

Enbridge Healthcare Limited

Magna House

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Requires Improvement



Are services caring?

Requires Improvement



Are services responsive to people's needs?

Requires Improvement



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

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

- We found that patients were not as involved as they could be with care planning and care plans were not always patient centred and recovery focused. In addition, discharge planning was not evident in the patient care plans we viewed.
- Staff did not update risk assessments after every incident, nor did they follow best practice after administering rapid tranquillisation with the monitoring and recording of physical observations in care records.
- We observed and patients and staff told us there was a lack of therapeutic activities.
- There were not enough registered mental health nurses on shift across the cottages to consistently meet the needs of the patients in a timely way.
- Some patients told us that staff were not always polite or kind and there were language barriers due to the number of nurses whose English was not their first language.
- We collated evidence that the ward environments were dirty and in need of repair. Two patient bedrooms viewed were untidy and cluttered with various personal items, including food and drinks.
- Whilst we found that governance systems were in place, they had not been effectively used to monitor the provisions of services provided and to make improvements.
- During 2022, three patients had been transferred to other units due to having more acute needs.

However,

- Staff completed risk assessments of all ward areas, including ligature anchor points and carried out observations safely.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Managers ensured that staff received supervision and an annual appraisal. Staff were up to date with mandatory training and had access to specialised training to support their roles.
- There were systems and processes to prescribe and administer medicines safely. Staff reviewed each patient's medicines regularly in ward round and staff completed medicine records accurately.
- Patients had access to advocacy on an individual basis and within community meetings.
- The service treated concerns and complaints seriously, which they investigated and identified themes and trends to improve patients experience.

Summary of findings

Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|--|--|------------------------------|
| Long stay or rehabilitation mental health wards for working age adults | Requires Improvement  | |

Summary of findings

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Summary of this inspection

Background to Magna House

Magna House is a 29-bed independent hospital in Lincolnshire, providing care, treatment and rehabilitation services to people who are experiencing mental health issues. It registered with the Care Quality Commission in August 2020 for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

The hospital comprises of four cottages, Aspen – seven female beds; Beech one – five male beds, Beech central – three male beds, and Beech two – three male beds. All the bedrooms in the cottages are ensuite and located on the ground floor. There is also an eleven bedded male assessment ward with ensuite bedrooms, over two floors, in a separate building known as Redwood ward.

Magna House has a registered manager. It was first inspected in June 2021, when only the cottages were open and in use, and was rated as good overall with requires improvement for safe. In July 2021 the CQC visited the hospital to review the management of a serious incident and became aware the provider had opened Redwood Ward which was not in use on initial registration. An urgent, unannounced and focused inspection of this ward was undertaken in July 2021.

Following the July 2021 inspection, and in respect of Redwood ward, the provider was found to be in breach of the Health and Social Care Act (regulated activities) Regulations 2014. Regulation 12 - safe care and treatment and Regulation 15 – premises and equipment. We served a notice of decision imposing conditions on the provider, including that they immediately move patients from Redwood ward and do not admit any further patients without CQC written approval. The provider actioned this request and submitted an action plan to address the issues we found and agreed to not admit any new patients to Redwood ward until they had met the requirements of the conditions.

In February 2022, the provider told CQC they had completed all the required works and formally asked if the conditions on their registration could be removed. An inspection was carried out on 16 May 2022 and found that the provider had met the conditions imposed on the service and they were removed. The service was not re rated.

This inspection was carried out to re rate the service.

What people who use the service say

We spoke with nine patients who were receiving care across the hospital.

Of the nine patients, three expressed that they did not feel safe at the hospital, due to there not being enough staff, with particular references made to the number of incidents staff have to attend.

Four patients told us that there was not enough staff. One patient talked specifically about incident management and there not always being enough staff to manage incidents effectively.

Summary of this inspection

Patients told us that staff sometimes missed intermittent observations if they were dealing with an incident, as the incident would be the priority. Although four patients said that staff did what they could.

Of the nine patients we spoke with, one patient from the cottages stated most of the time there was only one staff member – which was not enough to meet all patient needs. One patient told us the staff “do the bare minimum”. One further patient talked about staff not being responsive to patient needs, for example when asking for something – there were often delays.

