- spoke with commissioners for the service
- looked at a range of policies, procedures and other documents relating to the running of the service and
- carried out a Mental Health Act monitoring visit on Montrose ward.

## What people who use the service say

We interviewed 20 patients and four carers as part of this inspection.

Nearly all patients gave positive feedback about the staff on the wards. Several patients referred to the positive support they received from staff when they were anxious or upset. There were several patients who shared their experiences of the progress they had made and particular staff who had been key to this.

Patients also gave positive feedback about administrative staff who were described as friendly and helpful. The domestic staff were also noted to be friendly and positive and all patients reported that ward areas were clean. There was also positive feedback about members of the multidisciplinary team.

Most patients reported that they found the managers approachable and knew who they were and how to contact them.

We spoke to carers who gave positive feedback about the hospital. Arrangements to visit their relatives worked well. Carers told us they felt welcomed and encouraged to visit and attend meetings and reviews. Carers shared with us experiences where they felt staff had provided individualised, well planned care to deal with transitions and stressful events. Their descriptions of planning and staff's knowledge of patients were highly individual and patient centred. They felt staff got to know their relatives well, knew their interests and needs well and formed good relationships with them.

Patients and carers told us they knew how to raise concerns or complain. All patients were positive about the advocacy service and knew how to contact the advocate. We saw posters displayed on wards and saw an easy read leaflet explaining the role of advocacy was available for patients.

# 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?

Requires improvement

We rated safe as **requires improvement** because:

- Although ligature audits had been completed for each ward area and reviewed at six-month intervals, they were not up to date with maintenance that had been undertaken and did not include all ward areas, However, staff knew where the risks were on the ward and had acted to reduce them.
- Mandatory training figures were improved since the last inspection, however less than 50% of staff were up to date with moving and handling training. Although not all qualified staff were up to date with immediate life support training, staff had been booked to attend training in the two weeks following the inspection. Training rates had also been added to the risk register in December.
- Medicines management practice was good, but we found out of date urine testing kits and alcohol swabs on Cavendish ward.

**However:**

- Ward areas, including clinic rooms and kitchens, were clean and tidy.
- Staff checked resuscitation equipment was in good order on a daily basis.
- Staffing levels were maintained and additional staff could be booked if needed.
- Use of restraint was low and staff were knowledgeable about alternative strategies for managing agitation or aggression.
- Staff completed risk assessments which were thorough and regularly updated.
- Blanket restrictions had been reviewed and removed, including bans on mobile phones and previously limited kitchen access.
- Staff knowledge of safeguarding was good and safeguarding notifications were made when needed.
- Medicines management practice was generally good, with no issues found in relation to medication stock and pharmacy supply, controlled drugs practice and consent to treatment.

### Are services effective?

Good

We rated effective as **good** because:

- Nurses completed comprehensive, up to date care plans including physical health plans.
- Health action passports were stored with medicines cards and were updated following GP or hospital visits.

# Summary of this inspection

- On Oriel ward, staff had completed one page profile documents which were detailed and specific to the individual patient. There was also use of “all about me” booklets.
- There were effective multidisciplinary teams including occupational therapy and psychology staff.
- Staff were receiving regular supervision.
- Staff had good understanding of the Mental Health Act and its application.
- Staff had good understanding of the Mental Capacity Act and deprivation of liberty safeguards.
- Staff had received training in equality and diversity and transgender awareness.

However:

- On Oriel ward, only one record contained care plans in an accessible format. Care plans on Oriel ward also included using visual prompts for certain patients, but we did not observe this happening in practice.
- Whilst appraisal rates had improved, 64% of staff had a current appraisal and appraisals had been booked in for all staff.
- Not all Mental Health Act policies reflected the code of practice.
- There were no accessible Mental Health Act leaflets available on Oriel ward.

## Are services caring?

Good

We rated caring as **good** because:

- We saw positive and respectful interactions between staff and patients during this inspection.
- We received positive feedback about the hospital and staff from nearly all patients interviewed.
- Most patients reported that they found the managers approachable and knew who they were and how to contact them.
- Most patients interviewed were positive about their involvement in care planning.
- Patients told us they had regular individual sessions and knew who their keyworker was.
- Community meetings took place on all wards on a daily basis, these were either in the mornings or evenings, depending on patient preference.
- We spoke to carers who all gave positive feedback about the hospital.
- Carers shared with us experiences where they felt staff had provided individualised, well planned care to deal with transitions and stressful events.
- Carers told us they had good communication from the hospital.

# Summary of this inspection

- All patients were positive about the advocacy service and knew how to contact the advocate.
- A patient survey had been completed in November/December 2016.
- There was a patient forum which met on a monthly basis with the hospital managers.

## Are services responsive?

Good

We rated responsive as **good** because:

- Managers had devised an admission standard operating procedure.
- We saw transitional planning in place for a patient who was visiting on overnight leave leading up to admission.
- The service had reviewed all current patients recently with the commissioning manager regarding discharge pathways and plans.
- Discharge pathways were discussed as part of care programme approach review meetings and with commissioners and care managers.
- The transitional arrangements for patients admitted to Oriel ward were excellent.
- There were plans to refurbish rooms previously designated as de-escalation rooms.
- Patients on all wards were able to access their bedrooms throughout the day.
- On all wards, patients were able to have their own mobile phones, with use of these limited only if clinically indicated.
- Some patients had key fobs allowing them to access the gardens when they wished, patients without this level of leave were able to access the garden at regular intervals throughout the day.
- Patients on all wards were able to access kitchen areas to make drinks and snacks.
- There was well staffed occupational therapy and psychology provision.
- We saw information displayed within wards about the advocacy service and how to give feedback and make complaints.
- Suggestion boxes were in place on wards and we were told these were emptied regularly and any suggestions reviewed by managers.

