# Newmarket House

## Quality Report

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Date of inspection visit: 7 October 2015
Date of publication: 26/04/2016

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

### 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.

## Overall summary

We rated Newmarket House as **requires improvement** because:

- the ward environment was unsafe. Although some ligature points had been identified, and action taken to minimise the risk to patients, other ligature points had not been identified. There were poor lines of sight on wards and the hospital had not mitigated these risks
- arrangements for storing medicines were unsatisfactory. The nurse manager's office was in the clinic room where medicine was stored. Some medicines were kept inappropriately in a fridge with non- medical items such as food
- some patients' bedroom carpets were marked and needed to be replenished. Some bedroom walls and woodwork needed repainting, and were faded and worn. Redecoration might help promote recovery and comfort
- the hospital placed blanket restrictions on patients. For example, around the use of mobile phones, the need to keep patients' personal items tidied away daily, and the use of hair dye
- patients' risk assessments were not detailed including one in which details of self-harming behaviour and interventions were not recorded
- staff did not do enough to inform patients or engage them in decision-making. Some patients' care records

# Summary of findings

did not include patients' or staff comments where patients disagreed with aspects of their care or refused to sign care plans. Care records contained limited evidence that people's capacity to make decisions about their treatment was assessed. Patients' information pack were not welcoming or user-friendly. Staff were not aware of advocacy services, although all patients interviewed knew how to access advocacy services

- there was a lack of food and nutrition assessment and monitoring. Nutritional monitoring is vital for this patient group
- the hospital did not manage risk well. Staff and management differed in their understanding of which risks should be reported. Staff told us that they would like to receive more feedback from incidents that had been investigated
- the approach to service delivery and improvement was reactive and focused on short-term issues. Improvements are not always identified or action not always taken
- there was a limited range of rooms for patients to meet their visitors
- complaints procedures were lengthy and complicated
- access was limited to the first floor. There was no lift.

However:

- there were enough staff and appropriate use of bank staff
- resuscitation equipment was checked regularly and in good order
- staff prepared holistic care plans and reviewed them regularly
- patients were offered a wide range of activities and therapies
- staff received specialist training for their role
- staff and patients interacted positively and staff understood individual patients' needs and preferences
- patients' food was of a good quality, healthy and nutritious.
- most staff had worked at the service for several years and knew the patients and hospital well
- most staff said there were good team work, mutual support and visible leadership.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| Specialist eating disorders services | Requires improvement  | Newmarket House is an independent hospital providing specialist services for people with eating disorders. |

# Summary of findings

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### Summary of this inspection

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# Summary of this inspection

## Background to Newmarket House

Newmarket House is an independent hospital providing specialist services for people with eating disorders. The hospital does not admit detained patients.

The service provided ten beds for men and women. At the time of inspection, there were ten women patients receiving care and treatment.

The service has a registered manager and accountable officer. The regulated activities are accommodation for persons who require nursing or personal care; and treatment of disease disorder or injury.

Newmarket House has been registered since May 2014 and had no recent inspections or inspection history.

## Our inspection team

Our inspection team was led by:

Helen Abel, inspector mental health.

The team that inspected Newmarket House consisted of :

- one CQC inspector
- one specialist advisor
- one expert by experience

## Why we carried out this inspection

We inspected this 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 all areas of the hospital, looked at the quality of the environment and observed how staff were caring for patients
- met with six patients who were using the service
- spoke with the nurse manager, deputy nurse manager and general manager
- spoke with eight other staff members, including a consultant psychiatrist, nurses, an occupational therapist and therapists
- interviewed the senior managers of the service and those with lead roles within the team
- attended and observed a staff handover meeting
- spoke with one family member of a patient
- looked five care and treatment records of patients
- carried out a specific check of the medication management
- looked at policies, procedures and other documents relating to the running of the hospital.

# Summary of this inspection

## What people who use the service say

Patients told us they felt safe at the hospital and that staff were caring and approachable.

They felt staff listened to them and were sensitive to their needs. Patients said food was good quality, healthy and nutritious.

Patients said there were not enough quiet areas to meet visitors in private.

# 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:

- There were ligature points (places to which patients intent on self-harm could tie something to strangle themselves) in the hospital. Some risks had been identified in a ligature risk assessment and action taken to minimise risks to patients. Other ligatures points had not been identified. There were poor lines of sight on wards and the hospital had not mitigated these risks.
- The hospital placed blanket restrictions on patients. For example, around the use of mobile phones, the need to keep patients' personal items tidied away daily, and the use of hair dye.
- Some patients' bedroom carpets were marked and needed to be replenished. Some bedroom walls and woodwork needed repainting, and were faded and worn. Redecoration might help promote recovery and comfort.
- Staff were unsure how to report notifications and manage and record risks.
- Arrangements for storing medicines were unsatisfactory. The nurse manager's office was in the clinic room where medicines were stored. Some medicines were kept inappropriately in a fridge with non- medical items such as food.