Of the nine patients we spoke with, four said there was not enough activities offered. Two patients said they were frequently bored. A further two patients were unable to tell us what activities were on offer. One patient acknowledged that staff offered some activities but said that staff did not prompt or remind patient’s when they were happening.

Two of the nine patients we spoke with said that they had experienced some staff being unkind towards them. A third patient told us that staff lacked understanding of their needs and lacked empathy.

A patient on Redwood ward told us that staff regularly slept during the night, and that staff told patients to go to bed at 10pm so the lounge area could be used by staff to sleep. We brought this to the attention of the registered manager.

Two patients told us their experiences at the hospital had been positive and had no areas of concern.

One patient felt frustrated with the shower as it worked on a timer and found it difficult to regulate the temperature.

How we carried out this inspection

This was a comprehensive inspection and looked at all five key questions: safe, effective, caring, responsive and well-led.

The inspection team consisted of two CQC inspectors and one specialist advisor who was a registered mental health nurse and had experience of these settings. An inspection manager supported the inspection remotely.

The inspection team carried out the following activities during the inspection:

Spoke with nine patients who were being cared for at Magna House.

Observed staff interaction with patients.

Observed morning meetings.

Interviewed 12 members of staff including nurses, support workers, doctor, psychologist, and the registered manager.

Reviewed the environment of the hospital.

Reviewed six patient care records which included physical health records and medicine charts.

Reviewed three incidents on closed circuit television.

Summary of this inspection

Reviewed a range of documents and policies relation to the running of the hospital.

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

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **MUST** take to improve:

- The service must ensure that environments are clean and redecorated.
- The service must continue to advertise for qualified mental health nurse vacancies.
- The service must continue to advertise for occupational therapists to ensure patients' needs are met.
- The service must ensure that risk assessments are updated after every incident.
- The service must ensure that staff follow best practice guidance after administering rapid tranquilisation.
- The service must ensure that patients are involved with care planning and care plans are patient centred and recovery focused.
- The service must ensure that staff are polite and kind when interacting with patients.
- The service must ensure that they address the language barriers between staff and patients.
- The service must ensure that discharge plans are in place for all patients.
- The service must ensure staff complete all observation documentation fully and undertake observations as prescribed.
- The service must ensure that effective governance systems and processes are established to identify, assess and action risks to those who use the service.
- The service must ensure they thoroughly assess patients and only accept patient's whose needs can be met.

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

- The service should provide consistent and stable management and leadership.

Our findings






Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|--|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Long stay or rehabilitation mental health wards for working age adults | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement |
| Overall | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement |

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

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

Is the service safe?

Requires Improvement 

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

Safe and clean care environments

Not all wards were safe, well equipped, adequately furnished, maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Managers had completed full environmental risk assessment of the hospital.

Staff could observe patients in all parts of the wards. We noted that areas that could be a potential blind spot had convex mirrors in place and closed-circuit television cameras were used in some communal areas.

The ward complied with guidance and there was no mixed sex accommodation, there was separate male and female accommodation

There were some potential ligature anchor points in the service. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Ligature points had been reduced where possible and managers had produced a ligature hot spot floor plan and visual ligature assessment.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff had access to emergency call alarms and radios, and patients access to nurse call systems. The alarms were tested and linked to control panels across the hospital to alert staff to where help was needed.

Maintenance, cleanliness and infection control

The majority of the ward areas were clean, well maintained, well-furnished and fit for purpose. However, on Beech 1 ward we saw stains / marks on the patio door which lead out into the courtyard. In one patient bedroom, on Beech 1 we saw various stains and marks across the bedroom walls. The kitchen work top was damaged on Beech 2 and various

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

walls in the communal areas were marked or had not been redecorated when pictures had been removed. In addition, there had been an incident the weekend prior to the inspection which resulted in three windows being boarded up on Beech 2 and a broken door handle and lock on the door leading to the courtyard. The maintenance team were aware and had taken some action to minimise the risk of harm.

