# Tesito House

## Quality Report

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

## Ratings

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

### 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 Tesito House as Inadequate because:

- Patients receiving treatment at this service are a high-risk group, they have a history of high risk behaviours and self-harm. Therefore, it is a concern that not all patients had written risk assessments. Those risk assessments that were in place were poorly written and individual risks to the patients and others were not sufficiently mitigated. This means that opportunities to prevent or minimise harm could be missed.
- The need for a personal emergency evacuation plan for one patient was not identified before a fire drill. The personal emergency evacuation plan put in place for this patient following the drill was not sufficient to mitigate the risk of the patient refusing to leave the room.
- Staff had not undertaken comprehensive, holistic or recovery orientated assessments of patients' needs.
- Physical health examinations were not routinely carried out on admission and reviewed thereafter.
- Tesito house is a rehabilitation unit which admitted patients from other wards. Despite this care plans were not recovery focused and not what is expected from a ward that provided intensive rehabilitation.
- There was no discharge planning in place for any patients.
- Patients and staff agreed that meals provided to patients were not of good quality.
- Patient activities and leave were cancelled at the service due to a shortage of staff.
- There was no evidence to demonstrate the outcome of audits had led to improvements in the quality of the service provided.
- The service had identified key risks and developed an action plan to address theses. However, there was no immediate mitigation for these risks while the action plan was being completed.

However:

- The ward areas had an open layout and were clean and appropriately furnished.
- Patients were able to personalise their own rooms to their taste.
- Managers had undertaken a comprehensive ligature assessment for the building.
- The service had an occupational therapist.
- There were a good range of therapies available at the service.
- We observed respectful and polite interactions between patients and staff.
- There were daily meetings for patients to discuss their activities and any concerns they may have.
- The service had recently implemented a values based recruitment process.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| Long stay/ rehabilitation mental health wards for working-age adults | Inadequate  | See main body of the report |

# Summary of findings

## Contents

Inadequate

# Tesito House

**Services we looked at**

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

# Summary of this inspection

## Background to Tesito House

Tesito House is a 24 bedded treatment and recovery centre for women. Its' intention is to assist women with complex mental health and rehabilitation needs including women with emotionally unstable personality disorders. The service supported patients through the recovery pathway with three eight-bedded units (an acute ward, a stabilisation ward and a recovery ward) and eight self-contained flats. At the time of the inspection there were eight patients at the service who were all detained under the Mental Health Act. Tesito House works in partnership with the local NHS Trust who provide Mental Health Act administrative support, the registered clinician and the out of hours service.

The service is managed by Alternative Futures Group Limited. The service did not have a registered manager at the time of inspection but the interim hospital manager had applied for this role and this was being processed.

Tesito House is registered for the following regulated activities:

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

This was the first CQC inspection at Tesito House since the service opened in March 2017.

## Our inspection team

The team comprised: three CQC inspectors, an inspection manager, a mental health nurse specialist advisor and an expert by experience. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

## Why we carried out this inspection

We inspected this core service as it was a newly registered service. We inspected all new registered services 12 months following registration.

## 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 service, asked related organisations for information and sought feedback from patients at a focus group.

During the inspection visit the inspection team;

- Toured the service and looked at the quality of the environment
- Spoke with five patients
- Spoke with the interim hospital manager and Alternative Futures senior team members

# Summary of this inspection

- Spoke with eight other staff members including consultants, nurses and support workers
- Attended a ward round
- Attended a patient morning meeting
- Looked at all eight patient records
- Reviewed all eight medicine records
- Reviewed policies and procedures and other documents relating to the running of the service.

# 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?

Inadequate

We rated safe as Inadequate because:

- Patients receiving treatment at this service are a high-risk group, they have a history of high risk behaviours and self-harm. Therefore, it is a concern that not all patients had written risk assessments. Those risk assessments that were in place were poorly written and individual risks to the patients and others were not sufficiently mitigated. This means that opportunities to prevent or minimise harm could be missed.
- The need for a personal emergency evacuation plan for one patient was not identified before a fire drill. The personal emergency evacuation plan put in place for this patient following the drill was not sufficient to mitigate the risk of the patient refusing to leave the room.
- We identified a woman of child bearing potential who was prescribed sodium valproate. A safety notification had been issued by the Medicines and Health Care Products Regulatory agency regarding this medication, there was no available evidence that this had been discussed with the patient.
- Plans put in place by the hospital manager to assess and manage current and future risk to patients were inadequate.
- Staff did not sign medicine disposal documentation when medicines were disposed of.
- Caring for patients with this level of risk requires a stable and experienced staff group. There was a significantly high turnover of staff with a heavy reliance on bank and agency staff, which had a direct impact on patient care.
- Emergency equipment and medication on site did not meet the national guidance from The Resuscitation Council.

However;

- The ward areas were clean and appropriately furnished.
- The service had a clear and open ward layout.
- Staff received appropriate training.

### Are services effective?

Inadequate

We rated effective as inadequate because:

- Tesito house is a rehabilitation unit which admitted patients from other wards. Despite this care plans were not recovery focused and not what is expected from a ward that provided intensive rehabilitation.

# Summary of this inspection

- Seven out of the eight care records reviewed did not have a recovery focused care plan and one with patient did not have a care plan.
- Assessments of patients' needs were not comprehensive, holistic or recovery orientated.
- Physical health examinations were not routinely carried out on admission and reviewed thereafter.
- The service did not use any recovery focused patient outcome measures or tools, therefore the service could not monitor patient's recovery which can lead to delayed discharges.
- There was no discharge planning in place for any patients.
- Patient progress through the pathway was not measured or monitored effectively.
- There was no psychologist input.
- Staff had not recognised that a patient's detention under the Mental Health Act had lapsed.
- Five patients had not been read their rights under the Mental Health Act.
- Best interest decisions were not always recorded.
- A patient's prescribed treatment was not within the parameters of the legal certificate.

