Spring Wood Lodge

Quality Report

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Date of inspection visit: 9 January 2019
Date of publication: 28/02/2019

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 Spring Wood Lodge as good overall because:

- At this inspection the service had acted to address the breaches of regulation identified, as well as areas where we suggested they should take action, following the last inspection. These included physical health monitoring following rapid tranquilisation and for those prescribed medications with side-effects including high-dose anti-psychotics, staff clinical supervision and team meetings, staff understanding of the hospital's search policy and principles of the Mental Capacity Act, and ensuring correct documentation in relation to patients' detention and treatment. Whilst there remained some issues in the safe domain, the service has now been rated as good in the effective domain. With existing ratings of good in the caring, responsive and well-led domains the service has now been rated as good overall. Additionally;
- Staff completed a pre-admission risk assessment with each patient which was updated regularly including after any incidents. Staff were aware of, and dealt with, any specific risk issues such as falls. All patients had a care plan specific to their individual needs which was personalised, holistic and recovery-oriented. All staff knew what incidents to report and how to report them and reported incidents when they should, including safeguarding concerns.
- Staff provided a range of care and treatment interventions suitable for the patient group. The staff team included a range of specialists required to meet the needs of patients on the wards. Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Managers ensured that staff received the necessary specialist training for their roles.

However:

- At this inspection, whilst improvements had been made following our last inspection of the service, we identified some new areas of concern related to the safety of the service. These included, staff were observed to have painted and false nails, contrary to infection control principles, the clinic room was cluttered and was being used as storage for a number of items and cleaning of the clinic room varied in regularity with records not stipulating how often clinic rooms should be cleaned. Daily checks of emergency bags on both wards were not always completed, and several medications were not labelled with patient details or did not have a date of opening written on them. The service's protocol detailed that a doctor could attend within 45 minutes of a psychiatric emergency which is against AIMS standards for inpatient mental health rehabilitation services which state a doctor should be able to attend within 30 minutes. Additionally, we did not see evidence that staff were consistently completing patient-led recovery outcome measures which related specifically to patients' pathway of care, in order to measure effectiveness and safety of interventions as well as patient and carer experience.

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	Good 	

Summary of findings

Contents

Good

Spring Wood Lodge

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

Summary of this inspection

Background to Spring Wood Lodge

Spring Wood Lodge is an inpatient rehabilitation service provided by Elysium Healthcare Limited. The service provides care to a maximum of 21 female patients. There are two wards; Bronte and Byron.

- 9 bedded high dependency inpatient rehabilitation (Bronte Ward)
- 12 bedded inpatient rehabilitation (Byron Ward)

Spring Wood Lodge has been registered with the Care Quality Commission since October 2016 to carry out the following regulated activities:

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

• Treatment of disease, disorder or injury

• Diagnostic and screening procedures

The Care Quality Commission last carried out a comprehensive inspection of this service in May 2018. At that inspection we rated the service as 'requires improvement' overall with ratings of 'requires improvement' in the safe and effective key questions, and 'good' in the caring, responsive and well-led key questions.

The provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 12; safe care and treatment, because the service was not regularly assessing the risks to the health of patients by ensuring there was proper monitoring of long-term anti-psychotic use, and appropriate observations following the use of rapid tranquilisation.
- Regulation 18; staffing, because staff had not all received the appropriate clinical supervision necessary to enable them to carry out the duties they were employed to perform.

We also suggested the provider should take the following action:

- The provider should ensure that staff are able to attend team meetings to enable them to learn and develop skills.
- The provider should ensure that all staff understand the search policy and the use of the randomiser button.
- The provider should ensure that staff adequately record when patient's return from section 17 leave.
- The provider should ensure that section 61 treatment certificates are available to staff and accessible in patient files, and that requests for second opinion appointed doctors are completed appropriately.
- The provider must ensure that where patients lack capacity to make decisions, staff follow the principles of the Mental Capacity Act.
- The provider should ensure that the governance systems and processes in place enable the service to assess, monitor and improve the quality of the service and mitigate risks to the health, safety and welfare of patients. This includes that audits in place include all areas of risk and concern.

We reviewed both breaches of regulation at this focused inspection as well as areas we suggested the provider should improve in the safe and effective domains. We did not review action related to the final suggestion related to governance systems as since the previous inspection we have received no information that would cause us to re-inspect the well-led domain. This will be followed up at the next comprehensive inspection of the service. At this inspection we found that there had been significant improvements. The provider was no longer in breach of Regulation 18, and the service no longer met our ratings characteristics of 'requires improvement' in the effective key question. The provider had made improvements in relation to Regulation 12 but remained in breach of this regulation for additional concerns found. Therefore, the overall rating improved for this service from 'requires improvement' to 'good' at this inspection.

Summary of this inspection

Our inspection team

The team that inspected the service comprised three CQC inspectors including the team leader.

Why we carried out this inspection

This inspection was a focused inspection to follow-up concerns identified during the service's previous comprehensive inspection in May 2018 relating to staff receiving appropriate clinical supervision, and the monitoring of patients with long-term anti-psychotic use, and appropriate patient observations following the use of rapid tranquilisation. These concerns related to regulation 18 and regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also reviewed actions that we suggested the provider should take relating to staff being able to attend team meetings, staff understanding the hospital's search policy, staff recording when patients returned from section 17 leave, ensuring section 61 treatment certificates were available to staff and requests for second opinion appointed doctors were completed appropriately, and ensuring staff followed the principles of the Mental Capacity Act.

We looked at all the key lines of enquiry within the safe and effective domains to check that necessary improvements had been made and that quality had not deteriorated elsewhere.

How we carried out this inspection

As this was a focused inspection we reviewed the key lines of enquiry relating to the following key questions only:

- Is it safe?
- Is it effective?

Before the inspection visit, we reviewed information that we held about the service, spoke with stakeholders, and met with the service manager for regular engagement meetings.

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with the acting service manager
- spoke with seven other staff members; including doctors, nurses, healthcare assistants, occupational therapists, and psychologists
- attended and observed a hand-over meeting
- looked at four care and treatment records of patients
- reviewed medication management on both wards, including medication administration records of four patients, 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

During inspection we spoke with three patients who were using the service. Patients told us they felt safe, were involved in the planning of their care, and they were positive about staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff were observed to have painted and false nails which could contribute to the spread of infection contrary to infection control principles.
- Cleaning records did not detail how regularly clinic rooms should be cleaned, and we found that cleaning regularity varied week-to-week with no clear rationale as to why.
- The clinic room was cluttered and was being used as storage for a number of items including walking frames and shower chairs which were blocking access to the examination area.
- Daily checks of emergency bags had been missed on 12 out of 72 occasions checked.
- We found some medications prescribed for individual patients were not labelled with patient details, and some with limited shelf-life did not have a date of opening written on them.
- The service's protocol detailed that a doctor could attend within 45 minutes of a psychiatric emergency; this is against rehabilitation guidance which states a doctor should be able to attend within 30 minutes.
- Staff could not give examples of recent lessons learnt and were unsure how they would consistently be communicated.

However:

- Both wards were clean, had good furnishings and were well-maintained, and staff completed regular risk assessments of the care environment.
- Staff compliance with mandatory training was between 88% and 100% for all modules.
- Staff completed a risk assessment with each patient which was updated regularly, including after any incidents.
- All staff knew what incidents to report and how to report them and reported incidents when they should, including safeguarding alerts. Staff discussed incidents in daily handover meetings at ward and managerial level.
- Staff reviewed the effects of medication on each patient's physical health regularly, especially when the patient was prescribed a high dose of antipsychotic medication.
- Staff recorded patient physical health observations in line with policy and guidance following the use of rapid tranquilisation.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- All patients had a care plan specific to their individual needs which was personalised, holistic and recovery-oriented and evidenced the patient voice.
- Staff provided a range of care and treatment interventions suitable for the patient group.
- Interventions were delivered by suitably experienced and qualified specialists who had the right skills and knowledge to meet the needs of the patient group.
- Dependent on their role, staff at the hospital received trained in personality disorder awareness, and dialectical behaviour therapy awareness. Staff were also trained as qualified dialectical behaviour therapists.
- Staff used restraint as a last resort and figures demonstrated ongoing improvement from previous inspections.
- Staff received regular clinical supervision and appraisals and were encouraged and able to attend regular team meetings.
- Staff had a good understanding of the principles of both the Mental Health Act and the Mental Capacity Act.