However:

- There were enough staff and appropriate use of bank staff.
- Staff were trained in safeguarding.
- Resuscitation equipment was checked regularly and in good order.

### Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Patients' risk assessments were not detailed. For example, one patient self harmed but details of their behaviour and plans of action to improve were not recorded.
- Where patients refused to sign their care plans, the reasons were not recorded. There was a small section for patients to add comments to their care plan and sign.
- There was a lack of food and nutrition assessment and monitoring. Nutritional monitoring is vital for this patient group.
- There was limited evidence that patients' capacity was assessed and recorded in care plans.

# Summary of this inspection

However:

- Staff prepared holistic care plans and reviewed them regularly.
- Patients were offered a wide range of activities and therapies.
- Staff received specialist training for their role.

## Are services caring?

Good

We rated caring as **good** because:

- Staff and patients interacted positively and we saw evidence that staff had an understanding of individual patients' needs and preferences. We saw examples where staff sat beside patients for long periods talking quietly, reassuring them. Another example where a staff member was running a group therapy session ensuring everyone was involved at every stage.
- Patients told us that they had good relationships with staff. The occupational therapist and cook were identified as kind, caring and supportive staff members.
- The hospital provided the carers support group with regular support meetings.

However:

- Staff were not aware of advocacy services, although patients knew where and how to access advocacy services.

## Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- There were a limited range of rooms for patients to meet their visitors.
- The patient's information packs were not user friendly.
- Complaints procedures were lengthy and complicated.
- Access was limited to the first floor. There was no lift.

However:

- Patients enjoyed good quality, healthy and nutritious food.

## Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The hospital did not manage risk well. It's systems for reporting incidents of harm or risk of harm were not robust and staff did not always record serious incidents. Staff and management differed in their understanding of which risks should be reported. Risks and issues were not always dealt with appropriately or in a timely way. Staff told us that they would like to receive more feedback from incidents that had been investigated.

# Summary of this inspection

- The approach to service delivery and improvement was reactive and focused on short term issues. Improvements were not always identified or action not always taken.
- One staff member did not feel able to raise concerns without fear of victimisation.
- Staff told us that they would like to receive feedback from incidents.

However:

- Most staff said there were good teamwork, mutual support and visible leadership.
- Most staff had worked at the service for several years and knew the patients and hospital well.

Requires improvement

# Specialist eating disorder services

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

## Are specialist eating disorder services safe?

Requires improvement

### Safe and clean environment

- There were ligature points (places to which patients intent on self-harm could tie something to strangle themselves) across the hospital. Some had been identified in a ligature risk assessment, with some actions taken to minimise the risk to patients. There were other ligature points on curtain rails, in showers, on window blind cords and overhead light fittings for which no action had been taken to reduce risk. The provider made some immediate changes to wards to reduce some of the ligature points.
- Staff maintained cleanliness and hygiene to a high standard. Cleaning records were up to date and showed that the hospital was cleaned regularly.
- There were two single rooms and four twin rooms. One single room had en-suite facilities. All six bedrooms needed maintenance. Some patients' bedroom carpets were marked and needed to be replenished. Some bedroom walls and woodwork needed repainting and were faded and worn. The hospital had good furnishings.
- The service provided ten beds for men and women. At the time of inspection, there were ten women patients receiving care and treatment. The wards complied with same sex accommodation
- Staff and patients had access to appropriate alarms and nurse call systems in patient areas.
- Care and treatment records showed us that medicines were well administered. However, the arrangements for storing medicines were not adequate. The clinic room where medicines were stored was also the nurse manager's office. The room was regularly used as a meeting room and a thoroughfare to the general manager's office. Some medicines were kept inappropriately in a fridge with food. There was no separate clinical fridge. There was no examination couch. Staff reported the room was often hot, and room temperatures were not monitored. This meant medicines may be affected by excessive heat. Safety concerns were not consistently identified or addressed. Systems, processes and standard operating procedures are not always reliable or appropriate to keep people safe.
- Resuscitation equipment was in good order and checked monthly. The blood pressure monitor had not been calibrated. Calibration checks should take place yearly. Following our inspection, the provider bought a new blood pressure monitor.
- Staff completed environmental risk assessments and recorded actions taken to reduce risk to patients and staff. However, there was a lack of ligature risk assessments and action taken following risk assessments.

### Safe staffing

- Thirty eight staff were employed by the hospital. There were sufficient staff available to support patients. Bank staff were used to cover staff shortages. Patients told us they were familiar with bank staff, and agency staff were not used regularly.

