

Pelham Woods

Quality Report

Harrowlands Park
South Terrace
Dorking, Surrey
RH4 2AD

Tel: 01306 644100

Website: www.partnershipsincare.co.uk

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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

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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 Pelham Woods as good because:

- Wards were clean and comfortable. Environmental risk audits had identified risks and action taken to alleviate these. Patients were safe because there was adequate staff. All staff had completed the required mandatory training.
- Patients we spoke with told us staff were respectful and polite. They felt staff were caring and interested in their well-being. Staff interacted with patients positively and in a kind and caring way.
- There was a clear admission process. On admission each patient had a physical health assessment and records showed patients continued to have physical health checks. All patients had documented risk assessments and risk management plans. Patients had access to psychological therapies and national institute for health and care excellence (NICE) guidance was evident in care planning. Each patient had a personal timetable of activities. Records we reviewed showed staff assessed patients' needs and delivered care based on their individual care plans. On admission each patient had a physical health assessment and records showed patients continued to have physical health checks.
- The hospital kept detailed recordings of incidents when patients needed to be restrained and the governance group monitored the trends and action plans. The safeguarding and incident reporting processes included monitoring trends and fed back lessons learnt to staff.
- Patients told us they had access to good advocacy services. The hospital involved patients in developing and improving services through patient representatives who told us the hospital listened to them and responded to requests. Staff listened to patients' preferences and patients could personalise

their bedrooms. Patients had access to mobile telephone provided they had no internet access or cameras, could make hot drinks and snacks throughout the day dependent on risk assessment, and had access to a garden.

- All staff said they experienced good leadership at ward and organisational level. All staff had received regular support and managers made themselves available to staff. Staff we spoke with said senior managers were visible in the hospital and told us morale was good.
- We saw a clear structure of clinical governance at Pelham Woods through to a regional and national level. We saw good examples of a commitment to improve the quality of service provided. For example there had been a recent change in policy and procedure regarding patient monies following a review to ensure that patient money was recorded and kept appropriately.

However:

- Patients complained about restrictive practices, such as the difficulties in leaving the building as an airlock prevented informal patients from leaving the building easily. Patients could not have mobile telephones with internet access or cameras on the ward and patients had restricted access to the internet. There were rooms that patients could not freely access such as the toilets in the main area. There was no free access to outside space. These restrictive practices were not in response to current recorded patient risk. There was no record that the impact of the blanket restrictions on each patient had been considered and documented in the patient's records in accordance with the Mental Health Act Code of Practice.
- The unit had ligature risk assessments completed in December 2015 which identified ligature risks but did not include specific actions to mitigate all risks.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
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Long stay/ rehabilitation mental health wards for working-age adults	Good	
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Summary of findings

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Good 

Pelham Woods

Services we looked at

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

Summary of this inspection

Background to Pelham Woods

Pelham Woods Hospital is an independent hospital owned by Partnerships in Care, an independent organisation that has a number of specialist hospitals spread across the UK. Partnerships in Care provide care and rehabilitation through recovery and treatment centres for people with learning disabilities, physical disabilities, mental health problems, substance misuse issues, complex care, autism, dementia and young people in transition.

Pelham Woods opened nine years ago. It provides care and treatment for women who have complex mental health problems and a history of challenging behaviour. The service treats patients with a diagnosis of personality disorder, mental illness or mild learning disability, substance misuse problems, a history of trauma or offending behaviour or a combination of these difficulties. Some patients are detained under the Mental Health Act 1983.

The hospital has two wards. Elyn Saks ward has 18 beds, each with an en suite shower and toilet. Rosa Parks ward is a three bedroom step-down flat with kitchen, bathroom and toilet.

The hospital is located in a residential area of Dorking, Surrey.

Pelham Woods Hospital has been registered with the CQC since 29 December 2010.

There have been four CQC inspections carried out at Pelham Woods Hospital. The most

recent inspection took place on 5 August 2013. At our last inspection, Pelham Woods Hospital was fully compliant with the Health and Social Care Act 2008 Regulations.

Pelham Woods is registered to carry out the following regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures; and treatment or disease, disorder or injury. A registered manager was in place at the time of our inspection.

Our inspection team

Team leader: Meryll Paterson

The team that inspected the service comprised two CQC inspectors, a nurse specialist advisor and an occupational therapist specialist advisor.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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 and asked a range of other organisations for information.