However:

# Summary of this inspection

- There was a lack of pictures or information displayed on Oriel ward. There was a lack of easy read information on display, and leaflets/written information for patients, although this was in place in other ward areas.

## Are services well-led?

**Requires improvement**

We rated well-led as **requires improvement** because:

- The monitoring system to ensure all staff had the necessary training and supervision was not always effective. Supervision and appraisal figures were not up to date
- Although, the service had identified that training for immediate life support training had fallen below 75% following staff leaving and training was booked, this was not the case for moving and handling training.
- Additional training undertaken by staff was not being recorded so it was not possible to monitor when this needed updating.
- There was a lack of sufficient oversight of the Mental Health Act in terms of policies.
- There was no system in place for checking clinical sundries stocks.
- Ligature audits were not up to date despite recent reviews.
- A new governance structure was in place but this required further improvement in terms of the information being fed in and overall monitoring as above.

However:

- Staff knew who the managers in the organisation were and told us that managers were approachable and regularly visited the wards.
- A team meeting at 9am each morning had been introduced to ensure all staff were aware of any incidents or relevant information for that day.
- Managers were able to analyse data using an incident management system.
- Personnel files were well managed and contained all necessary information.
- Staff had completed a staff survey and gave positive responses regarding effective leadership and management, induction, vision and values and training.
- There were plans for rolling out freedom to speak out sessions and a staff welfare policy was being devised with staff.
- Staff interviewed felt morale was generally good and described good working relationships with their teams.
- Staff told us they could raise concerns appropriately.

# Detailed findings from this inspection

## Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

We found good understanding of the Act and its application amongst staff. Mental Health Act training was mandatory for staff and over 80% of staff were up to date with this. All consent to treatment documentation was in good order.

Whilst all Mental Health Act policies had been updated to reflect the revised code of practice some still contained paragraphs which were from the previous version, for example, the Section 61 policy referenced the wrong chapters. The visitors policy did not contain all required information about barring visits. There were several policies which had not been drafted as the code outlines, for example, a human rights and equality policy, learning disability or autism policies and a food and drink strategy.

We undertook a Mental Health Act monitoring visit on Montrose ward as part of this inspection.

## Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of this inspection, there were no patients subject to deprivation of liberty safeguards.

We found good understanding of the Act and its application amongst staff. Staff undertook training in the Mental Capacity Act and deprivation of liberty safeguards every two years. At this inspection, 81% of staff had completed this.

Medical staff completed regular capacity assessments in regard to consent to treatment. Copies of these were stored in patient files and with medicine cards.

There were forms in patient files on Oriel ward regarding access to information. Although these were signed by patients it was unclear whether capacity to understand this had been assessed appropriately.

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

Requires improvement

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Requires improvement |

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

Requires improvement

**Safe and clean environment**

Jigsaw Independent Hospital had four wards spread over four floors. Montrose ward was split between the first and second floor. Linden ward was on the first floor. Cavendish ward was on the ground floor. Oriel ward was on the lower floor.

Ward layouts did not always allow staff to observe all areas of the ward from a central point, this was mitigated by the use of parabolic mirrors and routine observations.

There were ligature points in the form of taps, window closures and door fittings. Ligature points are places to which patients intent on self-harm might tie something to strangle themselves. Staff on wards knew where the ward audits were kept, could identify anti ligature fittings in use on wards and understood what ligature points were. Individual ward ligature audits had been completed at six month intervals. These were not up to date with maintenance which had been undertaken or changes to the wards. For example, Linden ward risk assessment referred to shower screens which had been replaced with shower curtains and sash windows, when many of the bedroom windows were double glazed hinged units. The same audit had a mitigation plan for ligature points in the kitchen which was that the kitchen was locked and observed by staff when in use, whereas this had changed some time ago. There were unsupervised areas of all wards, for example, laundry rooms and quiet rooms, which had not been assessed.

All wards had clinic rooms. These varied in size but all were clean and well maintained. Oriel ward clinic had a sink which did not meet the hygiene code as it had an overflow and plug and did not have non touch taps. There was no risk assessment for this. Medicine pots on Oriel ward were being washed to reuse despite the policy saying these were disposable. None of the rooms had an examination couch and we were told that if this was necessary the patient's bedroom would be used. Patients generally visited the GP practice for physical health needs.

Resuscitation equipment, including a defibrillator and portable oxygen, was stored centrally in the hospital reception area. This was in a locked cupboard and a key for this was on all four wards medicine keys. Nurses checked the equipment on a daily basis. Not all staff knew where emergency equipment was located when asked.

All wards were clean and tidy during this inspection. Domestic staff undertook cleaning of ward areas during the day and staff at night also had cleaning duties. Domestic staff received a handover from nursing staff when they arrive on the ward to highlight any risks. They maintained a daily cleaning checklist including running taps to prevent legionella where needed.

Kitchens were all clean and tidy. Fridge and freezer temperatures were checked daily except on Oriel ward, where there was no sheet available.

Staff told us that maintenance services were easy to contact and responsive when issues were raised.

