Sturdee Community Hospital

Quality Report

Sturdee Community Hospital
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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

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

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

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

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated this hospital as inadequate because:

• Although the staff had completed a ligature risk assessment, they had not taken action or developed a strategy to mitigate any risks.

• The hospital placed blanket restrictions on patients rather than assessing individual needs. For example, patients could not have a key to their room, they all had to use plastic beakers for hot drinks, and all visits had to be authorised by the multidisciplinary team (MDT), including adult family members.

• The hospital used high levels of agency staff meaning patients did not always know staff working on the wards.

• Rates of staff training were low for bank staff, meaning the service did not have adequately or appropriately trained staff on shift at all times.

• Patients' care records did not include patients or staff comments where patients disagreed with aspects of their care plan.

• Staff could not provide us with a copy of their induction pack when asked. The hospital did not provide temporary staff with written guidance on the local health, safety and security procedures for the ward when they arrived on shift.

• The managers of the hospital did not recruit staff in line with the hospital policy. They did not carry out pre-employment checks thoroughly to make sure the staff were suited to work with the patient group.

• The hospital did not have effective discharge planning so could not ensure patients had safe and coordinated care when they were discharged.

• We found adjustments for people requiring disabled access were poor. The gym, new visitors /family room, and adapted kitchen were accessed via a steep staircase. There was no lift available.

• Patients had limited access to a full range of rooms and equipment to support care and treatment.

• Rutland ward did not have any quiet areas, where patients could meet visitors in private.

• Staff could not describe the vision and values of the organisation and they could not tell us who the senior managers of the service were.

• Senior managers failed to assess health and safety risks to the premises which impacted on the safety and wellbeing of patients.

• There was a lack of openness and transparency between the provider and the hospital director which resulted in the identification of risk, issues and concerns being discouraged.

• The hospital director had no administration support.

• Staff expressed concern about bullying and were reluctant to report concerns about the service to managers.

• The hospital director was appointed seven months before, but the hospital still did not have a registered manager.

However:

• Medical records and medicine management systems were good.

• Rutland ward and Aylestone unit areas were clean and well maintained.

• A full range of mental health disciplines and workers provided input to the ward.

• Patients' had good access to physical healthcare, including access to specialists when needed.

• Care records were up to date and comprehensive, apart from including patient's views.

• We observed effective staff handovers.

• There were effective working relationships with teams outside the organisation including joint risk meetings.

• Patients knew where and how to access advocacy services.

• Staff and patients interacted positively and we saw evidence that staff had an understanding of individual patients' needs and preferences.

Summary of findings

• Staff appeared interested and engaged in providing good quality care to patients.

• Most patients were involved in planning their care. Patients could attend the ward rounds fortnightly. Staff identified special occasions, such as patients' birthdays. Patients and staff would celebrate and kitchen staff made fresh cakes.

• Kitchen staff prepared fresh meals that were good quality. Staff prepared fresh fruit for patients that was available in communal areas.

• Staff supported patients to purchase their own food. This was stored in the kitchen with appropriate individual labels.

• Ward staff worked well as a team and offered support to each other.

• The hospital director arranged for staff annual appraisals and supervision. Ninety five per cent of staff received three monthly clinical supervision.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Inadequate 	This report describes our judgement of the quality of care provided within this core service by Sturdee Community Limited. Where relevant we provide detail of each location or area of service visited. Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations. Where applicable, we have reported on each core service provided by Sturdee Community Limited and these are brought together to inform our overall judgement of Sturdee Community Limited.

Summary of findings

Contents

Inadequate

Location name here

Services we looked at

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

Summary of this inspection

Our inspection team

Our inspection team was led by:

Helen Abel; inspector mental health.

The team that inspected Sturdee Hospital consisted of:

• two CQC inspectors

• one Mental Health Act reviewer

• one psychologist

• and one expert by experience.

Why we carried out this inspection

We inspected this core service as part of our on-going 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 these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

• visited Rutland ward and Aylestone self-contained independent living flats and Foxton ward which was closed but we were told it was about to be re-opened following refurbishment.

• spoke with seven patients who were using the service.

• spoke with one group operations director and one hospital director.

• spoke with 15 staff members including, a psychiatrist, psychologist, occupational therapist, nurses, social worker, support staff, training coordinator, and housekeeper.

• attended and observed one joint risk meeting and one staff handover.

• looked at nine care records of patients and four treatment cards and collected feedback from two patients using comment cards.

• carried out a specific check of the medication management on four patients.

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

• carried out a specific check of the medication management.

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

Information about Sturdee Community Hospital

Sturdee Community Hospital provides rehabilitation for up to 35 people with complex mental health needs, who in some instances require a locked and secure facility.

Summary of this inspection

The service provides care and treatment for adult females. The hospital is run by BRAND Inmind Healthcare Group. There were nine patients at the hospital at the time of our inspection. Although the hospital is registered for 35 patients, Sturdee has not had that many patients.

In the last two years there have been 10 to 15 patients at any given time.

The hospital has three units. Rutland ward is a locked rehabilitation ward with six beds. The four bed unit called Foxton was closed at the time of inspection for refurbishment work. Aylestone unit is nine self-contained flats.

Patients are referred predominantly from psychiatric intensive care units/acute services. The hospital accepts referrals from low and medium secure services for patients who have progressed through their pathway and ready to step down. Patients are admitted on to Rutland ward for assessment, treatment and rehabilitation and once their risk profile is reduced, they are able to step down to Aylestone semi-independent flats for further rehabilitation and community integration.

