Mildmay Oaks

Quality Report

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Date of inspection visit: 22 July 2019
Date of publication: 17/09/2019

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

During this inspection we found:

- The wards had enough nurses. Staff managed medicines safely, followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to work with patients who displayed behaviour that staff found challenging.
- Managers ensured that permanent staff received an induction to the hospital and training.
- Staff treated patients with compassion, kindness and respected their privacy and dignity.
- The service treated concerns and complaints seriously.
- Leaders had the right skills and made staff feel supported and valued. Mangers took action to address performance concerns.

However:

- Not all agency staff had received an induction to the hospital.
- Some patients told us that staff could be abrupt when they were busy.
- None of the agency staff had received documented training in learning disabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism		Mildmay Oaks Independent Hospital is a low secure and locked rehabilitation service for men and women with learning/intellectual disability and autism spectrum disorder and mental illness.

Summary of findings

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Services we looked at
Wards for people with learning disabilities or autism

Summary of this inspection

Background to Mildmay Oaks

Mildmay Oaks Independent Hospital is a low secure and locked rehabilitation service for men and women with learning/intellectual disability, autism spectrum disorder and mental illness.

The wards at Mildmay Oaks are:

Winchfield Ward - 18 bed male low secure

Mattingley Ward - 8 bed male low secure

Heckfield Ward - 8 bed female locked rehabilitation

Bramshill Ward - 5 bed male locked rehabilitation

Eversley Ward - 8 bed male locked rehabilitation

Mildmay Oaks is registered to provide the following 'regulated activities':

- Assessment or medical treatment for person's detained under the Mental Health Act
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

There was no registered manager in post at this location as they had recently left, however we were told one had been appointed and were currently going through pre-employment checks.

This location was last inspected in May 2018 when we rated them requires improvement overall. We rated safe, effective and well-led domains requires improvement and caring and responsive good and issued the following requirement notices:

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

- Patients were not protected from the risk of adverse side effects from medicines that were administered by not following post rapid tranquilisation protocol.
- Patients were not protected from the risks associated with blind spots which were not mitigated.
- Ligature risk assessment management plans were not thorough.
- The clinic room on Winchfield was not well-maintained and not all emergency equipment and medication was available.
- Infection control procedures on Bramshill ward were not being followed.

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing

- Agency staff were not trained to the standard set out in the staff training policy. Staff did not receive training that met patients' needs.

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Good governance.

- The provider did not have a sufficient overview of the training compliance across any of the wards.
- The provider did not have a clear overview of the frequency of prone restraints.

We will address the above requirement notices at a future comprehensive inspection.

Our inspection team

The team that inspected this service comprised one inspection manager, two inspectors and two specialist advisers with experience of working with people with learning disabilities.

Why we carried out this inspection

We carried out a focussed inspection of Mildmay Oaks due to concerns noted in the information we collect about the service and information passed to us from other sources. In 2019 we received two notifications of

Summary of this inspection

alleged staff on patient assaults from the provider. We received a whistle blowing concern about staff culture. We reviewed information we held about the service and found we had received five similar notifications since 2017.

How we carried out this inspection

As this was a focused inspection we did not re-rate the service as we only looked at some of the key lines of enquiry across each domain. The rating of the service remains the same as those awarded in the comprehensive inspection in 2018.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited three wards at the hospital and observed how staff were caring for patients
- spoke with 11 patients who were using the service
- spoke with the clinical manager and three ward managers
- spoke with seven other staff members; including nurses, social worker and health care support workers
- looked at 12 care and treatment records of patients
- carried out a specific check of the medication management on three wards
- looked at a range of policies, procedures and other documents relating to the running of the service
- used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

What people who use the service say

Patients told us that staff were approachable and they were treated well by them.

However, two patients told us that some staff could be abrupt in their responses to them when they were busy.

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?

- The service had enough nursing staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.
- 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.
- 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.

Are services effective?

- Not all agency staff had received a hospital induction.
- None of the agency staff had received documented training in learning disabilities.
- Not all issues identified on the management walk rounds had an action plan.