However;

- The service had an occupational therapist.
- There were a good range of therapies available at the service.
- Patient and relatives were invited to attend multidisciplinary team meetings.

## Are services caring?

**Requires improvement**

We rated caring as requires improvement because:

- Within rehabilitation units it is essential that staff work closely with patients in their recovery. Care plans at the service did not always demonstrate patient involvement.
- Patient's emotional and social needs were not always reflected in their care plan.
- Patients were not always provided with key information in regard to their care. Therefore, they were not supported to understand their care.
- Patients felt that the agency staff at the service did not care as they did not make an effort to learn the patients' names.
- Patients told the inspection team that there had been occasions where they had found night staff asleep on duty.

However;

- We observed respectful and polite interactions between patents and staff.

# Summary of this inspection

- There were daily meetings for patients to discuss their activities and any concerns they may have.
- The manager at the service had identified areas where patients could be more involved with the recruitment of staff at the service.

## Are services responsive?

**Requires improvement**

We rated responsive as requires improvement because:

- The stated purpose of the unit was to create a pathway to more independent living. Despite this, the patient care plans at the service had no discharge or recovery focus. Therefore, there was no identified recovery pathway for each patient.
- Patients and staff identified that meals provided to patients were not of good quality.
- The service was no delivered in a way that focuses on peoples holistic needs.
- Patient activities and leave was cancelled at the service due to a lack of staff.

However;

- Patients were able to personalise their own rooms to their taste.
- There had been no official patient complaints made to the service.
- Staff assessed patients within 14 days of being referred to the service.
- The service had provisions for patients and visitors with limited mobility.

## Are services well-led?

**Inadequate**

We rated well-led as inadequate because:

- The concept of the recovery journey for patients through the service was not reflected in the policies and procedures at the service.
- There was no evidence to demonstrate the outcome of audits had led to improvements in the quality of the service provided.
- The service had identified key risks and developed an action plan to address theses. However, there was no immediate mitigation for these risks while the action plan was being completed.
- There were a number of newly recruited senior managers that had been in post for three weeks prior to our inspection. These changes had had a negative impact on staff morale.

# Summary of this inspection

- Managers had taken action to try and fill vacant posts at Tesito House but there had been significant staff turnover and, at the time of the inspection, a significant number of key staffing posts remained unfilled.
- The service did not use key performance indicators to assess or monitor service provision.
- There was little innovation and no involvement in quality improvement initiatives.

However;

- The new senior managers had a good understanding of the challenges and were motivated to making improvements.
- The service had recently implemented a values based recruitment process.
- There were no reported incidents of bullying and harassment.

# 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 carried out a routine Mental Health Act monitoring visit in October 2017. At that visit we found that the approved mental health professional reports relating to the initial detention of two patients were absent. Care plans were often undated and unsigned with no evidence they were reviewed regularly and there was little evidence of recording of discussions with patients regarding their capacity to consent. There was also minimal evidence in regards to discharge planning. We found similar issues on this inspection.

Mental Health Act administration for Tesito House was provided by a local NHS Trust. During the inspection we found that the Mental Health Act paperwork was not effectively managed. One patient's detention paperwork had lapsed but they continued to be given section 17 leave. This demonstrated that the staff were unaware that the patient had become an informal patient. There had been no formal/active discussion recorded within the patient notes.

We reviewed all eight patient records and found that granted leave was recorded in all patient files with the parameters of the leave recorded and risk assessments attached.

Eighty three percent of clinical staff had received training on the Mental Health Act, with an overview of the Mental Health Act provided to unqualified staff at the corporate induction.

We found inconsistencies with the treatment forms for patients. One patient had a treatment form in place; however this was not necessary as they had been recently detained. While we were at the service, the new responsible clinician was updating the treatment forms for patients. We found that prior to this work, some patients did not have treatment forms in place and medication was not covered by the treatment forms.

We found that five patients at the service had no evidence of their section 132 rights under the Mental Health Act explained to them on admission or routinely thereafter. This is not in keeping with the requirements of the Act or the code of practice.

An audit around the Mental Health Act was undertaken in February 2018 by the staff which found that the audit checklist was not comprehensively completed. The audit identified that there was no information on the end date of a patients' section and a patients' prescribed treatment was not within the parameters of the legal certificate. However; there were no actions detailed following the findings of the audit.

We found that information about the independent mental health advocate was displayed around the service for the patients to access, they also visited the ward once a week. When speaking to the independent mental health advocate, we were informed that they had not received many referrals from Tesito House; however they were aware of many of the patients due to contact they had with them while they were at other hospitals.

## Mental Capacity Act and Deprivation of Liberty Safeguards

All clinical staff had training in the Mental Capacity Act. Support staff told us they had not received training and this area was performed by the nurses. However; the corporate induction for Tesito House covered the Mental Capacity Act as did the refresher training.

There had been no deprivation of liberty safeguards applications made since the opening of the hospital.

Tesito House had Mental Capacity Act and deprivation of liberty safeguards policies available on the intranet. The hospital manager informed us that all essential polices had been filed in hard copy for agency staff at the service.

