Rushcliffe Independent Hospitals Mill Lodge Hospital Kegworth

Quality Report

Mill Lodge
Mill Lane, Kegworth
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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?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

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.

Overall summary

We rated Mill Lodge Kegworth as good because:'

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors to keep patients safe. Staff assessed and managed risk well. They minimised the use of physical restraint, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-orientated care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

- Patients bedrooms were kept locked and patients had to ask staff to unlock them before they could use them. We raised this with managers as a concern who responded promptly with an action plan, to be completed by 02 December 2019, that would allow patients free access to their bedrooms.
- Staff had introduced set smoking times, this was a blanket restriction. We raised the issue with the managers and by the end of the inspection we saw evidence of, and patients confirmed, the smoking times had been removed and they could go for a vape or cigarette at any time.
- Although the ligature audit was complete, in date and included actions, the actions had not been given a timeframe for completion.
- Multidisciplinary team working needed to be embedded in practice, particularly as managers were moving towards a psychological informed environment (PIE) model approach to patient care.
- Healthcare support workers were not involved in patient care planning or feedback even though they were the people who had most day to day contact with the patients.
- The providers procurement processes were not clear, equipment required by staff for patients' care was not being supplied in a timely manner.
- Staff in the multidisciplinary team did not have enough computers to enable them to complete their work in a timely manner.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good 	Acute wards for adults of working age

Summary of findings

Contents

Good

Mill Lodge Kegworth

Services we looked at :
Acute wards for adults of working age

Summary of this inspection

Background to Rushcliffe Independent Hospitals Mill Lodge Hospital Kegworth

Mill Lodge Kegworth is an independent acute hospital owned and managed by Rushcliffe Health Care Limited. It is located in the village of Kegworth between Leicester, Derbyshire, Nottinghamshire and Lincolnshire. Mill Lodge caters for male and female adults of working age who are experiencing acute episodes of mental health illness. Mill Lodge accepts urgent referrals and patients who may be detained under the Mental Health Act. The hospital currently has seven male and seven female beds open these are commissioned as a block contract with Lincolnshire Partnership NHS Foundation Trust.

The hospital has a total 28 beds across four wards, Jared, James, Amrik and Alexander, each ward has seven beds. At the time of inspection only James and Jared wards were open. There were eleven patients at the hospital five males on James ward, three of whom were detained under the Mental Health Act and two informal patients. On Jared ward there were seven female patients four of whom were detained under the Mental Health Act and three informal patients. The average length of stay was 29 days.

The hospital registered with Care Quality Commission in May 2019. It is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the mental health act 1983;
- Diagnostic and screening procedures.

The hospital has not been inspected by Care Quality Commission before. There is a registered manager, nominated individual and controlled drugs accountable officer. This was the first unannounced comprehensive inspection of this service, though there had been a Mental Health Act review visit to James ward in October 2019. During this inspection we considered the findings of the Mental Health Act review and looked at James ward and Jared ward as they were only two wards open at the time.

Our inspection team

Team leader: Debra Greaves

The team that inspected the service comprised one CQC inspector, two CQC registration inspectors, and a specialist advisor consultant psychiatrist.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. Also, as the service was newly registered it needed to be inspected within a six-month timeframe of opening.

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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information and sought feedback from patients via an engagement meeting.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, though concentrated in detail on James and Jared wards, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with five patients and three carers who were using the service, and one carer who had previous experience of the service
- spoke with the registered manager, two senior managers and the two ward managers
- spoke with 23 other staff members; including doctors, nurses, occupational therapist, psychologists, healthcare support workers, administration and housekeeping
- attended and observed two hand-over meetings and one multi-disciplinary meetings
- collected feedback from 39 patient feedback forms
- looked at five care and treatment records of patients
- reviewed five staff files
- carried out a specific check of the medication management and prescribing practice on two wards, and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Patients and carers were generally complimentary about the hospital and the staff. Patients told us the staff were very good and that they were friendly, informative, caring and supportive when people were in distress.

Patients also told us that they liked the smaller wards as staff seemed to have more time to speak with them. They felt their cultural preferences were understood and had been respected, the food was good quality and staff were good at communicating with their families.

Carers told us that staff had kept them informed about their relatives care planning meetings and follow up meetings. One carer who had visited the hospital on separate occasions had seen how the managers had responded to patient and carer feedback and made better provision for visiting relatives, more comfy chairs and offered visitors a hot drink.

However

Patients had complained about the set smoking times and not being able to access their bedrooms without asking. Though when this was raised with managers both practices were reviewed.

Other patients told us the family visiting room was small and the therapy program could be better with more resources and activities for ladies.

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:

- The wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- 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.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. 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.

However:

- Although the ligature audit was complete, in date and included actions, the actions had not been given a timeframe for completion.
- Patients bedrooms were kept locked and patients had to ask staff to unlock them before they could use them. We raised this with managers as a concern who responded promptly with an action plan, to be completed by 02 December 2019, that would allow patients free access to their bedrooms.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-orientated.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients 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.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills need to provide high 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.
- Staff had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Multidisciplinary team working needed to be embedded in practice, particularly as managers were moving towards a psychologically informed environment (PIE) model approach to patient care.
- Healthcare support workers were not involved in patient care planning or feedback even though they were the people who had most day to day contact with the patients.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Summary of this inspection

- 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.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. However, while each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe the bedrooms were kept locked. There were quiet areas for privacy.
- The food was of a good quality and patients could make or have access to hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Summary of this inspection

- Staff engaged actively in local and national quality improvement activities.

However:

- The providers procurement processes were not clear, equipment required by staff for patient's care was not being supplied in a timely manner.
- Staff in the multidisciplinary team did not have enough computers to enable them to complete their work in a timely manner.

Detailed findings from this inspection

Mental Health Act responsibilities

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

All staff had completed training in Mental Health Act and had good understanding of the Act and the code of practice guiding principles. The service had a Mental Health Act administrator who could support staff with questions or concerns they had around understanding or applying the Mental Health Act. Managers told us they did monthly audits to check their compliance with Mental Health Act legislation and escalated any concerns arising from the audits through the clinical governance systems.

The provider had relevant policies and procedures that reflected the most recent guidance and staff had easy access to these policies. Patients had easy access to information about independent mental health advocacy. This information was available in their information pack and displayed on walls at the hospital. Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. • Staff requested an opinion from a second opinion appointed doctor when necessary. Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them.

Informal patients knew they could leave the ward at any time and we saw notices on the doors of the wards explaining this. Care plans referred to identified Section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had completed training in the Mental Capacity Act. Staff we spoke with had a good understanding of the Mental Capacity Act, in particular the five statutory principles. The service had arrangements to monitor adherence to the Mental Capacity Act. • Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

The service had made no Deprivation of Liberty Safeguards applications made since the hospital opened in May 2019. The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards, and took all practical steps to enable patients to make their own decisions.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. When patients lacked capacity, staff knew they had to make decisions in the patients' best interests, recognising the importance of the person's wishes, feelings, culture and history.

Acute wards for adults of working age and psychiatric intensive care units

Good

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Good

Safe and clean environment

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. However, staff had not indicated a completion date for the action points on the ligature risk assessment and so we did not know when they should be completed by. Staff could observe patients in all parts of the wards.

The hospital complied with same sex guidance. Wards were separate environments and nominated either male or female. Therefore, during the period May 2019 to August 2019 there were no mixed sex breaches at this location. Staff had easy access to alarms and patients had easy access to nurse call systems.

The service did not have a patient-led assessment of the care environment (PLACE) score. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including hand washing.

The service did not have seclusion rooms. Rooms that had originally been intended for use as seclusion areas had been decommissioned and were being used as quiet areas for patients to have time out if they so wished.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment.

Safe staffing

At the time of inspection, the service had enough nursing, healthcare support workers and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients.