Staff made sure cleaning records were up to date but not all areas of the hospital were clean. Managers audited the cleaning records. Patients told us that housekeeping staff cleaned their bedroom floors and replaced toilet paper, but they had to clean the rest of their room and ensuite as part of their rehabilitation programme. Two patients showed us their bedrooms. Both rooms were untidy and cluttered, with numerous food on the floors (boxes of cereal for example and packets of crisps). We observed a fly in each room which the patients did not seem to notice.

Staff followed infection control policy, including COVID-19 guidance such as handwashing. There were hand sanitisers at strategic points and signage advising people to wash or sanitise their hands.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency medicines that staff checked regularly. Records showed that all equipment had been calibrated and checked regularly. Staff checked emergency medicines and recorded that they were present and in date on a weekly basis.

Staff checked, maintained, and cleaned equipment. Staff completed cleaning records daily which included any actions that they needed to take to maintain the cleanliness of the clinic.

Safe staffing

The service had nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, the use of agency staff had increased which could impact the consistency of care.

Nursing staff

The service had enough nursing and support staff to keep patients safe. At the time of the inspection the service employed 15 registered nurses, 34 healthcare workers and 4 patient safety officers. Managers deployed the staff across the service to meet patient need. If the service was impacted by short unplanned sickness, then the patient safety officers who were supernumerary would be counted in the numbers to support the ward teams and patients. However, at times there was a registered general nurse in charge of a shift. The registered manager told us that when this occurred, they would provide cover as the registered mental health nurse. We were concerned that the one person could not be across the four wards at one time or have the knowledge of the patients risks to make clinical decisions quickly if required. For example, emergency interventions of utilising section 17 leave.

The service had reducing vacancy rates. From January to September 2022 the service had a total of 47 new staff start employment and 24 staff leave. However, the reducing vacancy rates had been impacted by the staff turnover rate, which at the time of the inspection was 5%.

From April to September the use of agency staff had increased from 9% to 15.5%.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement



Managers limited their use of bank and agency staff and requested staff familiar with the service. Agency staff were used to increase staffing levels although this was not always achieved. When this occurred the provider used supernumerary staff to achieve the required number of staff to meet patient's needs.

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

Managers supported staff who needed time off for ill health. Levels of sickness had been reducing. From April 2022 the sickness rates were 8% by September 2022 the sickness rate was 1.5%.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. We reviewed records which showed from January to September 2022 all shifts had the required number of qualified nurses on shift. However, there were 13 shifts in the same period when shifts did not have the required numbers of healthcare support workers. We found evidence that these 13 shifts had been filled using supernumerary staff.

Managers could adjust staffing levels according to the needs of the patients although to do this agency staff or supernumerary staff were used.

Patients had regular one to one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely. 83% of staff had been trained in management of violence and aggression techniques.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the wards quickly in an emergency. The service had a planned on call rota that was available to staff if they needed it.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

As of September 2022, 92% of staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. It included, Mental Health Act training, basic life support, intermediate life support (for qualified nurses and medics), Prevent, self-harm and suicide, positive behaviour support, first aid, and management of violence and aggression techniques training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to a mandatory training compliance report, which highlighted when individual staff training was going to expire or had expired.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Assessing and managing risk to patients and staff

Staff did not consistently assess and manage risks to patients effectively. Where possible, staff achieved a balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool. Staff did review these regularly, but not after every incident.

Staff ensured that all individual risks were assessed for each patient, this included any physical health issues.

We reviewed five risk assessments and found that one had not been updated after incidents. We sampled incidents for the patient from 18 August to 06 of September and found that 8 incidents had occurred that had not been added to the risk assessment.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. The risk assessments we reviewed all had risk management plans in place for the individual risks that had been identified for each patient.

Staff identified and responded to any changes in risks to, or posed by, patients. For example, if patients' risk had increased for self-harming behaviours then staff restricted access to specific items for a set period of time to keep the patient safe, or increased staff interactions to distract and support the patients.

Staff could observe patients in all areas of the wards. Staff followed procedures to minimise risks where they could not easily observe patients. Managers had formulated a revised observation protocol for staff to follow and familiarity with this document was part of the provider's new induction program.