Requires improvement

# Specialist eating disorder services

- The total number of qualified nurses employed by the hospital was 10. The total number of support workers employed by the hospital was 13.There were seven bank staff: three nurses and four support workers. The hospital provided information to confirm there were 0.08 whole time equivalent (WTE) nursing posts vacant and 2.25 support workers posts were vacant at the time of inspection. The hospital had enough staff with the appropriate training and skills to meet the needs of the patients.
- Managers used a spread sheet system that identified the shortfalls in staff cover and provided adequate staff cover. Managers arranged cover for staff vacancies and absence effectively.
- The sickness rate was 2.8% and staff turnover was 9% from September 2014 to August 2015. There was a high use of agency staff with 184 hours between June-August 2015. Two long-serving bank staff had just left the hospital at this time. Managers told us they were advertising for more bank staff, support workers and nurses. If bank staff were unable to cover staff shortages, permanent staff were asked to cover with overtime pay. As a last resort, the hospital would use agency staff, employing staff familiar with patients. The hospital risk register did not identify staff recruitment as an issue.
- Staff were 94% compliant with mandatory training across the service, 4% were new staff who had not yet completed all their mandatory training.
- There was adequate medical cover, with consultants on call for each of their own patients. Consultants covered for each other if on holiday. There was a nurse on call day and night and a locum named doctor out of normal working hours.

**Assessing and managing risk to patients and staff**

- The ten patients were all informal (in hospital by choice rather than being detained for treatment).
- Staff assessed risks to patients on admission to the service. Patients risk assessments were generally up to date, but some information was missing. For example, information around hydration and nutrition, and incidents of one patient self harming was not being recorded. This meant risks to patients were not fully recognised, assessed or managed.
- All staff had completed training on safeguarding children and adults from abuse. Staff we spoke with could describe different types of abuse and the reporting procedure for raising concerns.
- Some practices were restrictive. Patients had limited opportunities to personalise bedrooms. There were secure areas for patients to store their possessions. Patients were able to personalise their rooms on a noticeboard and had to keep their bedrooms tidy and items cleared away. For example they were not allowed to leave items on their bedside table. Managers were unable to provide us with reasons why. Following our inspection staff confirmed bedside baskets had been purchased to store personal items. Patients were not allowed to dye their hair with permanent and temporary colour, whilst staying at the hospital. This information was included in the patient welcome pack.
- The mobile phone policy was restrictive and unfriendly. The telephone policy was included in the patient welcome pack. For example, mobile phones would need to be given to the person in charge upon admission, the patient would be able to check their phones once or twice a day. The psychiatrist and nursing team would need to agree if the patient could have their phone returned to them in the first month. The rationale for this was unclear. A payphone was available in the communal hallway outside the kitchen and bathroom. These meant patients could not make telephone calls in private. All these restrictions should be reviewed.

**Track record on safety**

- The Care Quality Commission (CQC) had received nil notifications from the hospital since registration. An audit showed there were six serious incidents from December 2014 to June 2015. Following on the inspection the provider confirmed, the six serious incidents recorded were incidents of a minor nature. Staff were not confident in how to report notifications and manage and record risks.There was limited use of systems to record and report safety concerns, incidents and near misses.

**Reporting incidents and learning from when things go wrong**

- Incidents of harm or risk of harm were reported to the registered nurse manager and we saw the incidents log.

Requires improvement

# Specialist eating disorder services

Staff gave us examples of recent incidents of patients self-harming. However, these incidents were not reported as incidents, serious incidents or recorded in care records. Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. There was no learning when things go wrong.

- Staff told us there had been serious incidents in the service and that they had not received any debriefing, although managers told us staff were offered support after a serious incident.

## Are specialist eating disorder services effective?

(for example, treatment is effective)

Requires improvement

### Assessment of needs and planning of care

- Specialist examinations took place with patients on admission. This process would take several hours with the patient and their family members (where appropriate). The assessment included physical, psychological and social needs, and an assessment of risk to the patient. Clinicians considered physical and psychological treatments, treatment with medicines, and what kinds of services best helped patients with their eating disorders. This was in line with the National Institute for Health and Care Excellence (NICE) guidelines.
- Staff prepared holistic care plans and reviewed them regularly. However, patients' risk assessments were not detailed and up to date. For example, one patient self harmed but details of their behaviour and plans of action to improve were not recorded. Another patient was at risk of pressure areas, and equipment had been obtained to meet their needs. The waterlow risk assessments and the patients care and treatment needs were not easy for staff to find on care records. We did not find dietetic assessments to meet individual patient's food and hydration needs. Care plans were recovery oriented with goal setting, but did not include patient's strengths. Staff did not always have the complete information they needed for providing care and treatment. Care plans did not consider the full range of patients' needs. This meant patients were at risk of not receiving effective care and treatment.
- In two patients' care plans, patients had refused to sign parts of their care plans. The reasons for that were not recorded. There was a small section for patients to add comments to their care plan and sign but this was not used. The provider had not monitored the process for seeking consent to ensure patients agreed to their care and treatment.
- We saw limited evidence that people's capacity was assessed and recorded in care plans. Patients should be supported to make decisions and, where appropriate, their mental capacity is assessed and recorded. Staff should gain informed consent from patients.
- Patients we spoke with had received a copy of the plan in their bedroom. Staff recorded care plans on paper and all files were made available to us during the inspection.

### