Woodleigh Community Independent Hospital

Quality Report

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

Ratings

Overall rating for this location	**Good**
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
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 Woodleigh Community independent Hospital as **good** because:

- During our last inspection the service did not meet the Department of Health guidance on same sex accommodation. During this inspection, we found the provider now met the same sex accommodation guidance and was successfully protecting the safety, privacy and dignity of patients.
- Staff promoted the recovery and wellbeing of patients through positive risk taking and the provision of individualised activities and outings. This helped to build patients' confidence and skills to be able to manage in a less supported environment when they were ready to progress.
- Staff had a good understanding of safeguarding and knew what to report as an incident. Incident data was regularly analysed. Staff reflected on individual incidents, and identified learning or changes to the service to prevent similar incidents reoccurring.
- Staff effectively managed and monitored patients physical health needs. Many staff had experience working in physical healthcare services. Specialised training to enable staff to manage patients with specific conditions, such as diabetes, was delivered by specialists.
- Staff members took ownership of their training needs. Multidisciplinary team members came together to share knowledge about specialist areas to upskill the whole staff team.
- Staff had a clear understanding of the individual needs of patients and knew their individual risks well.
- Staff morale was high. Staff were well supported by each other and the hospital manager. Staff were part of a cohesive multidisciplinary team and all members contributed equally to discussions about how the service should be run, regardless of their role.
- All staff took responsibility for audits. The system of audits was structured and organised. It gave the hospital manager comprehensive, accurate oversight of the service and assurance that it was delivering good quality services.
- Patients were always consulted with about decisions that needed to be made about the service and the way in which it operated.
- All patients were partners in their care and had a good understanding of their care plans.

However,

- The corporate senior management team at the In Mind hospital healthcare group were not visible to those working at the service.

Summary of findings

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Good

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Services we looked at

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

Summary of this inspection

Background to Woodleigh Community Independent Hospital

Woodleigh Community Independent Hospital is part of the In Mind Hospital Healthcare Group. It is a complex care inpatient rehabilitation service for people living with substantial and on-going mental health conditions. The service also provides a step down to some patients from the national obsessive compulsive disorder unit. The service can provide care for up to 23 male and female patients across three floors which were gender segregated.

At the time of our inspection, there were 20 patients in the service. Six patients were detained under the Mental Health Act 1983 (MHA), some of which were detained under section 37 of the MHA.

Woodleigh Community Independent Hospital is registered to provide:

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

The service has a registered manager.

The service receives referrals from NHS organisations inside and outside of London.

There have been three previous inspections at the service. The last inspection was in February 2016.

Our inspection team

The team was led by Sam Hunt, inspector, two other CQC inspectors, one expert by experience who had experience of using a similar type of service, and one specialist advisor with a background in mental health nursing.

Why we carried out this inspection

We gave the service three days' notice of our comprehensive inspection, and we aimed to find out whether they had made improvements to their long stay/ rehabilitation mental health ward for adults of working age since our last inspection of the service.

During the inspection we also wanted to find out whether the provider had met the requirement notice served at the last inspection. Following this inspection we re-rated all the key questions to 'good' except caring which we rerated as 'outstanding'. The provider is rated good overall.

When we inspected Woodleigh Community Independent Hospital in February 2016, we rated long stay/ rehabilitation mental health wards for adults of working age as good overall. We rated this core service as requires improvement for safe, good for effective, good for caring, good for responsive and good for well led.

Following the February 2016 inspection we told the provider it must take the following action to improve long stay/rehabilitation mental health wards for adults of working age:

- The provider must ensure they follow national guidance regarding same sex accommodation

We issued the provider with a requirement notice at the previous inspection. This related to the following regulation under the Health and Social Care Act (Regulated Activities) 2014.

Regulation 10 Dignity and respect.

Summary of this inspection

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

During the inspection visit, the inspection team:

- looked at the quality of the hospital environment and observed how staff were caring for patients
- spoke with nine patients who were using the service
- spoke with one relative of a person using the service
- spoke with the registered manager and deputy hospital manager
- spoke with the operational director for the provider
- spoke with 12 other staff members including nurses, support workers, an occupational therapist, a clinical psychologist and a consultant psychiatrist
- reviewed six patient care records and risk assessments
- observed a handover meeting
- reviewed patient prescription charts and treatment authorisation forms
- checked the management of medications and clinical equipment in the service

reviewed policies, procedures and other records relating to the running of the service.

What people who use the service say

During our inspection we spoke with nine patients and one relative. All were extremely positive about staff who worked in the service, saying that there was a warm culture and staff always tried their hardest to help. Patients with obsessive compulsive disorder told us that staff had a detailed understanding of how to address their specific needs. Two patients told us the reason they felt they were getting better was because the psychology input had such a positive effect on their recovery. Patients told us that they felt there was a sufficient number of staff to cater to their needs and make them feel safe. They felt that the registered manager was very supportive and compassionate. Two patients felt that staffing levels were low during night shifts because staff were not easily accessible to them when they required assistance.

Feedback about food and accessibility of snacks was generally positive, and patients told us they were able to provide feedback about food and other important aspects of their care easily. Patients understood what their rights were, particularly when detained under the Mental Health Act.

Most patients were positive about the therapeutic activities on offer. They gave us examples of outings that built their confidence in the community, and times when they had helped staff prepare food to build up their skills. However, three patients felt that there were not enough activities during weekends.

Patients understood their medication and were all familiar with their care plans which they had helped produce. Information was given to patients on admission to orientate them to the service, and patients said they would be confident making a complaint and knew how to do so.

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?