However:

- Staff were not consistently completing patient-led recovery outcome measures which related specifically to patients' individual pathway of care.

Are services caring?

Good

At our last inspection in May 2018 we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive?

Good

At our last inspection in May 2018 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services well-led?

Good

At our last inspection in May 2018 we rated well-led as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Mental Health Act training was mandatory for all staff and compliance with training was 100%. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff had access to Mental Health Act policies and procedures that reflected the most recent guidance and copies of the Code of Practice were situated on the wards.

Patients had easy access to information about independent mental health advocacy and could access support from an advocate who visited the service once a week. Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act and Deprivation of Liberty Safeguards was mandatory for staff, with compliance at 88%. Staff we spoke with had a good understanding of the Mental Capacity Act, including the five statutory principles. The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards, which staff could access via the service's intranet.

Following our previous inspection in May 2018 we told the provider they must ensure that where patients lacked capacity to make decisions, staff followed the principles of the Mental Capacity Act. During this inspection we saw evidence that staff had assessed and recorded capacity to consent appropriately for a patient where there were concerns about their capacity. They did this on a decision-specific basis regarding a significant decision. Staff made and clearly recorded decisions in the patient's best interests, recognising the importance of their wishes, feelings, culture and history.

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	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

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

The service had two wards which had recently been reconfigured to provide a 12-bed ward (Byron) and a nine-bed ward (Bronte). Staff completed regular risk assessments of the care environment including conducting regular ligature point audits (a ligature point is something that can be used for the purposed of hanging or strangulation). Staff carried out individually risk assessed observations to mitigate risk of identified ligature points. The service also carried out weekly fire alarm testing as well as full evacuation drills twice a year.

The service only admitted female patients and was therefore compliant with the Department of Health and the Mental Health Act 1983 Code of Practice guidance regarding elimination of mixed-sex accommodation.

Staff carried personal alarms and patients had nurse call points in their bedrooms. Panels located on the wards indicated the location of any alarms raised. Call points were regularly tested as part of environmental maintenance checks.

Both wards were clean, had good furnishings and were well-maintained. The service had an infection control policy in place which staff could access via the intranet. All staff attended infection control training to a level applicable to their role, with training compliance at 96% for clinical staff at levels one and two, and at 100% for support staff at level one. Staff also had access to personal protective equipment, including gloves, and clinic rooms had appropriate hand wash and hand gels available. However, whilst clinic rooms were noted to be clean, cleaning records did not state how often rooms should be cleaned, and we saw that cleaning regularity varied as some weeks they were cleaned once and other weeks they were cleaned up to three times, with no rationale for the variance. The clinic room was also cluttered and was being used as storage for a number of items including walking frames and shower chairs which were blocking access to the examination area which would have made it difficult for patients to access the clinic room should they wish to do so whilst also making it difficult to ensure appropriate cleanliness. Additionally, staff were observed to have painted and false nails which could contribute to the spread of infection contrary to infection control principles.

The service had one clinic room located in the communal entrance to the service, as well as two medication-dispensing rooms; one on each ward. The clinic room contained an examination couch and privacy screen, and equipment for conducting physical healthcare checks, including an electro-cardiograph machine, weighing scales and a blood pressure monitor. Staff told us that patients preferred to access the medication-dispensing rooms on the wards, or to have examinations in their bedrooms, rather than attending the clinic room. Patients did not raise any concerns around the administration of medications.

Staff stored patient medications in the dispensing rooms on each ward. Staff from Bronte ward utilised the fridge in the dispensing room on Byron ward whilst awaiting delivery of an additional fridge. Room and fridge temperature checks were reviewed from 1 December 2018

to 9 January 2019. Staff had recorded both daily except for one omitted fridge temperate check and one omitted room temperate check in December 2018; both on Byron ward. Temperatures recorded were within recommended range. Fridge temperatures were audited by an external pharmacist on a monthly basis whereby omissions or temperatures out of range were reported back to service managers.

Staff had access to emergency equipment including oxygen and a defibrillator. Emergency bags were stored in the ward office on both wards to enable all staff to access them. Staff were required to undertake daily checks of emergency bags on both wards. However, staff on Byron ward had not undertaken checks on two occasions, and staff on Bronte ward had not undertaken checks on ten occasions between 5 December 2018 and 9 January 2019. This equated to 12 missed checks out of 72 that should have been completed. Bags were checked during inspection and were found to contain all necessary equipment which was in-date.

Safe staffing

Managers had calculated the number and grade of nurses and healthcare assistants required per shift using an acuity tool. When necessary, managers deployed bank and agency nursing staff to maintain safe staffing levels. Between July 2018 and December 2018 there were no shifts that did not meet the provider's safe staffing levels. Use of agency and bank staff had increased since the re-opening of Bronte ward. Most recently in December 2018, 9% of shifts were covered by bank staff and 14.5% by agency staff. When agency and bank nursing staff were used they were familiar with the ward and were supported by a permanent member of nursing staff who was on shift at all times. Managers including charge nurses could adjust staffing levels daily to take account of case mix and need, for example if a patient required increased observation levels.

At the time of inspection there were a number of vacancies at the hospital; largely due to the recent reconfiguration and re-opening of Bronte ward. Positions had been appointed to, including a ward manager and two charge nurses, with start-dates for commencement of employment within three weeks from inspection. There were outstanding vacancies for one charge nurse and five qualified nurses. However, vacancies advertised were to bring the hospital to full-staffing capacity if the wards were fully occupied. At the time of inspection, the hospital had only admitted patients to 14 out of 22 beds and were staggering admissions to ensure safe staffing levels were maintained whilst recruitment was ongoing.

Staff were available to patients in communal areas of the ward. Staffing levels allowed patients to have regular one-to-one time with their named nurses and we saw from patient records that patients accessed this.

Staff were trained to safely carry out physical restraint interventions with patients where they were required. Most staff told us that they felt there was enough staff to respond to incidents and that they felt well supported. One member of staff told us that they had raised a concern about the impact of some staff on the ward not being able to support with physical interventions due to personal medical reasons. Managers were aware of staff who were not able to support with physical interventions and that these members of staff were supernumerary on the wards; they were not counted within required staff numbers to ensure sufficient staff were available who could support with physical interventions.

A consultant psychiatrist was available on-site between 9am and 5pm from Monday to Friday. Any absence or sickness was covered by medical staff from another hospital. The service had a system for on-call medical staff to cover the service out-of-hours. The doctor on-call would be expected to attend the hospital within 45 minutes of a psychiatric emergency. This is contrary to AIMS standards for inpatient mental health rehabilitation services which suggests a doctor should be able to attend within 30 minutes of a psychiatric emergency. However, there were no recorded incidents in the last six months whereby a doctor had been requested to attend the hospital due to a psychiatric emergency. Staff shared an example of where they had contacted the on-call medic following an incident requiring rapid tranquilisation and had been provided with advice in a timely manner.

Staff were required to complete a number of mandatory training modules including conflict resolution, managing violence and aggression, basic life support and immediate life support. Compliance for all modules was between 88% and 100%.

Assessing and managing risk to patients and staff

During inspection we reviewed four patient care records. Staff completed a pre-admission risk assessment with each

patient which was updated regularly, at a minimum of every three months, or more regularly if required including after any incidents. The service used recognised tools for assessing risk, including the 'short-term assessment of risk and treatability' for all patients, and other tools including the 'historical clinical risk management-20, version 3', and the 'health of nation outcome scale' where appropriate.

Staff were aware of the patients' risks and managed them appropriately. For example, we saw a specific 'managing falls' care plan within a patient's care records which detailed management plans relating to specific footwear, physiotherapy support, and medical checks such as blood pressure monitoring.

At our last inspection in May 2018 we suggested that the provider should ensure that all staff understood the hospital's search policy, including how and when to use a randomiser button for searching patients. Since this inspection the randomiser button has been removed. Staff we spoke with had a good understanding of the service's search policy and could explain how and when this would be used to search patients or their bedrooms. Staff also followed robust policies and procedures for the use of observation, including to minimise risk from potential ligature points.