The core establishment was one qualified nurse and three healthcare support workers per ward on all shifts with one further qualified nurse per shift to cover nurses breaks and training. The ward managers could also bring in extra staff as patients' needs required. A qualified nurse was always present in communal areas of the ward. Staffing levels allowed patients to have regular one-to-one time with their named nurse. Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. There were enough staff to carry out physical interventions

As of 08 November 2019, the service had 16 qualified nurses, and 22 healthcare support workers to cover two seven bedded wards on two 12.5 hour shifts per day. The manager explained that they intended to increase staffing as more wards opened.

This core service reported an overall vacancy rate of zero for registered nurses and 28% vacancy rate for healthcare support workers as of 08 November 2019.

Acute wards for adults of working age and psychiatric intensive care units

Good

Between 23 August 2019 and 08 November 2019, agency staff had filled 42 shifts, there were no unfilled shifts. The reasons for requiring agency staff was enhanced observations, healthcare support worker vacancies, sickness and holiday absence. This was a significant improvement since 16 May 2019 to 22 August 2019 when agency staff had filled 479 shifts.

For the period 16 May 2019 to 08 November 2019 staff turnover was 3%, and staff sickness was 11%. Managers explained that sickness was mainly short term with one episode of long-term sickness. Managers supported staff who needed time off for ill health.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers worked closely with five local staff agencies to secure known agency staff on block contracts where possible. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. All agency staff had to be trained in management of actual or potential aggression (MAPA).

Patients had regular one to one session 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. Staff shared key information through morning and evening shift handovers, 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 ward quickly in an emergency.

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

Data provided during inspection showed that 95% of staff had completed mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training included MAPA, safeguarding adults and children, Phlebotomy (for those staff requiring this in their work role), ILS for qualified staff, BLS for all other staff, basic food hygiene, Mental Health Act, and Mental Capacity Act. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

We reviewed five patients risk assessment records. All records demonstrated good practice in the areas reported on below. Staff did a risk assessment of every patient on admission and updated it regularly, including after any incident. Staff used a recognised risk assessment tool and positive behavioural support plans.

Staff were aware of and dealt with any specific risk issues, such as sepsis and withdrawal from substances. Staff identified and responded to changing risks to, or posed by, patients. Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms. There was search policy and staff had been trained to use search techniques correctly.

While staff adhered to best practice in implementing a smoke-free policy they used set smoking times to help manage the risks associated with this. We raised this issue with the managers, and by the end of the inspection period we had received assurances that there were no longer set smoking times, and patients confirmed this.

Informal patients could leave at will and knew that.

Between 16 May 2019 and 30 August 2019 there were six episodes of restraint on five different patients, none of the episodes included prone restraint. These were highest on James ward. The service did not use seclusion or segregation. The wards in this service participated in the provider's restrictive interventions reduction programme. Staff used restraint only after de-escalation had failed and used correct techniques tis was evidenced in the incident reports.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Staff followed British National Formulary (BNF) and National Institute for Health and Care excellence guidance when using rapid tranquilisation and this was verified by the external pharmacist.

Safeguarding

Acute wards for adults of working age and psychiatric intensive care units

Good

There had been no safeguarding concerns raised since the hospital opened in May 2019. All staff had trained in safeguarding adults and children, and those we spoke with knew how to raise a safeguarding concern and said they would do that when appropriate. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Staff followed safe procedures for children visiting the ward and used the family friendly visiting room away from the wards.

Staff access to essential information

The service was using paper records but was in the process of transferring to an electronic data base. All information needed to deliver patient care was available to all relevant staff including agency staff when they needed it and was in an accessible form. This included when patients moved between teams. Managers had decided to keep the paper records system until they were assured that the electronic system was fully functioning and working reliably, they had decide to implement it on one ward to start with and then roll out the process to the other wards when any problems that may arise had been resolved. This ensured that staff would not have difficulty in recording or accessing patient information.

Medicines management

Staff followed good practice in medicines management including, storage, dispensing, administration, medicines reconciliation, recording, disposal, and use of covert medication and did it in line with British National Formulary and National Institute of Health and Care Excellence guidelines. Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute of Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication. An external pharmacist visited weekly to audit medications management and provide advice on training and any other issues they may come across.