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

Requires improvement

Staff adhered to infection control principles. There was personal protective equipment available where needed, including aprons and gloves. There were hand gel dispensers at the entrances to wards. Staff were trained in infection prevention. There were monthly infection control audits and hand hygiene audits completed with no concerns noted. The organisation had also developed a healthcare associated infections and infection prevention work plan. This was scheduled for the next 12 months and included actions for policies and procedures, ensuring clean environments, training and monitoring. Staff had completed a mattress audit in September 2016.

Nursing staff completed daily environmental assessments of each ward area.

Staff had personal alarms which could be used to summon assistance in the event of an incident.

One nurse on each shift was responsible for security issues, including environmental checks and accessing restricted items. On one ward, in the office, there was a laminated poster with pictures of the different keys used throughout the ward (window keys, alarm keys, security keys, light keys, lift keys) as an aide memoir for staff.

**Safe staffing**

All wards had an established number of staff per shift. This was ordinarily one qualified nurse and three to four support workers per day shift and one qualified nurse and two to three support workers at night. An additional qualified nurse was available during the day to cover qualified nurse attendances at meetings and breaks.

At the time of this inspection, there were 10 vacancies for qualified nurses. The hospital management were actively trying to recruit staff and had recently increased the salary for qualified nurses. They were also considering other strategies to increase recruitment. The hospital had offered short term contracts for full time agency staff to ensure consistent staffing. There were four contracted agency nurses working within the service who had worked at the hospital for a number of months. Additional bank and agency staff were regularly booked to cover shifts and there were a core group of staff booked who were familiar with the service.

Staff told us that when additional staff were needed, for example, to facilitate leave, these would be booked by managers. Duty rotas showed that additional staff had been booked when needed, for example, when observation levels were increased. Duty rotas also showed that staffing levels were maintained at the level the service had calculated. Some staff felt the hospital was short staffed or their ward needed more staff, but there was no indication that staffing levels were affecting patient care or leave for example.

Nurses were able to ensure they had regular one to one sessions with their patients. They also told us that managers would arrange protected time for nurses to complete care programme approach reports or tribunal reports.

Staff and patients told us that leave and/or activities were rarely cancelled because of staffing difficulties.

There were three doctors working within the service. All three were responsible clinicians to patients. There was not always a doctor on site during office hours. Out of hours there was a doctor on call.

Staff completed mandatory training with figures above 75% of staff overall for all courses apart from immediate life support and moving and handling training. Immediate life support training was mandatory for qualified nurses but only 64% of qualified staff had completed this. However, all qualified nurses had dates booked for this by the end of January 2017. Similarly, only 46% of staff had completed moving and handling training but staff had been booked on to courses taking place within three months of our inspection.

**Assessing and managing risk to patients and staff**

There were no seclusion facilities within the hospital and there had been no instances of seclusion or long term segregation.

Staff rarely used restraint techniques. There had been no instances of prone restraint in the last six months. Staff were trained in team teach techniques which emphasised de-escalation strategies and staff described techniques they would use if patients became agitated or aggressive. Episodes of restraint were analysed as part of the incident data each month and were also reviewed by multidisciplinary teams.

We reviewed 15 care and treatment records. Risk assessments were thoroughly completed and reviewed regularly. Staff used the integrated risk management plan or the Sainsbury Centre for Mental Health clinical risk tool.

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

Requires improvement

Staff and managers had reviewed the use of blanket restrictions and rules throughout the hospital. Many of the restrictions in place at the previous inspection had changed. For example, patients on all wards were able to access kitchen areas to make drinks and snacks. There were more patients able to access garden areas or the local community with the use of electronic key fobs. Patients could use mobile phones and the use of these was individually care planned. When restrictions were in place, for example, limiting access to the kitchen, staff discussed this with patients. Patients were aware of the reasons for limitations and what would need to happen for this to change.

The hospital had policies and procedures for observations. We saw detailed individual descriptions of the reasons for observations and care plans which described how these should be undertaken.

There was a policy for searching patients but routine searches were not completed. Some patients had their bags checked when they returned from leave if there were individual risks and these were clearly care planned.

There had been one episode of intramuscular rapid tranquillisation used in the service in the six months prior to our inspection. This had been in July 2016. Use of rapid tranquillisation and as needed medication was being analysed each month.

Staff described safeguarding concerns and situations that they had encountered. All staff were aware of how to report concerns. In the last two years, 79% of staff completed safeguarding training. Safeguarding incidents were analysed with incident data each month to identify any themes or actions that could be taken in addition to multidisciplinary reviews of incidents which occurred.

The service had good medicines management practices. The medicines management policy was comprehensive and covered specific medicines, for example, clozapine guidance. It also included guidance for rapid tranquillisation and high dose antipsychotic prescribing.

We reviewed all prescription charts across four wards and found no issues. For two patients, we noted that medicines were omitted when the patient was sleeping or on leave, but these were for medicines which could have been given earlier or later and this was fed back to managers. We also reviewed controlled drugs storage and stock checks with no discrepancies found. Nurses checked daily fridge temperatures as part of a daily medicines handover.

The pharmacist outlined the storage and supply of medicines to the hospital. The pharmacist visited the hospital weekly and a technician visited each week to check stocks. Qualified nurses and managers were informed of any issues by email.

On Cavendish ward, a stock of clinical supplies was kept for the hospital. There were two boxes of alcohol swabs which were past expiry date and out of date urine drug test kits. Staff immediately removed and disposed of these. There was also no medicines disposal bin in place on Cavendish ward.