Good

We rated **safe** as **good** because:

- During our last inspection the service did not meet the Department of Health guidance on same sex accommodation. During this inspection, we found the provider met this guidance and protected patients' safety, privacy and dignity. Residential corridors were gender segregated and separate bathroom facilities were situated within gender defined areas. Staff remained alert to the potential need for a female-only space at any point in the future, but had already undertaken an extensive consultation with patients about whether a female-only space was appropriate.
- Staff had a good understanding of patients' individual risks and responded to changes in risk promptly. Staff used positive risk taking to help develop patients' day to day skills and promote their recovery. Risk assessments were detailed and regularly reviewed.
- All staff knew what to report as an incident and how to report. Recent incidents were routinely discussed during staff meetings and handovers, and a detailed quarterly analysis of incidents was completed. Learning points were identified following each incident and were shared with staff to prevent similar incidents reoccurring. Staff were well supported following incidents and formal debrief sessions took place with staff and patients who had been involved.
- Medicines were well organised and managed, minimising the risk of medication errors.
- The environment was clean and maintenance issues were resolved quickly. Numerous rooms and a large garden were used for therapeutic activities.
- Staffing levels were stable and many staff had worked in the service for many years and were experienced. The identified number of staff worked on each shift and sometimes these staffing levels were exceeded.

However,

- Some staff told us they felt under pressure during weekend mornings. Kitchen staff did not work during weekends, and the hospital manager who would normally provide additional support to the core staffing establishment during busy times did not usually work during weekends.

Summary of this inspection

Are services effective?

Good

We rated **effective** as **good** because:

- Physical health needs were met for each patient. Patients told us they felt their physical health needs were well managed by staff. Staff responded promptly to changes in patients' physical health conditions, and they received specialist training to enable them to provide appropriate care to these patients. Many of the qualified nurses were registered mental health and general nurses. The local GP was present on regular occasions and could easily be contacted out of hours. Routine physical health checks took place and were documented in care records.
- The clinical psychologist and occupational therapist used specific, meaningful outcome measures. Nationally recognised good practice measures were used for specific conditions and helped measure the progress of each patient.
- A robust system of audits was in place, which every staff member played a part in completing. These were comprehensive, covering clinical and operational functioning of the hospital. Managers regularly checked the results of audits and had detailed oversight of all aspects of service delivery.
- The multidisciplinary team (MDT) was made up of a diverse range of professionals, including an occupational therapist, a clinical psychologist, a psychiatrist and nurses. All patients were able to access these disciplines easily. The MDT collaborated during weekly reviews, which involved patients as partners in their care.

Are services caring?

Outstanding

We rated **caring** as **outstanding** because:

- People who used the service, and those who were close to them, gave consistently positive feedback about the way staff treated people. They felt that staff had a good understanding of their needs and went the extra mile to help them, better than at other services they had experienced.
- Staff were extremely caring and had an excellent understanding of the individual needs of patients. Multidisciplinary team members took time to communicate with patients outside of structured intervention sessions whenever necessary, and supported patients with their personal, cultural, social and religious needs.
- Patients were partners in their care. Staff were committed to working in partnership with patients. They were involved in all

Summary of this inspection

decisions about their care and had each contributed to their care plans. Relatives had also contributed to care plans when appropriate. People's emotional and social needs were highly valued by staff and are embedded in their care and treatment.

- Staff actively sought feedback from patients when decisions about the service had to be made. Staff consulted with patients about all decisions that had to be made about the way the service was run. Staff had designed tailored surveys so that patients could help with decisions. For example, surveys were shared to help establish whether a female only communal space would be appropriate for the client group, and to measure the success of a trial female communal space.
- Feedback given by patients during weekly community meetings was actioned promptly by staff who were in attendance, including maintenance and kitchen staff. Updates were provided at subsequent meetings to keep patients informed.
- All patients received useful information on admission to orientate and welcome them. Patients told us that they could access the advocate easily and were confident in making complaints should they need to, and that staff would support them.

Are services responsive?

Good

We rated **responsive** as **good** because:

- All patients had discharge plans in place that were reviewed regularly. Patients helped to identify their own goals to help them work towards recovery.
- Individual activity programmes were in place for all patients, including group and one to one sessions. These programmes were aligned with individual recovery goals, and sought to promote the recovery and wellbeing of patients.
- Staff supported patients' diverse needs. Multidisciplinary team members had taken time, outside of structured interventions, to provide additional support to patients with their gender and sexuality. Staff recognised religious and culturally significant events and celebrated them to help promote awareness and inclusion.
- Patients knew about the complaints process, and staff helped people complain if they needed support to complain. Complaints were managed promptly and in a compassionate manner. Complainants were told how to escalate their complaints if they were dissatisfied with the response.

Are services well-led?

Good

We rated **well led** as **good** because:

Summary of this inspection

- Staff morale was high. Staff felt well supported by the hospital manager and were given the opportunity to provide feedback and raise any concerns about the service with ease.
- Robust governance systems were in place to ensure an effective delivery of the service. The hospital manager had good oversight of the service and its operations through a comprehensive system of audits that all staff took some responsibility for completing.
- Service-level quality and governance issues were easily escalated to an organisation level corporate governance meeting for discussion by senior managers in the organisation.
- Although the In Mind Hospital Healthcare Group did not have a clear vision or set of values to share with staff, the hospital manager held a strong ethos, which staff working at the service showed in their work.

However,

- Staff did not feel able to approach the corporate senior management team at the In Mind Hospital Healthcare Group.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Ninety six per cent of staff had completed training in the MHA, and staff showed that they had a thorough understanding of the MHA, the code of practice and its guiding principles.

Where detained patients did not have capacity to consent to their treatment, appropriate treatment authorisation forms were attached to their medication charts. They were scrutinised and filed by the MHA administrator. Staff regularly ensured that detained patients understood their rights, and gave patients leaflets about their rights. The extent to which patients understood their rights was routinely recorded in an electronic MHA recording system.

The MHA administrator conducted regular audits to ensure correct implementation of the MHA. The audits and the electronic MHA recording system alerted staff in advance to sections that needed renewal and the need to check that detained patients understood their rights.