Summary of this inspection

During the inspection visit, the inspection team:

- visited two wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with six patients who were using the service;
- spoke with the operations director (South) and hospital director;
- spoke with 20 other staff members; including a doctor, nurses, occupational therapist, psychologist and social worker;
- received feedback about the service from one commissioner;
- spoke with an independent advocate and advocacy manager;
- attended and observed one hand-over meeting and one multi-disciplinary meeting;
- collected feedback from one patient and two carers using comment cards;
- looked at six care and treatment records of patients;
- carried out a specific check of the medication management at the unit; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us that they and their possessions were safe as they had their own bedroom key. They liked the support of the 'buddy' system for new admissions. That the food was good with choice to meet dietary requirements.

Patients felt listened to and said staff were friendly, caring and supportive. Staff knocked on their bedroom doors before entering and were interested in patients.

Patients understood their detention, rights and how to apply for a tribunal. Patients knew how to complain and had support from advocates.

However:

Patients complained about restrictive practices, such as the difficulties in leaving the building and the ban on using mobile telephones with internet access or cameras. Toilets in the main area were locked, as was the ward garden. They were concerned about the level of cleanliness of the ward and the mould and dirt in the en-suite shower rooms.

Patients said they usually had little to do and that more activities had been planned due to the comprehensive inspection. Two patients said there was a lack of dignity and respect shown to them by some staff and that confidential discussions were held in communal areas. The same two patients also said that they felt their concerns were not taken seriously when bullying or exploitation allegations were made and that no support was forthcoming.

Comment cards showed concerns relating to the cleanliness of the environment. Families and carers told us that they could only have weekly contact with staff and that staff were defensive and dismissed legitimate concerns from carers. They also said that patients were not given one to one time regularly and that there was a lack of fresh air for some patients due to staff availability.

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?

We rated safe as requires improvement because:

- We found restrictive practices on the unit in relation to patient access to the internet, mobile telephones and that rooms were locked, such as bathrooms in the main area. There was no free access to outside space. An airlock prevented informal patients from leaving the building easily. There was no record that the impact of the blanket restrictions on each patient had been considered and documented in the patient's records in accordance with the Mental Health Act Code of Practice.
- One patient ensuite bathroom ceiling had extensive black mould. Efforts had been made to rectify the problem but further work was required. There had been no assessment as to the impact on patient health and safety due to this mould.
- There was only one mirror to mitigate an area with blind spots and not on other corridor areas.
- The unit had ligature risk assessments completed in December 2015 which identified ligature risks but did not include any specific actions to mitigate risks.

However:

- The ward appeared clean, comfortable and had good furnishings and was well maintained apart from some mould in one en-suite bathroom.
- Environmental risks audits had identified risks and some action taken to mitigate these.
- Staff implemented a range of measures to manage violence and aggression.
- Patients were safe because there were adequate staff.
- All patients had risk assessments and risk management plans.
- Weekly reviews of risk management plans took place.
- There were detailed recordings of incidents when patients required restraint. The hospital governance group monitored the trends and action plans.
- There were safeguarding and incident reporting processes in place that included monitoring of trends and feeding back lessons learnt to staff.
- All staff were up to date with mandatory training.

Requires improvement



Are services effective?

We rated effective as good because:

Good



Summary of this inspection

- Records reviewed showed the assessment of patients' needs and care was delivered in line with their individual care plans.
- Each patient had an assessment of physical health needs on admission and there was evidence of on-going physical health checks.
- A nationally recognised recovery tool assisted in monitoring recovery outcomes.
- Patients told us they felt involved in decisions about their care.
- Patients had access to psychological therapies and national institute for health and care excellence (NICE) guidance informed care planning.

Are services caring?

We rated caring as good because:

- Patients told us that staff were respectful and polite, and felt staff were caring and interested in their wellbeing.
- We observed staff interacting positively with patients in a kind and caring way.
- Patients we spoke with told us they had been orientated to the ward and given information about what to expect on admission.
- Patients told us they had access to good advocacy services.
- The organisation involved patients in developing and improving services through patient representatives who told us the organisation listened to them and responded to requests.
-

However:

- Two patients told us that there was a lack of dignity and respect shown to them by some staff, that confidential discussions were held in communal areas and that concerns were not taken seriously when bullying or exploitation allegations were made and that no support was forthcoming. However, we found no evidence of this.

Good



Are services responsive?