**Track record on safety**

There had been 113 incidents in the six months before inspection. There were peaks in July and December 2016 and the reasons for this had been identified. Incidents were analysed to identify themes or trends and plans made to address these. Managers were using data to monitor the use of restrictive interventions.

Managers monitored accident reports on a monthly basis. There had been 24 accidents reported in the six month period before this inspection. In September 2016 there had been nine accidents reported and steps were taken to reduce this, in particular in relation to slips, trips and falls. The following months showed a marked decline in accidents as a result of slips, trips and falls, with only one reported by December 2016.

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

All staff were aware of how to report incidents and what needed to be reported. Patients were told of incidents which affected them.

Managers investigated incidents and shared lessons learnt with staff through staff meetings and email.

Some staff reported being involved in debriefs following incidents. Staff on wards with a higher number of incidents reported regular debriefs following incidents, whilst staff on wards were there were few incidents were less sure about whether debriefs happened. Some staff gave personal examples of support they had received following incidents.

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

Requires improvement

We reviewed the ongoing investigation into a medicines error. The nurse identified the error immediately and took appropriate action. This had been reported to CQC and the local safeguarding authority. The record did not indicate that the patient had been informed or an apology offered.

**Duty of Candour**

The provider had a policy for duty of candour. This met the requirements of the regulation. There were clear steps for staff to follow. It detailed how incidents should be escalated to the board and lessons learned. We saw minutes of the Mental Health Act scrutiny committee and the board meeting where this was a standing agenda item. Staff were aware of the duty of candour and the policy.

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

(for example, treatment is effective)

Good

We reviewed 15 care and treatment records. Nurses completed comprehensive, up to date care plans. These were holistic and recovery focused. There was evidence of patient involvement, plans included patients views and were personalised and individual. It was not always possible to tell if patients had been offered copies of their care plans from the records, although patients told us they were offered these. On Oriel ward, only one record contained a care plan in an accessible format. Care plans on Oriel ward also included the use of visual prompts, but we did not see staff using visual prompts during interactions with patients on the ward.

Staff told us their caseloads as keyworkers were manageable and that they were able to see their patients regularly for one to one sessions and planning care. We saw that some nurses' caseloads were aligned with their skills and relationships with particular patients.

Health action passports were stored with medicines cards and staff updated these following GP or hospital visit. Nurses completed physical health checks on a weekly basis. Nurses described a good relationship with the local GP practice in terms of organising appointments and prescriptions.

Clinical records were paper based and stored in secure lockable cabinets. On reviewing records, there were occasions where documents had been removed from files, for example, Mental Health Act copies, but these were replaced by the Mental Health Act administrator.

On Oriel ward, staff had completed one page profile documents which were detailed and specific to the individual patient. There was also use of "all about me" booklets.

**Best practice in treatment and care**

We saw evidence during this inspection that doctors discussed medication choices with patients, and that best practice was followed in terms of offering clozapine when treatment with conventional antipsychotic medication had not been fully effective in treating symptoms. We also saw that where a treatment was clinically indicated and the patient expressed a preference for this, medical staff and managers ensured this would happen.

The hospital had a full time clinical psychologist and two recently recruited assistant psychologists. They were working to ensure that psychology provision was available to all patients.

The hospital had a good working relationship with the local GP practice and medical staff liaised with them regularly about the physical health care needs of patients. Physical health information was stored on the GP system but every patient file had summaries of interventions and consultations printed out by the practice. There were also copies of blood results and electrocardiograph traces available.

Staff completed physical health care plans when needed and these were of good quality. Physical observation checks were undertaken each week. Staff completed a health passport for each patient outlining their medical history and any current problems. A physical health committee had been formed and reviewed physical healthcare across the hospital. This had recently included ensuring that each ward had height charts and weighing scales and a body mass index calculation scale displayed in the clinics.

The hospital had arrangements to ensure regular podiatry care, dental appointments and eye tests at local opticians. A speech and language therapist would visit when required.

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

Requires improvement

The hospital staff and managers had worked to reduce restrictive interventions throughout the hospital, in keeping with Department of Health guidance. This was evident in terms of patients having key fobs to enter and leave the building on unescorted leave, patients having access to the kitchens on the ward to make drinks and snacks when they chose to and a revised policy for searching which was only when risks were identified for specific individuals.

The hospital had a clinical audit cycle with regular audits of Mental Health Act compliance, a consent to treatment audit undertaken, pharmacy and clinic room audits and clinical care file audits.

The hospital was a training placement for student nurses although there were no students on placement at the time of this inspection.

**Skilled staff to deliver care**

The hospital had a good range of workers who provided input to patients. Nursing staff were mental health or learning disability trained. A full time occupational therapist worked alongside three occupational therapy assistants. A full time psychologist worked at the hospital and there had recently been two assistant psychologists recruited. A clinical pharmacist visited the hospital on a weekly basis and there was access to a pharmacist out of hours if needed.

Staff received an induction when they started work, including mandatory training and a period of time where they were not included in the staffing establishment to gain confidence and experience. Support workers completed the care certificate or national vocational qualifications.

Staff told us they received regular supervision. Supervision figures from the hospital showed a rate of 84% of staff had received supervision within three months of this inspection, the figure for qualified nurses was 93%.

The overall appraisal rate for nursing staff was 64%. All qualified nurses with the exception of agency contracted staff and preceptorship nurses had received an appraisal in the last twelve months. An appraisal cycle was underway with all staff that were overdue booked for appraisals within three months of our inspection.