Track record on safety

The provider had reported on two serious incidents since opening in May 2019. The incidents related to a staff members' poor clinical judgement while managing two separate patient incidents. The provider had fully investigated both incidents and taken appropriate remedial action including debriefing and support for staff and patients involved in the incidents and disciplinary procedure in line with provider policy and advice.

Reporting incidents and learning from when things go wrong

We reviewed the managers incident data base. All staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. There was a duty of candour policy and staff understood the duty of candour. Documentation showed that staff were open and transparent and gave patients and families a full explanation when things went wrong.

There was robust clinical governance system that enabled incidents to be escalated and discussed at senior management level, and then lessons learned to be cascaded down to staff in the providers locations. Staff told us, and we saw evidence in the staff room that staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss that feedback at team meetings. There was evidence that changes had been made because of feedback. Examples included a measured approach to opening the remaining two wards at the hospital, increasing the nursing establishment to include a floating qualified nurse to cover colleagues breaks and revised use of some of the rooms on the wards. Staff were debriefed and received support after a serious incident.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed five patient care plans and associated documentation. All records were complete, in date and showed evidence of comprehensive mental health, social and physical healthcare assessment and monitoring.

Acute wards for adults of working age and psychiatric intensive care units

Good

Staff developed care plans that met the needs identified during assessment. Care plans were personalised, holistic and recovery-orientated. Staff updated care plans when necessary. Care plans included the patients views through the staying healthy and my mental health recovery sections of the plan. However, we found that healthcare support workers were not involved in patient care planning or feedback even though they were the people who had most day to day contact with the patients.

Care pans included the patients views through the staying healthy and my mental health recovery sections of the plan

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. Intervention included medication and psychological therapies and encouragement to engage in meaningful activity.

Staff encouraged patients to maintain contact with their family, social and work networks in the community while in hospital. Staff ensured that patients had good access to physical healthcare, including access to specialists when needed.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration as required. Staff supported patients to live healthier lives – for example, through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, and dealing with issues relating to substance misuse.

Staff used recognised rating scales to assess and record severity and outcomes for example, Health of the Nation Outcome Scales; model of human occupation screening tool and self-assessment of function.

Staff used technology to support patients effectively for example, online cognitive behavioural therapy, and access to self-help tools.

Staff participated in clinical audit, benchmarking and quality improvement initiatives, and managers had adopted the Lester tool framework for auditing their physical healthcare provision. Managers had developed a comprehensive audit program over time using best practice standards from other independent healthcare providers, including audit principles of National Institute for Health and Care excellence and the Mental Health Act Code of Practice. Managers had aligned the audit program to the services CQUIN targets.

Managers told us it was their intention to join the network for Royal College of Psychiatrists accreditation when they had opened the remaining two wards at the hospital.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, occupational therapists, clinical psychologists, social workers, and pharmacists. While speech and language therapists, and dieticians could be accessed as and when required. A general practitioner also visited the hospital once a week to hold a physical healthcare clinic.

Staff had enough experience, were qualified, and had the right skills and knowledge to meet the needs of the patient group. Managers provided new staff with appropriate induction and orientation, using the care certificate standards as the benchmark for healthcare assistants. Managers identified new staffs training needs early on and ensured the identified training was completed at the earliest opportunity.

Managers provided staff with supervision, meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development, and there was a schedule of annual appraisal to monitor their work performance. In addition, managers ensured that staff had access to regular team meetings.

The percentage of staff that had had an appraisal in the last 12 months was 0%, because the hospital had opened in May 2019, though there was an appraisal schedule to ensure that all staff had an appraisal after one year in post.