Mental Capacity Act and Deprivation of Liberty Safeguards

Ninety six per cent of staff had completed training in the Mental Capacity Act (MCA) and had a good understanding of when assessments for specific decisions should be completed.

At the time of our inspection, none of the patients were subject to deprivation of liberty safeguards (DoLS).

Capacity assessments were decision specific and if patients lacked capacity decisions were made in their best interests, whist recognising the importance of their wishes, culture and history.

The deputy hospital manager, who took responsibility for Mental Health Act administration, helped staff with queries about the MCA. MCA and DoLS policies were available for all staff to refer to.

Long stay/rehabilitation mental health wards for working age adults

Good

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good

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

Good

Safe and clean environment

- Although staff did not have clear lines of sight of all patients at all times because numerous blind spots existed across the building, this was mitigated by staff observations, mirrors and individual risk management plans. For example, if a patient displayed sexually disinhibited behaviour they would be placed on 15 minute observations. In general, patients cared for were deemed to be at low risk of self-harm or suicide.
- Staff had a good understanding of the risks posed by ligature points. A ligature point is a place where an individual intent on self-harm might tie something to attempt strangulation. They were familiar with where potential ligature anchor points were situated in the building. Ligature cutters were located on each floor and staff knew where to find them. An environmental ligature risk assessment had been completed recently and was being finalised during the time of our inspection. This was detailed, identified all potential ligature anchor points and set out how staff should manage risks.
- During our last inspection the service did not meet the Department of Health guidance on same sex accommodation. During this inspection we found that the same sex accommodation guidance was correctly adhered to. The first and third floors of the premises provided single sex accommodation. The second floor was mixed, but locked doors separated the male and female sections of the floor. Females had a door code to access their section, and a shower room had been installed within the female section to ensure females did not need to pass male bedrooms to access bathroom facilities. Staff remained alert to any need to designate a space as female only in the future if the needs of patients changed. The current patient group had overwhelmingly stated that they did not want a female only designated communal area.
- The clinic room was well organised and equipment was clean, well maintained and equipment was regularly calibrated. The clinic room was small, so physical examinations took place in patients' bedrooms if needed.
- Emergency medicines and equipment including a defibrillator were available and checked regularly to ensure they were within date and fit to use. All staff had completed training in emergency first aid and basic and immediate life support.
- Patients were not secluded and the service did not have a seclusion room. If patients became agitated staff employed verbal de-escalation techniques.
- The building was clean and well maintained. Staff adhered to infection control principles and had undertaken training in infection, prevention and control. Hand gels were available throughout the building. An environmental risk assessment was regularly completed by the maintenance worker. Issues identified in this assessment were addressed promptly. If needed, external professionals could easily be arranged by the registered manager to rectify maintenance issues.

Long stay/rehabilitation mental health wards for working age adults

Good

- The registered manager had quickly commissioned a fully comprehensive fire report following the Grenfell Tower tragedy, which was ahead of the government's independent review of building regulations and fire safety in July 2017.
- A cleaning schedule was in place and records showed when items were last cleaned. Staff had access to protective personal equipment such as gloves and aprons and cleaning equipment was appropriately stored and colour coded. A cleaning audit was also in place.
- A fire risk assessment had been completed by an external fire safety company. Where recommendations had been identified these had been addressed by the provider. Regular fire drills took place with staff and patients so that they were aware of the procedures to follow in the event of a fire. Each patient had a personal emergency evacuation plan recorded within their care records. These showed the support people required to evacuate the building in an emergency situation.
- Wall alarms were situated throughout the building for staff and patients to use if needed. Panels on each floor indicated where the alarm had been triggered so that staff could locate the person in need with ease. Alarms were regularly tested and we observed alarms sounding and staff responding promptly during our inspection.

Safe staffing

- Safe staffing levels were maintained. Staffing establishment levels had been decided according to the needs of the patient group, and the appropriate number of staff worked on each shift to meet patients' needs. One qualified nurse was supported by four support workers during the day. At night one qualified nurse worked with two support workers. Staffing levels consistently met establishment levels and were often exceeded during the day. Any vacant shifts due to sickness were usually filled by regular staff that lived close by, although staff sickness occurred very infrequently. Agency staff were not used.
- However, three staff told us that they felt particularly stretched during weekend mornings. This was because kitchen staff did not work during breakfast time at weekends and because senior staff did not usually work at weekends to provide additional support to the core staffing establishment. The qualified nurse on shift would focus on medications, one support worker would usually be required to prepare breakfast, leaving just one support worker to help all the patients with their morning routines. We did not identify any impact on the safety of patients.
- There were no staff vacancies during the time of our inspection and no staff were sick at the time of the inspection.
- Turnover was very low. Only one nurse had left the service during the previous 12 months, and most staff in post had worked at the service for a number of years.
- Agency staff were not used, and vacant shifts were filled by substantive staff who were familiar with the service.
- The hospital manager nurses in charge had the authority to change staffing levels according to change in case mix, for example, if patients needed to be put on enhanced observations.
- A member of care staff was present in communal areas at all times and at least one qualified nurse was on duty at all times, who care staff could easily access for support if needed.
- Any vacant shifts due to staff sickness would be filled by other permanent staff that lived within close proximity to the service and could be called upon at short notice to prevent short staffing during shifts.
- Staff were trained to carry out physical interventions safely and there were enough staff on each shift to carry out physical interventions, although these were not needed.
- A consultant psychiatrist worked at the service and spent one day per week on site, when they took part in a thorough review of patients. Staff were able to contact the consultant psychiatrist out of hours for advice; in their absence the consultant psychiatrist at a neighboring hospital in the organisation could be contacted. All patients were registered with a local GP and the service was situated close to the local accident and emergency department.
- All mandatory training courses for staff had compliance rates of more than 90%, showing that staff were up to date with their training in areas including safeguarding, Mental Health Act, first aid, fire safety, immediate life support, and medication management.

