The Billingham Grange 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?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

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

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

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

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 The Billingham Grange Independent Hospital as good because:

- Patients spoken with gave positive feedback on staff. They said staff treated them with dignity and respect, and were caring. Mental Health Act documentation was clearly recorded and up to date and records showed that patients' rights and status under the Act were explained to them.
- Patients' needs were assessed before and on admission, including physical assessments, which were reviewed regularly. Twelve out of the14 records that we reviewed had good up to date risk assessments. Care plans were holistic and reviewed regularly.
- Staff had assessed the risks posed by fixtures and fittings that patients at risk of suicide could use to attach a ligature. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves.
- The clinical workforce included a range of allied professionals dedicated to each ward. All staff felt supported by managers and had access to supervision. A total of 88% of staff had completed their mandatory training which was above the requirement of 85% set by the provider. Clinical governance systems, which included a range of audits and checks, helped the service provider to monitor and improve the quality of care.

But we also found:

- The hospital did not always manage medicines safely by following its medicines management policy. Nurses routinely wrote and transcribed prescription sheets and not all of these medications had been countersigned by either a doctor or a nurse prescriber. This potentially could put patients at risk of receiving incorrect medication. Staff did not always follow infection control principles when giving medication and were reusing single use medicine pots which also exposed patients to unnecessary risks
- There was limited evidence of patient involvement in care plans and none of the records reviewed indicated patients had received a copy of their care plan.
- Although all staff could tell us how they kept patients safe from the risk of harming themselves, not all support staff understood what a ligature point was and the risks associated with them. There was no central risk register or log to provide an overview of identified risks and actions taken to manage or eliminate them.
- Managers' understanding of the organisations vision and values were mixed.

Summary of findings

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Good

The Billingham Grange Independent Hospital

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Summary of this inspection

Background to The Billingham Grange Independent Hospital

The Billingham Grange Independent Hospital is a 50-bed hospital that provides 24 hour support seven days a week for people aged 18 years upwards with early onset dementia or mental health problems or both. It is registered with the Care Quality Commission to provide the following regulated activity:

- assessment or medical treatment for persons detained under the Mental Health Act 1983/2007
- treatment of disease, disorder or injury.

The hospital's registered manager has been in post since 2004.

The hospital provides care and treatment for people with young onset dementia and behaviour that challenged. It aims to develop effective treatment programmes for improving quality of life and maximising independence.

Patient accommodation is over two floors and comprises:

- The Grange Unit – 18-bed ward for men with young onset dementia and behaviour that challenged.
- The Hart Unit – 16-bed ward for men with young onset dementia and behaviour that challenged.
- The Wynyard Unit – 16-bed ward for women with young onset dementia and behaviour that challenged.

The hospital had been inspected on five occasions since 2011. On the last three occasions, March 2012, November 2012 and May 2013 it was fully compliant with the CQC essential standards of quality and safety.

Our inspection team

Team leader: Patti Boden

The team that inspected the service included four CQC inspectors, four specialist advisors, a Mental Health Act reviewer and an expert by experience (someone with experience of similar services).

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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?

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

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 15 patients who were using the service;
- spoke with four patients relatives;
- spoke with the registered manager and managers or acting managers for each of the wards;

Summary of this inspection

- spoke with 24 other staff members, including a doctor, nurses, an occupational therapist, a university tutor who was visiting the hospital and a GP;
- attended and observed a ward round, a multidisciplinary meeting and a Mental Health Act review tribunal;
- looked at 18 care and treatment records of patients;
- carried out a specific check of the medication management on all wards;
- carried out an unannounced visit in the evening;

looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Most patients we spoke with said staff were caring and that they were treated with dignity and respect. Most patients felt safe on the ward but some said they had had possessions go missing.

Most patients told us that the food was good and that they had a choice of meals. Not all patients were aware they could access snacks and drinks 24 hours a day.