Regular team meetings took place, the minutes of these were placed on the intranet for staff who did not attend. Staff told us they also received updates about the service in emails.

Some staff had attended additional training in positive behavioural support, autism awareness, learning disability awareness and transgender awareness training. We also saw a 'use of a blanket restriction blended learning awareness pack' in staff files.

Some staff working on Oriel ward told us they had not received training in learning disability or autism.

**Multidisciplinary and interagency team work**

There were regular multidisciplinary meetings for all patients. These were patient centred with comprehensive discussion and planning evident in meetings we attended and minutes we reviewed. We saw use of ward round prompt sheets and patient summaries that patients could use if they attended or were used to present their views if they did not want to attend. The independent mental health advocate attended meetings when patients requested this and would help patients complete ward round forms.

Regular handovers took place between shifts; the shift pattern was a day shift and a night shift. We saw handover sheets that outlined what had been discussed. Qualified nurses handed over medicines keys with notes taken of any issues and a stock check of controlled and recordable drugs completed.

**Adherence to the MHA and the MHA Code of Practice**

The Mental Health Act administrator checked Mental Health Act paperwork when patients were admitted. The Mental Health Act administrator worked full time at the hospital. They offered support to staff in relation to appeals, renewals and consent to treatment.

Medical staff completed section 17 forms when authorising patient leave. Doctors clearly completed these with conditions of leave and leave destinations. Staff checked these and nursing staff completed a risk assessment prior to patients using leave.

When patients were absent without leave, we saw evidence that staff followed the hospital policy.

Staff undertook training in the Mental Health Act every two years. At this inspection, 81% of staff had completed this. Staff we spoke to had a good understanding of the Act and its application to their roles.

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

Requires improvement

Copies of consent to treatment paperwork were stored with medication charts. Prescribing was in line with consent to treatment. We saw regular reviews of treatment and capacity assessments completed for treatment.

In the files we reviewed, we saw evidence that patients regularly had their rights read in relation to their detention and that the extent of understanding was also recorded.

The Mental Health Act administrator stored original section papers and documentation securely. Copies of all necessary documentation were additionally stored in clinical records.

Managers hearings and tribunals took place at the hospital site, with no cancellations recently. Patients told us they received good support from staff in preparing for hearings.

There were regular audits completed of Mental Health Act consent to treatment, which showed issues found and action taken, although this did not specify when or who by.

The Mental Health Act scrutiny group oversaw issues relating to the act. There was no identified board lead or standing agenda item for the Mental Health Act at board meetings. Minutes from the meeting showed that policies had been reviewed and ratified, however there were issues with the Mental Health Act policies which had not been identified. Whilst all Mental Health Act policies had been updated to reflect the revised code of practice some still contained paragraphs which were from the previous version, for example, the Section 61 policy referenced the wrong chapters. The visitor's policy did not contain all required information about barring visits. There were several policies which had not been drafted as the code outlines, for example, a human rights and equality policy, learning disability or autism policies and a food and drink strategy.

There were no accessible Mental Health Act leaflets available on Oriel ward.

**Good practice in applying the MCA**

Staff undertook training in the Mental Capacity Act and deprivation of liberty safeguards every two years. At this inspection, 81% of staff had completed this. Staff we spoke to had a good understanding of the Act and its application to their roles.

Staff were aware of principles of the Act and gave examples of best interests decisions that they had been involved in.

Medical staff completed regular capacity assessments in regard to consent to treatment. Copies of these were stored in patient files and with medicine cards.

There were forms in patient files on Oriel ward regarding access to information. Although patients signed these, it was unclear whether patients' capacity to understand this had been assessed appropriately.

**Equality and human rights**

We looked at staff training records. Most staff had completed equality and diversity training with 83% of staff having completed this in the last two years. Equality and diversity training was part of the mandatory training programme. We also saw that some staff had completed additional training in transgender awareness.

The organisation as a whole completed an annual equality report. The most recent was published in June 2016. This reviewed the legal and governance arrangements in relation to equality, diversity and human rights. Employees updated their personal details to allow their employer to compile data relating to protected characteristics and check human resources procedures and training were being completed equitably. An action plan had been devised from the report which aimed to ensure the service was compliant with the national health service equality delivery system (as a service commissioned largely via the national health service) and the national health service workforce race equality standards.

The service had some blanket restrictions that related to risk items, for example, lighters and sharp objects. During the last year some blanket restrictions were removed, for example, relating to aerosols and perfumes, and decisions were now made on an individual basis.

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

Good

**Kindness, dignity, respect and support**

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

Requires improvement

During this inspection, we saw respectful interactions between staff and patients on all wards visited. We saw that staff knew patients well and were able to assist in individualised ways when patients were distressed or agitated.

On Oriel ward, we used the short observational framework for inspection tool to observe interactions. Inspectors use the tool to capture the experiences of people who use services who may not be able to express this for themselves. This recorded five positive interactions between staff and patients over a half hour observation period, with one poor interaction noted where staff had spoken over the patient between themselves.

We interviewed twenty patients during this inspection, and they gave positive feedback about staff in terms of being available when needed and being respectful and polite. Several patients referred to the positive support they received from staff when they were anxious or upset. Several patients shared their experiences of the progress they had made and particular staff who had been key to this.

Patients also gave positive feedback about administrative staff describing them as friendly and helpful. The domestic staff were also noted to be friendly and positive and all patients reported that ward areas were clean. There was also positive feedback about members of the multidisciplinary team.