Long stay/rehabilitation mental health wards for working age adults

Good

Assessing and managing risk to patients and staff

- We examined six care records during our inspection. Staff completed detailed and individualised risk assessments and management plans for all patients on admission and updated these regularly, including after incidents. Risk assessments were clear and staff linked them to individual care plans.
- Patients were involved in developing their risk management plans. For example, one patient described the actions that they wanted staff to carry out to keep them safe when they were distressed. Another patient had agreed to escorted visits in the community in line with the management plan. Staff discussed changes to patients' risk in detail at handovers and during MDT reviews.
- Identified risks were addressed in individual care plans so staff knew how to manage these risks. We saw that where a patient's health had deteriorated, risks had been reviewed and amended to meet their increased level of need. For example, the care plan for a person with unstable blood sugar was updated to reflect the change in risk and staff worked closely with the diabetic specialist nurse and GP to monitor them.
- Patients were positively supported to take risks to promote their recovery and wellbeing. For example, the service collaborated with local shop keepers who helped support patients to shop on their own and develop their budgeting and personal interaction skills.
- There was minimal use of blanket restrictions and patients would only be searched if staff had reason to suspect the patient had a harmful object on their person or in their bedroom.
- Informal patients could come and go as they liked. They were made aware of their right to leave at any time.
- Staff undertook two hourly environmental observations to reduce the risk posed by potential ligature anchor points. Observations were increased for individual patients according to change in risk. For example, one patient at risk of displaying sexually disinhibited behaviour was subject to increased observation.
- There were no examples of restraint, rapid tranquilisation or seclusion over the past year. Staff were trained in how to restrain patients safely, but successfully used de-escalation techniques to calm agitated patients.
- Staff were trained in safeguarding and knew how to protect patients from abuse. They demonstrated a good understanding of safeguarding and were able to describe the actions taken where a safeguarding concern had been raised. They were aware of who to contact within the organisation and how to contact external agencies if necessary. Two safeguarding referrals had been made during the 12 months before our inspection. Where safeguarding concerns were identified protection plans were in place to keep people safe. For example, for two patients we saw that plans to keep them safe from sexual and financial exploitation were being followed.
- Robust management of medicines was in place. This covered ordering, storage, administration, recording, reconciliation and disposal of medicines. Staff received pharmacy support from the local pharmacy. Medicines were well organised in colour coded storage units so that staff could easily keep track of what medications were assigned to which day of the week. Medication administration records were correctly completed. Clinic room and medicine fridge temperatures were checked daily to ensure that medicines were stored appropriately and safe to use, and staff audited medication management to help minimise the risk of medication errors.
- The service had safe procedures in place for children that visited the premises. Visits were facilitated in small rooms separate from communal areas.

Track record on safety

- No serious incidents had been reported in the 12 months prior to our inspection**.**

Reporting incidents and learning from when things go wrong

- All staff knew how to identify incidents and report them correctly. A comprehensive guide to following the incident reporting procedure was in place for staff. Staff told us about incidents they had reported and were familiar with incident reporting procedures.

Long stay/rehabilitation mental health wards for working age adults

Good

- Staff exercised their duty of candour, being open and transparent and explaining to patients when things went wrong. For example, all residents and relatives were kept informed verbally and in writing about a police investigation that was being undertaken as a result of residents' possessions going missing. Staff continually exercised their duty of candour at every stage in the subsequent investigation. Residents who had been affected also received a formal written apology and were recompensed. We spoke with the patients whose possessions had gone missing, and they told us they had been well supported by staff following the incident.
- Staff completed comprehensive incident records. We reviewed five incident records in detail. These detailed any lessons learnt as a result of the incident. For example, an incident of self-harm at another hospital in the organisation had led to a drive to support allied health professionals to include detail about the conversations they were having with patients in their care notes. This was because changes in individual risk had not been identified and documented by allied health professionals shortly before the incident.
- Feedback and learning from recent incidents was discussed at clinical governance and support workers meetings, handovers and in training sessions. Staff also received debrief sessions where appropriate. The registered manager had completed extensive training in undertaking root cause analyses to help incident and complaint investigations.
- Staff completed a detailed quarterly report on all incidents that had occurred so that themes could be identified. The most prevalent incident type was violence and aggression. Most of these incidents were attributed to particular patients with behaviour that challenge that had joined the service. An increase in the number of patients' personal possessions that were reported as missing had led to the dismissal of a staff member. Meeting minutes from the quality governance meeting detailed the number of incidents and the actions taken by the service.

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

- We reviewed six sets of care records, all of which demonstrated a holistic approach to assessing, planning and delivering care and treatment.
- Patients had a comprehensive assessment of their needs on admission. Physical, medical, mental health, nursing, risks and social needs were all assessed and regularly reviewed.
- All patients received regular physical health checks. Records showed staff routinely supported them in addressing their physical health care needs. A number of nurses held dual registration and were both general and mental health nurses. All nurses were confident in managing patients' physical health needs, and conditions such as diabetes. For example, regular blood pressure, blood glucose monitoring, weight, urine analysis and body mass index measures were completed and the results shared with the GP so that any follow up interventions could be actioned. We observed staff responding promptly to a diabetic patient whose blood sugar levels became high during our inspection. Staff took appropriate action in a timely manner to bring their blood sugar level back to the appropriate range. Patients who smoked were supported by staff to give up smoking if they wished. Staff referred patients to the GP for smoking cessation.
- Care plans promoted a recovery and outcomes based approach to care planning, and were based on the 'my shared pathway' care planning tool. Care plans were written in a therapeutically optimistic way to help engage patients in their recovery. They covered all aspects of patients' mental and physical health, as well as recovery goals and social factors.
- Care plans were person-centred, had been developed in partnership with patients and reflected their opinions. For example, one care plan contained a discharge plan which the patient had worked on and had chosen where they wanted to be discharged to. People's needs were reviewed weekly during MDT reviews.