We were not assured that staff undertook nursing observations, as required to keep patients safe. We reviewed a sample of patient's observations records and found two records were not dated. Two records did not stipulate the reason the observations were needed. We also found between 21 September 2022 and 01 October 2022 staff had failed to record observations on five different patients recording sheets.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The policy was in line with the Mental Health Act Code of Practice and gave clear procedures for searching detained and informal patients, their bedroom spaces and ward areas.

Use of restrictive interventions

Levels of restrictive interventions fluctuated each month from the data we reviewed from January to August 2022. The highest levels of physical interventions were in June 2022 at 50 incidents.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff participated in the provider's restrictive interventions reduction programme. This programme supported staff to reduce the number of incidents when restraint was required to keep the patients safe. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff did not fully adhere to NICE guidance when using rapid tranquilisation. On Beech 1 staff did not complete all required documentation after rapid tranquillisation had been administered. Two patients had been administered rapid tranquilisation which was evidenced by their medicine administration record. However, when we reviewed the patient files there was a lack of monitoring and recording of physical observations.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Managers ensured that staff received training on how to recognise and report abuse, appropriate for their role. The training was initially completed as part of the induction training and then annually. The training included safeguarding children. In 2022, staff had made 17 safeguarding referrals.

85% of staff had kept up to date with their safeguarding children training and 97% for adult safeguarding.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, accessing interpreters to support patients during safeguarding procedures and reporting racial abuse to the police.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. We reviewed a random sample of safeguarding referrals during this inspection and it was clear that staff had reported safeguarding incidents correctly and worked with the local authority to maintain the safety of victims. Additionally, staff knew how to make a safeguarding referral correctly and who to inform if they had concerns.

Staff followed clear procedures to keep children visiting the hospital safe. There was a dedicated room for visitors. The service was able to safely facilitate child visits whenever appropriate, coordinated by the social worker team and supported by the multidisciplinary team.

Managers took part in serious case reviews and made changes based on the outcomes. Out of the 17 safeguarding referrals made in 2022, three of these led to Section 42 enquiries and one national enquiry.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain clinical records – whether paper-based or electronic.

Patient paper-based notes were comprehensive and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Records were stored securely in cupboards within locked offices.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. We saw staff carried out robust checks of medicines and has regular discussions with the ward doctors to discuss any required changes to medicines prescribed for patients.

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

Staff completed medicines records accurately and kept them up to date. We reviewed 10 records during the inspection and found no issues.

Staff stored and managed all medicines and prescribing documents safely. An external pharmacist audited medicine management monthly and nurses audited weekly.

Staff followed national practice to check patients had the correct medicines when they were admitted, or as they moved between services. There was a British National Formulary for staff to check if they needed information in relation to administering prescribed medicines.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Systems were in place to monitor the use of medicines from feedback from patient's community meetings, morning meetings, ward rounds, multidisciplinary meetings, serious incidents and learning from medicine management audits. From January to August 2022 the use of rapid tranquilisations was low at less than 5 administered each month, no rapid tranquilisation was administered in May and June.

Staff reviewed the effects of each patient's routine medicines on their physical health according to NICE guidance. Medical staff involved patients when making decisions about their health, care and treatment.

Patients mental and physical health checks were carried out regularly, to ensure the medicines were safe and effective for them to take. The service had a physical health lead who was responsible for patient's physical care across site. A GP also attended the service every Monday and carried out any assessments that were required.

Track record on safety

The service had a variable track record on safety. Prior to the inspection we were aware of a serious incident in the community with a patient. In addition, we have been notified that the police had been called to the service numerous times due to incidents of aggression.

Reporting incidents and learning from when things go wrong

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

The service managed patient safety incidents but at times needed the support of the police. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and described to us during the inspection how they report them. Managers ensured that all incidents in the preceding 24 hours were discussed at the morning management meeting.

Staff reported serious incidents clearly and in line with the providers policy. Across the service, from January to August 2022 there had been a total of 905 incidents. In August 2022 Beech 1 had the highest number of incidents at 69 and the lowest was Beech 2 at 10. The majority of these incidents were due to patients self-harming.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The provider had policies and procedures in place to support a culture of openness and transparency, and ensured staff followed them.