However:

- Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided an induction programme for new staff.

Are services caring?

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

However:

- Two patients told us staff were sometimes abrupt when they were busy.

Summary of this inspection

Are services responsive?

- 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?

- Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- Staff performance and risk were managed well.

However:

- Not all issues identified during the managers quality walk rounds had an action plan.

Detailed findings from this inspection

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe staffing

- The service made sure it had enough nurses who knew the patients, by employing agency nurses on longer contracts. Nurses had received basic training to keep people safe from avoidable harm. The hospital followed the Priory Group staffing ladders. These indicated how many qualified nurses and health care support workers each ward needed to provide safe care. The ward manager could also adjust the staffing levels according to the needs of the patients. For example, when patients required constant nursing observation additional staff were brought in for this.
- We reviewed three months of rotas for all the wards at the hospital. Wards had enough staff with the right skills on duty. All the shifts had the agreed number of qualified nurses on duty. However, we identified five shifts over the three months when one ward in the hospital was one health care support worker short.
- Although the vacancy rate for qualified nurses remained high service had reduced its staff vacancy rates since our last inspection. The establishment for qualified nurse was 29 with eight in post and 21 vacancies, a vacancy rate of 72%. At the time of our inspection the overall staff vacancy rate was 46%, when we inspected in July 2018 the staff vacancy rate was 89%. There was an additional 11 staff waiting for pre-employment checks to be completed, which would reduce the vacancy rates further. The service was able to fill its vacant shifts by using agency staff booked on longer contracts, three months.
- The service had enough staff on each shift to carry out any physical interventions safely. Ward staff, including those working for agencies, received the providers training on preventing and managing violence and aggression.
- Staff had completed and kept up to date with their mandatory training. This included learning disability, autism and positive behaviour support training. There were also additional training modules for staff on learning disabilities and autism. At the time of our inspection 98% of staff had completed the autism module and 79% had completed the learning disability module. Overall compliance for mandatory training was 85% with the Priory Group target set at 95%. Managers could see when staff needed to complete training and would remind them to do this, and staff would receive an email daily until they had completed their training. The hospital would pay staff to complete training, outside of shifts.

Use of restrictive interventions

- We reviewed the use of seclusion in the hospital and saw there had been one incident of seclusion in the last six months prior to inspection. Staff recognised the importance of communicating with patients, as well as assessing their needs and their particular situation, and aimed to reduce the incidence of restrictive interventions in line with the providers policy. Patients had care plans which supported staff to help and communicate with them when they were distressed.
- There had been no use of rapid tranquilisation, on two of the three wards we visited, in the past 12 months. On the ward where there had been one incident of rapid tranquilisation in April 2019, staff had completed appropriate physical health monitoring following the

incident. We saw that when staff used 'as required' medication to manage patients' behaviour, records showed that staff would use the lowest dose and gave it orally.

Medicines management

- 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. We reviewed 29 medicine charts across three wards and saw that staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed patient's medicines regularly and provided specific advice to patients about their medicines and we saw that information was provided in an easy read format when needed.
- Staff followed current national practice to check patients had the correct medicines.
- Mildmay Oaks managers had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.
- The Hospital was not following the Stopping the over medication of people with a learning disability, autism or both (STOMP) project guidance to prevent the over use of medication. However, decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed patient's positive behaviour support plan and saw these were used to help reduce the use of when required (PRN) medicines.

Reporting incidents and learning from when things go wrong

- Managers encouraged openness and transparency when investigating incidents on the wards. We reviewed six incidents where there had been either allegations of abuse from staff or incidents when restraints had not gone well, and patients had been hurt. Staff thoroughly documented what had occurred on the provider's electronic incident record, the safeguarding lead for the provider kept a detailed spread sheet of all actions taken and this was regularly reviewed. Managers had taken steps to protect patients and inform the Police, the local authority and the CQC where necessary. For example, staff had been reminded that they can only use the agreed physical interventions to restrain a patient.