Long stay/rehabilitation mental health wards for working age adults

Good

- Each patient had an individual activity programme which was based on their needs, goals and preferences. The occupational therapist and activities coordinator worked with patients to develop personalised activity plans. These included group and one to one activities. Patients were supported to engage in activities that assisted them to gain skills for community living. Recovery goals were set in care plans and staff had established links with community resources. For example, staff supported patients to apply for voluntary jobs and college courses. Other community based activities included accessing the local library, cinema, shops and using public transport safely. One patient worked for a local mental health charity, and another had recently started a scheme where they helped staff in the kitchen. Patients were supported to develop their cooking skills, and once they were able to self-medicate, budget and cook their own meals, a residential placement in a lower support environment was considered for them.
- All care records were stored on an electronic system. Care plans and risk assessments were also available in paper form so staff could refer to information quickly. A rigorous system of audits ensured consistency between electronic and paper care plans and risk assessments, and staff only updated the electronic versions, which were then copied on paper.

Best practice in treatment and care

- Staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions and prescribing medication. The consultant psychiatrist led sessions where staff discussed changes to guidance. For example, staff followed guidance for managing type two diabetes, including supporting the patient to understand their condition, providing dietary advice, managing cardiovascular risk, managing blood glucose levels, and supporting patients to manage long-term complications such as eye disease.
- The clinical psychologist offered psychological interventions recommended by NICE. These included cognitive behavioural therapy and dialectical behavioural therapy for patients with mood disorders. All patients had some input from a clinical consultant psychologist, either through formal structured sessions or ad-hoc interventions.
- Staff facilitated seamless access to physical healthcare. Patients were encouraged to attend appointments at the local GP, where all patients were registered. The GP visited the service if patients were unable to attend appointments. Comprehensive care plans for specific physical health needs and conditions were in place and community dental, optometry and general health facilities were readily accessed. For example, care staff worked closely with catering staff to support diabetic patients with healthy eating and weight reduction programmes. Catering staff had details about the specific dietary needs of patients. Patients could access exercise activities such as a walking group and could use exercise equipment at the service. Nursing staff had developed a diabetes training pack for all staff and carried out physical health training so that they could meet the physical health needs of patients.
- Physical health monitoring for patients prescribed Lithium Carbonate and clozaril was carried out at the local GP surgery. Nurses reported that any concerns related to these medicines were communicated to the consultant psychiatrist at the service. Staff also kept in close contact with the GP. For example, for one patient had been referred to a cardiologist by the GP following an abnormal ECG reading.
- Staff measured outcomes to monitor improvements to patients' health. The occupational therapist used the model of human occupation screening tool to review patients' occupational functioning. The clinical psychologist used the Yale-Brown obsessive compulsive assessment to monitor severity and type of symptoms in patients with obsessive compulsive disorder throughout their stay. A psychotic symptom rating scale was also used for some patients with psychosis. Detailed reports to community mental health teams (CMHT) also served as a useful indication of progress for staff. These included quality of life and relationship factors as a marker of progress, such as engagement with activities and staff, changes in alcohol and drug use and changes in frequency of types of incident.
- Staff supported patients to regain their autonomy. Some recent patients had administered their own medications and budgeted, shopped for and cooked their own meals. These patients had since been discharged to the provider's step-down residential service in the same

local area because they were ready for a lower support environment. Where patients were working towards moving on from the service, staff supported them to gain skills for community living.

- A robust system of clinical and operational audits was in place. All staff members took responsibility for a list of audits they had to complete. Audits were stored in well organised, easy to access folders so that gave staff a clear, current evaluation of the service and its operations. A record was completed by all staff to confirm that they had completed their audits on time. The hospital manager did regular spot checks on audit files to check they had been completed and to prompt staff to take action to maintain a consistent, good quality service if needed. Audits included monitoring completion of progress reports for commissioners, medication management, care programme approach completion, supervision compliance and health and safety.
- An effective audit to keep track of blood tests for people on Clozapine, which flagged when people were due for a blood test in advance, had been created by the service and subsequently adopted by a local NHS trust. Essential audits were also copied and kept in a grab bag to help minimise impacts on care and treatment following a fire or building failure.

Skilled staff to deliver care

- A full range of professionals worked in strong partnership, including nurses, support workers, a clinical psychologist, occupational therapist and consultant psychiatrist. One of the support workers also took a lead on activities.
- Many staff had worked at the service for a number of years and were very experienced. Some support workers were encouraged to train to become qualified nurses, and were well supported by their colleagues.
- Since our last inspection the service had started to provide placements for student nurses. New staff including students on placement were provided with detailed information to induct them to the service and help them get to know the patients, their needs and medications.
- All staff received structured one to one supervision sessions which included discussions about performance, career development and clinical discussions. Frequency of supervision varied across the staff group. Supervision frequency was gradually reduced over a two year period to four or six monthly sessions for experienced staff. Frequency of supervision sessions could easily be adjusted for staff who required additional support. Staff found one to one supervision very useful and felt that individualised frequency of sessions kept supervision meaningful. They were able to request additional supervision sessions whenever they felt necessary.
- Eighty three per cent of permanent staff had received an annual appraisal. The clinical psychologist and consultant psychiatrist were working under practicing privileges rather than employment contracts. They were well supported by the hospital manager through regular managerial supervision and external clinical supervision was arranged for them. Although an annual appraisal had not been completed for the clinical psychologist during the time of our inspection, one was completed shortly after our visit.
- Staff received useful specialist training to support them to work with patients within a rehabilitation service. Staff had collaboratively put together their own training programme in diabetes to increase awareness and support when caring for patients with diabetes. The clinical psychologist led sessions with staff to upskill them in areas such as obsessive compulsive disorder and personality disorders. Staff had also attended training courses in cognitive behavioural therapy and mentalisation based treatment.
- Staff told us about development opportunities and access to specialist training. Some qualified nurses had started working at the service as support workers, and had been supported to develop into qualified nurses. The deputy manager was supported to complete a diploma in Mental Health Act law during their previous administration post in the service.
- Staff performance was addressed promptly and effectively through supervision, and the registered manager gave examples of improvements to performance that had been achieved through supervision. The registered manager proactively addressed poor performance issues, and gave an example of managing poor performance effectively following an incident.