Sturdee Hospital registered with CQC in April 2011. The last inspection took place on 8 April 2013 and the service complied with all regulations inspected. There is no registered manager or accountable officer for controlled drugs.

What people who use the service say

We spoke with seven patients. Patients told us they felt safe at the hospital and were pleased with the care provided.

Some patients told us the service often cancelled escorted leave because of staff shortages. They also said there was a lack of physical activities and trips out. However, patients told us they liked the new healthy eating menus.

We read two completed comment cards. One patient was happy with care received. The second patient was unhappy they had to return from their leave to pick up their medicine because staff could not make arrangements for them to take this with them.

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?

Inadequate

Are services safe?

We rated this hospital as Inadequate for safe because:

• Although the hospital completed a ligature risk assessment, they did not take action or develop a strategy to mitigate any risks.

• The hospital placed blanket restrictions on patients rather than assessing individual needs. For example, patients could not have a key to their room, they all had to use plastic beakers for hot drinks, and all visits had to be authorised by the multidisciplinary team (MDT), including adult family members.

• The hospital used high levels of agency staff meaning patients did not always know staff working on the wards.

• Staff could not provide us with a copy of their induction pack when asked. The hospital did not provide temporary staff with written guidance on the local health, safety and security procedures for the ward when they arrived on shift.

However:

• Medical records and medicine management systems were good.

• Rutland ward and Aylestone unit areas were clean and well maintained.

Are services effective?

Good

We rated effective as good because:

• A full range of mental health disciplines and workers provided input to the ward.

• Patients' had good access to physical healthcare, including access to specialists when needed.

• Care records were up to date and comprehensive, apart from including patient's views.

• We observed effective staff handovers.

• There were effective working relationships with teams outside the organisation including joint risk meetings.

However:

• Rates of staff training were low for both permanent and bank staff, meaning the service did not have adequately or appropriately trained staff on shift at all times.

Summary of this inspection

Are services caring?

Good

We rated caring as good because:

• Patients knew where and how to access advocacy services.

• Staff and patients interacted positively and we saw evidence that staff had an understanding of individual patients' needs and preferences.

• Staff appeared interested and engaged in providing good quality care to patients.

• Most patients were involved in planning their care. Patients could attend the ward rounds fortnightly. Staff identified special occasions, such as patients' birthdays. Patients and staff would celebrate and kitchen staff made fresh cakes.

However:

• Patients' care records did not include patients or staff comments where patients disagreed with aspects of their care plan.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

• The hospital did not have effective discharge planning so could not ensure patients had safe and coordinated care when they were discharged.

• We found adjustments for people requiring disabled access were poor. The gym, new visitors /family room, and adapted kitchen were accessed via a steep staircase. There was no lift available.

• Patients had limited access to a full range of rooms and equipment to support care and treatment.

• Rutland ward did not have any quiet areas, where patients could meet visitors in private.

However:

• Kitchen staff prepared fresh meals that were good quality. Staff prepared fresh fruit for patients that was available in communal areas.

• Staff supported patients to purchase their own food. This was stored in the kitchen with appropriate individual labels.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

• Staff could not describe the visions and values of the organisation and they could not tell us who the senior managers of the service were.

Summary of this inspection

• Senior managers failed to assess health and safety risks to the premises which impacted on the safety and wellbeing of patients.

• The managers of the hospital did not recruit staff in line with the hospital policy. They did not carry out pre-employment checks thoroughly to make sure the staff were suited to work with the patient group.

• There was a lack of openness and transparency between the provider and the hospital director which resulted in the identification of risk, issues and concerns being discouraged.

• The hospital director had no administration support.

• Staff expressed concern about bullying and were reluctant to report concerns about the service to managers.

• The hospital director was appointed seven months before, but the hospital still did not have a registered manager.

However:

• Ward staff worked well as a team and offered support to each other.

• The hospital director arranged for staff annual appraisals and supervision.

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.

We found that:

• Ward staff lacked training and formal support in Mental Health Act (MHA) and the new Mental Health Act Code of Practice.

• The Mental Health Act administrator lacked training and formal support.

• Staff did not know whether hospital policies had been updated in line with the revised Mental Health Act Code of Practice. Policies we checked had not been updated in line with the Mental Health Act Code of Practice.

• We checked five patients care records and Mental Health Act documentation complied with the Mental Health Act.

• Records we reviewed showed evidence of patients' capacity to make decisions about their treatment being assessed and their consent to treatment being recorded around the time that treatment began.

• Qualified staff routinely reviewed patients' capacity assessments.

• Patients' rights were explained to them and were revisited with patients appropriately.

• Patients had information about the Independent Mental Health Advocacy (IMHA) service. Noticeboards on wards displayed information about the MHA and the IMHA service.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that:

• Ninety per cent of staff completed training in the Mental Capacity Act 1985 (MCA), as part of the staff training programme.

• Staff assessed patients' capacity to make decisions about their treatment appropriately in line with the principles of the MCA.

• A mental health administrator supported patients and staff with guidance around the Mental Capacity Act and Mental Health Act.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Inadequate	Good	Good	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Good	Good	Requires improvement	Inadequate	Inadequate

Long stay/rehabilitation mental health wards for working age adults

Inadequate

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

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

Inadequate

Safe and clean environment

• The Rutland ward was well maintained and clean. Cleaning records were up to date and demonstrated the environment was regularly cleaned. Aylestone accommodation was visibly clean and well maintained.