Some patients felt the décor and furnishings of the wards needed updating.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The provider did not follow its medicines management policy, and staff did not always follow infection control principles when giving medication.
- There were multiple ligature points and not all support staff we spoke with understood what a ligature was, although they told us that they kept patient safe through observation and having nursing staff present in communal areas at all time. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves.
- A number of areas on the wards required refurbishment, particularly bathroom and showers.
- There was no central risk register or log to provide an overview of identified risks and actions taken to manage or eliminate them.

However:

Staff did thorough assessments of the risks to patients when they were admitted and at regular intervals during their care.

Staff showed a good understanding of safeguarding patients from abuse and could explain how and when they would make a safeguarding alert.

Most patients said they felt safe on the ward.

The duty rota for the two months before the inspection showed that staffing levels were adequate and adjusted appropriately when necessary.

All wards were visibly clean and tidy.

An annual ligature point assessment and comprehensive health and safety assessment had been completed.

There was a robust monitoring system to review incidents involving aggression or violence or both.

All staff carried personal alarms and we observed staff responding to an alarm quickly during our inspection.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Staff did comprehensive assessments of patients and their care plans described how their physical and mental health needs should be met. Staff kept care records up to date and stored them safely.
- A range of allied health professionals were dedicated to each ward.
- Staff had training to support them in improving their skills and knowledge to support patients.
- The consultant psychiatrist held ward rounds weekly.
- Staff received regular managerial supervision and had annual appraisals of their work performance.

However:

- Ward staff did not communicate all necessary information about patients risks to those starting a new shift in a shift handover we observed.

Are services caring?

Good

We rated caring as good because:

- Patients felt staff treated them with dignity and respect and they described staff as caring.
- All patients had access to an independent advocate who visited the hospital weekly.
- Detained patients had access to an Independent Mental Health Act Advocate and could make direct contact with them.
- Monthly patient meetings took place and we saw evidence of changes being made following patient feedback.

However:

There was little evidence of patient involvement in care plans.

Ward rounds consisted of a pre-meeting of the multidisciplinary team at which the patient was not present before being seen by the consultant. This meant the patient was not involved in the full discussion and decision-making process about their care

Are services responsive?

Good

We rated responsive as good because:

- There was a good range of facilities to support treatment and care, including a sensory room, meeting rooms, craft rooms, a faith room and lounge areas.
- Patients could access pleasant, well-kept outdoor space. There were enclosed courtyards for patients on the first floor.

However:

There was little evidence of discharge planning in records.

Summary of this inspection

Are services well-led?

Good

We rated well-led as good because:

- Staff training had good levels of compliance within many areas and an overall compliance of 88% which was above the requirement of 85% set by the provider. An action plan was in place to ensure that staff who had not yet completed their training were booked onto a course before the end of September 2015.
- Staff felt they could discuss their concerns with their line manager or more senior managers without fear of victimisation.
- Staff tried to involve patients in the service and gather feedback.
- Bi-monthly 'quality first' audits took place, which helped to improve the quality of care and ensure best practice was being used.

However:

The staff were not aware of the organisation's vision and objectives.

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 Provider.

A Mental Health Act reviewer had visited the three wards at the hospital (Grange unit, Hart unit and Wynyard unit) on 9 March 2015, 14 May 2015 and 21 July 2015 respectively.

We reviewed progress regarding past action points from these visits and audited two sets of care records on each ward and found that:

- actions from previous reports had been fully addressed or were in the process of being addressed
- relatives of patients who lacked capacity to make decisions about their treatment had been contacted and asked to assist in the formulation of more person-centred care plans
- there was in-house documentation relating to assessment of a person's level of understanding regarding their rights and referral to an independent mental health advocate for those who lack capacity had been revised
- the provider had started using a variety of easy read leaflets to help explain information to patients
- staff were trained in the Mental Health Act, its Code of Practice and the guiding principles
- There was good assessment and recording of capacity, revisiting of patients' rights and section 17 leave paperwork. Section 17 covers the process of giving a patient detained under the Mental Health Act permission to leave the hospital for a short time.