Some patients on male wards felt there was an uneven gender mix of staff (towards all male staffing at times) and would prefer a more balanced mix of male and female staff.

Staff clearly knew patients well and developed individualised plans with patients to support them.

Most patients reported that they found the managers approachable and knew who they were and how to contact them. We were told of one example where a patient had asked to speak to the hospital manager and they were able to go off site to a local café to talk.

**The involvement of people in the care they receive**

We spoke with 20 patients individually as part of this inspection. Patient told us that they received information at admission. Some patients received written and verbal information and had found this helpful. We saw a patients guide, given at admission, which was colourful, had photos and pictures to explain, and gave information about the hospital location, food, activities, wards, staff, care planning, advocacy and complaints.

Most patients interviewed were positive about their involvement in care planning. We also saw evidence that families and carers had been involved in some care plans. Patients told us they had regular one to one sessions and knew who their keyworker was. Several patients had clear discharge plans in place and others told us they were aware of future plans and likely discharge plans.

Patients attended multidisciplinary meetings regularly and the advocate would attend if requested. Patients could complete summary sheets prior to the meeting to ensure that the meeting addressed issues or requests that they had. Families and carers could also attend meetings and were encouraged to do so.

Community meetings took place on all wards on a daily basis, these were either in the mornings or evenings, depending on patient preference. Staff and patients used these to plan the day or the evening meetings were used to review the day for patients and plan evening activities.

We spoke to carers who gave positive feedback about the hospital. Arrangements to visit worked well. Carers told us they felt welcomed and encouraged to visit and attended meetings and reviews. Carers shared with us experiences where they felt staff had provided individualised, well planned care to deal with transitions and stressful events. Their descriptions of planning and staff's knowledge of their patients were highly individual and patient centred. They felt staff got to know their relatives well, knew their interests and needs well and formed good relationships with them.

All carers told us they knew how to complain if necessary and some also referred to the advocate as someone they could raise concerns with if needed. Carers told us they had good communication from staff at the hospital.

Carers told us that transition planning for patients transferring to Oriel ward had been planned in detail, including highly individualised approaches to patient's needs and preferences. Staff who had been involved throughout visits to the hospital and then, when patients moved, they had moved with them and now worked on Oriel ward.

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

Requires improvement

We spoke to patients who had regular home leave or leave with families, which they reported went well. Staff told us that they would ensure staff were available to facilitate leave. Carer told us that staff familiar with the patient would escort on home leaves and this was helpful in ensuring leave was successful.

Patients were positive about their physical health care, including regular physical health checks on the ward and accessing the GP service.

All patients were positive about the advocacy service and knew how to contact the advocate. We saw posters displayed on wards and saw an easy read leaflet explaining the role of advocacy was available for patients.

Several patients on Cavendish ward felt the ward environment was too noisy.

Patients told us leave was never cancelled because of staffing difficulties.

Patients completed a survey in November/December 2016, 18 patients participated, giving a response rate of 64%. There were positive responses for the admission process, including whether patients had felt welcomed when they had been admitted.

Responses to questions about the ward and hospital, around environment, privacy and dignity and feeling safe were all responded to positively by most patients, with two to three negative responses but there were a number of patients who endorsed a prefer not to say option. Similarly with questions about the multidisciplinary team patients responses were positive but with a number of patients endorsing the prefer not to say option.

Half the patients who responded said they knew their section rights, with 22% saying no and a further 28% endorsing the prefer not to say option. All patients were aware of the advocacy service.

In terms of ward rounds, 44% of patients felt these were effective, with 16% disagreeing and the remainder endorsing the prefer not to say option.

Nearly two thirds of patients felt involved in their care and treatment, with only one indicating that they did not feel involved.

Half the patients surveyed indicated they were listened to regarding discharge and actively involved in discharge planning. Again, a third of respondents did not wish to answer with the remainder responding negatively. Nearly two thirds of patients knew their discharge pathway.

Additional comments to the survey had been individually responded to by the hospital managers and actioned in terms of ward environments, access to community workers, patient mix, noise levels, safety and dignity concerns.

Patients and managers attended a monthly patient forum. Discussions and actions from the patient's forum formed part of the monthly clinical governance meeting. Patients from Linden ward were involved in planning the redecoration of the ward and repurposing of the de-escalation room on the ward.

Patients told us they had also requested to be service user representatives for some of the organisation committees.

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

Good

**Access and discharge**

Managers had devised an admission standard operating procedure. This outlined the pre-admission assessment and discussions, operation of a multidisciplinary panel to discuss referrals, and admission arrangements. We looked at the documentation for two recent admissions to the service. Pre-admission assessments and risk assessments had been completed. Staff reviewed care programme approach documents and clinical summaries prior to admission and these were stored in the clinical files. Medical staff completed a mental health and physical assessment at admission.

Admissions to the service were planned in advance. We saw transitional planning in place for a patient who was visiting on overnight leave leading up to admission.

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

Requires improvement

As part of the admission protocol, we saw that extensive pre-referral information, including risk assessments and clinical summaries, was gathered for patients to enable planning for admission.

The average length of stay for patients was three years. The service had reviewed all current patients recently with the commissioning manager regarding discharge pathways and plans. They maintained links with the local commissioners and case managers. There were several patients highlighted as being "delayed discharges" from the service and this was due to difficulties identifying suitable discharge placements.