We rated responsive as good because:

- There was a clear admission process. Prior to admission, a pre-admission assessment was undertaken which included a pre-admission needs formulation.
- Staff listened to patients' preferences and patients could personalise their bedrooms.

Good



Summary of this inspection

- Patients had access to a basic mobile telephone, could make hot drinks throughout the day if they had the required risk assessment and snacks if staff agreed. Patients also had access to a garden which staff opened if requested.
- Each patient had a personal timetable of activities.
- We saw notice boards contained up to date information including the Mental Health Act and advocacy services.
- Patients were aware of how to make a complaint.

Are services well-led?

We rated well-led as good because:

- Staff said they experienced good leadership at ward and at organisational level.
- The service was responsive to feedback from patients, staff and external agencies.
- There was clear learning from incidents.
- The service had been proactive in capturing and responding to patients' concerns and complaints. There were creative attempts to involve patients in all aspects of the service.
- Staff received regular support and good access to their manager. Staff spoke about the high visibility of senior managers and told us morale was good.
- We saw a clear structure of clinical governance at Pelham Woods through to a regional and at national level.
- We saw examples of a commitment to improve the quality of service provided such as the improvements in the patient money handling policy and procedures.

However:

- The whistleblowing policy for staff discouraged anonymous disclosures.

Good



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.

All staff were trained in the Mental Health Act (MHA) and its Code of Practice and had a good understanding of the principles. Consent to treat forms were attached to medicine charts where applicable. Patients had their rights explained to them on admission and routinely thereafter.

There was administrative and legal advice on the administration of the MHA and the Code of Practice available from a central team based at The Dene hospital. Detention paperwork was available and appeared correct. It was evident that regular audits to ensure MHA documentation and compliance were undertaken.






The service did not have clear justifications recorded for each individual patient for the blanket restrictions across the service. This is contrary to chapter one of the MHA Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff were trained in the use of the Mental Capacity Act (MCA) and were aware of the need for capacity assessments to be made dependent on the decision to be made. The unit had no patients who required deprivation of liberty applications.

Long stay/rehabilitation mental health wards for working age adults

Good 

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

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

Requires improvement 

Safe and clean environment

- Entry to the ward was via a secured “air lock” entry system. The reception area displayed a list of high risk items for visitors and patients. There was a signing in system for staff to obtain keys to the ward and alarms before entering and leaving. All visitors and patients were required to sign in and out of the premises for fire safety regulations. However, this made it more difficult for informal patients to leave the ward. Signs were present at the front door to let informal patients know of their right to leave the building.
- Staff were aware of relational security (this was the knowledge, and understanding, staff have of a patient and of the environment, and the translation of that information into appropriate responses and care).
- The ward layout allowed staff to observe some parts of the wards. However, there was only one mirror to mitigate corridor area blind spots and none on other corridor areas.
- Staff were allocated observations to carry out. On the day of our visit, patients were on general observation levels.
- The unit was an all-female ward. All rooms had en-suite facilities
- The unit had ligature risk assessments completed in December 2015 which identified ligature risks but did not include actions to mitigate every identified risk.

There were ligature risks in the patients’ bedrooms and en-suite bathrooms that were assessed but did not have specific mitigation measures recorded for each ligature point or risk.

- Ligature cutters were stored in the clinic room to use in an emergency. These were easily accessible. The clinic room was clean and tidy.
- We looked at the resuscitation equipment and emergency drugs. Ward staff recorded they had checked equipment and emergency drugs. Calibration checks had occurred on the equipment. However, one blood pressure machine was not working and had not been removed after it had failed calibration checks in February.
- Clinic room audits were completed and the emergency resuscitation equipment was checked regularly. Records showed completion of daily and weekly checks such as: the clinic room, fridge temperature, infection control, environment, medicines management and controlled drugs prescriptions.
- A maintenance audit was carried out regularly of the grounds.
- There were protocols for managing the environment. Records confirmed that environmental risk assessments had been completed and reviewed.
- All staff carried alarms. The inspection team received alarms when we visited patient areas and these were in good working order.
- There were nurse call alarms in bedrooms and bathrooms to summon assistance.
- The ward appeared clean, had good furnishings and was well maintained apart from some mould in the en-suite bathrooms. We were told that repairs were being made to the en-suite bathrooms.