Mental Capacity Act and Deprivation of Liberty Safeguards

As part of their mandatory training, staff were trained in the Mental Capacity Act 2005. Most staff had a good understanding of this and how to apply their training on a daily basis with patients whose capacity to make decisions was impaired. Most records reviewed showed staff took practicable steps to enable patients to make decisions about their care and treatment by using a variety of communication methods wherever possible.

Notes

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Requires improvement

Safe and clean environment

All wards were visibly clean and tidy with comfortable seating and furnishings. Flooring and seating was appropriate for patients with dementia. However all wards had areas that required refurbishment. This was mainly bathroom and shower areas. Some rooms, such as the dining room on the Grange Unit were sparsely decorated. Other areas across the three wards had décor and furnishings that required updating. The hospital had a five year estates plan for the upgrading of key areas including bathrooms and showers.

The bathroom on the Grange Unit was out of order due to a fault during our visit so patients only had access to two showers on the ward. The bathroom on the Wynyard Unit was also out of use during our visit as this was being refurbished.

There were multiple ligature points in bathroom and bedroom areas which the hospital were aware of and had identified during its annual ligature risk assessment (2014). Actions were in place to mitigate these risks. Staff told us observation was the main means of mitigating risks to patients from ligature points. Self-harm and suicide risk was assessed and managed individually. Some support staff we spoke with did not fully understand how ligature points could pose a risk to patients. The annual ligature risk assessment had been repeated (July 2015) however the report was not yet available at the time of our assessment.

There were blind spots (an area where a person's view is obstructed) on the wards and staff told us they managed this by having nursing staff present in communal areas at all time and positioning staff in specific corridor locations at night.

We observed a lack of signage on all of the wards to identify rooms and facilities such as bathrooms and toilets. Clear signs for toilets and exits are particularly important in settings, which provide care for patients with dementia.

Drinks or snacks were not freely available as some patients were at risk of choking. This had led to kitchen and dining room doors being locked when not in use. Patients were offered regular drinks and snacks. Patients could also ask a staff member if they wanted a drink.

Clinical rooms were clean and secure with drug trolleys, cupboards and fridge's locked. We saw care plans for medications to be given as needed and care plans for patients requiring feeding tubes who could not swallow.

There were regular equipment and fridge temperature checks. We saw single use medicine pots being washed and re-used as well as tablet cutters, which exposed patients to unnecessary risks. We brought this to the attention of the hospital manager who took action to have this stopped.

Safe staffing

Key Staffing Indicators:

Establishment levels: qualified nurses (WTE) 23

Long stay/rehabilitation mental health wards for working age adults

Good

Establishment levels: nursing assistants (WTE) 57

Number of vacancies: qualified nurses (WTE) 1

Number of vacancies: nursing assistants (WTE) 0

The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies in 3 month period 326

The number of shifts that have NOT been filled by bank or agency staff where there is sickness, absence or vacancies in 3 month period 0

Staff sickness rate (%) in 12 month period 3%

Staff turnover rate (%)in 12 month period 22%

Each ward had a daily staffing establishment of two trained nurses and five support workers during the day and one trained nurse and three support workers at night. The hospital manager told us that the staffing establishment had a 10% increase in order to manage unexpected sickness or increases in patient observations. This meant that they had more staffing hours. The number of qualified nurses in post was 23 whole time equivalents and the number of health care assistants was 57 whole time equivalents. In the period May 2015 – July 2015 there was only one qualified nurse vacancy across the hospital. The hospital had a stable bank with six qualified nurses and seven health care assistants, this had resulted in no agency staff used in this period.

The majority of staff told us there were enough staff and that activities and patient leave were rarely or never cancelled due to staff shortages. Several patients said they had experienced an activity being cancelled when the ward was short of staff due to staff sickness.

We carried out a review of the staffing level rotas during July and August 2015 and looked at the staffing rota for the current week. The rotas showed that the staffing establishment was as required in the majority of cases. Where there had been sickness at short notice and replacements could not be found, short shifts, for example twilight shifts 5pm – 8pm, had been put in place as well as cover from other wards.

A consultant psychiatrist provided cover for the hospital as well as on call cover. During holidays, two consultants provided consultant cover.

Information provided by the hospital prior to the inspection of compliance with mandatory and legislative training was 88%. This was above the requirement of 85% set by the provider. We saw ward managers monitoring of who required training and when staff would be attending. All staff we spoke with told us they had completed relevant training or were booked to attend.

Assessing and managing risk to patients and staff

Information provided by the hospital showed there had been 28 incidents of restraint recorded between January 2015 and June 2015. No restraints involved the prone position, this is when the patient is restrained in a face down position.

The hospital had a monitoring system in place for incidents of aggression, violence or both. We reviewed an audit of incidents between January 2015 and July 2015 which scrutinised what had taken place and if physical intervention had been required.

All clinical staff reported they had received training in the management of actual or potential aggression. Staff carried personal alarms and we observed staff responding to an alarm quickly during our inspection.

The hospital did not have seclusion facilities and did not seclude patients.

We reviewed 18 care records for the hospital. A total of 17 had up to date risk assessments in place. All patients were assessed prior to admission and used the Sainsbury risk assessment tool. Risk assessments were reviewed monthly or earlier if required. Each identified risk had a scored risk assessment and a risk management plan that ran alongside the care plan.

We found there was a restriction for doors to kitchens, dining rooms and bathrooms to be locked for the purposes of maintaining patient safety due to ligature points or risk of choking. At the time of our visit all patients were detained under the mental health act or were subject to a DoLs authorisation.

Staff understood the hospital's policy on observation and we saw this in practice. The level of observation required was usually decided at MDT meetings. However, nurses were able to increase observation levels immediately dependent on need.

Long stay/rehabilitation mental health wards for working age adults

Good

Nurses were routinely wrote and transcribed prescription sheets and not all of these medications had been countersigned by either a doctor or a nurse prescriber. They were not using medication administration records (MAR). The providers policy does allow prescribing straight onto a pre-printed MAR sheet (page 6 Barchester Medicines Management policy). Their policy also states that each MAR chart item and any new prescription on a pharmacy generated prescription sheet must be validated by the full signature of the prescriber; we found this was not happening. If the MAR becomes ambiguous or unclear at any time, the practitioner responsible for the administration of the medicine must request either the prescriber to rewrite it or the pharmacy to print out a new chart. This too we found was not happening. We felt this was exposing patients to possible medication errors.

Most patients told us they felt safe on the ward; however, some told us they had experienced aggression towards them from other patients. We reviewed notifications of incidents where this had happened. Staff acted appropriately in such instances and we saw evidence of referrals to the local safeguarding authority so these instances could be reviewed by an independent agency.

Track record on safety

There had not been any serious incidents reported in the six months prior to inspection.

Staff knew how to report incidents and accidents. This was done on a paper form which was then reviewed by the ward manager or clinical lead and then it was entered into the central electronic system. We reviewed a summary of incident data from both the paper system and electronic governance system and saw that this was taking place.

All care providers must notify the CQC about certain events and incidents affecting their service or the people who use it in order for us to understand how they have handled the event or incident. A review of notifications received over the past six months showed the hospital was complying with this statutory requirement.

Staff showed a good understanding of safeguarding and could explain how and when they would make a safeguarding alert.

The hospital had a dedicated nurse prescriber who supported staff in the management of medicines.

Reporting incidents and learning from when things go wrong

Learning from incidents was shared in handover, morning meetings, staff meetings and we saw this at the handover we observed, and within meeting notes we reviewed.

Ward managers and staff told us that a debrief was always given to staff involved in incidents and gave us an example of a choking incident that had happened. This had involved a wider team de-brief and 'lessons learnt' sessions.