Since our last inspection in May 2018 staff had worked to better understand and reduce blanket restrictions on patients' freedoms and other rights. Managers told us that the hospital's list of contraband items was no longer in place as patients were risk assessed for access to items on an individual basis. Managers had also recently introduced a blanket restrictions audit which staff were requested to complete to establish any existing blanket restrictions. Results from this audit were due to be collated by the end of January 2019 and any outstanding restrictions entered into an action plan with actions, responsibilities and completion dates for resolutions sent on to dedicated corporate leads and relevant clinic commissioning groups for review. Following a Mental Health Act Review visit in November 2018 concerns were raised around staff understanding of patient access to the communal courtyard as patients stated this was sometimes being locked off. Staff and patients spoken with during this inspection told us they were not aware of any blanket restrictions and that restrictions identified around access to the courtyard had been rectified with patients always able to access the courtyard unless there was a specific risk assessed reason as to why they could not.

The service previously did not allow patients to smoke on-site except for e-cigarettes in the hospital's courtyard. Due to an increase in incidents because of this restriction, and complaints from neighbours around patients smoking excessively around the external perimeter of the hospital, managers had made the decision to re-introduce smoking within the hospital's courtyard. All patients were individually risk assessed for access to cigarettes and lighters. The hospital continued to offer smoking cessation advice and support to patients.

During the inspection we spoke with an informal patient who told us that they knew they could leave the hospital at will. Information was available to patients detailing their rights.

The hospital did not have a seclusion room and had not recorded any episodes of seclusion or long-term segregation in the six months prior to inspection. The hospital did have a 'de-escalation room' which patients were able to use if they required time away from other patients on the ward. Staff and patients understood that this room was not to be used for seclusion and that patients were able to leave this room at any time.

Between 1 July 2018 and 31 December 2018 there 128 recorded incidents of the use of restraint. None of these incidents involved prone restraint. Eighty-two percent of restraints recorded were low-level and involved restraint in a standing or seated position. Staff used restraint as a last resort and figures demonstrated ongoing improvement from previous inspections.

Between 8 August 2018 and 8 December 2018 there were 16 recorded incidents of the use of rapid tranquilisation. At our last inspection in May 2018 we told the provider that they must ensure that the correct monitoring and recording of a patient's physical health observations was undertaken following the use of rapid tranquilisation. The hospital's policy stated that staff should record observations every 15 minutes for a minimum of one-hour post-rapid tranquilisation. National Institute for Health and Care Excellence guidance states that observations should continue to be recorded every hour until there are no further concerns about the patient's physical health status.

Long stay/rehabilitation mental health wards for working age adults

Good

During this inspection we reviewed three episodes of rapid tranquilisation. We saw that staff were recording patient physical health observations in line with policy and guidance. Where patients were recorded as declining to have observations taken staff continued to record patient respirations and observed state, for example 'alert'. Hospital managers audited the use of all incidents of rapid tranquilisation monthly to ensure staff compliance.

Staff used restraint only after de-escalation had failed. Rapid tranquilisation records reviewed demonstrated that on each occasion staff attempted to verbally de-escalate the patient before offering them oral PRN medication if appropriate (medication prescribed by a doctor to be used as needed in given situations). Patients were also offered time in the hospital's de-escalation room or a space away from other patients. Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.

Safeguarding

All staff were trained in safeguarding children and safeguarding adults with training compliance at 97.2% for both modules. Staff had access to an up-to-date safeguarding policy. All staff we spoke with had a good understanding of safeguarding procedures. Staff knew how to identify adults and children at risk of, or suffering, significant harm and could give examples of how to protect patients from harassment and discrimination. Staff knew how to make safeguarding alerts and did so when appropriate. The hospital had a designated safeguarding lead for children and adults who staff could approach for advice and support. This member of staff attended daily management handover meetings where they could feed back any concerns from staff. The hospital manager liaised regularly with the local authority safeguarding team to discuss referrals and practice. A representative from the local authority safeguarding team provided feedback that they were satisfied that the hospital was managing safeguarding risks appropriately and were taking steps to minimise risks where possible.