We saw evidence of patients' capacity being assessed at Tesito House.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Long stay/ rehabilitation mental health wards for working age adults** | Inadequate | Inadequate | Requires improvement | Requires improvement | Inadequate | Inadequate |
| **Overall** | Inadequate | Inadequate | Requires improvement | Requires improvement | Inadequate | Inadequate |

**Notes**

The Care Quality Commission are placing this service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration

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

Inadequate

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

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

Inadequate

**Safe and clean environment**

Tesito House was a purpose built unit that opened in March 2017. The layout of the service allowed staff to observe patients on its acute and stabilisation ward from a central nurses' hub. Each patient had their own en-suite room. Doors to bedrooms had observation windows for staff to check on patients. There were blind spots in the corridors leading to the wards but these were mitigated by the use of convex mirrors and patients were always accompanied by staff whilst in these areas.

A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The service completed a ligature assessment in February 2018 which identified a number of high risk ligature points within the service. Many of the risks on the audit were mitigated by observations and individual risk assessments. However; we found in patient records that consistent and comprehensive risk assessments were not being completed. Staff informed us that all the changes highlighted on the audit had been approved for the work to be completed.

The hospital cared for female patients only therefore it was compliant with national guidance on eliminating same sex accommodation.

The service had a single clinic room with a small waiting area. This was located in a corridor that was accessed by staff with a key card. The clinic room was visibly clean. However; the cupboards in the room were untidy and disorganised and we found an unwrapped syringe. The room had blood pressure machines that were routinely checked and calibrated. Staff had access to a defibrillator and oxygen at the nurse's station but emergency resuscitation equipment did not meet the national guidelines as there were no emergency resuscitation medication on site. The nurses' station held an emergency door opening tool kit so staff could access patient rooms. Ligature knives were also available to staff in the nurses station, we observed that a knife was visible to patients through the window as it was stored on the windowsill. We raised this with staff due to patient accessibility concerns and they were moved.

The service had a de-escalation room. This allowed clear observation, two-way communication and the toilet had two separate entrances. The room also contained comfortable seating including bean bag chairs. The hospital manager told us that they recognised the location of the de-escalation room was not dignified for patients as they needed to be escorted through the ward and down a long corridor to access the room. Therefore, the service was looking at relocating the room to a more appropriate position on the ward.

The service was located in a new building; however multiple issues had been highlighted by the hospital manager. such as the inconsistency of the heating and showers not working in patient rooms. Ongoing work was taking place to fix these issues. The ward areas were clean and were furnished appropriately. The self-contained flats at the service had not yet been used since the service opened and were well maintained.

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

Inadequate

All staff carried personal alarms but we were informed that the personal alarms did not work in the outside areas of the service. The service had an emergency call system throughout. When the emergency buttons were pressed the alarm could be heard throughout the service. The system also had alarm notification boards which told staff and patients where the emergency button had been pressed. Each time the emergency buttons were used, the notification boards throughout the service would read 'staff attack'. Staff had identified that this caused the patients distress. Therefore the system had recently been updated to rectify this.

**Safe staffing**

The provider had implemented an electronic rota system called people planner which allowed staff to be utilised from other areas. The provider identified that each day and night shift should have two registered nurses and seven support staff based on the needs of patients at the time of the inspection. However; we were informed that the number of support workers could increase depending on the acuity of the patients for example; if a patient needed two to one or one to one care. The senior nurse practitioner and hospital manager were able to adjust the staffing levels daily taking into account the acuity of the patients. At the time of the inspection, the service had seven patients on their acute ward and one patient on the stabilisation ward. We were informed by the hospital manager that the staffing numbers had been increased due to the number of acute patients.

The staffing establishment level for the service was 13.1 whole time qualified nurses and 46.6 whole time support workers. The actual in post positions at the time of inspection were 7.6 qualified nurses and 17.6 support workers. The service had 5.5 whole time equivalent vacancies for qualified nurses and 29 whole time equivalent vacancies for support workers. In the 12 months prior to inspection, out of 28 substantive staff 17 had left the service which equated to a 45% turnover. The total vacancy rate in the 12 months prior to inspection was 46%. Due to this, half of the shifts were being filled by bank and agency staff, which we were informed was due to the recent increase in patient numbers from two to eight. Bank and agency staff were provided with a checklist for the service which included the layout of the service, emergency procedures, locations of key equipment, security, staffing information, policies and procedures and information about the patients. This form was checked off and signed by bank and agency staff to confirm that the information had been explained to them and understood.

Prior to and during the inspection, Tesito House had undertaken a recruitment drive to fill the vacancies.

Patients and staff informed us that leave and activities were regularly cancelled due to a lack of staff on the ward. Where possible, senior staff came into the numbers and assisted the ward staff to avoid cancelling patients' leave. There was no system in place to record when section 17 leave and activities were not able to take place due to low staffing.

Staff provided previous minutes of the morning meetings where patients had raised concerns that evening activities were not taking place but there was no response from the team in the notes in relation to these concerns.

The responsible clinician for Tesito House was a consultant psychiatrist provided by a local NHS Trust. The consultant provided two sessions per week at the service. A staff grade psychiatrist was available at the service five days a week. Physical and mental health out of hours cover was provided by the out of hours service at a local NHS Trust. The out of hours team were trained in phlebotomy, completing ECGs, mental state assessments, prescribing treatment for minor injuries, prescribing other psychiatric and physical medications within their agreed formularies and complete seclusion reviews as per agreed policy and procedure. Staff could contact the team from 5pm to 9am to attend the service if required.

Staff mandatory training was captured electronically enabling managers to review compliance of individual staff.