Managers ensured that staff were debriefed and supported by them and a psychologist after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations if appropriate.

Staff received feedback from investigation of incidents, both internal and external to the service via regular team meetings.

Staff met to discuss the feedback and look at improvements to patient care in the clinical governance meetings.

There was evidence that changes had been made as a result of feedback. For example, we raised concerns that notifiable incidents had not always been sent to us following the police attending the service. We now receive these notifications.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Care plans were holistic, but not always recovery orientated, and person centred.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. This was evidenced in the patient care records.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Out of the five care plans we reviewed two patients were involved in the plan, one patient was too poorly to be involved but staff had tried and two had no patient involvement.

Staff regularly reviewed and updated care plans when patients' needs changed.

Whilst care plans were holistic, they were not always person centred or recovery oriented. Some care plans set out a list of instructions for staff to follow.

Best practice in treatment and care

Whilst staff had a timetable of activities and a range of treatment and care for patients based on national guidance and best practice, this was not always followed. The timetable included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff told us about the range of care and treatments suitable for the patients in the service. However, during the inspection we did not observe these sessions taking place. Patients and staff we spoke with reported that there was a lack of therapeutic activities.

Staff delivered care in line with best practice and national guidance. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation.

Staff identified patients' physical health needs and recorded them in their care plans. We saw good examples of blood monitoring and electro cardiograms taking place.

Staff made sure patients had access to physical health care, including specialists as required. The service employed a physical health lead nurse that supported patients.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff recorded in patient records their weight, diet plans and any dietetic involvement.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, weight loss or smoking cessation.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Nation Outcome Scores and Clinical Outcomes in Routine Evaluation (CORE) client self-reporting questionnaire to record progress.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff took part in clinical audits, benchmarking and quality improvement initiatives. For example, regular quality visits and an annual audit calendar which included care plans, medicine, safety and patient experience.

Managers used results from audits to make improvements. Following a quality visit and the recommendations within the report, night fire drills had been introduced as had the use of national early warning score tool, for monitoring physical health.

Skilled staff to deliver care

The ward teams included or had access to specialists required to meet the needs of patients on the wards apart from occupational therapists where the posts were vacant. Managers made sure they had staff with the range of skills needed to provide quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. Although there were vacancies for occupational therapists these were being advertised. Where possible, staff continued with individual and group activities.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. In addition to the required induction programme and mandatory training, managers ensured that staff attended training in learning disability, oral health, diabetes, effective communication, and autism awareness training.

Managers gave each new member of staff a full induction to the service before they started work. The induction programme had been reviewed and updated to ensure it met the needs of the service and the staff.

Managers supported staff and permanent medical staff through regular, constructive appraisals of their work. Managers had ensured that 85% of staff had received their annual appraisal.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Records showed that 87% had received supervision.

The medical director supported medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information via email from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. This was evident in the annual appraisals.

Managers made sure staff received any specialist training for their role. We reviewed the training that was available to staff and found that specialist training for oral health, learning disability and autism training and diabetes. Healthcare support workers had to complete their certificate in care, at the time of the inspection 96% of staff had been trained.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Managers recognised poor performance, could identify the reasons and dealt with these with support from the providers human resource team. When poor performance placed patients at risk staff had been dismissed from the service.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These were well attended by different members of the team.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handover meetings took place at the beginning of every shift and highlighted any associated risks or positive interaction or interventions that each patient had been involved in.

Ward teams had effective working relationships with external teams and organisations. We saw evidence that the team had worked well with the local authority safeguarding team and patients commissioners.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Whilst managers made sure that staff could explain patients' rights to them there had been occasions when a registered general nurse had been in charge of shifts. As these nurses were not trained specifically in mental health, they were aware of certain limitations, for example, making urgent clinical decisions. The registered manager was a registered mental health nurse, and they would be within the hospital to ensure that patient's rights under the Mental Health Act were discharged appropriately on occasions when a registered general nurse was in charge of a shift.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of the inspection 97% of staff had attended Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. There was a Mental Health Act Administrator on site five days a week.