• Staff could not observe all parts of Rutland ward because the layout was an L shape. There were ligature points identified on Rutland ward. Ligature points are places to which patients intent on self-harm could tie something to harm them. Although the hospital completed a ligature risk assessment, they did not take action or develop a strategy to mitigate the risk. The hospital director confirmed they would review the ligature risk assessment.

• Staff checked emergency equipment such as defibrillators and oxygen regularly to ensure it was fit for purpose and could be used effectively in an emergency. Staff also checked medical devices such as oxygen supplies and emergency medication.

• Patients' privacy was compromised because the vision panels in bedroom doors only opened from the outside, giving patients no control over when they were opened or closed. Spy holes on ward bedroom doors were fixed open and could not be closed.

• Foxton ward was being refurbished at the time of the inspection. The hospital director told us the specification and building plans were not made available to him despite requests, and staff and patients were not consulted. Changes were made to services without due regard for the impact on people's safety. There were inadequate plans in place to assess and manage risks associated with the refurbishment and anticipated future events or emergency situations. The provider told us refurbishment work was still ongoing. The provider was reviewing areas of concerns, and told us new patients would not be admitted until the unit was safe.

• There was access to appropriate alarms and nurse call systems in patient areas.

Safe staffing

• There were seven posts vacant. Therefore the hospital had to use used a lot of agency and bank staff. The impact meant that patients did not always know staff working on the wards. The provider was recruiting to vacant posts. The hospital employed four qualified nurses and 15 healthcare support workers. Each shift comprised one qualified nurse and five healthcare support workers. There were three qualified nurse vacancies and four healthcare support workers vacancies.

• Bank staff were employed by the hospital, but the provider did not provide CQC with the numbers of bank staff available when requested. One bank nurse worked regularly at the hospital. The provider were urgently addressing vacancy levels and with a view to reduce agency staff and recruit more bank staff.

• Two qualified nurses were due to start in September and October 2015 and two healthcare support workers had

been appointed. The numbers of patients were low at the service as patient referrals were not increasing. The hospital risk register did not identify staff recruitment and low patient numbers as a risk.

• The staff sickness rate January - September 2015 were 5%. In August there were higher levels of staff sickness. Nurses covered five 12.5 hour shifts and healthcare support workers covering 21 shifts in this month. This was above staff's contacted hours. In September staff cover improved to nil shifts being covered by nurses and healthcare support workers covered 17 shifts. Staff turnover rate was 4% in a 12 month period.

• The hospital director told us they were able to increase staffing levels based on the changing needs of the patients. The needs of patients were reviewed at multidisciplinary team meetings.

• Patients and staff told us escorted leave and trips were often cancelled as there was not enough staff. The staffing levels did not include cover for patients to attend therapeutic activities outside the service, and take leave. We found the numbers of staff on shifts were not sufficient.

• Managers used a spreadsheet system that identified the shortfalls in staff cover and provided staff cover.

• Staff told us agency staff who had not worked on the ward before were given a brief induction to the ward. This included orientation to the layout of the ward. Staff could not provide us with a copy of their induction pack when asked. Staff did not have any written guidance on the local health, safety and security procedures for the ward.

• Staff were trained in the use of physical restraint and were allocated to each shift to ensure there were enough staff to carry out interventions if required.

• Medical staff were available day and night to attend the ward quickly in an emergency. An out of hours locum doctor known by patients and staff were available on call with an identified nurse and manager.

• Staff completed mandatory training. Topics included: fire safety, and training in the management of actual and potential aggression (MAPA) which included de-escalation and restraint techniques, infection control, food hygiene, equality and diversity and responding to emergencies. The service provided a gym but gym training was not provided.

• Staff were 90% compliant with mandatory training. However bank staff were not up to date with their mandatory training. All staff training needs were being reviewed. Mandatory training ensured staff were able to deliver care to patients safely, and to an appropriate standard.

• Staff were 90% compliant with Mental Capacity Act (MCA) training. Mental Health Act (MHA) training was not offered to staff. The training coordinator confirmed this training had been planned, but not yet taken place. The provider confirmed MHA training would be arranged following on our inspection.

• The Mental Capacity Act (MCA) administrator had not received training around the new Mental Health Act Code of Practice and was unsure whether policies have been updated in line with the revised Code of Practice.

Assessing and managing risk to patients and staff

• Staff completed a START (short term assessment of risk and treatability) for patients upon admission and updated this regularly and after every incident. Risk assessments covered aspects of health including medication, psychological therapies, physical health and activities. Risk assessments were updated at fortnightly multi-disciplinary team (MDT) meetings and at three and six month care programme approach (CPA) meetings.

• Staff managed risk to patients through increased observations. The service used a traffic light colour system to identify the level of risk for each patient. Staff identified ways in which staff could help reduce the impact of risky behaviours and keep the patient safe. Patients would be given a copy of the RAG (Red Amber Green) each time it was changed by the nursing staff. The RAG colour could be changed quickly depending upon the nurse in charge's assessment of how the patient presented each day.

• Some practices were restrictive. Patients could not have a key to their bedroom or their personal locker. All patients used plastic beakers for hot drinks. Some patients reported their personal items were frequently mislaid around the ward. All visitors had to be authorised by the multidisciplinary team (MDT) including adult family members.

• Staff searched patients' bedrooms for items which were not allowed on the ward. This ensured the safety of the

Long stay/rehabilitation mental health wards for working age adults

Inadequate

patient and others. Information about prohibited items was contained in the patient handbook. In addition information for informal patients about their rights was available in the patients' handbook.

• The hospital did not seclude patients. Restraint was used after de-escalation had failed using the correct techniques. There were 36 restraints on Rutland ward between 1 March and 16 September 2015. Restraints were recorded, investigated and monitored via clinical audits. Staff did not use prone (face down) restraint. Eighty per cent of staff had received training in the management of actual and potential aggression (MAPA) which included de-escalation and restraint techniques.

• Rapid tranquilisation was rarely used. Rapid tranquilisation was used in one instance in August 2015 in a six month period. Staff followed the National Institute for Health and Care Excellence (NICE) guidance and investigated and monitored the incident.

• Ninety per cent of staff were trained in safeguarding vulnerable adults and were able to describe how to recognise a safeguarding concern and how to report a concern. It was not clear what level of safeguarding training staff received. Staff did not know the name of the safeguarding lead but would refer any safeguarding concern to the most senior person on shift. Safe guarding children training was not on the hospital training plan and had not been identified as staff training need.

• Staff managed medicines effectively. Controlled drugs records were signed for and in good order. The clinic room was tidy, clean and well ventilated. Fridge temperatures were recorded to ensure medications were stored appropriately. Four medicine charts were inspected and were appropriately signed, dated and individualised. The records showed patients were receiving their medicines as prescribed.

• When reviewing patients' medication records four out of five T2 certificates matched the medication listed on the prescription chart. However, one patient had been prescribed a drug they had not consented to on the certificate. The provider agreed to address this urgently following our inspection.

• The medical team authorised any children's visit to wards. A room was available in the first floor. Staff explained to patients that an assessment from the local authority may be required prior to visits taking place.

Track record on safety

• There had been ten serious incidents recorded in the last twelve months. We examined the serious incident file and found that in seven incidents the forms were detailed and had action plans about how to implement the learning from the investigation. Three incident reports were less detailed. The hospital director told us they were following up three outstanding issues.

Reporting incidents and learning from when things go wrong

• Staff knew how to recognise and report incidents on the recording systems. Incident forms included a description of the incident, triggers, actions and staff involved. The psychologist and clinical nurse manager reviewed all incidents and reported them to the governance team. This system ensured senior managers were alerted to incidents promptly and could monitor the investigation and respond to these.

• There were daily morning handover meetings in the board room. This involved all members of the multidisciplinary team (MDT). There were discussions of the previous day and night given for all patients. We saw there were caring discussions around patients' physical health needs, improvements, reviewing of risks, difficulties and strengths, and staff allocated tasks.

• Managers did not offer debriefing sessions to staff following an incident. Staff provided support to each other.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

• We looked at nine patients' care records. The detail and standard of care plans were variable. Staff had carried out multidisciplinary team pre-admission assessments and risk profiles carried out prior to the patient being transferred to the service. Care plans were developed from the initial assessment.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

• Risk assessments summarised the risk areas and levels of risk. All records sampled included a care plan that showed staff how to manage risks. Care plans related to the patients legal status, rights, physical needs, mental health, personal care, self-harm and coping strategies. All patients had personal emergency evacuation plans.

• There were signed consent forms for room searches, information sharing, photographs, capacity and consent to treatment.

• The nursing staff carried out regular monitoring of blood pressure, weight and other observations. Patients who had an ongoing health care need had appropriate care plans in place. One patient received regular hospital appointments and support with epilepsy. Their care plan included comprehensive interventions on how to respond to a seizure, with monitoring and emergency actions. Four patients care plans related to healthy eating and weight management.

• The care records were large and unwieldy with frequent duplication. Staff were concerned that temporary staff would not be able to read and follow care plans easily as they were so large. Not all care plans stated a review date or frequency of review. Staff told us care plans were monitored during ward rounds. Care plans were reviewed monthly and more often if needed, for example related to observation levels or patients leave.

• Patients planned weekly activities with their keyworker and held a paper copy in their bedroom. Patients told us they wanted more physical outdoor activities. Staff and patients told us trips and leave were cancelled due to staff shortages. The hospital had a seven seated vehicle.

Weekly plans confirmed most activities were based on the ward. Activities included room cleaning and laundry, arts and crafts, board games, relaxation, creative design, cooking with the occupational therapist.

• Staff recorded care plans on paper and all files were made available to us during the inspection.

Best practice in treatment and care

• Staff used the mental health recovery star tool designed for adults managing and recovering from mental illness. Staff used a spectrum star tool for adults on the autistic spectrum to enable them to make daily living choices and meet personal goals and develop plans. This outcome measurement tool was incorporated into person centred planning with patients.

• Staff assessed patients using the Health of the Nation Outcome Scales (HONOS) to measure the health and social functioning of people with severe mental illness upon admission. This enabled clinicians to build up a picture over time of their patients' responses to interventions.

• The psychiatrist (responsible clinician) provided patients with their medical treatment. The psychologist and assistant psychologist met with patients within the first few days of admission, and thereafter once a week and provided individual psychology treatment and support and next steps planning.

• The occupational therapist team promoted patients wellbeing and developed patients' holistic recovery oriented care plans. The clinical nurse manager, nursing team, and health care support workers supported patient care. The locum social worker was five days in post and on induction during our inspection.