All staff attended a corporate induction with Alternative Futures Group Limited. The induction programme included training on person centred care approaches, equality and diversity, mental health, dementia and learning disability awareness, proactive working, basic life support, safeguarding and the Mental Capacity Act. Each of these sessions linked to units of the care certificate which staff were given an overview of on the induction.

All staff had completed the 'supporting essentials' induction training and refresher bi annually. Eighty eight percent of staff had received therapeutic management of violence and aggression and 83% on the Mental Health Act. Extra basic life support and advanced life support training

was refreshed annually for qualified staff; seven out of eleven staff had completed basic life support and first aid. Six out of eleven staff had completed advanced life support. Four of these eleven staff were new starters and were booked on training. Seventy three percent of qualified staff had received fire warden training.

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

The inspection team reviewed all of the eight patient records at the service. In five care records we found that, although risk assessments were present, they were not comprehensive. For example; there was no or limited detail in relation to previous incidents (including the antecedents, dates and details of the incidents). Risk management plans lacked detail to ensure that identified risks were mitigated. Where a level of risk was identified for one patient, there was no evidence of review or updates of the assessment. For example; recording the number of types of incidents over any given period to assess whether the patient was making progress in terms of their identified risks. Following incidents, risk management plans were not updated. It was not clearly recorded within the patient care records we reviewed what the current observation levels were for patients and how levels of observations were decided. There was limited recorded discussion about current observation levels and the rationale for these in the multi-disciplinary ward round. The Mental Health Act code of practice states that levels of observation and risk should be regularly reviewed and a record made of decisions agreed in relation to increasing or decreasing the observation. This meant that staff were unable to respond to patients' specific needs in good time.

We found that six patients' care notes recorded patients as being at risk of suicide, self-harm and/or using ligatures. These risks were ongoing as identified through ongoing incidents, where individual patients had attempted to self-harm. We found that two patients did not have any written risk management plan in place to assess and manage the risks to themselves or others. This meant that the lack of assessment, monitoring and managing of risks to patients did not allow staff to prevent or minimise harm.

We found that there were no associated risk management plans around monitoring the risks of a patient receiving high dose anti-psychotic medication and the need for increased baseline and ongoing physical health checks to note any adverse effects of receiving medication above the British National Formulary levels. The Medicines and Healthcare Products Regulatory Agency issued a safety notice in April 2017 that sodium valproate during pregnancy has a 30-40% risk of developmental disability and 10% risk of birth defects. We found no evidence available on the patients' records on inspection that this had that the risks of this prescribed mood stabiliser had been discussed with a patient who was prescribed this medication.

A fire drill had taken place in March 2018, this identified that staff had not identified a need for a personal emergency evacuation plan for a patient who confined herself to her room until a fire drill took place. An action plan was developed following the fire drill and a personal emergency evacuation plan was developed for the patient. The personal emergency evacuation plan was not sufficiently detailed enough to mitigate the risk of the patient not wanting to leave the room.

We found that a patient's care record identified that they may have had an allergy that may require emergency treatment. Staff we spoke to were unaware of this allergy and it was not identified in the patient's risk management plan or care plan.

There was a list of items that were permitted and not permitted on the services acute ward. This was appropriate for patient safety.

The service did not have any medication on site for rapid tranquilisation. When we spoke to staff about how they would manage a patient that may require rapid tranquilisation, they informed us that they would talk to the patients to try and calm them.

The service reported no incidents of seclusion or long-term segregation between June and December 2017.

The service reported two episodes of restraint used between June and December 2017 neither of which were in the prone or face down position. This was in line with best practice guidance.

Specific safeguarding training was provided to qualified nurses and the therapy team. All of the therapy team had received safeguarding training and 64% of the qualified nurses. Support workers at the service received training on the principles of safeguarding at induction and on the one year refresher training. Staff we spoke to told us they were confident in how to report safeguarding.

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

Inadequate

The service received patients' medication through prescriptions from a local GP. Prescriptions took 48 hours to arrive at the service. Patients and staff told us that there had been instances where patients had ran out of medication. Although we found no evidence of this in regards to incidents, it was recognised by the service that the system was not working and it was under review. Medicines were stored in the clinic room with a separate tray for each patient. Medicines were dispensed by two qualified members of staff along with a support worker, who escorted patients from the ward to the clinic room for their medication.

A medicines disposal process was in place; however we found that on multiple occasions there was no second signature to confirm the disposal.

A new medicines order book had been started at the service. During the inspection, we found that the medicines listed for one patient were incorrect as they missed multiple medications.

A pharmacist visited the service daily and carried out a medicines check. Any issues identified by the pharmacist were recorded in a clinical communication book for the staff at the service to review and action. A medicines audit carried out in March 2018 identified that the service was not conducting a weekly stock check. This was to be put in place following the audit and was due for review in three months. However this was not in place at the time of inspection.

The service had a visiting room away from the ward for families, this included seating and some children's toys available for children visiting the service. We also saw that visitors were allowed to visit patients in the dining area.

**Track record on safety**

At the time of the inspection there had been no reports of any serious incidents at Tesito House.

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

Staff recorded incidents onto an electronic incident reporting system. Staff understood what incidents needed to be reported and how to report and record these. Support workers told us that they would fill out an incident form and registered nurses informed us that they report incidents directly onto the electronic system. Agency staff did not have access to the reporting system therefore the regular staff had to do this for them. We were informed at the time of the inspection that there was a culture of filling in incident forms but these forms were piling up before they were inputted into the electronic system. This had been identified by the management team.