Staff knew who their Mental Health Act administrators were, when to ask them for support and had access to them during the week.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff we spoke with knew how to access them if they needed to.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw posters displayed around the service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. This was closely monitored by the Mental Health Act administrator to ensure the rights were explained when they needed to be. For example, when the patient was admitted or when there was a change in their treatment plan.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and / or with the Ministry of Justice. The use of section 17 was only stopped based on the risk of the patient. At times it was delayed to ensure they had the required staff to support the leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

The Mental Health Act administrator ensured that copies of patients' detention papers and associated records were stored correctly, and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

The Mental Health Act administrator ensured that managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings in monthly governance meetings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of the five principles. At the time of the inspection 93% of staff had attended training which included Deprivation of Liberty Safeguards training.

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

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

The Mental Health Act administrator gave staff advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. This was evident in patients care records. Staff had clearly considered the patients capacity and assessed it prior to making specific decisions.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. This was evident within patient records.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff understood that if patient did not have capacity, they would make decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The Mental Health Act administrator monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. This was reported into the clinical governance meetings.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

We saw that staff treated patients with compassion and kindness. However, two patients reported that they weren't always polite or kind. Staff understood the individual needs of patients and supported them to understand and manage their care, treatment or condition.

We saw that staff were discreet, respectful, and responsive when providing emotional support for patients. However, two patients we spoke with said that staff were not always polite or kind. Another one told us that due to the overseas staff there was at times issues with communication due to the language barrier.

Staff told us they supported patients to understand and manage their own care treatment or condition.

Staff understood and respected the individual needs of each patient. They offered one to one time with patients regularly to discuss their needs.

Staff told us they would raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. We viewed three incidents via CCTV. During two incidents, staff had appeared caring and respectful. However, during one incident viewed, one staff member was not calm and respectful towards a patient. Other staff witnessed this. This was reported to the hospital manager who assured us it would be looked into further.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff told us that they introduced patients to the ward and the services as part of their admission. However, one patient reported that this did not happen when they were admitted.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff involved patients and gave them access to their care planning and risk assessments. We saw evidence in some patient records that they had been involved and had copies of care plans, but not in all. When patients were deemed to poorly to be involved or would not be able to keep their records safely and securely this was documented with the care records.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Psychologist provided flash cards to support non-verbal communication when patients were distressed. Positive behaviour support plans outlined in a patient centred way their treatment, prevention strategies and coping skills to support both the staff and patients.

Staff involved patients in decisions about the service and could give feedback about the service and their treatment in the morning meeting. This support patients to make decisions on their care.

Staff made sure patients could access advocacy services. Patients told us they had access to advocacy. We were pleased to be told that managers had increased the advocacy support to four hours each week for patients, which included advocacy being involved in governance and community meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Family members or carers were encouraged to contact the hospital for a general update, or to voice any queries or concerns. Staff respected the privacy of patients and ensured they had permission to relay information to callers.

Staff supported, informed and involved families or carers. All new patients and families were offered a hospital welcome pack. The pack included information about how they could give feedback about the service, who to contact for further support, and how to make a complaint. Additionally, visits were welcomed within the hospital, or outside of the hospital if appropriate. Family members or carers were able to attend multi-disciplinary meetings, with the patient's consent.

Staff helped families to give feedback on the service. The service had received numerous compliments from family and carers of patients. One relative had made a formal complaint which had been investigated.

Staff gave carers information on how to find the carer's assessment and directed them to online resources as appropriate.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Some patients admitted to the service needed to move on to alternative hospitals as this service was not suitable to meet their needs. Staff planned and considered patient discharges. However, these were not fully documented or recorded well from the point of admission. When required staff worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers made sure bed occupancy did not go above 85%. At the time of inspection, occupancy was just under 76% with 25 patients. The service had four vacant beds.

Managers would review length of stay for patients to ensure they did not stay longer than they needed to. They had regular discussions with patients' commissioners about the patients length of stay.

At the time of inspection, the average length of stay was 46 days.

Staff assessed all patients prior to admission. However, we noted that some patients may have been better suited to a different service, due to acute presentations and needs.

Managers and staff worked to make sure they did not discharge patients before they were ready unless the risk of the patient increased, and they needed a more secure environment to keep the patient safe.