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Good

Multi-disciplinary and inter-agency team work

- A clinical review meeting took place weekly, where each patient was discussed every two to four weeks, according to their presentation and needs. The consultant psychiatrist, occupational therapist, clinical psychologist and nursing staff all attended and provided valuable contributions to the discussion. Effective nursing handovers also took place between shifts. We observed one handover which was attended by a range of multidisciplinary team members. The team reviewed events that had taken place during the previous shift and prioritised actions that needed to be taken.
- Staff worked effectively with other organisations. Very detailed reports were sent to community mental health teams and commissioners. The registered manager kept in close contact with commissioners, of which there were many because patients came from across the UK. Care coordinators were invited to attend care programme approach meetings in person or virtually.
- Staff had collaborated with the local general hospital about how best to manage individuals who self-harm and present to accident and emergency. The local accident and emergency department had changed their protocol around triaging individuals who had self-harmed as a result. For example, patients would be guided to a separate room at accident and emergency so they did not have to wait with other people, and would not necessarily need to go through the triage process.
- The service worked closely with the local safeguarding authority. The registered manager took part in reviews of other providers in the borough following safeguarding concerns, in collaboration with the local authority. The deputy manager also attended multi-agency safeguarding meetings in the borough and cascaded good practice.

Adherence to the MHA and the MHA Code of Practice

- Six patients were detained under the Mental Health Act (MHA) at the time of our inspection. The deputy manager took responsibility for MHA administration. They examined MHA paperwork on admission and provided support to staff about the MHA. Detention documents were in order and stored appropriately.
- Detained patients had their rights explained to them regularly, and their understanding of their rights was clearly documented. Leaflets about rights, including an easy read version, were available to patients.
- An electronic database was used to hold all information about the MHA. The database generated prompts for staff when sections were due for renewal or patients' rights needed to be explained. In addition to this system the MHA was audited monthly to ensure it was being implemented correctly and to help staff identify when renewals were due in advance.
- Consent to treatment forms were kept with medication records in the clinic room. Copies were also kept in the deputy manager's office so staff could check they had been completed correctly, and were kept in order. Audits ensured consistency between the two copies.
- Ninety six per cent of staff had completed training in the MHA. Staff had good knowledge about the MHA and knew which patients were detained and understood how they were restricted.
- A section 17 leave log was kept in the nurses' office for staff to refer to. This ensured staff understood individual patient's leave arrangements. Patients were given copies of their leave forms. The staff section 17 leave folder also provided maps and detail about patient exclusion zones where applicable. This enabled staff to support patients to adhere to the conditions of their leave.
- An independent mental health advocate visited the service each week. Patients were referred to them by staff when needed, but could also approach them of their own accord. The advocate was also accessible at other times by telephone.

Good practice in applying the MCA

- Ninety six per cent of staff had received training in the Mental Capacity Act (MCA). None of the patients were subject to deprivation of liberty safeguards.
- Staff had a good understanding of the MCA and understood the principles that underpinned it. The deputy manager was able to support staff in applying the MCA if they needed advice.
- Assessing mental capacity and enabling patients to make decisions was thoroughly embedded across the

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Good

service. Capacity assessments were recorded appropriately and were decision specific. Staff supported patients to make decisions and where patients lacked capacity, decisions were made in their best interests, whist recognising the importance of their wishes, culture and history.

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

Outstanding ☆

Kindness, dignity, respect and support

- Throughout our inspection we saw patients being treated with compassion, kindness, dignity and respect by staff. Staff interactions with patients and families were professional, sensitive and appropriate at all times. Staff spoke to patients in a relaxed and friendly manner, and collaborated with them as partners in their care. The atmosphere was calm and positive, and all staff supported patients well, both during and outside of structured therapy sessions.
- We spoke with nine patients and one relative during our inspection. They were consistently positive about the respectful and polite manner in which staff treated them. All patients told us that staff went the extra mile to help them and were able to meet both their mental and physical health needs appropriately. Staff always took patient's personal, cultural, social and religious needs into account.
- There was a strong, visible person-centred culture. Staff had a detailed, genuine understanding of patient's individual needs. Staff offices were situated on residential corridors and staff and patients could easily interact with each other at all times. Kitchen staff consulted with patients and knew their individual dietary needs, likes and dislikes.
- Staff spoke about patients with respect and kindness and demonstrated their knowledge and understanding of how living with a mental health condition could impact on people and their families. Relationships between patients, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.

The involvement of people in the care they receive

- Patients told us they had received detailed welcome information on admission to help orientate and introduce them to the service. This also included information about how to complain, community meetings, contact numbers, visitors, personal property and mealtime arrangements.
- Patients were active partners in their care. Staff were fully committed to working in partnership with patients. All patients we spoke with had a clear understanding of their care plans, and most had accepted a copy to keep for themselves. Patients were supported to make their own decisions with staff and were encouraged to contribute meaningfully to ward rounds as partners in their care. Relatives and carers had also been consulted about their relative's care, and their views were included in care plans when appropriate.
- All patients knew about the advocate and could access them easily during their visits to the service and at any other time. The advocate attended in person each week.
- Carers were well supported by staff, who kept in close contact and updated them about any changes to their relative's care. Staff supported patients to keep in contact with their friends and relatives, particularly those who were far from home. Patients were able to use a payphone or their own personal mobile phones at any time. All patients could access the internet and use their own electronic devices.
- Staff empowered patients to have a voice and realise their potential. Community meetings took place weekly and patients were asked to give feedback about the service. These meetings were clearly recorded, and the agenda included regular discussions about maintenance, housekeeping, activities and outings, hygiene reminders and discussions about using different areas of the building. Issues that were raised were delegated to staff members, including the maintenance worker, who all attended the meeting. Updates at subsequent meetings were then given to keep patients notified about changes that were being made.