Patients were debriefed regarding incidents if it affected them directly. Patients told us they were informed of what had occurred each time the alarms were activated, as the notification boards stated 'staff attack' irrespective of the reason for the alarm. This notification was changed at the time of the inspection. Staff were debriefed after incidents.

Staff did not have the ability to submit items onto the service risk register. Any concerns would be raised with a manager.

**Duty of Candour**

There had been no notifiable events at Tesito House that fall under the Duty of Candour. Staff were provided guidance on Duty of Candour within the Alternative Futures Group Limited standards of business conduct policy.

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

(for example, treatment is effective)

Inadequate

**Assessment of needs and planning of care**

Patient records were not holistic, they did not all cover patients' social, educational, vocational and psychological needs, therefore these were not monitored and reviewed. No consideration had been given to patients' strengths or weaknesses.

None of the eight care records reviewed contained evidence of consistent monitoring of patients' physical health. Seven patients had not received a physical health examination on admission to the service. There was limited evidence of ongoing health checks in some records but for the majority this was not the case. This is not in line with best practice guidance. This lack of assessment and monitoring placed patients at risk.

Staff used Modified Early Warning Scores to monitor some patients but this was not completed consistently. In three

patient records a comprehensive baseline modified early warning score was not completed upon admission. There was evidence in one patient record of dentistry and opticians appointments; however this was not the case for the other seven patients.

Of the eight care records we reviewed, seven of these records did not have a care plan that was recovery focused and one record did not have a care plan. It was therefore not clear from the plans what interventions and actions needed to be undertaken to enable patients to progress through the care pathway. This meant that patients were unclear about their recovery journey, which meant recovery and discharge could be delayed as there was no clear individual pathway. This was reflected in conversations with patient who reported that they were unsure how they progressed through the pathway and some patients believed they should be further along than they were.

There was limited evidence of the patient's voice within care plans and in two cases no rationale provided in the notes as to why there was no patient involvement into the care plan.

All patient records were paper based; patient records spanned three separate files. Files were stored in a locked staffed area and were accessible to all staff.

**Best practice in treatment and care**

The service did not use any recovery focused patient outcome measures or tools. This meant that the progress of patients could not be measured effectively.

Tesito House did not participate in any relevant benchmarking schemes.

At the time of the inspection Tesito House did not have a psychologist on site; however they were in the process of recruiting two psychologists. Therefore psychologist input had not been available since the opening of the service.

Tesito House offered art therapy, dance therapy, dialectical behaviour therapy, cognitive behaviour therapy, trauma focussed cognitive behaviour therapy, mentalisation based therapy and eye movement desensitisation reprocessing.

The staff had completed a record keeping audit which was a detailed audit of two patient files. This audit was not dated so whilst there was a list of actions, there were no details of when, and by whom each action was going to be carried out. This meant that whilst staff were identifying shortfalls in the quality of records, sufficient action was not being taken to improve the quality of the records and practices around record keeping. Tesito House did not participate in any national clinical audits.

**Skilled staff to deliver care**

Tesito House had three therapists on site; an art therapist, dance and sensory motor therapist and an occupational therapist trained in dialectical behaviour therapy. Support workers were undergoing training in dialectical behaviour therapy to support the patients and therapy staff. The service was in the process of recruiting an occupational therapy assistant and two psychologists. A pharmacist visited the service daily from the local mental health NHS trust.

Tesito House reported that clinical supervision was at 100% and non-clinical supervision was at 81%; however staff we spoke to informed us that they had not always had regular supervision. The occupational therapist at the service informed us they had outside professional supervision from a former colleague.

**Multi-disciplinary and inter-agency team work**

Multidisciplinary meetings were held weekly. During the inspection, we observed a multidisciplinary team meeting attended by a consultant, locum doctor, care co-ordinator, senior nurse practitioner, nurse and the patients' relative. Patients were invited to attend the meetings along with their independent mental health advocate and relatives as appropriate. The patient views were taken into account and next steps were identified.

Staff had a handover at the changeover of each shift. Staff told us that these handovers were not always effective as they ran out of time.

The service had a close working relationship with the local NHS Trust as they provided the out of hours service, mental health act administration, pharmacy and registered clinician cover for Tesito House

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

Mental Health Act administration for Tesito House was provided by a local NHS Trust. During the inspection we found that the Mental Health Act paperwork was not effectively managed. One patient's detention paperwork had lapsed but they continued to be given section 17 leave.

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

Inadequate

This demonstrated that the staff were unaware that the patient had become an informal patient. There had been no formal/active discussion recorded within the patient notes.

We reviewed all eight patient records and found that granted leave was recorded in all patient files with the parameters of the leave recorded and risk assessments attached.

Eighty three percent of clinical staff had received training on the Mental Health Act, with an overview of the Mental Health Act provided to unqualified staff at the corporate induction.

We found inconsistencies with the treatment forms for patients. One patient had a treatment form in place; however this was not necessary as they had been recently detained. While we were at the service, the new responsible clinician was updating the treatment forms for patients. We found that prior to this work, some patients did not have treatment forms in place and medication was not covered by the treatment forms.

We found that five patients at the service had no evidence of their section 132 rights under the Mental Health Act explained to them on admission or routinely thereafter. This is not in keeping with the requirements of the Act or the code of practice.

An audit around the Mental Health Act was undertaken in February 2018 by the staff which found that the audit checklist was not comprehensively completed. The audit identified that there was no information on the end date of a patients' section and a patients' prescribed treatment was not within the parameters of the legal certificate. However; there were no actions detailed following the findings of the audit.