When patients went on leave there was always a bed available when they returned.

If staff did move patients between wards during their stay, there were clear clinical reasons or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

One patients discharge had been delayed. A placement had been found for the patient but it fell through two weeks prior to the patients discharge date. Staff were working with commissioners to find an alternative placement.

Patients did not have to stay in hospital when they were well enough to leave. Managers monitored discharges from the service.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. This was evident in some patient's records. However, in three out of the five records we reviewed there was no documented discharge planning within care plans. Whilst the three patients had been admitted two months prior to the inspection, it was not evident that discharge planning had been discussed.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

The design, layout, and furnishings of the ward did not always support patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of variable quality although patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. However, we noted that some patients had not personalised their bedrooms and some were in need of redecorating, especially on Beech ward.

Patients had a secure place to store personal possessions in their bedrooms.

Staff used a full range of rooms and equipment to support treatment and care. All patients had access to outside spaces, and quiet lounges. Rooms were available for patients to meet with visitors in private.

All wards had easy access to outside space.

Patients could make phone calls in private. They had access to their own mobile phones and tablets.

Patients could make their own hot drinks and snacks and were not dependent on staff if risk assessed safe enough to do so.

The quality of the food offered to patients was variable. We spoke with six patients about the food. Four patients were positive about the food, saying that it had improved and that there was enough for them to eat. However, two of the six stated the food lacked variety and that they don't get enough. A group of patients from one ward (Redwood) had contacted the Care Quality Commission prior to the inspection and expressed unhappiness with the variety and portion size of the main meals. The registered manager had received this complaint and was working with the patients to try to resolve.

Patients' engagement with the wider community

Staff supported patients with activities outside the service for example family relationships.

Staff helped patients to stay in contact with families and carers. When family or friends visited the service, staff supported visits in the local community.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients regularly used the local shops, garden centre and fishing lake.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospital had wards on the ground floor with access to gardens. However, Redwood ward was

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

entered up a flight of stairs. We observed the hospital had a lift, but we were informed it was not in use. The registered manager assured us that all new admissions to Redwood ward would be fully assessed, to include mobility issues, to ensure the ward was accessible and appropriate. Evacuation chairs were in place and ready to use if needed, in an emergency.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. We saw posters on various notice boards across the service.

Staff could access information leaflets available in languages spoken by the patients and local community if they needed to.

If required, managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Although the patient feedback about the food was variable.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

From January to September 2022 the service had received 20 complaints. All complaints had been investigated, nine were not upheld, one was upheld, five were partially upheld and 5 were still in progress at the time of the inspection. One complaint met the threshold for duty of candour, an apology was given in a formal letter.

Patients, relatives and carers we spoke with knew how to complain or raise concerns. How to complain posters were displayed on ward noticeboards and leaflets were placed in patient welcome packs.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The outcomes of these were discussed in clinical governance meetings and shared with staff.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers collated lesson learnt from complaints and shared these with staff and patients. We were pleased to see that changes to practice had been put in place to reduce the likelihood of repeated complaints. For example, patients were now informed every Friday the date of their multi-disciplinary meeting the following week.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. From January to September 2022 the service had received 12 compliments. The hospital director ensured that these were shared with all members of the team.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. The registered manager had a good understanding of the service. Staff said the registered manager was visible in the service and approachable for patients, staff, families and visitors.

The service has had several registered managers since registering with the Care Quality Commission.

Leadership development opportunities were available to staff of different grades. The provider encouraged staff development and internal promotions.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Senior managers relayed the providers vision and values during mandatory induction for all staff. Staff knew that the provider aimed to provide safe and effective care. Staff were able to tell us that they are expected to be kind and caring. Staff placed emphasis upon the stabilisation of mental health, which aimed to ultimately support patients with transitioning into the community.

We were not assured that all staff applied the provider's vision and values to their work on a day to day basis. Whilst the vision and strategy for this service had a focus upon rehabilitation and the development of skills, we observed minimal activities taking place during the inspection. Four patients told us there were a lack of individual or group activities. In addition, three out of nine patients we spoke with told us they felt unsafe at the hospital. Two patients described how some staff had been unkind towards them.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff we spoke with felt proud to work at the hospital. Staff said they felt able to raise any concerns with senior staff without fear of retribution. Staff knew they could raise concerns openly or anonymously internally. Some staff were also aware that they could share experiences with the Care Quality Commission.