The percentage of staff that received regular supervision was 95%, one staff members supervision was out of date due to their long-term sickness. Managers used supervision to identify the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles. Managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

Acute wards for adults of working age and psychiatric intensive care units

Good

While staff held regular multidisciplinary meetings, multidisciplinary team working needed to be more embedded in practice, particularly as managers were moving towards a psychologically informed environment (PIE) model approach to patient care. We attended three multidisciplinary meetings where patients and service developments were being discussed and only one demonstrated full multidisciplinary discussion and planning. Staff also told us they did not always feel welcome at all multidisciplinary meetings, and their views and opinions were not always respected or taken on board at such meetings.

Staff shared information about patients at handover meetings held every morning and every evening on each ward. The ward teams had effective working relationships, including good handovers, with other relevant teams such as care co-ordinators, community mental health teams, and the crisis team. The ward managers had effective working relationships with teams outside the organisation for example the local authority, social services and GPs.

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

All staff had completed training in Mental Health Act and had good understanding of the Act and the code of practice guiding principles. The service had a Mental Health Act administrator who could support staff with questions or concerns they had around understanding or applying the Mental Health Act. Managers told us they did monthly audits to check their compliance with Mental Health Act legislation and escalated any concerns arising from the audits through the clinical governance systems.

The provider had relevant policies and procedures that reflected the most recent guidance and staff had easy access to these policies.

Patients had easy access to information about independent mental health advocacy. This information was available in their information pack and displayed on walls at the hospital. Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. • Staff requested an opinion from a second opinion appointed doctor when necessary. Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them.

Informal patients knew they could leave the ward at any time and we saw notices on the doors of the wards explaining this.

Care plans referred to identified Section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.

Good practice in applying the Mental Capacity Act

All staff had completed training in the Mental Capacity Act. Staff we spoke with had a good understanding of the Mental Capacity Act, the five statutory principles. The service had arrangements to monitor adherence to the Mental Capacity Act. • Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

The service had made no Deprivation of Liberty Safeguards applications made since the hospital opened in May 2019. The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards, and took all practical steps to enable patients to make their own decisions.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions. When patients lacked capacity, staff knew they had to make decisions in the patients' best interests, recognising the importance of the person's wishes, feelings, culture and history.

Acute wards for adults of working age and psychiatric intensive care units

Good

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Patients and carers were generally complimentary about the hospital and the staff. Patients told us the staff were very good and that they were friendly, informative, caring and supportive when people were in distress.

Staff supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate and, if required, supported them to access those services.

Patients told us that they liked the smaller wards as staff seemed to have more time to speak with them. They felt their cultural preferences were understood and had been respected, the food was good quality and staff were good at communicating with their families.

However, patients had complained about the set smoking times and not being able to access their bedrooms without asking. We raised these issues with the managers. By the time we left site managers had stopped using set smoking times and patients confirmed this. Managers had also given us an action plan that ensured all patients would have free access to their bedrooms by 02 December 2019. We accepted and agreed this action plan which would be monitored by the relationship owner for this service through the provider, staff and patient's engagement process.

Other patients told us the family visiting room was small and the therapy program could be better with more resources and activities for female patients. A staff member advised us they had ordered specific equipment for female focussed activities several weeks before but had not had confirmation if the order was going to be fulfilled or when. We advised the managers of these issues.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff maintained the confidentiality of information about patients.

This service did not have a PLACE survey score for privacy, dignity and wellbeing.

Involvement in care

Staff used the admission process to inform and orient patients to the ward and to the service. Staff involved patients in care planning and risk assessment as shown by evidence in care plans, patients' participation in multidisciplinary team reviews, and staff giving patients a copy of their care plan.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Staff involved patients when appropriate in decisions about the service through discussion groups and in the recruitment of staff.

Staff enabled patients to give feedback on the service they received for example, via surveys and community meetings. Staff knew that they should enable patients to make advance decisions, to refuse treatment, sometimes called a living will, when appropriate. Staff ensured that patients could access advocacy.

Staff informed and involved families and carers appropriately and provided them with support when needed. Carers confirmed this and told us that staff had kept them informed about their relatives care planning meetings and follow up meetings.