Female patients often moved from Cavendish ward to Montrose ward as they made progress towards discharge. For male patients, the two wards did not form a similar pathway. Ward moves and discharges were planned, including transitional plans, for example, visits on leave.

Discharge pathways were discussed as part of care programme approach review meetings and with commissioners and care managers. We saw discharge planning evident in patient files, including care programme approach meetings and care plans.

Oriel ward had opened in 2016 and admitted patients from another hospital, which was closing. Patients were admitted with space between admissions to allow them to settle and with transitional visits beforehand. The order in which patients were admitted was planned to minimise any difficulties between patients. Staff from the hospital moved over in a gradual planned way as patients moved so that patients were nursed by familiar staff. Carers told us this transitional planning had worked well, with thought and planning for each individual's needs.

As part of this transitional work, a pathway had been devised for a twelve week period outlining responsibilities and actions for staff. This had proved successful and managers were developing this to use across the service for patients newly admitted to the hospital.

There had been four patients who moved to Oriel ward who had since been discharged with appropriate support packages in place. Care and treatment reviews had been arranged for all patients transferred and there was good liaison with commissioners and care managers evident.

**The facilities promote recovery, comfort, dignity and confidentiality**

The hospital had rooms available within the communal areas of the building for sessions, including an occupational therapy kitchen. Rooms within the main hospital building, off the wards, would also be booked for family and friend visits.

On Cavendish and Linden wards, there had been a room previously identified as a de-escalation room. On Cavendish ward, this had been converted to a quiet lounge, with relaxing seating, music and paintings on the wall. There were plans for this to be carried out on Linden ward with patients leading on the décor and furnishings needed. This would be beneficial as the ward layouts had limited quiet areas, with the main lounge and dining rooms used mainly for ward activities.

Patients on all wards were able to access their bedrooms throughout the day. On Oriel ward, we noted one patient's bedroom was locked and it was unclear why this was. This was unlocked for the patient to access when they requested this.

Portable phones were available on all wards to enable patients to make or take private phone calls. On all wards, patients were able to have their own mobile phones, with use of these limited only if clinically indicated.

In terms of outside space, there were secure garden areas for wards to use. Some patients had key fobs allowing them to access the gardens when they wished, patients without this level of leave were able to access the garden at regular intervals throughout the day.

Food was prepared on site by the chef. There had been regular meetings with patients to discuss menu choices. All wards had kitchens that patients could use to prepare food. Three patients referred to limited menu choice when interviewed.

Patients on all wards were able to access kitchen areas to make drinks and snacks. Patients had their own cupboards in the kitchen to store food. On Linden ward, access to the kitchen was by key and most patients had their own key. Access would only be limited on an individual basis if there were safety or risk concerns.

Patients were able to personalise bedrooms with their own possessions and belongings. There were also lockable drawers available to store items in each room.

In terms of activities available, occupational therapy staff offered individual and group sessions. These included

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

Requires improvement

creative sessions, current affairs groups, exercise groups, music appreciation, relaxation, healthy cooking sessions and social activities such as bingo and coffee mornings. Occupational therapy and nursing staff facilitated patients attending a monthly community disco in the evenings including arranging use of the minibus and a driver. There were also themed events, for example, a Halloween party.

Ward based activities were more ad-hoc and occurred in the evenings and weekends in the main, for example table tennis or film nights.

There was internet access available to patients with a computer located in one of the activity rooms.

Many patients had community leave to visit local areas and made good use of this. Staff told us they would try to incorporate health promotion into activities and leave, for example, walking rather than using public transport or taxi's for local leave. Occupational therapy staff planned a walking group for each ward once per week.

Occupational therapy staff had a good knowledge of local community resources including vocational projects and local colleges. Several patients were attending community projects and work placements.

A full time clinical psychologist and two assistant psychologists worked at the hospital at the time of our inspection. Their focus was on up to date patient formulations and risk assessment/management and individual work.

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

The hospital had been adapted to allow disabled access, with a ramp leading up to the front door. Patients and staff had access to a lift to all floors.

At the time of this inspection, no interpreter services were needed, but services could be sought if needed.

We saw information displayed within wards about the advocacy service and how to give feedback and make complaints.

On Oriel ward there was a lack of pictures or information displayed. There was a lack of easy read information, although this was in place in other ward areas. Additionally, there were no easy read leaflets available on the ward relating to patients' rights under the Mental Health Act or treatments.

The chef would discuss dietary requirements and provide specific menus, for example, for religious reasons.

There were no visiting religious professionals. Staff assisted patients to find local religious services if needed and leave could be arranged for patients to attend services if they wished.

One carer commented positively that the hospital blended in well with the surrounding area and that they felt this may be beneficial in terms of reducing potential stigma towards patients.

**Listening to and learning from concerns and complaints**

All patients that we spoke to were aware of how to complain. Managers discussed complaints and compliments at the local governance meeting. Compliments were fed back to individuals or teams.

Suggestion boxes were in place on wards and we were told these were emptied regularly and any suggestions reviewed by managers.

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

Requires improvement

**Vision and values**

As part of the statement of purpose, the hospital identified "the aim for Jigsaw Independent Hospital is to provide therapeutic treatment for adult men and women with enduring mental illness and/or learning disability with complex needs to the point that meets their recovery plan. We also aim to provide this treatment within a person-centred approach, which responds to changes in our patient's needs. We aim to do our best for the patients we support by enabling them to live a fulfilling life and to be in control as much as possible."