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Good

- Patients were always consulted with about significant decisions that needed to be made about the service. For example, two surveys were run to evaluate the need for a designated female only space and the success of a trial where a designated female only area was created. Tailored food surveys were completed to help staff to identify future menu options. Patients were consulted with about future activities and outings that they would be interested in.
- A trial had taken place where the main activity room was designated female only during set times. Patients then completed two detailed surveys about the change, where they overwhelmingly stated that they were in favour of mixed communal facilities. Staff remained alert to the potential need for a female-only space at any point in the future.
- Advance decisions that reflected patients' preferences were in place.

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

(for example, to feedback?)

Good

Access and discharge

- The average length of stay for patients was 55 months. Patients were classified into two broad cohorts.
- One cohort was for those diagnosed with severe and enduring chronic mental health conditions who were being managed at the service in the least restrictive environment possible. Most of these patients were from London or the south east of England. These patients had complex needs and had been with the service for several years. They had discharge plans in place and were working towards moving to a low support residential service in future.
- The second cohort of patients had stepped down from the national obsessive compulsive disorder unit and generally stayed at the service for between six to 12 months. These patients came from across the UK. These patients had discharge plans in place from an early stage. These patients were generally discharged back to community mental health teams.
- Detailed, personalised discharge plans were included in patient care records, and patients collaborated with staff to develop them. Patients were able to identify their own discharge settings when appropriate, and identified their own goals to help them progress towards discharge. Discharge plans were regularly reviewed during multidisciplinary team meetings.
- Patients progressed through the service and moved on to less supportive environments when they were ready. The provider ran a residential service in the same local area which some patients stepped down to in a timely manner. Three patients had stepped down to the residential service during the week before our inspection. Staff considered patient referrals at MDT meetings and patients were offered trial stays before being formally admitted.
- Some patients took overnight leave, which helped to promote their recovery. Bedrooms were always available to patients on return from leave. Patients did not move bedrooms unnecessarily.
- There were no examples of delayed discharges for reasons other than clinical reasons. Staff maintained close contact with patients' community mental health teams and care coordinators, who were invited to attend reviews and care programme approach meetings. Most patients who lived locally aimed to be discharged to a step down residential service in Croydon, provided by the same organisation.

The facilities promote recovery, comfort, dignity and confidentiality

- A range of rooms were available on site to support treatment and care. A variety of small quiet rooms were used for reflection, structured interventions, for small activities or for people to meet their relatives, including children who visited the service. A large group activity room was available for art and music therapy. The activity room also housed a kitchenette which was used by patients during occupational therapy sessions, and to prepare their own drinks and snacks. A clinic room housed patients' medications, and if needed, physical examinations took place in individual bedrooms.

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Good

- Phone calls could be made in private either using the payphone in the front porch area, or using mobile phones, which were not restricted.
- A large garden was situated at the back of the building. Gardening activities and sports took place in the garden. There was a designated smoking area at the back of the garden, and a pond with fish that the patients cared for. The service also had a cat, which patients were given responsibility for feeding and looking after.
- Patient feedback about food was very positive. Staff ate with patients each day. Patients regularly completed specific food surveys and staff reflected on feedback about the quality of food. Food and meal feedback was an agenda item at community meetings. Staff asked patients for their view about all prospective changes to food and menus.
- Drinks and snacks were scheduled at set times. Patients could also access their own snacks at any time or ask staff for snacks from the main kitchen.
- Patients were given their own key to their bedroom. Bedrooms were personalised, and also contained locked cabinets for patients to securely store their possessions.
- Social and leisure activities were available to support patients in their rehabilitation. However, three patients told us that they felt there should be more activities at weekends.

Meeting the needs of all people who use the service

- A lift was used to provide access to all the floors, and males and females each had access to one accessible bathroom. Communal areas and the garden were all easily accessible on ground level.
- Information to welcome people to the service and summarise the complaints procedure were available. If required, leaflets were translated using an interpreting service.
- Interpreters could be booked two weeks in advance to attend meetings such as CPAs or tribunals. A Turkish interpreter had recently been booked to support a patient during a CPA meeting. At short notice, a telephone interpreting service was used to access interpreters in any language.
- Cultural events were celebrated to promote diversity. Religious festivals including Christmas, Easter and Diwali were celebrated. A weekend celebration of black history month had been organised, involving Jamaican cooking and a steel band. Women's Day was also marked to promote gender equality and to recognise achievements made by women.
- Staff actively supported patients with gender and sexuality concerns. Patients had been encouraged to attend LGBT pride celebrations. We saw that a patient had been positively supported to come to terms with their sexuality by staff, which had a profoundly positive impact on the presentation of their mental health condition.
- Kitchen staff worked in collaboration with patients to ensure the service met individual dietary needs. Dietary needs including religious requirements were detailed in each patient's care plan, and kitchen staff had a good understanding of individual dietary needs and likes and dislikes. Menus were tailored to suit individual needs.
- Patients received religious and spiritual support. A pastor visited regularly, and patients received dates of their visit in advance. An imam had recently been accessed to support one Muslim patient. Another patient was regularly escorted by staff to a local Buddhist centre. Religious texts were available in the building, and bedrooms were used for prayer.