• Staff supported patients to access physical health care, including access to specialists when needed. The clinical nurse manager was the lead for physical health. Nurses carried out physical health checks on admission, with ongoing regular physical health monitoring. Staff used the tool NEWS (national early warning score). The tool alerted staff to any medical deterioration and triggered a timely clinical response. For example one patient's care records showed staff identified anomalies relating to their blood pressure and acted on this. We saw records of physical health screening for smear tests, regular blood tests, and ophthalmology and dentists checks. The service offered smoking cessation and individual sessions with patients.

Skilled staff to deliver care

• Staff received appropriate induction. The training coordinator told us they were mapping mandatory training to care certificates standards. The care certificate aims to equip staff with the knowledge and skills which they need to provide safe, compassionate care. Whilst not compulsory it is expected that the induction programme has similar breadth and depth to the care certificate standards, we did not find this at this location.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

• One staff member told us they had made suggestions of training for unqualified staff appropriate to their level. For example personality disorders, self-harm, self medication, cognitive behavioural therapy and brief solution focused therapy and others, but these had not been considered by senior managers.

• Medical staff received clinical supervision and took part in monthly reflective practice meetings, where they were able to reflect on their practice and incidents that had occurred. The hospital director told us there was 95% completion rate for clinical supervision. Appraisals were in two stages 90% of non-medical staff had received an appraisal and 10% were at the final stage of completing their appraisal in September 2015 with the operations director.

• There were regular team meetings and ward staff felt well supported by the hospital director and colleagues at the service. Staff told us there was good team work with the hospital director. Managers told us two staff members' poor performance was in the process of being addressed.

Multi-disciplinary and inter-agency team work

• We observed a multi-agency risk meeting attended by external agency professionals including criminal justice and probation staff. The meeting was well led with a clear agenda. The responsible clinician, hospital director, clinical nurse manager, lead occupational therapist, psychologist, mental health administrator attended. We saw evidence of good risk planning and patient involvement throughout the process.

• Multidisciplinary team (MDT) ward rounds were carried out two weekly. Each patient would be discussed, including their presentation, history, medication, capacity and appointments. Staff were knowledgeable about each patient's risk, care and treatment needs and spoke about patients in a respectful way. We saw ward round notes indicated the input by each MDT member.

• The commissioners managed the relationship with the provider to mirror the East Midlands framework agreement and contract style meetings are held on a quarterly basis to monitor care services.

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

• Staff told us they had not received training in the Mental Health Act (MHA) and Code of Practice. The training coordinator was arranging this following on our inspection.

• The use of the MHA was mostly good on Rutland ward. Copies of detention papers including those relating to renewals and transfers were on all files. Patients were reminded of their legal status on admission. Staff regularly assessed patient capacity relating to day to day and this was recorded on patient notes. Information provided included the role of the Care Quality Commission and the role of the independent mental health advocate (IMHA). We saw advanced directives and consent forms evident. A poster displayed information about the role of the IMHA and how to make contact. The IMHA visited the hospital every week and had supported patients to complete the most recent survey.

Good practice in applying the Mental Capacity Act

• Staff had received training in the Mental Capacity Act 2015 (MCA) and Deprivation of Liberty Safeguards (DoLS). Medical staff kept electronic updates to keep them aware of recent legal decisions on the MCA, and any changes. In the last six months there had been no Deprivation of Liberty Safeguards applications made to the local authority.

• The mental health administrator and ward staff were not aware of any audits taking place to monitor the use of the MCA.

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

Good

Kindness, dignity, respect and support

• We spoke with seven patients receiving care and treatment on Rutland and Aylestone. They told us staff treated them with respect, and were friendly and helpful.

• We observed staff treated patients in a kind, caring and compassionate way. Staff appeared interested and engaged in providing good quality care to patients.

• When staff spoke about patients they discussed them in a respectful manner and showed a good understanding of their individual needs.

• We saw an incident with one agency staff member where they did not positively interact with a patient. We spoke

Long stay/rehabilitation mental health wards for working age adults

Inadequate

with the hospital director who dealt with this immediately. Patients told us that agency staff did not know them. Managers employed a high level of agency staff that had not always worked at the hospital, and were actively recruiting bank staff.

• Staff identified special occasions, such as patients' birthdays. Patients and staff would celebrate and kitchen staff made fresh cakes. Staff supported patients to purchase their own food. This was stored in the kitchen with appropriate individual labels.

The involvement of people in the care that they receive

• Care plans stated that, if patients did not agree with their care plan, staff should record the reason why, and how staff engaged the patient with their care plan. We found on two patients care records the patient disagreed with the contents, but there was no record of discussion, negotiation or compromise.

• There were fortnightly multidisciplinary team (MDT) reviews on Wednesdays which were also ward rounds. Patients could attend part of the ward round and discuss their progress, medication, and involvement in treatment. Discussions were around risks relating to patients, and how these risks should be managed, and patients could submit requests for example relating to leave.

• Patients told us they had opportunities to keep in contact with their family where appropriate. Visiting hours were by appointment in advance. There was a dedicated room for patients to see their visitors on the first floor. However, there was no lift available and the staircase was steep. One patient told us their disabled relative could not access the first floor.

• Detained patients were entitled to see an IMHA (Independent Mental Health Advocate). We saw posters around the service telling patients how to contact either general or independent advocates, or staff could contact them. Advocates visited the service once a week.

• Patients told us there were weekly community meetings, which patients attended along with the

hospital director and some members of the MDT. Meeting notes confirmed varied requests, concerns and suggestions. Action points were allocated to staff to follow up at the next meeting. Patients were positive about community meetings. For example, patients used the dining area for table activities, cooking, and arts and crafts and asked for a sink. The provider confirmed the sink was due to be installed.