Long stay/rehabilitation mental health wards for working age adults

Good 

- Patients had access to their own bedrooms dependent on individual risk assessments.
- Cleaning records were up to date and demonstrate that the environment was cleaned regularly.
- Infection control audits were not undertaken by the named person responsible for infection control which was the ward manager but by bank health care workers or housekeeping assistants. We were told that the unit had an infection control champion who was a registered nurse supported by the ward manager.
- Staff adhered to infection control principles including handwashing.

Safe staffing

- The unit had one consultant who worked at the unit four days per week. There were no junior doctors. Medical cover was provided by an on call consultant rota including consultants from The Dene Hospital which was 28 miles away. The on call doctor was available by telephone for advice.
- The unit was able to maintain safe nurse staffing, despite the hospital's recruitment challenges. Staffing issues were on the risk register and there was a clear action plan to address this.
- The provider had estimated the number and grade of nurses required and the number of nurses matched this number on all shifts. There was appropriate use of agency and bank nurses who were familiar with the ward. On the day of our visit there were two registered mental health nurses (RMNs) and three health care workers (HCAs) on duty. The night shift comprised two RMNs and two HCAs. Staff and rotas confirmed the ward worked on this core establishment during the day and registered nurse and two health care workers at night. Staff worked 12.5 hour shifts that provided continuity of care.
- Bank and agency staff covered 70 shifts over the period between 5 March 2016 to 17 April 2016 due to staff vacancies and sickness.
- There were enough staff to carry out physical interventions and provide one to one time for patients to talk. Patients we spoke with told us they had not had leave cancelled.
- All staff were up to date with mandatory training.
- Social workers made assessments before children visited the unit to determine their best interests.

- The training room was used for family visits. It was equipped for child visits.

Assessing and managing risk to patients and staff

- The ward dashboards and patient records showed that all patients had risk assessments and care plans in place. These involved completing the Short Term Risk Assessment and Treatability tool (START), and the Historical, Clinical Risk assessment tool (HCR20), a tool predicting a patient's probability of violence. Risks or physical health needs were documented in the care notes and shared with team members.
- Updates of the START assessment occurred every three months and following patient incidents.
- The use of a traffic light system helped patients and staff rate the level of risk and plan what patients could do, for example, if leave could be taken. The consultant psychiatrist told us positive risk taking was very much part of the treatment approach and undertaken by the multidisciplinary team with maximum patient involvement.
- All patients we spoke with said they felt safe and their possessions were safe.
- Staff agreed a patients' property allowance in collaboration with patients. Each person's allowance was dependent upon her risk level. Patients would progress from admission to amber then to green.
- Partnerships in Care policies were available on the intranet, this included management of violence and aggression. Staff discussed policies in team meetings and supervision. The observation policy had a dedicated electronic training module.
- Patients raised concerns about the justification for some blanket restrictions used at the unit. These included locked toilets in the main area of the ward, computers behind safety screens in the internet café, the high risk items list of controlled items on the unit and the restrictions on internet and telephone usage. The internet access policy for the internet café was very restrictive giving patients no access to facebook, emails or to look up phone numbers or addresses. Staff searched patients following return from leave and random room searches were undertaken. This was in accordance with policies, and commissioning contracts. Staff obtained consent prior to searches.
- Safeguarding training was mandatory for staff. Figures provided by Partnerships in Care for all wards at Pelham Woods showed 100% of staff had completed the

Long stay/rehabilitation mental health wards for working age adults

Good 

training. Staff could describe different forms of abuse. The social worker took the lead in safeguarding but nursing staff could raise alerts out of hours. Health care workers reported any concerns to a staff nurse or more senior person if necessary and the qualified nurse completed the safeguarding referral form and this was sent to the social worker.

- We reviewed the arrangements for medicines management. The hospital kept controlled medicines in locked cupboards and two qualified nurses checked and dispensed these drugs. There were no controlled drugs currently prescribed on the unit. All emergency medicines were present and in date. The hospital director told us the pharmacist monitored the stock of medicines.
- Staff were trained in the National Early Warning (NEWS) a scoring system for physical health assessment.
- All staff undertook basic life support training.
- There were 68 uses of restraint between the 1 October 2015 and 27 April 2016, one of which was a prone restraint. Restraint was used following failed attempts at de-escalation. The use of rapid tranquilisation followed NICE guidelines.

Track Record on Safety

- There were no reported serious incidents between April 2015 and April 2016.