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

Staff did comprehensive assessment of patients' needs when admitted to the ward which included assessment of clinical needs and a physical wellbeing check which included nutritional needs. The records of patients that had been admitted a long time ago did not always contain a physical health examination on admission. A nurse practitioner was now in post with responsibility for conducting physical health checks on admission.

We reviewed 18 patient records across all wards:

- Files were clearly labelled, stored in a locked cupboard and easily accessible by staff.
- Each folder held comprehensive information relating to the patient to support their treatment and care.
- Care plans were comprehensive and covered all aspects of care including physical health.
- Care and treatment was regularly reviewed and there was evidence of consent and capacity in most of the records.

Best practice in treatment and care

The hospital used a modified recovery model to aid rehabilitation. Patients were offered up to eight weeks of assessment. Care plans were drawn up based on evidence-based therapy, care and treatment, practice and research. This included compliance with national 'Institute

Long stay/rehabilitation mental health wards for working age adults

Good

for Health and Care Excellence' guidance, sports therapy, regular massage or other non-invasive complementary therapy, work with a Nordoff Robbins-accredited music therapist, horticultural therapy and group based activities.

We attended a handover of day shift to night staff. Six members of staff were in attendance that included all night staff coming on duty. They used a handover sheet that included each individual patients risk, status and observations. A wide variety of information was handed over to incoming staff but did not include the patients' individual risk, status or observation level required. Information that was discussed included a patient's:-

- Diet
- Presentation
- Medication
- Visitors
- Incidents / attempts to leave
- Activities

We observed a music therapy session taking place with music and lyrics being used to engage with a patient who had been uncommunicative. We observed a positive experience for the patient.

Clinical risk assessment was based on the Sainsbury model and other rating tools were used including the Waterlow tool for pressure area care and the malnutrition universal screening tool. Occupational therapy and music therapy also used a range of assessment tools.

Skilled staff to deliver care

Staff working across the hospital came from a wide range of backgrounds including nursing, medical, occupational therapy and art therapy. Other staff providing support included pharmacy.

Two dedicated trainers provided all mandatory and legislative training and supported staff in completing their eLearning training.

Staff appraisal compliance was 88% at the time of our inspection and we viewed records for staff which monitored supervision and appraisals. Supervision was completed at least every eight weeks.

Multi-disciplinary and inter-agency team work

Ward rounds consisted of a pre-meeting of the multidisciplinary team at which the patient was not present before being seen by the consultant. This meant the patient was not involved in the full discussion and decision-making process about their care.

A community mental health nurse and patient advocate attended the hospital for a patient review meeting during our inspection. They said the patient's condition had much improved since admission.

The local GP who had 60% of the patients at the hospital registered at his practice attended the hospital to speak with inspectors, as he was aware the inspection was taking place. He described the clinical team as an "exceptional team". The GP managed physical aspects of patient care and attended the hospital every three months to review patients together with their named nurse and the psychiatrist. He said staff were very good at detecting and recognising early physical symptoms in patients and took proactive steps before health conditions deteriorated.

We spoke with the field placement leader from the local university who was attending the hospital for a student nurse meeting. He described the hospital as providing "very good placements" for student nurses.

Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working practices were in place.

Adherence to the MHA and the MHA Code of Practice

A Mental Health Act reviewer had visited the three wards at the hospital (Grange unit, Hart unit and Wynyard unit) on 9 March 2015, 14 May 2015 and 21 July 2015 respectively.

We reviewed progress regarding past action points from these visits and audited two sets of care records on each ward and found that:

- actions from previous reports had been fully addressed or were in the process of being addressed;
- relatives of patients who lacked capacity had been contacted and asked to assist in the formulation of more person-centred care plan;
- there was in-house documentation relating to assessment of a person's level of understanding regarding their rights. Referral to an independent mental health advocate (IMHA) for those who lack capacity had been revised;

Long stay/rehabilitation mental health wards for working age adults

Good

- the provider had commenced using a variety of easy read leaflets to assist with explanation of information to patients.;
- staff were trained in the MHA, the MHA Code of Practice and the guiding principles;
- there were good assessment and recording of capacity, revisiting of patients' rights and section 17 leave paperwork.