The registered manager, supported by the senior leadership team, had addressed poor staff performance in a timely way.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff appraisals included a discussion around career development and opportunities and how staff could be supported.

Staff sickness levels had been reducing and was 1.5% at the time of inspection. Staff had access to physical and mental health support through the provider as and when required.

Governance

Our findings from the other key questions demonstrated that governance processes did not consistently operate effectively at team level. Governance systems were in place to highlight some issues and risks. However, these were not always actioned in a timely way.

Staff undertook regular cleaning audits. However, areas of the hospital were dirty or in need of redecoration. Senior managers had failed to rectify this. Additionally, one ward had no dedicated quiet space. A dining room would be available when not in use.

Effective systems were not in place to audit clinical records. Some nursing observation records were incomplete which included gaps in recordings. Staff had not always updated individual patient risk assessments following incidents. Staff had not consistently followed best practise when administering rapid tranquilisation. Not all care plans were person centred and some lacked evidence of any patient involvement. Staff did not plan for discharge from the point of admission.

We found no governance process in place to monitor the therapeutic activities that were offered and accepted by patients. We were concerned that senior managers were not fully sighted on the lack of therapeutic activities offered to patients.

There was not always a registered mental health nurse in charge of the shifts on each ward. While there was a contingency plan in place, with the registered manager providing support, we felt this was not ideal. For example, if an informal patient tried to leave a ward and required immediate detention under the Mental Health Act, the registered manager may not be in a position to attend immediately, and a registered general nurse is unable to do this.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The registered manager kept a hospital risk assessment which senior managers reviewed regularly and discussed. Appropriate action plans were in place to address all risks highlighted. Staff knew they could highlight areas of concern to senior staff who would discuss with the registered manager.

The provider had contingency plans in place, in case of an emergency, for example, adverse weather conditions or a flu outbreak.

Information management

Staff collected and analysed some data about outcomes and performance and engaged actively in local and national quality improvement activities.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff had access to the equipment and information technology needed to do their work. At the time of this inspection, some documentation was held electronically, and some were still on paper. Senior managers were working towards achieving a full electronic record across the hospital. Staff we spoke with were aware of where to find information they needed.

Staff ensured all patient documentation was held securely to maintain confidentiality.

The provider made external notifications as and when required to do so, for example to the Local Authority; Care Quality Commission or to NHS providers.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Senior staff maintained communications with relevant health and social care providers as and when needed to optimise patient care.

Patients had ample opportunity to share their feedback and experiences through regular community meetings; one to one meetings with key staff; through the advocacy service, or via the providers complaint process.

Families and carers could share any concerns or give feedback face to face, electronically or in writing. Where appropriate, family and carers were invited to attend multi-disciplinary meetings.

Learning, continuous improvement and innovation

We were unaware of any active research or innovations which were occurring at the service at the time of inspection.

No wards had participated in accreditation schemes relevant to their services.

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 Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not ensure that all patients had been involved in their care planning. The provider did not ensure patients care plans were patient centred and recovery focused. The provider did not ensure discharge planning was evident within patient care plans. The provider did not ensure all patients had regular, therapeutic activities. |
| Regulated activity | Regulation |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure a Registered Mental Health nurse was always in charge of a shift. The provider did not have adequate Occupational Therapists in post. |
| Regulated activity | Regulation |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured there were effective governance systems and processes in place to identify, assess and action risks to patients in a timely way. |

This section is primarily information for the provider

Requirement notices

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

The provider had not ensured all staff were kind and polite to patients.

The provider had not addressed language barriers between staff and patients.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The provider did not ensure the environment was clean and appropriately decorated.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

The provider had not ensured risk assessments were updated after every incident.

The provider had not ensured that staff fully adhered to NICE guidance following administration of rapid tranquillisation.

The provider had not ensured staff completed patient observation documentation in full.

The provider did not always ensure the staff team were able to effectively meet the needs of all accepted patients.