• The views of patients using the service were gathered through the use of surveys. An independent mental health advocate service LAMP organised a patient survey in 2015. Responses were obtained from seven patients and fed back to the hospital director and ward staff to enable them to make changes where needed. Action plans were produced with work to be completed by the 28 September 2015. Patients asked for meaningful activities, improved menus and choice of food, and regular one to one meetings with their named nurse. These actions had been completed. Patients said the hospital environment did not allow for privacy, and requested staff wear name badges. These actions were still being finalised.

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

Requires improvement

Access and discharge

• The referral process involved an application for funding which was considered clinically and financially and a process of approval undertaken prior to placement. In-Mind was in the process of bidding for Sturdee to become a provider on the commissioner's provider framework.

• The hospital was designed for a capacity of up to 35 places but had adapted to a smaller number of beds. There were nine patients using the service during our inspection. There were no out of area placements attributed to this service in the last six months.

• Patients and staff confirmed there was access to a bed upon return from leave.

• When patients were admitted to hospital they would go to Rutland ward for assessment, treatment and rehabilitation. Once their risk profile reduced, they were able to step down to Aylestone semi-independent flats for further rehabilitation and community integration.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

• The hospital did not have effective discharge planning so could not ensure patients had safe and coordinated care when they were discharged. We saw on one patient's care plan a brief note to prepare for discharge staff had increased community leave. Another patient told us they wished to move to a different hospital and had stated this to staff several times. We could not find any discharge plans that reflected the patient's wishes.

• The locum social worker was new in post and told us discharge planning was not identified as part of their role. The clinical nurse manager confirmed there was no specific discharge planning documentation available.

One patient had been discharged in the last three years.

The facilities promote recovery, comfort, dignity and confidentiality

• Staff told us the hospital owners identified a visitors' room for refurbishment one week before the Care Quality Commission inspection. The new visitor's room was located on the first floor via a steep stair case. Staff and patients told us they were not consulted about the location of the visitor's room. We observed when people were talking in the visitor's room their voices were clearly heard outside, and did not provide a private and confidential meeting space.

• Patients' bedrooms included en-suite facilities were kept locked to keep patients' belongings safe, and furniture was in good condition and comfortable. We saw bedrooms were personalised clean and well maintained. We saw lockers were available for patients to store items, however, patients did not hold the key. The nurse's station and clinic room were kept locked to ensure confidentiality. The kitchen and laundry were located off Rutland ward and kept locked to ensure safe access when needed. .

• Rutland ward bedroom doors' spyholes had blind spots. The door spyholes were fixed and did not close properly. Patients' privacy and dignity were compromised because they could not control when someone could view into their bedroom. The hospital director confirmed the spyholes were wrongly fitted and would be repaired following our inspection.

• There were no quiet rooms on Rutland ward. Staff told us meetings were often held in the downstairs corridor outside the ward as there was lack of space. They found it difficult to find a quiet and confidential area for patients to have one to one meetings with their named nurse. The facilities and premises used do not meet patient's needs or are inappropriate.

• Medical staff told us one patient could become distressed at times. The patient had been assessed as needing sensory input and quiet space to meet their needs. Staff told us they could not routinely access quite areas. Services were planned and delivered without consideration of patient's needs.

• Patients had access to telephones on either the ward or using personal phones. This allowed patients to remain in contact with their family, carer (where appropriate) and representatives. There was an allocated smoking area at the rear of the building.

• We spoke with nine patients and they told us the meals were of good quality. Menus had improved with healthy eating choices. There were plates of freshly chopped fruit replenished daily. Patients were not allowed on the ward kitchen. There was a thermos on the ward to make hot drinks.

• Patient activities were based mostly on wards such as, cooking, arts and crafts. Four patients told us they were bored and wanted physical activities off the ward. Each patient had an activity timetable but no records were completed to confirm activities were undertaken. Patients and staff told us activities and leave were often cancelled due to shortages of staff.

• Patients had access to occupational therapists that completed individual assessments of patients' needs. Therapeutic staff arranged one to one activities, walking groups and swimming as part of social anxiety management, which did not impact on ward staffing levels.

• The therapy kitchen was on the first floor had not been used since 2013. Staff had requested essential works be carried out but these had not been done. An extended worktop had been fitted two weeks before the Care Quality Commission inspection. Other works were still outstanding.

• Staff told us there had been a therapy suite on the ground floor for patients. The hospital owners started building work on the ground floor high dependency unit without consultation with staff and patients. This meant the range

Long stay/rehabilitation mental health wards for working age adults

Inadequate

of rooms to support treatment and care was reduced. Staff used the dining room as an activity area, but patients told us they did not like using this area as this was where they ate their meals.

• The multi faith room had been changed into a gym. There had been no consultation with patients, managers and staff about the room change. Staff told us the provider made the changes two weeks before the Care Quality Commission inspection. There is no legislation that states organisations must implement a faith room, although is best practice from a corporate responsibility and human resources point of view to provide this for patients and staff.

• The gym was accessed via a steep staircase. Staff told us the gym was not safe to use. The room was too small, parts of the roof were slanted and gym equipment had not been positioned correctly. Staff said they had not received gym instructor training. Medical staff told us one patient needed access to the gym to undertake strengthening exercises but was unable to access the first floor.

• Patients were encouraged to undertake laundry activities to develop independent living skills, with support. The ward had laundry facilities.

• We observed locks on the main entrances with entry and exit controlled by staff and around all internal doors. Staff carried personal alarms. During our inspection, we were offered personal alarms.