We found that information about the independent mental health advocate was displayed around the service for the patients to access, they also visited the ward once a week. When speaking to the independent mental health advocate, we were informed that they had not received many referrals from Tesito House; however they were aware of many of the patients due to contact they had with them while they were at other hospitals.

**Good practice in applying the MCA**

All clinical staff had training in the Mental Capacity Act. Support staff told us they had not received training and this area was performed by the nurses. However; the corporate induction for Tesito House covered the Mental Capacity Act as did the refresher training.

There had been no deprivation of liberty safeguards applications made since the opening of the hospital.

Tesito House had Mental Capacity Act and deprivation of liberty safeguards policies available on the intranet. The hospital manager informed us that all essential polices had been filed in hard copy for agency staff at the service.

We saw evidence of patients' capacity being assessed.

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

Requires improvement

**Kindness, dignity, respect and support**

We spoke with six patients who were generally complimentary about permanent staff. Patients told us they felt staff did care but patients mentioned that the constant change over of staff had a negative effect on their care. For example; the change of responsible clinician has resulted in one patient's diagnosis changing with each new clinician. Patients told us that they felt agency staff did not appear as if they cared, had not made an effort to learn their names and were not aware of their needs.

Patients informed us there had been occasions where the night staff had fallen asleep while doing observations. This had been raised with the hospital manager at the service. They had approached this with staff and had an action plan in place which included the senior nurse practitioner conducting visits to the service during the night shift.

We observed respectful, responsive and friendly interactions between staff and patients.

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

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

Inadequate

Patients were assessed prior to admission. Staff visited potential patients to ascertain if they were appropriate for the service. Patients were invited to visit Tesito House before admission. Upon admission patients were given a tour of the hospital to orientate themselves.

We found that the patient involvement in care planning and risk assessments was inconsistent. Patients informed us they had received a worksheet to help develop their own care plan but they were not confident completing this themselves. Care plans we reviewed had some patient involvement but we found that one patient did not have a care plan in place.

An Independent Mental Health Advocate was available to the patients. Information about the Independent Mental Health Advocate was visible in the patient dining room and the service reception. We spoke with the IMHA at the service and were informed they had not received many referrals from the service; however they were aware of some of the patients as they have been at other services.

We observed a multidisciplinary team meeting that was attended by relatives who were encouraged to give their opinion and feedback. Patients were involved in ward rounds and had the opportunity to discuss their care with clinical staff. We observed relatives also having the opportunity to speak to the responsible clinician regarding the patients' diagnosis.

Staff facilitated a morning meeting with patients each day which provided an opportunity for patients to identify the things they would be doing that day and the support required. It was also an opportunity for the patients to raise any concerns or ideas they had. This meeting was attended by the therapy team and support workers. At the meeting we observed, the hospital manager was in attendance. The service also had a comments box in the reception area where patients and visitors could give feedback on the service.

Staff worked with the patients to create a patient charter. This was a set of guidelines for staff on how to interact with patients and how to approach particular topics such as leave, observations and communication. The hospital manager identified to the inspection team that they wanted patient involvement to increase at the service and this was part of the current on-going action plan.

Patients informed us that they did not always have regular contact with their named nurse and their named nurse had changed multiple times.

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

Requires improvement

**Access and discharge**

At the time of inspection all patients at Tesito House had been referred through the NHS and funded through local clinical commissioning groups. Staff assessed patients who had been referred within 14 days of referral.

Tesito House had 24 beds split over three areas, with eight beds on the 'acute ward', eight beds on the 'stabilisation ward' and eight self-contained flats. At the time of the inspection there were seven patients on the acute ward, one patient on the stabilisation ward and no patients in the self-contained flats. This gave a bed occupancy rate of 33%.

Tesito House had been built with the primary focus of bringing women receiving treatment in other parts of the country back to their local area. All the patients at Tesito House at the time of the inspection were from the Manchester area.

The provider informed us the expected length of stay at the service was between nine to twelve months. However, since the service opened there had been no discharges.

We identified that the patient care plans at the service had no discharge or recovery focus therefore there was no identified recovery pathway for each patient. The service had not reported any delayed discharges.

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

Tesito House had a clinic room with an adjacent waiting area for patients. The service also had a gym which contained weightlifting equipment and a bike. Patients were required to have an induction to the gym and were supervised while using the space. An art therapy room was

available to patients with supervision by the therapy team; this room also housed the service's gerbil. The patients also had accompanied access to a studio for yoga and dance therapy.

There were lounges on both wards which consisted of a television and couches. Patients had access to a central dining room which also housed a television and sofas. Staff told us that once more patients were admitted; this area would become a separate dining area. Some patients commented that there was a lack of quiet space at the service as patient bedrooms had televisions along with the lounges and the dining area. There was a visitor's room in the reception area where patients could meet with visitors.

Patients had access to a payphone in a quiet area of the ward. Patients also had access to their mobile phones; however this was assessed on an individual basis. A new router had been ordered due to issues with the Wi-Fi at the service. One patient told us they were paying monthly for a Wi-Fi device so they could connect to the internet, while they waited for the Wi-Fi to be fixed.

There were multiple outside spaces for patients to access at the service, including a court yard at the centre of the service. Staff told us that this was used regularly by patients particularly smokers. There were also separate outdoor spaces with seating.

All six patients we spoke to told us that the food was not of a good standard. The evening meals provided were frozen ready meals and many of the patients commented that the portion sizes were too small. The hospital manager was aware of these complaints and was working with Alternative Futures Group Limited and the patients to improve the food standard. This included an option of using the onsite purpose built kitchen. If the patients did not want the food provided, they were given an allowance of £3.00 to make their own meals. We observed a member of the domestic staff informing a patient that their chosen meal was not available and informed them that if they continued to order meals not on the set menu for that day, they would continue to run out of that option.