Staff enabled families and carers to give feedback on the service they received through feedback forms. One carer who had visited the hospital on separate occasions had seen how the managers had responded to patient and carer feedback and made better provision for visiting relatives, more comfy chairs and offered visitors a hot drink.

Staff provided carers with information about how to access a carer's assessment.

Acute wards for adults of working age and psychiatric intensive care units

Good

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

Bed occupancy for this service since it opened in May 2019 was 75%. This service had 14 neds block booked for patients in the Lincolnshire area. Beds were available when needed for patients living in the 'catchment area'. There was always a bed available when patients returned from leave. Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. When patients were moved or discharged, this happened at an appropriate time of day. A bed was always available in a psychiatric intensive care unit (PICU) if a patient required more intensive care and this was sufficiently close for the person to maintain contact with family and friends.

In the last six months, the hospital opened in May 2019 there were no delayed discharges from the inpatient wards. Staff planned for patients' discharge, including good liaison with care managers and co-ordinators. Discharge was never delayed for other than clinical reasons.

Staff supported patients and their families during referrals and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. The service complied with transfer of care guidance.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Patients could personalise bedrooms and had somewhere secure to store their possessions. However, patients' bedrooms were kept locked, and patients had to ask staff to unlock them when they wanted to use the bedroom or toilet. We raised this with the managers. By the end of the inspection managers submitted an action plan to remove the locked bedroom policy by 02 December 2019. The inspection team accepted the action plan and agreed to monitor the actions through the ongoing provider and patient's engagement process. And provider.

Staff and patients had access to the full range of rooms and equipment to support treatment and care, including clinic room to examine patients, activity and therapy rooms. However, some patients told us there was not enough or a range of therapeutic activities for ladies choose from.

There were quiet areas away from the ward where patients could meet visitors. Patients could make a phone call in private. Patients had access to outside space. The food was of a good quality and patients could make hot drinks and snacks 24/7.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had opportunities to maintain links with any education or employment networks they had outside of the hospital environment. Staff supported patients to maintain contact with their families and carers and encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service planned for disabled patients – for example, by ensuring disabled people's access to premises and by meeting patients' specific communication needs.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, how to complain advocacy and activity programs. Staff made information leaflets available in languages spoken by patients. Managers ensured that staff and patients had easy access to interpreters and, or signers. Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Staff ensured that patients had access to appropriate spiritual support, we saw a designated multi-faith room at the hospital.

Listening to and learning from concerns and complaints

Total number of complaints since opening was two. One complaint related to a staff member complaining about a

Acute wards for adults of working age and psychiatric intensive care units

Good

colleague, and the other related to a patient wanting to change his doctor. Neither complaint was referred to the ombudsman. Managers upheld both complaints and took appropriate action to resolve the complaints.

Patients knew how to complain or raise concerns. When patients complained or raised concerns, they received feedback. Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff knew how to handle complaints appropriately. Managers either dealt with complaints at local level according to policy or escalated them through the clinical governance systems. All complaint investigations were discussed at the organisation's clinical governance meetings and any lessons learned were cascaded back to staff within the hospital. Staff received feedback through team meetings, written briefings and on handover if relating to patient care for action.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Leadership

Most leaders had the skills, knowledge and experience to perform their roles. Though managers acknowledged that following recent feedback staff felt there was a need for better modelling and support for nurses to carry out duties when leading smaller teams. Managers had addressed this by offering leadership development opportunities, including opportunities for staff below team manager level.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Leaders were visible in the service and approachable for patients and staff. Managers showed us minutes of meetings when senior managers had attended to explain their roles and responsibilities.

Vision and strategy

The provider described their service in terms of a model of care. Their aim was: "to support and treat all of our patients to maximise their potential and enable them to live as independently as possible".

The providers approach was: "person centred, we acknowledge everyone is an individual. We aim to promote recovery across the hospital where every patient has clearly defined care goals and outcomes which are realistic and achievable. We will encourage positive risk taking and promote a 'least restrictive approach'. We will always involve patients and their careers. Care is delivered collaboratively by a multi-disciplinary team."