Listening to and learning from concerns and complaints

- Four formal complaints were received between January and July 2017. None had been referred to the ombudsman.
- Formal complaints were responded to within 20 days, with a maximum extension of a further 20 days possible, on the condition that the complainant was informed about a possible extension. Although the complaints policy did not stipulate a timeframe for acknowledgement of complaints, we found that complaints were acknowledged by the manager on the day they were received.
- Complaints were accepted in any format, including verbally, in writing, by phone and by email. Staff could

Long stay/rehabilitation mental health wards for working age adults

Good

access a template for recording verbal complaints. Responses to complaints were compassionate and fair, and reflected all of the issues identified in the complaint.

- During our last inspection in February 2016 we found that the complaints policy for the hospital did not advise patients to contact the provider or an external body if they were unhappy with the outcome of the complaint. During this inspection we found that complainants were told to escalate their complaints to the provider if they were dissatisfied with the response at location level. This information was given in response letters and on complaints leaflets.
- Patients told us they knew how to complain. Leaflets were available explaining the complaints procedure, and this information was also included in patient welcome packs. Patients felt confident that staff would support them if they needed to complain or had any concerns.
- Informal complaints and general feedback were addressed promptly by staff. This feedback was also clearly recorded so staff could identify themes. A variety of staff members attended weekly community meetings so that patients' feedback could be looked into by the most appropriate individual straight away.

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

Good

Vision and values

- The registered manager held a strong ethos of enabling patients to embrace who they were, whilst developing their skills and preparing them to move on to a low support environment. We found that staff working at the service shared this ethos. However, the In Mind Hospital Healthcare Group did not have a vision or set of values that it shared with staff.

Good governance

- An effective governance system was in place. Safeguarding and Mental Health Act and Mental Capacity Act procedures were correctly followed. Shifts were covered by a suitable number of experienced staff.
- A comprehensive system of regular audits was in place. All staff, including non-clinical staff, were given responsibility for completing some of these audits. The manager and deputy manager had oversight of audits.
- A two monthly quality governance meeting took place locally, where the registered manager presented performance data to staff, including incidents, safeguarding referrals, complaints and training compliance, which they then discussed. A two monthly health and safety meeting also took place, where staff discussed operational issues that impacted on the safety of the service.
- All mandatory training courses for staff had compliance rates of over 90%, and the audit system alerted staff when training was due. All staff received regular supervision appropriate to individual experience and levels of support and guidance required, and all staff received an annual appraisal. Incidents were analysed quarterly. A series of graphs were shared with staff. These enabled the service to identify incident themes and trends.
- Key performance indicators (KPIs) were used to monitor performance of the service. This information was collected monthly and fed up to the directors in the organisation for oversight. KPIs included admission and discharge information, details about skilled staffing including training and supervision compliance, and other operational monitoring such as patient reviews and documentation completion. All KPIs were being comfortably met at the time of our inspection.
- The deputy manager and two administrators supported the registered manager and clinical nurse manager with operational work. The deputy manager had oversight of Mental Health Act administration and was responsible for measuring quality.'
- The manager held a service level risk register, which staff could contribute to. A risk register enables staff to log, track and prioritise issues that affect the safe running of service as they arise. This fed up to organisation level and more significant risks would feature on the provider's risk register.

Long stay/rehabilitation mental health wards for working age adults

Good

Leadership, morale and staff engagement

- Staff told us they felt very well supported by the hospital manager, and that they felt they could support them for advice and support. However, senior managers in the organisation were not visible at the service. The operational director sometimes visited to support the manager, for example, when following up on investigations into significant incidents. Staff and patients did not have contact with the most senior managers at the In Mind Hospitals Healthcare Group.
- Staff sickness was 0% during the year leading up to our visit. Staff did not report any cases of bullying or harassment.
- Staff felt able to raise concerns without fear or victimisation. They felt confident sharing their concerns with the registered manager, but also told us they could escalate their concerns to the operational director if necessary.
- Staff morale was high. Many staff had worked at the service for a number of years and staff felt well supported by each other.
- Staff were open and transparent when things went wrong. As incidents and complaints were investigated, individuals were kept up to date with progress of the investigation. Two patients whose possessions had gone missing a few months before our inspection were apologised to by staff and recompensed.
- Staff were given the opportunity to feed back about the service and its operations during team meetings and at one to one supervision sessions. Staff were actively encouraged to use the formal complaints procedure if necessary.

Commitment to quality improvement and innovation

- The service had developed a questionnaire for all staff members to help develop their understanding of the Mental Health Act (MHA), and help inform the manager about the level at which training needed to be pitched. The questionnaire involved staff members proactively seeking answers in the workplace, and successfully engaged them in learning about the MHA. This was recognised as having been successful, and the MHA questionnaire was implemented elsewhere in the organisation to help engage staff with MHA training.
- The service did not participate in any national quality assurance programmes.

Outstanding practice and areas for improvement

Outstanding practice

- Staff had collaborated with the local accident and emergency (A&E) department to help them develop a protocol for managing patients who present at A&E having self-harmed. This work subsequently benefitted a patient from the hospital who needed to go to A&E.
- An effective audit to keep track of blood tests for people on Clozapine, which flagged when people were due for a blood test in advance, had been created by the service and subsequently adopted by a local NHS trust.
- Staff collaborated with patients as partners in their care. Patients were involved in all decisions that needed to be made about the way the service was run, and staff ate meals with patients and their offices were situated on patient corridors, enabling ease of communication with staff.
- Patients were routinely consulted with about all decisions to be made about the way the service operated. Patients were regularly asked for their feedback or to complete surveys specific to decisions that the service needed to make.
- All staff took responsibility for a set of audits to ensure effective the continued effective running of the service.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure senior staff from the In Mind Hospital Healthcare Group are visible so all staff are aware of who they are and feel able to approach them.