Reporting incidents and learning from when things go wrong

- Staff we spoke to were able to explain the process for reporting incidents and what to record. Health care workers told us they would report incidents to the nurse in charge. Staff completed an incident form on the electronic system and information was referenced into the patient's notes. We saw evidence of incidents categorised as physical and verbal abuse or aggression from the 1 October 2015 to 27 April 2016. Staff knew how to report incidents of verbal or physical abuse or aggression from patients.
- Learning from incidents took place during clinical governance/operations meetings, shift handover, supervision, and reflective practice meetings and by email.
- We saw minutes of Pelham Woods clinical governance and operations meetings and noted a review of incidents and lessons learnt was a standard agenda item.

- Most staff we spoke with could give examples of learning from incidents and changes in practice made because of this learning. For example there had been a recent change in policy and procedure regarding patient monies following a review to ensure that patient money was recorded and kept appropriately.
- Staff reported they had de-briefing sessions following incidents, recorded as supervision. Support from psychology, the ward manager and advice from the consultant psychiatrist and access to a help line was available.
- Patients received de-briefing following an incident and staff recorded this in the patient's care notes.

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

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- The assessment of patients' needs and planning of their care began prior to admission. The pre-assessment report contained the initial needs formulation (a plan of treatment). When the initial care plan was agreed, the formulation was included in the plan.
- The initial assessments were followed up with detailed assessments of patients' needs and care. We looked at six patients' case notes which identified individual care plans, clear goals and interventions.
- Patients had their pre-admission needs formulation reviewed with them during individual case reviews and care programme approach (CPA) meetings.
- Records showed there was an assessment of physical health needs on patient admission and ongoing physical health checks. The ward used the national early warning system (NEWS); it is a scoring system for physical health assessment. There was a flow chart in the clinic room showing the process to follow. A physical health nurse attends the unit weekly.
- Patients told us they had appointments with the dentist, opticians, and regular blood pressure and weight checks.

Long stay/rehabilitation mental health wards for working age adults

Good 

- All information needed was stored securely and available to staff via the care notes computerised system.

Best practice in treatment and care

- National Institute for Health and Care Excellence (NICE) guidance was evident in care planning and underpinned working with people with a personality disorder with least use of medicines. Prescribing followed British National Formulary (BNF) guidelines.
- Patients had access to clinical psychology and psychotherapy including dialectical behaviour therapy (DBT), coping skills group, trauma work and relapse prevention.
- Individual and group treatment sessions occurred.
- The service carried out an assessment of patients' needs for psychological therapies on admission and subsequently throughout their treatment.
- The tools used to measure patients' recovery outcomes included health of the nation outcome scales (HoNOS). HoNOS is a routine clinical outcome measure recommended by the English national service framework for mental health that covers twelve health and social domains and enables clinicians to build up a picture over time of patients' responses to interventions.
- Psychologists worked with new patients on admission to complete psychological assessments of need.
- Patients had access to occupational therapists, and technical instructors. The occupational therapy service saw patients within 72 hours of admission. The team used standardised assessments such as Recovery Star. Following a baseline assessment, an assessment occurred every three months to provide a measure of patient progress.
- There was access to physical health care via the local general practice.
- Patients could also attend coping skills and problem-solving groups, had access to real work opportunities and there was a drugs and alcohol group. The care plan was developed during a programme planning week which allowed the involvement of members of the multidisciplinary team to be involved in this process
- A full range of mental health disciplines and workers provided input to the ward. The multidisciplinary team included the ward manager, responsible clinician, lead nurse, occupational therapist, psychologist, and social worker. There were regular meetings to plan and review patient care.
- Team meetings included a daily team meeting attended by the senior team on site and staff nurses. There was a weekly individual review by the doctor plus a monthly multidisciplinary team meeting with the patient for an individual care review (ward round). Monthly meetings included all members of the team and others the patient wished to invite.
- A care programme approach (CPA) meeting occurred 12 weeks after admission that included external services and the patient's family with consent of the patient. CPA meetings occurred every six months subsequently.
- Staff reported the doctor was very approachable, open and included health care workers and recovery workers in the team in discussions and decisions regarding the care of patients. Staff who attended individual case reviews told us they felt able to put ideas forward and their contributions accepted. For example, if a patient wanted to progress with their leave they would be asked about possible risks in this area.
- A review of the contract between Pelham Woods and the GP service had resulted in monthly GP visits to the unit in addition to existing access to the local GP surgery.
- A registered general nurse and visiting GP provided physical healthcare assessments.
- Staff received an appropriate induction and supervision and appraisals of staff were up to date. We saw evidence that poor performance was addressed promptly and effectively.
- The unit had effective working relationships with other organisations including the patient locality care co-ordinators, commissioners, local authority, general practitioners and social services.
- Bank and agency staff were familiarised with standards and procedures for observation. The hospital director told us the agency they used guaranteed a similar level of induction to that undertaken by permanent staff joining Partnerships in Care.
- All the staff we spoke with told us they received good regular managerial and clinical supervision, attended regular reflective practice sessions and had an appraisal in the last year.