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Senior staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff we spoke with said they felt respected, supported and valued they confirmed that managers kept them infirmed of changes that would affect them through team briefings and notifications. Most staff felt positive and proud about working for the provider and their team, they were keen to help develop this new service.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process if they needed to and knew about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed and where there were difficulties managers dealt with them appropriately. Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Managers told us they had a staff group recruited from an ethnically diverse set of communities that reflected the local populations of Nottingham and Leicester, and that it was their intention to continue recruiting on this basis.

The hospitals staff sickness and absence were low compared to similar organisations. Staff had access to support for their own physical and emotional health needs through an occupational health service. Mangers explained

that they wanted to introduce a range of measures that celebrated staff success in the hospital and that once finalised and agreed this would be introduced in the next year.

Governance

There were systems and procedures to ensure that wards were safe and clean, that there were enough staff, that staff were trained and supervised, that patients were assessed and treated well, that the ward adhered to the MHA and MCA, that beds were managed well, that discharges were planned, that incidents were reported, investigated and learnt from.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Staff had implemented recommendations from reviews of incidents, and complaints at service level. Staff undertook or participated in local clinical audits. The audits were enough to provide assurance and staff acted on the results when needed. Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register. The service had plans for emergencies – for example, adverse weather or a flu outbreak. Where cost improvements were taking place, they did not compromise patient care.

The providers procurement processes were not clear, equipment required by staff for patient's care was not being supplied in a timely manner.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. While most staff had access to the equipment and information technology needed to do their work, staff in the multidisciplinary team told us they did not have enough computers to enable them to complete their work in a timely manner.

The information technology and infrastructure, including the telephone system, worked well and helped to improve the quality of care. The service was in the process of transferring from a paper-based patient record system to an electronic one. Managers explained they were doing this one ward at a time and resolving any problems before rolling out the transfer. Managers and staff had decided to keep the paper-based system running as normal until they could be sue that the electronic system was functioning effectively.

Information governance systems included confidentiality of patient records. Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, and was timely, accurate and identified areas for improvement. Staff made notifications to external bodies as required.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used through the intranet, bulletins, and briefings displayed in the staff room and on notice boards on the wards.

Managers told us they recognised staff were their most valuable resource. Managers took time to engage with staff to give them the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. They said the top three issues staff had identified were, the staffing rota and regularity of shift patterns, communication with senior management, and clarity of responsibilities of senior staff. Managers showed us minutes of meetings where these issues had been discussed, and we saw how managers had addressed all the issues raised.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. This was evidenced in the 39 feedback forms we reviewed. Patients were involved in decision-making about changes to the service through community meetings. Patients and staff could meet with members of the provider's senior leadership team to give feedback. Directorate leaders engaged with external stakeholders such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

Acute wards for adults of working age and psychiatric intensive care units

Good

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Staff had opportunities to participate in research that would benefit the service. Staff participated in national audits relevant to the service and learned from them.

Managers explained that as a new service they had developed a three-year program of continuous development and improvement. We saw that the program included an initial first year development plan, based around opening services and creating a solid and sustainable staff team. At year two managers focus would be on stabilisation of the staff team and contracts, building relationships with key local commissioners to ensure a stable financial future, and review how the hospital's policies and procedures were embedded in the functioning of the hospital. While in year three, managers focus would be on reviewing the service provision, the role and purpose of each ward, and potentially developing pathways into other Rushcliffe Hospital services.

Although the wards did not participate in any accreditation schemes managers had put in place the infrastructure for this to happen.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that their action plans to allow patients free access to their bedrooms by 02 December 2019 are implemented by that date.
- The provider should ensure that all actions in the ligature audit have a timeframe allocated.
- The provider should ensure that there is evidence of multidisciplinary input at all levels of the care and treatment process, and that healthcare support workers are included in the treatment planning for the patients they work with.
- The provider should ensure that the organisations procurement processes are completed in a timely manner.
- The provider should ensure that their allied health professionals have access to enough computers to complete their work in a timely manner.