Staff followed safe procedures for children visiting the ward by assessing safety within multidisciplinary meetings prior to visits taking place, and by designating space off the wards where visits could take place. Staff gave examples whereby a decision was made not to allow a child to visit due to a patient's presentation and safety concerns for the child, with rationale being explained to the patient and visitors.

Staff access to essential information

The service used an electronic system to store patient records. All staff, including agency staff, could access the system to enable them to see information needed to deliver patient care and to contribute to ongoing patient notes.

Medicines management

In general staff followed good practice in medicines management including in relation to transport, storage, dispensing, administration, medicines reconciliation, recording, and disposal. However, in the dispensing room on Byron ward we found that three creams and two inhalers prescribed for individual patients were not labelled with patient details. We also found two medicines with limited shelf-life that did not have a date of opening written on them.

At our last inspection we found that whilst there had been some improvements in physical health monitoring of patient's prescribed medication which could have serious side-effects, there were still concerns this practice was not entirely embedded. During the current inspection we found that staff reviewed the effects of medication on each patient's physical health regularly and in-line with National Institute for Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication. An alert banner was present on every patients' care record stating what type of medication they were prescribed and when they required physical health checks in line with their medication. The service had two staff trained in phlebotomy who could also conduct electro-cardiogram tests, to ensure timely and effective monitoring of patients' physical health.

An external pharmacist visited the service weekly to conduct audits of patient medication cards, controlled drugs, and general storage of medication. The pharmacist reported back to the service monthly as well as producing quarterly reports. The pharmacist would attend hospital governance meetings when required to provide further information or guidance. The pharmacist and senior managers monitored outstanding actions to ensure they were rectified in a timely manner.

Long stay/rehabilitation mental health wards for working age adults

Good

Track record on safety

There were no serious incidents recorded in the six months prior to inspection; from 1 July 2018 to 9 January 2019.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them and reported incidents when they should. Staff discussed incidents in daily handover meetings at ward and managerial level. This included discussions around required changes to patient observation levels, as well as risk assessments and management as a result of incidents. Staff understood the duty of candour; they were open and transparent and gave patients and families a full explanation if things went wrong. A written apology would be issued if an incident reached a certain threshold. Managers told us that even when incidents did not meet the threshold for duty of candour, for example when harm was classified as low, they would still offer the patient an apology if appropriate.

Managers told us that staff would receive feedback from the investigation of incidents via email and in monthly team meetings. Managers could give examples of where changes had been made as a result of incidents. For example, following an incident whereby a member of staff had revealed personal information to a patient the service's information governance training package was reviewed. We reviewed team meeting minutes from 3 August 2018 to 9 January 2019. Meeting minutes did not follow a standard agenda and varied on each occasion. Minutes from 3 August 2018 stated that lessons learned following two recent complaints would be communicated to staff once reports were finalised. Staff we spoke with could not give examples of any recent lessons learnt. Not all staff we spoke to were sure how lessons learnt would be communicated but told us it would most likely be via email.

Staff told us they would receive a debrief following a serious incident. Staff told us they felt supported by managers following incidents.

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

During the inspection we reviewed four patient care records. All records contained a comprehensive assessment of the patients completed in a timely manner. All patients had a care plan specific to their individual needs which was holistic and recovery-oriented. Care plans were personalised and evidenced the patient voice. Where appropriate patients had positive behaviour support plans in place detailing triggers to negative behaviours as well as coping strategies and preferences if restraint were to be required. Staff discussed patient care plans monthly at multidisciplinary review meetings, an updated them when necessary. Care plans were goal directed and specific to individual need. For example, goals were set around financial planning, self-medication and work.