Good practice in applying the MCA

As part of their mandatory training staff were trained in the Mental Capacity Act 2005. Most staff had a good understanding of this and how to apply their training on a daily basis with patients whose capacity was impaired. Most records reviewed (12 out of 14) showed good evidence of consent and capacity.

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

Good

Kindness, dignity, respect and support

We observed interactions between staff and patients on the ward, in communal areas and in therapy sessions. Staff spoke with patients in a respectful and appropriate manner.

Most patients we spoke with told us they were treated with dignity and respect by staff and felt the staff were caring. Patients told us "I would recommend this place to anyone who was poorly" "the staff are smashing" and "I like the staff".

Not all patients we spoke to felt staff were caring. Some said most were but it depends who was on duty.

We saw patient bedrooms had been personalised and staff told us they encouraged this. Patients we spoke to said they could access their bedrooms during the day whenever they wanted.

Relatives told us staff were approachable and said the ward was always clean and tidy. Relatives were included in care planning and were invited to regular reviews.

The involvement of people in the care they receive

The hospital held monthly patient meetings and we reviewed minutes of these. The recording of items and outcomes discussed varied and it was difficult at times to see what discussions and agreements had taken place. Some patients told us about these meetings and felt they were useful. One patient said he had suggested a visit to a nearby museum which had been arranged following the meeting.

All patients had access to an independent advocate who visited the hospital weekly. Detained patients had access to an Independent Mental Health Act Advocate and could make direct contact with them.

There was little evidence of patient involvement in care plans and patients own views.

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

Good

Access and discharge

Billingham Grange had 50 beds and in the six month period prior to inspection the mean bed occupancy was 96%. The hospital provided care and treatment for people with young onset dementia and behaviour that challenged including patients with psychotic illness.

Care plans reviewed did not show evidence of discharge planning. Staff told us that discharge discussions took place in care reviews and that discharge plans would be put in place when discharge was agreed. Some staff told us the hospital could do better with discharge planning and said that some patients no longer required inpatient care but finding suitable placements was preventing their discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The wards had limited quiet areas that could be utilised as private interview rooms.

Patients had access to activities rooms and occupational therapy support was available. There was a faith room and

Long stay/rehabilitation mental health wards for working age adults

Good

patients told us they could attend church if they wished. All the wards offered access to an outside space, which included a smoking area. The outside areas included some grassy areas around the building which could be accessed if desired by the patients. The garden areas were well maintained.

There was a payphone available for patients to make private calls and patients told us they also used the ward phone. Some patients had their own mobile phones.

Menus showed a choice was available for all mealtimes which catered for different needs including religious needs if required. Most patients told us the food was good. Both staff and patients told us they could give feedback about the food and we saw evidence of this in patient meeting notes.

Several patients showed us their rooms and these were personalised.

Some patients told us there were limited activities at weekends and there was not always enough staff to support them. We observed a number of patients taking escorted leave for 1:1 activities during our inspection. Most patients had 1:1 activities with very few group activities taking place.

Meeting the needs of all people who use the service

Food was cooked on site with a choice of meals and a varied menu. All staff and most patients told us there was access to drinks and snacks 24 hours and that they could ask staff for snacks and drinks outside of mealtimes. Some patients did not seem aware of this when we talked to them and felt they were only available at certain times. One patient told us she was offered a drink every hour.

Listening to and learning from concerns and complaints

Carers and most patients we talked to knew how to make a complaint or raise a concern. All managers told us the hospital received very few written complains and that verbal concerns tended to be dealt with immediately. The hospital did not keep records of informal complaints or concerns.