We spoke to staff who shared these aims. Staff spoke of wanting to provide good, person centred care and to work with patients to enable them to move on from hospital.

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

Requires improvement

Staff knew who the managers in the organisation were and told us that managers were approachable and regularly visited the wards.

**Good governance**

Senior managers established a new governance structure in the hospital during 2016. This had involved the creation of several new committees, which reported in to the hospital governance meetings, which in turn reported to the board. These included a medicines management committee, a physical healthcare committee, a Mental Health Act scrutiny group, catering and hospitality meetings, clinical audit group, human resources effectiveness and recruitment and an infection prevention committee.

In terms of the findings of this inspection, this structure was in place but still being established and there were some issues noted in terms of oversight and scrutiny, for example, in relation to supervision/appraisal figures where these were not up to date at inspection. Staff told us they had completed additional training, for example, some staff had completed autism awareness training, but records were not available for this. There were issues with mandatory training in terms of immediate life support training levels. Despite this being on the risk register, there was no system to ensure that there was at least one immediate life support trained nurse on duty at all times. There was a lack of oversight and scrutiny of policies in terms of missing policies, updated policies and the ratification of these.

We saw in the monthly clinical governance meeting minutes that information was discussed from committees alongside incident data, bed occupancy and workforce data. Information was also received and reviewed from the independent mental health advocate and the patient forum. Audit data was fed into the meetings, including infection control audits, CPA audits and health and safety audits. When audits identified areas for improvement, we saw actions taken however action plans did not identify who was responsible and the timeline which meant that it was difficult to have effective monitoring of action plans. We also saw examples where similar errors recurred, for example on the Mental Health Act audit, because no action plan had been developed or shared but instead a one off action to rectify the issue had been taken. This meant the opportunity for sustained improvement had been missed.

A team meeting at 9am each morning had been introduced to ensure all staff were aware of any incidents or relevant information for that day.

New software for incident management and analysis had been in use since June 2016. This worked well and could be used to analyse data and generate reports which could be scrutinised for themes or actions to be taken. Managers were using this to analyse incident data, as needed medication usage and safeguarding trends.

We reviewed personnel files and found these to be in good order. Supervision records were detailed. All relevant checks had been completed for employment.

**Leadership, morale and staff engagement**

Managers monitored sickness and absence rates. There had been no recent bullying or harassment cases. Staff knew whistle blowing processes and all felt they could raise concerns.

Staff had completed a survey at the end of the year. The survey was written using the five Care Quality Commission domains. For questions about the service being well led, there were five or six respondents who did not respond for the majority of questions. There were positive responses regarding effective leadership and management, induction, vision and values and training. The highest responses were for questions relating to whether the service encouraged positive behaviours (openness, honesty and respect), patient feedback and safeguarding knowledge, with all staff agreeing with these.

Hospital managers noted that they planned to increase the level of engagement between staff and management including attending some of the governance forums and introducing reflective practice meetings. There were also plans for rolling out freedom to speak out sessions in 2017 and managers and staff were devising a staff welfare policy.

Staff interviewed felt morale was generally good and described good working relationships with their teams. Some staff had worked at the hospital for long periods and described the level of support from colleagues and managers as one reason they have stayed, they also described enjoying working at the hospital and seeing patients' progress. Staff told us they felt able to suggest changes and that they were listened to.

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

Requires improvement

Some staff reported that the hospital rota had improved recently with less staff moves, which improved consistency for patients and staff.

Staff said managers visited the wards regularly and that this felt supportive.

Qualified nurses told us they could raise concerns and speak openly with hospital managers. Support workers felt less confident in raising concerns at that level but did say they would raise issues with their nurse in charge or in supervision.

Staff told us about additional roles they had been able to take on as representatives at hospital committees for example.

Staff had been offered the seasonal flu vaccine and uptake was monitored.

**Commitment to quality improvement and innovation**

The service was completing self-reviews towards accreditation for inpatient mental health services (AIMS) accreditation in future.

# Outstanding practice and areas for improvement

## Outstanding practice

Start here...

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that ward ligature audits are comprehensive and up to date.
- The provider must ensure that there is a system in place to ensure that there are sufficient staff with immediate life support training available on each shift.
- The provider must ensure that there is a system in place to monitor clinical stocks and ensure expiry dates are noted.
- The provider must ensure that Mental Health Act policies are reviewed where needed and that policies are in keeping with the Code of Practice
- The provider must review the systems for recording key data, including supervision, appraisal and training.
- The provider must ensure sufficient oversight in terms of audits so that identified improvements are made and sustained for example, ligature audits.

### Action the provider SHOULD take to improve

- The provider should ensure that all staff receive an appraisal
- The provider should review the gender mix of staff on wards.
- The provider should review noise levels on Cavendish ward.
- The provider should ensure that accessible format information is available (care plans, leaflets, posters, treatment information) particularly on Oriel ward.

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<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>There was a lack of sufficient oversight in terms of ligature audits and clinical stocks.<br><br>There was a system for capturing key data, including supervision, appraisal and training but this was not up to date at this inspection and training which had been undertaken was not being captured.<br><br>Mental Health Act policies had not been updated to reflect the current Code of Practice.<br><br>Practice had not been reviewed in line with the new Code of Practice.<br><br>Oriel ward did not have accessible information in place.<br><br>This was a breach of regulation 17(2)(b)(c) |

This section is primarily information for the provider

# Enforcement actions

## 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.