Staff had assessed patients' physical health needs in a timely manner after admission. Care records included electronic alert banners to indicate when physical health checks were required dependent on the medications the patient was prescribed. We saw that where necessary patients had specific care plans in place to support their physical health, including diet, fitness and wellbeing, and falls prevention, which were directly linked to risks identified.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. This included activities, training and work opportunities intended to help patients acquire living skills. Patients had access to a range of psychological therapies on both a group and individual basis, including dialectical behaviour therapy, trauma work, cognitive behavioural therapy and recovery work. Patients also had access to bespoke occupational therapy assessments to support with functional skills, including cooking or accessing the community, as well as to aid with education and leisure opportunities. In addition to interventions run by therapy staff, all staff at the hospital had undertaken a one-day

training course in personality disorder awareness, all clinical staff had undertaken a three-day dialectical behaviour therapy awareness training course, and five registered nurses had trained as qualified dialectical behaviour therapists.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Patients were routinely referred for GP and dentistry appointments, as well as to other specialists such as chiropodists, physiotherapists and opticians where required.

Staff supported patients to live healthier lives through participation in smoking cessation schemes, healthy eating advice, and support to access local gymnasiums and fitness clubs.

Staff used recognised rating scales to assess and record severity and outcomes, including Health of the Nation Outcome Scales, and the 'Lester' tool to monitor cardiac and metabolic health. However, we did not see evidence that staff were consistently completing patient-led recovery outcome measures which related specifically to patients' pathway of care, in order to measure effectiveness and safety of interventions as well as patient and carer experience.

Staff used technology to support patients effectively, including prompt access to blood test results via email, and access to dashboards for overviews of key dates including review dates for patient risk assessments and care plans. Managers also used these dashboards to review incident and restraint data, and to establish trends or areas for concern.

The service followed an annual audit schedule set by the provider as well as conducting local audits. Provider level audits were broken down into areas including clinical effectiveness, promoting involvement, and improving patient safety. Recently conducted local audits included the audit of ligature risks and self-harm, and the review of care plans and risk assessments. Staff were involved and participated in these audits.

The service participated in benchmarking against other services through ward to board reports, and national medical audits. Managers told us that their aim for the future was to get involved with a quality network that works with services to improve the quality of inpatient rehabilitation wards.

Skilled staff to deliver care

The team included a range of specialists required to meet the needs of patients on the wards, including doctors, nurses, healthcare assistants, occupational therapists and clinical psychologists. Staff told us that they could access support from other specialists including speech and language therapists and physiotherapists where required. Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Managers provided new staff, including bank staff, with an appropriate induction.

Following our last inspection, we told the provider they should ensure that staff were able to attend team meetings to enable them to learn and develop skills. At this inspection staff told us that they were encouraged to attend monthly team meetings. We reviewed notes from team meetings and saw that these took place regularly and were well attended but did not follow a structured agenda each time. Staff were also able to attend wider hospital staff meetings which also took place monthly.

Following our last inspection in May 2018 we told the provider that they must ensure that all staff have clinical supervision. Between July 2018 and December 2018, the percentage of staff that received regular clinical supervision was on average 98.7%. The percentage of staff that had had an appraisal in the last 12 months was 94%. Both figures showed an improvement since our previous inspection.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff told us that clinical supervision and appraisals were useful forums to discuss learning needs.

Managers ensured that staff received the necessary specialist training for their roles, for example all staff received training in personality disorder awareness, and clinical staff received additional training in dialectical behaviour therapy awareness. In total seven members of staff were trained as dialectical behaviour therapists. The service operated a formal procedure to enable staff to apply for additional training should they wish to do so, and we saw examples of where the service had supported staff to access external training courses. The service offered staff a range of leadership training programmes specific to the role, for example team leader training for health care assistants, and formal leadership training for charge nurses.

Managers dealt with poor staff performance promptly and effectively and could give examples of investigations carried out into staff misconduct.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings. The multidisciplinary team saw patients at least every four weeks but patients could request to see the team sooner if there was a specific need they wished to be addressed. Patients, families and carers, and care co-ordinators and/or other professionals relevant to the patient were invited to these meetings.

Staff shared information about patients at twice daily handover meetings on each ward. The senior leadership team, including a lead from each discipline and a representative from each ward, also met each morning, Monday through to Friday, to discuss a set agenda of items including incidents, risk, observation levels, patient leave and any new referrals.

The ward teams had effective working relationships, including good handovers, with other relevant teams within the organisation. For example, we observed staff discussing their liaison with a patient's care co-ordinators during the senior management team daily meeting, including the outcome of several visits to the wards from the care co-ordinators. The ward teams also had effective working relationships with teams outside the organisation including social services and GPs.