Each ward had a kitchen which could be used by patients throughout the day and patients on the services' 'acute ward' were accompanied by a staff member as part of therapy. We were informed that the service promoted sleep, so if patients required a drink/snack at night they could request this from staff.

Patients were allowed to personalise their own rooms to their taste and we observed one patient's bedroom that had been personalised with furniture and had also been painted.

Patients had access to their room throughout the day via a fob which meant that their possessions were secure.

The services' 'acute' and 'stabilisation' wards both had an activities board with a number of activities advertised for throughout the week. Patients and some staff told us that it was common for activities to be cancelled due to staff shortages. This had been noted on two occasions in the morning meetings that activities had not gone ahead without any clear reason.

Patients informed us that the activities advertised on the ward did not always go ahead due to staffing levels. Patients told us they enjoyed the pamper night that had been organised by a fellow patient with help from their relative. Patients told us they enjoyed Sundays as staff and patients cooked Sunday lunch together then sat and ate together. However; patients had identified that the kitchen they used for this was very small and could get cramped. Patients raised the idea of using the central kitchen at Tesito House at the morning meeting on the day of the inspection. This was being reviewed by the hospital manager.

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

Tesito House was a recent purpose built service, the access to the building was easily accessible for wheelchair users and the ward areas were wide enough to accommodate wheelchair users. The building had a lift for wheelchair access to the second floor; however this area was not accessed by patients. Each patient bedroom had an en-suite with shower and the wards had central bathrooms with baths. Staff told us that hoists were available if a patient required it.

There were information leaflets available in the languages spoken by the patients who used the service, all patients at the time of the inspection were English speaking. The service could access translation services and documentation for people whose first language was not English if required.

The dining room had an information board with key information including the Independent Mental Health Advocate, information about section 3 of the Mental Health

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

Inadequate

Act, a list of local solicitors in the area to contact if required for a mental health review and the safeguarding number. An information board about complaints was available in the reception area of the service.

Patients were given a choice of meals which included vegetarian options. Patients informed us that if they had food intolerances these were catered for; however the overall feel about the food provided was poor and this was being reviewed by the hospital manager.

Provisions were in place for patients who transferred in to the flats to self-medicate in preparation for discharge; this included secure storage for medication.

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

At the time of the inspection there had been no complaints to the service. There was an information board available in the reception area about how to complain. Patients informed us that there was a box where they could raise concerns but they preferred to speak to a member of staff. Patients raised concerns within the morning meeting we attended with staff. Staff and patients informed us that this was the forum where patients tended to raise complaints. We observed staff addressing complaints in the meeting, asking to meet with patients to discuss issues outside of the meeting and taking actions away from the meeting to address.

Staff were informed of complaints and feedback from complaints from the manager at handover.

Tesito House reported receiving three compliments between March and December 2017. A comments box was available for patients to feedback in the reception area.

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

Inadequate

**Vision and values**

New values were launched by the provider Alternative Futures Group Limited in December 2017; their ambition was to be the employer of choice with a healthy and engaged culture. The new values were produced in collaboration with staff and were;

- We are one. We succeed together with a shared purpose and vision.
- We inspire others, take pride in what we do and trust each other. We all have a part to play. Every person matters. We are people focused and value skills, gifts and potential.
- We listen. How people think and feel matters; everyone has a voice. We make a positive difference. We change lives. Our 'can do' attitude and passion enables people to be the best they can be.
- We raise the bar. We learn from the past, are adaptive and excited by our future.
- We innovate and lead the way. We strive for best quality with least waste. Better never stops.
- We take ownership. We do the right thing, are solution focused and get results.
- We are responsible for our behaviour and hold each other to account.

Tesito House had recently implemented a values based recruitment process for their recruitment drive.

Staff told us that the recent changes in leadership had a negative impact on staff morale and culture.

One staff member we spoke to told us they were not aware of who their immediate line manager was but they did know the hospital manager as they had recently started at the service. There were low levels of staff satisfaction with high levels of stress, we found that staff did not feel appreciated.

Service specific visons and values were not in place however staff had created a service user charter with patients.

**Good governance**

The service had identified a number of areas where improvements were needed which included the process of ordering patients' medication, the need for a robust assessment of risk for each patient and the lack of physical health monitoring. An action plan had been developed to

address these concerns; however there was a lack of oversight of the mitigation of these issues between the recognition of the concern and the completion of the action plan.

The systems and processes in place were not fully completed for example; we found documents such as risk assessments and care plans were unsigned and undated. Audits had identified where records were incomplete and if they were being reviewed and updated as necessary. We identified shortfalls in the quality of patients' risk assessments and risk management plans for example; two patients had no current risk management plan. One patient had no recorded care plan and two patients had care plans containing very limited information. We informed the management team that staff were unaware of a patient's allergy a week before the inspection. We asked that this be rectified for the patient's safety. When we returned to inspect the service, we found that the patients allergy had not been highlighted or addressed in their care plan. This meant issues that could threaten the safety and effectiveness of care were not being adequately managed.

Although there was evidence staff had completed some audits there was no evidence that the outcome of audits had been used to improve the quality of the service.

Staff were informed of incidents but the incident reporting method was inconsistent between staff and there was no procedure to ensure paper based records were uploaded consistently.