We reviewed the complaints record book; this contained six formal complaints since 2010. Most complaints related to care program approach reviews; this is the process used to organise and review patients care. All complaints were responded to in writing in line with the hospital policy.

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

Good

Vision and values

The vision and values of the organisation were not clearly evident during our inspection, for example they were not displayed on walls. The Hospital manager described them as having an emphasis on quality of care and treatment.

Quality monitoring systems were effective in identifying areas for improvement in the service and we saw 'clinical governance meeting' minutes and bi-monthly 'quality first' audits which assisted the provider to monitor and improve the quality of care and ensure best practice was being used.

We saw reports from unannounced out of hours and night visit reports conducted by managers from the hospital. We saw governance reviews conducted by regional managers to review quality of care.

The hospital manager told us that relationships with external commissioners were good and we reviewed minutes from a stakeholder meeting in April 2015 which discussed the hospital's annual quality account. Commissioners and patient relatives and carers were invited to these meetings.

Good governance

An electronic governance system was in place which was used for collation and monitoring of a range of items including incidents, medications to be given as needed medication, infection control and quality audits. Regular meetings took place between staff and management to monitor and assess the quality of the service provided. These meetings were used to highlight any issues and

ensure they were resolved. Meetings and discussions with patients were supported by the service, relatives, staff and management to ensure that any concerns could be identified and addressed quickly.

We reviewed the following audits in the hospital and found them thorough and complete with identified action points:-

- Infection control
- Care records documentation
- Medication
- Health and safety
- Mental Health Act paperwork
- Housekeeping

We reviewed health and safety risk assessments and found them to be thorough and comprehensive. There was clear evidence of identified risk, who was at risk, control measures and actions required to manage these risks. However, there was no central risk register or log to provide oversight of all risks and how these were being managed and monitored.

We found the hospital had the right systems and meetings in place to help ensure the service was of a high standard and that any issues could be resolved. Monthly reports on quality were produced which helped to ensure management and the provider were aware of any issues that were raised locally.

Leadership, morale and staff engagement

Staff said there were good working relationships with hospital managers and senior clinicians within the hospital.

The hospital manager encouraged an open door policy and we saw numerous interactions with staff throughout the inspection. The hospital provided an out of hours on call manager rota which ensured staff had access to a senior manager 24hrs a day seven days a week.

Staff felt supported by their line managers and felt able to raise any concerns or issues. We saw minutes from regular staff team meetings where concerns had been raised. They contained action points that identified who were responsible for addressing their concerns.

We observed a weekly multidisciplinary team meeting which contained a mixture of clinical issues and managerial issues. These meetings included the full clinical team and items discussed included patient updates from each ward. Other items discussed included observation levels and patient deteriorations, Mental Health Act issues, sickness, recruitment and the use of bank or agency staff as well as finance updates. The hospital consultant also used these meetings to update the team on case studies, clinical audits and new guidance.

Staff told us that the company, which the hospital belongs to, was very good at recognising what staff did and a dedicated conference to celebrate work in their hospitals was to take place.

Commitment to quality improvement and innovation

All wards participated in the accreditation for in-patient mental health services scheme and we saw evidence of this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The service provider must:

- Enforce its own policies and procedures on managing medicines.
- Keep a central risk register or log to provide an overview of all risks identified, with clear actions and timeframes. This should be reviewed and updated regularly.

Action the provider SHOULD take to improve

The service provider should:

- Make sure all support staff understand what the ligature risks are and that actions to remove or reduce those risks are clear and known to all staff.
- Ensure that staff make full use of the handover sheets developed by them outlining each patient's risk and status for the information of staff on the next shift.
- Make staff aware of the vision and objectives of the service.
- Review the estates five-year plan for refurbishment to enable improvements to the wards to be made more quickly.
- Ensure that patients can access water at all times and snacks and drinks 24 hours a day.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Staff did not follow the provider's own policies and procedures on managing medicines.** This was a breach of Regulation 12(2)(g

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have a current risk register.** This was a breach of Regulation 17(2)(b)