Adherence to the MHA and the MHA Code of Practice

Mental Health Act training was mandatory for all staff. Compliance with training was 100%. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had access to administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice. The Mental Health Act administrator was 0.6 whole time equivalent. As part of their role they audited Mental Health Act paperwork, managed tribunals, coordinated care programme approach meetings, and ensured patient rights were read on a regular basis.

The provider had relevant Mental Health Act policies and procedures that reflected the most recent guidance. Staff had easy access to policies and procedures via the service's intranet, and copies of the Code of Practice were situated on the wards.

Patients had easy access to information about independent mental health advocacy and could access support from an advocate who visited the service once a week.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff ensured that patients could take Section 17 leave when this has been granted. Details of authorised leave were clearly detailed within patient care notes with accompanying leave risk assessments. At our last inspection in May 2018 we suggested that the provider should ensure that staff were adequately recording when patients returned from section 17 leave. The provider had addressed this concern and we could see that staff were documenting this.

Our Mental Health Act reviewer visited the service in October 2018. Following this visit, concerns were raised around blanket restrictions related to courtyard access, staff clarity around patient searches, access to the approved mental health professional reports from patients' current detention, and identical wording on patient consent to treatment forms. The provider had addressed these concerns by the time of our visit.

At our last inspection in May 2018 we found that a Second Opinion Appointed Doctor request and Section 61 review of treatment certificate were not available for one patient; staff had not stored these documents with the prescription charts and ward staff could not access them on the day of our inspection. During this inspection we reviewed four patient prescription charts and found that paperwork was accurately completed and stored correctly.

Informal patients we spoke with were clear that they could leave at will. However, the service did not display notices to tell informal patients that they could leave the ward freely.

Good practice in applying the MCA

Training in the Mental Capacity Act and Deprivation of Liberty Safeguards was mandatory for staff, with compliance at 88%. Staff we spoke with had a good understanding of the Mental Capacity Act, including the five statutory principles. The provider had a policy on the

Long stay/rehabilitation mental health wards for working age adults

Good

Mental Capacity Act, including deprivation of liberty safeguards which staff could access via the service's intranet. Staff told us that they would support patients to make specific decisions themselves.

Following our previous inspection in May 2018 we told the provider they must ensure that where patients lacked capacity to make decisions, staff followed the principles of the Mental Capacity Act. During this inspection we saw evidence that staff had assessed and recorded capacity to consent appropriately for a patient where there were concerns about their capacity. They did this on a decision-specific basis with regard to a significant decision. Where the patient was deemed to lack capacity, staff made and clearly recorded decisions in the patient's best interests, recognising the importance of their wishes, feelings, culture and history, and involving family where appropriate.

The service had not made any deprivation of liberty safeguards applications within the last 12 months.

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

Good

At our last inspection in May 2018 we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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

Good

At our last inspection in May 2018 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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

Good

At our last inspection in May 2018 we rated well-led as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff comply with infection prevention and control guidance in relation to the wearing of nail varnish and false nails at work.
- The provider must ensure that clinic rooms are cleaned frequently and that this is clearly documented in line with service protocol.
- The provider must ensure that the clinic room is safe and accessible for patients to receive treatment and is not used as a storage area.

Action the provider SHOULD take to improve

- The provider should ensure that they are able to respond to psychiatric emergencies in line with national rehabilitation services guidance.
- The provider should ensure that staff are documenting checks of emergency bags daily.
- The provider should ensure staff are following best practice in the storage of patient medications.
- The provider should ensure that they display a notice informing informal patients of their rights to leave the hospital freely.
- The provider should ensure that lessons learnt following investigation of incidents are communicated clearly to all staff.
- The provider should ensure that staff are consistently completing patient-led recovery outcome measures which are specific to patients' individual care.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way for patients because staff did not adhere to infection prevention and control guidance in relation to the wearing of nail varnish and false nails. The clinic room was cluttered and was being used as storage for a number of items and cleaning of the clinic room varied in regularity with records not stipulating how often clinic rooms should be cleaned. **This was a breach of regulation 12(2)(e)(h)**