We identified that a patient's detention under section 3 had lapsed and this was not recognised by the Mental Health Act manager, medical or nursing staff. The patient continued to be given section 17 leave although they were an informal patient. The patient had been re-detained at the time of the inspection; however the systems and processes in place to monitor the detention of patients had failed to identify this before the section had lapsed.

Managers said they were not currently working towards specific key performance indicators as the main focus was the implementation of an action plan developed by the new hospital manager.

We were informed by the governance lead at the service that the staff did not have the ability to submit items to the Tesito House risk register. Any issues were raised to a manager and/or the service administrator if in relation to the facilities of the building.

At the time of the inspection the staffing establishment levels were below those identified for the service. This resulted in 50% of the shifts being filled by bank and agency staff. The service did not have a robust process for identifying the required staffing levels. Alternative Futures Group Limited had an electronic rostering system, however it was not clear if this system was being utilised by the staff at Tesito House. The high use of bank and agency staff meant that there were inconsistencies in the care provided; this was corroborated when we spoke to patients.

**Leadership, morale and staff engagement**

At the time of the inspection, the service did not have a registered manager. The interim hospital manager was applying to be the registered manager and had been in post three weeks. The clinical lead and senior nurse practitioner were also new to the service and had been in their roles for three weeks.

Although only in post for a few weeks the senior managers had a good understanding of the challenges and risks within the service and were motivated to making improvements with the involvement of patients and staff in service improvement initiatives.

Alternative Futures Group had undertaken an employee opinion survey. The results found staff believed the organisation had high standards in its work and they knew where to get the information they required to do their job. However; staff highlighted that they did not feel they were paid well in comparison to other organisations and they did not feel they knew what was happening within the organisation. These opinion survey results were not broken down specifically for Tesito House.

Tesito House reported the staff sickness rate at 14% in the 12 months prior to inspection

Tesito House had reported no incidents of bullying and harassment cases. The staff we spoke to felt that they could raise any concerns they had.

Staff told us there was a shortage of staff which hindered them from doing their job. This resulted in staff informing us that they felt stressed and in some cases feared for their nursing pin number. We were informed by staff and the management team that the morale of staff at the service was low and this was due to the recent changes in management at the service.

**Commitment to quality improvement and innovation**

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

Inadequate

Tesito House were not involved with any accreditation or peer review schemes.

There was minimal innovation or service development, with a lack of learning and reflective practice.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that all patients detained under the Mental Health Act have been informed of their section 132 rights.
- The provider must ensure that all patients have risk management plans in place to assess and manage the risk to themselves and others.
- The provider must ensure that risk assessments are comprehensive, detailed and are regularly updated to ensure on going risks are mitigated.
- The provider must ensure that each patient has a physical health check on admission and their physical health is monitored throughout their time at the hospital.
- The provider must ensure that each patient has a comprehensive and recovery focused care plan.
- The provider must ensure that patient care plans are patient focused and include patients' views.
- The provider must ensure they have a robust audit system that identifies clear actions and timescales.
- The provider must ensure that all patient records are signed and dated.
- The provider must ensure that patient medications are covered by the appropriate legal certificate.
- The provider must ensure that there is effective discharge planning in place for all patients.
- The provider must ensure that they have a robust procedure for identifying staffing requirements.
- The provider must ensure they adhere to national guidance in relation to emergency equipment and medication.

### Action the provider SHOULD take to improve

- The provider should ensure that the food available at the service is of a good standard.
- The provider should ensure that all incidents are reported in a timely manner onto the reporting system.
- The provider should ensure that cancelled leave and activities are kept to a minimum.
- The provider should ensure that patients have access to external health checks.

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>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>Five patients detained under the Mental Health Act had not had their section 132 rights read to them.<br>This was a breach of Regulation 9(1)(a) (3)(g)(6) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>Seven out of eight records did not have a care plan that was recovery focused.<br>Assessments of patients' needs were not comprehensive, holistic or recovery orientated.<br>Patient's care plans were not always person centred.<br>The service did not use any recovery focused patient outcome measures or tools.<br>There was no discharge planning in place for any patients.<br>Patient progress through the pathway was not measured or monitored effectively.<br>This was a breach of Regulation 9(1)(3)(a) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

This section is primarily information for the provider

# Requirement notices

| | |
|---|---|
| Treatment of disease, disorder or injury | Significantly high turnover of staff with a heavy reliance on bank and agency staff,<br>no robust procedures for identifying staffing requirements.<br>This was a breach of Regulation 17(1)(2)(a) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The emergency equipment and medication on site did not meet National Guidance.<br>This was a breach of Regulation 12 (1)(2)(f) |

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.

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Two patients who use the service had no risk management plans. Risk assessments that were in place were not comprehensive enough to mitigate the risk to the patient. Risk assessments lacked detail to ensure identified risks were mitigated.<br><br>Patients' personal emergency evacuation plan was not comprehensive enough to mitigate the risks.<br><br>This was a breach of Regulation 12 (1)(2)(a)(b)<br><br>We issued a warning notice to Alternative Futures Ltd, telling them that they must improve in these areas by 2 May 2018. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>One patient at the service did not have a care plan.<br><br>Actions from a records audit were not given a timeframe for completion or identified who would carry out the actions.<br><br>There was a lack of monitoring of physical health care of patients when admitted to the service and throughout their stay.<br><br>Patients were given medication without the appropriate legal certificate.<br><br>Records were incomplete and in three cases care plans were undated and unsigned. |

This section is primarily information for the provider

# Enforcement actions

This was a breach of Regulation 17 (1)(2)(a)(b)(c)(f)

We issued a warning notice to Alternative Futures Ltd, telling them that they must improve in these areas by 4 July 2018.