Skilled staff to deliver care and multidisciplinary and inter-agency team work

Long stay/rehabilitation mental health wards for working age adults

Good 

- Information provided by Pelham Woods stated they were 100% compliant for supervision from January 2016 to April 2016 and 100% for staff appraisals within the last year. Reflective practice sessions occurred on a weekly basis.
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- There was a vacancy for a social worker which was being covered in the meantime by the social work team at The Dene. Social workers based at The Dene maintained links with other teams out of area. The frequency of contact varied according to distance from the referring authority

Adherence to the MHA and the MHA Code of Practice

- We saw evidence that 100% staff were trained in the Mental Health Act (MHA) and Code of Practice and had a good understanding of the principles. Consent to treat forms were attached to medicine charts where applicable. Patients had their rights explained to them on admission and routinely thereafter.
- There was administrative and legal advice on the administration of the MHA and the Code of Practice available from a central team based at the Dene hospital. Detention paperwork was available and appeared correct. It was evident that regular audits which ensured MHA documentation compliance were undertaken and evidence of learning from those audits.
- Patients had access to the services of an independent mental health advocate (IMHA) who attended the ward weekly.
- There was no record that the impact of the blanket restrictions on each patient had been considered and documented in the patient's records in accordance with the Mental Health Act Code of Practice.

Good practice in applying the MCA

- All staff were trained in the use of the Mental Capacity Act. The majority was aware of the five statutory principles and the need for capacity assessments to be made dependent on the decision to be made. The unit had no patients who required deprivation of liberty applications currently.

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

Good 

Kindness, dignity, respect and support

- We observed respectful and caring staff attitudes and behaviours when interacting with patients.
- Patients reported that staff were kind, caring, respectful in their approach and interested in their wellbeing.
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- However, some patients reported that there was a lack of dignity and respect shown to them by some staff. They were concerned that confidential discussions were held in communal areas. Two patients also told us they felt concerns were not taken seriously when bullying or exploitation allegations were made and that no support was forthcoming.

The involvement of people in the care they receive

- When admitted to the wards all new patients had an identified peer who acted as a "buddy" to introduce them to the ward. The patients were introduced to their primary nurse and saw the responsible clinician. The clinical team agreed the level of observations on admission.
- A booklet was given to patients which contained information about Pelham Woods. The booklet included information about members of the multidisciplinary team and explained what treatments they offered.
- The patient information booklet included details of the role of the ward representatives. Information about psychology and occupational therapy services were included as well as detailed information about ward routines and expectations. Views of patients about their experience at Pelham Woods were also included in the document.
- We found good access and uptake of advocacy services. All patients we spoke with told us they had good access to advocacy services. The advocacy service visited the unit once a week, and spoke to all patients who wished to see them. A new advocate had commenced working at the unit and had made one visit which they felt was a positive start to building a working relationship. The advocates attended CPA meetings and individual case reviews when requested. Staff were also willing to meet the advocate outside of these times to avoid waiting for

Long stay/rehabilitation mental health wards for working age adults

Good 

formal meetings. The advocacy service provided the independent mental health advocacy service (IMHA). The advocate spoke to managers on a weekly basis and there was a meeting with the management of Pelham Woods on a quarterly basis. The advocacy service manager told us that complaints were dealt within hours of any escalated concerns. The advocate said that patients felt involved in their assessment, developing their care plans and risk management plans and reviews.

- Patients told us they felt very involved in their care and had copies of their care plans and this was well documented. Patients said they were listened to in care programme approach meetings (CPA), which involved family members and advocacy. We saw care plans for life skills, physical health, relationships, safety, and risks insight. The language in the care plans was a mixture of the patient voice and professional language.
- The social worker managed the approval list for visitors working with patients, relatives, and ward staff. They spoke to the family of the patient, agreed, and updated necessary records and care plans.
- The process for establishing if the patient consented to family members receiving information was discussed with the patient and recorded in the electronic care notes. Prior to home leave, the social worker completed an environmental risk assessment and established relationships with relatives.
- The social work lead produced a quarterly carers newsletter. Pelham Woods had events throughout the year to which carers and relatives were invited. The Queen's birthday event had been held the week prior to the inspection.