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

Skilled staff to deliver care

- Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care. All permeant staff had a comprehensive induction to the hospital that included elements of working with people who had a learning disability and/or autism. We reviewed the induction programme for all new staff and saw that it covered all the areas needed for staff to work with this patient group. We were told that all agency and bank staff would also receive an induction to the hospital that included areas that were specific to different roles. For example, registered nurses had a medication competency assessment as well as the standard hospital induction. We reviewed seven long line agency staff records and saw that the hospital had received assurance of the staff members training and qualifications from the agency and had a copy of this and that they all had a documented induction relevant to their role.
- However, we reviewed 10 ad-hoc agency staff records and found that five of the records, one qualified nurse and four health care support workers, did not have assurance of training and qualifications or a documented induction in their record. There was not a system in place at the hospital that would flag up if an agency member of staff needed an induction and it relied on the hospital alerting the staff to this. None of the agency staff had received documented training in learning disabilities, because none of the local agency they used could provide staff with these skills. However, the managers used staff with skills in mental healthcare. Senior managers told they did not have permission for the agency staff to use the hospitals on line training system at the time of the inspection.

Are wards for people with learning disabilities or autism caring?

Kindness, privacy, dignity, respect, compassion and support

Wards for people with learning disabilities or autism

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity.
- We spoke with 10 patients across three wards and most patients told us that staff were respectful and treated them with compassion. All the interactions we saw between patients and staff were respectful. Patients clearly knew senior members of staff and spoke to them freely. Patients appeared confident when speaking to staff. For example, patients were happy to interrupt staff to speak to the inspection team. However, two patients told us that some staff could be abrupt and did not respond to requests quickly when they appeared busy. We brought this to the attention of the senior managers at the time of the inspection and they told us they would work with the ward managers to address these concerns.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Listening to and learning from concerns and complaints

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. These were shared with the whole team and the wider service. Patients knew how to make complaints and told us they were happy to raise concerns with staff. Patients told us that when they had made a complaint the manager had acted to resolve the issue quickly and patients were given the opportunity to sit down with staff to discuss their concerns.
- We reviewed seven complaints made in 2019. Complaints were dealt with in line with the organisational complaints policy. Investigations were transparent, and managers took appropriate action, when needed, involving outside agencies such as the local authority, safeguarding team and the police. Any identified learning from complaints was shared with staff via handovers, team meetings and via email.

Are wards for people with learning disabilities or autism well-led?

Leadership

- Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them.
- We interviewed three ward managers and they all had the skills and experience needed for their role. Ward managers all had supernumerary time allocated depending on the size of their ward. All managers told us that they had enough time to complete their tasks and enjoyed the role.

Culture

- Staff felt respected, supported and valued. They could raise concerns without fear.
- All staff we spoke to told us that senior managers were approachable and that they listened to and acted on staff members suggestions. Staff told us they knew how to and could raise concerns about the service without fear.

Management of risk, issues and performance

- Leaders managed staff performance issues and risk issues. We saw that managers responded to concerns that were raised and addressed performance issues with staff promptly. After we shared the whistle blowing concerns raised with us the senior leadership team responded by increasing the number of quality walk rounds they completed. They completed quality walk rounds out of hours including on weekends and in the early morning.
- We reviewed the paper work for the past four months of quality walk rounds and the additional out of hours walk rounds. We saw that mostly when they had identified issues they had dealt with them and recorded what action was taken. For example, staff not following the hospital dress code or not following observation policies. However, we identified two occasions when patients had said that staff were abrupt to them and there were no documented actions following this. They had monitored staff arrival to work times and when

needed spoke to staff in relation to this. Staff we spoke with told us that time keeping had improved following this and that managers had agreed flexible working with some staff when appropriate.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that any issues found during the managers walk rounds have a documented action plan to address them. Regulation 17: Good governance.
- The provider should ensure they follow the stopping the over medication of people with a learning disability, autism or both, project guidance. Regulation 12: Safe care and treatment.