Meeting the needs of all people who use the service

• Adjustments had not been made for people requiring access to the first floor. A lift was not available. Staff and patients were not consulted about this service change. One patient told us their relative had difficulty accessing the first floor visitor's meeting room. The provider told us that, following the inspection, they would carry out an assessment for accessibility as a priority in adherence with the Disability Discrimination Act.

• A dietician visited the service in August 2015. They led a patient activity group on food, advised the staff team on healthy eating for individual patients, and reviewed the hospital menu planning.

• Meals were freshly prepared. A varied menu catered for patients' particular dietary needs, and individual preferences. We saw fresh fruit available for snacks in communal areas and homemade pizza being prepared. Patients told us they enjoyed the new menus. One patient told us they made fruit smoothies with staff.

• A variety of information was available to patients on the wards. This included the Mental Health Act, local services, complaints, procedures and advice on how to get help. Weekly community meetings were available.

• Patients could access the internet in the computer room without supervision (pending their care plan and risk assessments). Electronic systems allowed staff to monitor the history of websites patients visited on line to ensure that patients were safe.

Listening to and learning from concerns and complaints

• Staff knew the complaints process and showed patients how to make a complaint. Information about the complaints was available on notice boards around the building and in the patient's handbook.

• Patients we spoke with knew how to make a complaint. Complaints were recorded on the complaints records. We saw two complaints had been received since March 2015 around breach of confidentiality and safety on the ward. There were no complaints records systems prior to this date. We saw the two written complaints and been dealt with. The complaints record included how the issues were investigated the outcomes and learning points. Staff received feedback on the outcome of investigation, and action taken as a result to improve the quality of care.

• The hospital director had close working relationship with patients and dealt with any concerns quickly and informally as they arose. Patients told us the hospital director was approachable and accessible.

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

Inadequate

Vision and values

Long stay/rehabilitation mental health wards for working age adults

Inadequate

• Staff were unclear about the provider's vision and values. They were keen to provide good care for the patients. However they were not aware of the provider's strategy or service development plans.

• Staff did not know the management team, although they sometimes visited the service there was minimal contact with staff and patients.

Good governance

• The hospital director attended governance meetings and provided monthly reports to the management team with ward incidents and risks. He told us these meetings did not provide guidance on how to make improvements at the hospital.

• Senior managers failed to assess health and safety risks to the premises which impacted on the safety and wellbeing of patients. Medical staff and managers were not aware of a risk register. A risk register was completed after our inspection and identified four risks that the Care Quality Commission identified during the inspection. Significant issues that threatened the delivery of safe and effective care were not identified. Adequate action to manage risks was not always taken. We saw in staff meetings notes, that the service had low patient numbers, and decreasing. There was a lack of openness and transparency between the provider and the hospital director which resulted in the identification of risk, issues and concerns being discouraged. A director of governance was due in post.

• Although the hospital had completed a ligature risk assessment, it had not taken action or developed a strategy to mitigate the risk on Rutland ward. Quality and safety were not the top priority for the provider. At the time of our inspection Foxton ward was being refurbished. The hospital director told us the specification and building plans were not made available to him despite requests, and staff and patients were not consulted. Changes were made to services without due regard for the impact on people's safety.

There were inadequate plans in place to assess and manage risks associated with the refurbishment and anticipated future events or emergency situations. The hospital did not provide a full range of rooms to support treatment and care, and therapy. There was a significant lack of accessible and quiet areas available which impacted on patient care. The staff had placed unjustified blanket restrictions rather than assess individual patient needs. Patients discharge arrangements were not being facilitated, and discharge planning documentation not available.

• Escorted leave, therapeutic activities and trips were frequently cancelled due to shortages of staff. However, the provider was actively recruiting bank staff with a plan to significantly reduce the use of agency staff. Following our inspection three nurses and two healthcare support workers were recruited.

• We looked at five sets of staff recruitment records. All records contained evidence that appropriate recruitment checks had not been undertaken prior to employment. For example three people did not have written references, one person did not have checks through the Disclosure and Baring Service (DBS) check. Two clinicians were not checked with their appropriate professional body. The provider did not recruit staff in line with the hospital policy. They did not carry out pre-employment checks thoroughly to make sure the staff were suited to work with the patient group. A staff member was identified to work on improving staff recruitment records. The provider agreed to immediately follow up these issues.

• Although staff were 90% complaint with mandatory training, bank staff were not up to date with mandatory training. Staff had not received training in Mental Health Act (MHA) and the new Mental Health Act Code of Practice. There were no safeguarding children training. Some staff had suggested additional training but senior managers had not responded. A review of staff training needs was now taking place. Most staff had received annual appraisals and supervisions, and clinical supervision. The hospital director had been in post for seven months and not received an appraisal.

• There were regular meetings, morning handover meetings, multidisciplinary team (MDT) ward rounds, and team meetings. We saw positive multidisciplinary team working at morning handovers, ward rounds and at risk meetings. Staff attending these meeting knew the patients and understand their needs well.

• We saw evidence of clinical audits around medicines and record keeping. The hospital director kept staff informed of learning from incidences, complaints and patient feedback.

• There was a strong focus on medication management and meeting patients' physical health care needs.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Leadership, morale and staff engagement

• Two staff told us they were concerned about staff recruitment and retention. Staff sickness and absence rates were high 11% in August. The hospital director told us this was due to two staff members with sickness absence in late July and August. Staff were unhappy with their terms and conditions. This impacted on staff morale and job satisfaction.