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

Good 

Access and discharge

- The ward admitted patients from the South of England and from clinical commissioning groups nationally.

- All new referrals to the ward were brought to the team for discussion and it was agreed which member of the team would undertake the initial assessment. A member of the team always assessed the patient within five working days.
- An initial needs formulation was included in the pre-assessment report. The senior manager morning meeting reviewed the pre assessment report and made the decision to accept or refuse the referral. Patient mix and ward dynamics were considered as part of the decision making process. The ward could refuse to admit a person referred if the team felt the referral was not appropriate.
- Patients accessed their own beds on return from leave. No patients were moved between wards, unless it was part of their planned pathway to step down to the Rosa Parks semi-independent flat. Following their stay at the unit, patients were considered for other placements in consultation with their locality teams and clinical commissioning groups.
- Discharge planning was discussed during care programme meetings. Patients visited placements to consider options when nearing discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients on all wards had access to a variety of rooms used for therapy, activities, and interviews, some of which were locked. The ward was welcoming and comfortable.
- Patients had access to the well-maintained communal garden and smoking in a designated area at the front of the hospital if they had leave. Informal patients could access the outside space for smoking until 10pm.
- We saw there was a visitors' rooms and visiting was by appointment. Children visited by arrangement and could use the large meeting room which was accessed without entering the ward. The room had toys for children to play with.
- Patients had access to their own mobile telephone provided it had no internet access or a camera. On ground and community leave patients had access to their own personal mobile telephones with internet access and camera. There was also access to telephone in a separate room.
- Patients could personalise their bedrooms and patients had access to their bedrooms during the day unless there was a risk.

Long stay/rehabilitation mental health wards for working age adults

Good 

- Patients could make hot drinks during the day provided they had access to the kitchen, which was dependent on their risk rating, otherwise staff provided hot drinks. Fresh fruit was available at all times. Other snacks were locked away in the kitchen area but were available in between meal times with staff approval.
- Patients and staff ate together in the dining area. All patients said that the food was of excellent quality and that they met with the chef regularly to discuss menus.
- Patients were offered more than 15 hours a week of activities Monday to Friday with nurse-led activities during the weekends.
- The hospital audited the uptake of activities. We saw up to date information about patient activities displayed on the notice board and an individualised patient planner for each day in the patients' notes we reviewed.
- Patients said they participated in a range of activities such as attending therapy groups, cooking and arts and crafts.
- There was one occupational therapy lead, two occupational therapists, one working two days per week and one working full time, and one full time occupational therapy assistant.
- Occupational therapists provided an individual timetable of activities that they evaluated with the patient on a quarterly basis. Activities included groups such as thrive and survive, mindfulness, DBT skills group, body and mind, fitness sessions and recovery workshops.

Meeting the needs of all people who use the service

- We saw up to date information including the Mental Health Act and independent mental health advocacy. We saw information that gave an overview of treatments, healthy lifestyles, advocacy services, CQC, how to complain, red, amber, green (RAG) system (with a clear explanation of both red and green behaviours) and weekly activities.
- Leaflets were not available in other languages on the ward, they could be ordered in the language required when needed.
- Staff respected patients' diversity, religious and cultural needs, and human rights. For example, the hospital director told us they had links to the local church and made arrangements for patients to attend the church and a minister attended the ward regularly.

Listening to and learning from concerns and complaints

- Partnerships in Care reported one formal and five informal complaints for Pelham Woods for the period between October 2015 and April 2016. The formal complaint was made by a carer regarding bullying/harassment by staff. This was withdrawn and named staff were interviewed. However the resolution letter was not sent for three months following the meeting.
- We saw complaints leaflets were available. Staff reported complaints were often resolved at a local level.
- An informal complaints book recorded complaints. Managers investigated all complaints.
- There was a weekly community meeting which also gave the opportunity for patients to raise concerns the ward could action.
- Health care workers we spoke with were able to explain what they did if a patient wanted to make a complaint.
- Records showed complaints were also recorded in the electronic patient records. Staff reported patients received information on how to make a written complaint. Patients we spoke with were aware of the complaints procedure.
- The organisation had a staff complaints booklet that answered questions staff may have had about complaints.
- We saw a review of complaints was a standing item on the Pelham Woods clinical governance and operations meeting. We saw minutes of the regional service clinical governance and operations meeting in which both formal and informal complaints were monitored. Feedback on learning from complaints occurred through training and reflective practice.