• Staff expressed concern about bullying and were reluctant to report concerns about the service to managers. The provider confirmed this aspect would be discussed at the next corporate governance meeting and future staff meetings.

• Staff told us there were no opportunities for leadership development. There was minimal engagement with staff or the public. Staff told us of repeated examples where the provider had not known their names, or their role despite working at Sturdee Hospital for some years. Service changes were made to the premises without consulting staff and patients, which had a negative impact on staff morale. Staff did not feel respected, valued, supported and appreciated by leaders. There was poor collaboration or cooperation between leaders and high levels of conflict.

• Senior managers did not take account of the hospital director views when making decisions on the change of use in premises. The hospital director had no administration support. After our inspection the provider agreed administration support would be reviewed on the 1 October 2015. The providers were out of touch with what was happening on the front line. There was a lack of clarity about authority to make decisions and how individuals are held to account.

• The hospital director was appointed seven months before, but the hospital still did not have a registered manager. The provider had not arranged for the submission of a registered manager's application to the Care Quality Commission despite repeated reminders. This was a breach of Regulations.

• We saw the results from the patient survey 2015 and action plan conducted by advocates. The results confirmed a lack of meaningful activities, menus and choice inadequate, one to one sessions not being completed, environment does not allow for privacy, difficulty to identify staff members. Action plans had been set for 28 September 2015. Improvements had been made around the menus and choice, and work was still in progress for other aspects of the survey.

• A staff survey was conducted in July 2015 and the results were still being analysed. The hospital director told us themes were emerging, low staff morale, staff experiencing high levels of stress, lack of candour and lack of openness with senior managers.

• Most staff were positive about their work with patients, and colleagues and working together. Ward staff told us the hospital director led good team work. On a day to day basis, the Rutland ward and Aylestone flats were well managed.

Commitment to quality improvement and innovation

• There is little innovation or service development. There is minimal evidence of learning and reflective practice. The impact of service changes on the quality of care was not understood.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

• The provider must review the ligature risk assessment, and take action or develop a strategy to mitigate the risk.

• The provider must assess individual needs, rather than place unjustified blanket restrictions on patients.

• The provider must ensure that there are sufficient experienced staff on duty at all times to provide care to meet patients' needs with appropriate induction, training and support.

• The provider must ensure that permanent and bank staff are up to date with mandatory training around Mental Health Act and safeguarding children training.

• The provider must carry out pre-employment checks to make sure the staff are suited to work with the patient group.

• The provider must make arrangements for discharge planning, to ensure safe and coordinated care when patients are discharged from the hospital.

• The provider must ensure that adjustments for people requiring disabled access to the service are in place.

• The provider must take action and provide access to a full range of rooms and equipment to support patients' care and treatment; and quiet areas identified where patients could meet visitors in private. The provider must ensure the premises are suitable for the intended purposes.

• The provider must take account of patients' views when premises are being renovated and adapted.

• The provider must ensure that staff know and agree with the organisations values; and know who the most senior managers in the hospital are and that these managers have visited the wards.

• The provider must assess health and safety risks to the premises which impact on the safety and wellbeing of patients.

• The provider must ensure that systems are in place for staff to raise concerns without fear of victimisation; and bullying cases are taken seriously and acted upon.

• The provider must ensure that a registered manager is appointed.

Action the provider SHOULD take to improve

• The provider should ensure a debriefing policy is available for staff and patients to follow after an incident.

• The provider should ensure patients care records include patients or staff comments where patients disagreed with aspects of their care plan.

• The provider should provide temporary staff with written guidance on the local health, safety and security procedures for the ward when they arrived on shift.

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 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing** **The provider did not have sufficient numbers of suitably qualified, competent skilled and experienced persons available.** **Mandatory training was not up to date for bank staff. Mental Health Act and safeguarding children training were not available to all staff.** **This was a breach of regulation 18(1) 2(a)**

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 **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **Although the hospital completed a ligature risk assessment, they did not take action or develop a strategy to mitigate any risks.** **This was a breach of regulation 12 (2) (a) (b).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment**

This section is primarily information for the provider

Requirement notices

There were no identified quiet patient areas, reduced access to the first floor meeting/ therapy rooms, and there were no adjustments for people requiring access.

Patient's views were not taken account of when the premises were being renovated and adapted.

This was a breach of regulation 15 (1)(b) (c) (d).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person-centred care** We identified blanket restrictions. Patients were not able to hold the key to their bedrooms, or to their personal lockers. All patients used plastic beakers for hot drinks. All visitors had to be authorised by the multi-disciplinary team (MDT)including adult family members. There was no evidence of discharge planning for patients. There were no care plan discharge planning templates to complete. This was a breach of regulation 9 (3).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed** The provider must ensure a registered manager is appointed. This was a breach of regulation 19 (2).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Staff did not know and agree with the organisations values. Staff did not know who the most the senior managers in the hospital were, although these managers had visited wards.

Health and safety risks to the premises which impacted on the safety and wellbeing of patients had not been

identified and managed.

Systems were not in place for staff to raise concerns without fear of victimisation; and bullying cases were

not taken seriously and acted upon.

Governance meetings were not effective and did not provide information on how to improve performance.

There were no opportunities for leadership development. There was low staff morale. Staff did not feel senior managers consulted with them and sought their feedback.

The provider was not carrying out robust pre-employment checks to make sure the staff were suited to

work with the patient group.

This was a breach of regulation 17 (2) (a) (b).