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

Good 

Vision and values

- All staff we spoke with were clear about Partnerships in Care's vision and purpose.

Long stay/rehabilitation mental health wards for working age adults

Good 

- All staff spoke about the high visibility of senior managers. Staff told us that senior managers visited regularly and that the chief executive officer visited once a year.
- Staff reported that the operations director was very approachable for both patients and staff.

Good governance

- We saw comprehensive minutes of the regional clinical governance and operations meetings. These showed that a range of governance areas were reviewed. Agenda items included governance, risk management, staffing, and staff management including education and continuing professional development. Other items included information management, effectiveness and outcomes, clinical audit and patient and carer involvement. These meetings fed into local staff meetings, supervision and ward information.
- Weekly reviews of all ward dashboards occurred. The detailed dashboard included areas such as care planning, community meeting, and patient sessions with their primary nurse and access to psychological therapies. We saw minutes that showed the monthly Pelham Woods and regional service development and clinical governance meetings reviewed the ward dashboards and any required actions identified. Board governance committees included an overview of risks and actions plans and provided recommendations and advice. Managers shared lessons learnt with staff.
- We looked at the unit's dashboard and it included items such as whether all patient details had been completed, details of Mental Health Act status, access to psychological therapies, dates of individual case reviews and care programme approach meetings, numbers of incidents.
- Managers told us they reported on a range of key performance indicators. The key performance indicators were monitored by the hospital, regional and board committees. The performance indicators included commissioning for quality and innovation (CQUIN) targets, contract performance and monitoring, service development and the clinical audit programme.
- Regular audits took place that scrutinised adherence to the CQUIN framework. The areas covered in the first

quarter for 2016 included collaborative risk assessments, friends and family tests, needs formulation at transitions, reducing premature mortality in people with severe mental illness and quality dashboards for specialised services.

- We saw in the service development and clinical governance meetings and staff team meeting records that there was a four weekly cycle of information governance bench marking including lessons learned and feedback to staff.
- Staff had received all mandatory training and supervision, and appraisals were up to date.
- Staff felt able to raise concerns without fear of victimisation and knew how to use the whistle-blowing process. However, the whistle-blowing policy for Partnerships in Care did not encourage anonymous disclosure which may put some staff off making such allegations.
- Staff sickness was low.

Leadership, morale and staff engagement

- Without exception, every member of staff we spoke with told us they experienced good leadership at a ward and organisational level. They all received regular support and good access to their manager.
- We heard many positive comments from staff about how they felt about their work and colleagues. For example, one member of staff said they loved their job. They said it was the longest time they had stayed in one job and that they were passionate about their work and developments to improve the service. Other staff member told us morale was good. They said there was some stress but the de-briefings, supervision and support from other staff helped this.
- The whistleblowing policy for Partnerships in Care did not encourage anonymous disclosure which may put some staff off making such allegations. The policy did state that efforts would be made to preserve the confidentiality of any whistle-blowers.

Commitment to quality improvement and innovation

- Pelham Woods is accredited by 'investors in people' and a member of the accreditation for inpatient mental health services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must reduce the number of blanket restrictive practices and ensure that any blanket restrictions can be justified as necessary and proportionate responses to risks identified for particular individuals.

- The provider must ensure that the ligature risk assessments show specific actions to mitigate the ligature points in patient bedrooms.

Action the provider **SHOULD** take to improve

- The provider should accelerate the programme of resolving the issues with mould in ensuite bathrooms and ensuring adequate ventilation

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that care and treatment was provided in a safe way for service users. The ligature risks in patients' bedrooms had not been fully assessed or mitigated. This is a breach of regulation 12 (1) (2) (a) (b) (d)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider did not support autonomy, independence and involvement in the community of the service users Blanket restrictions were in place which were not in response to current recorded patient risk. Patients could not use mobile telephones with internet access or cameras and patients had restricted access to the internet. There were rooms that patients could not freely access such as the toilets in the main ward area. There was no free access to outside space. This is a breach of regulation 10 (1) (2) (b)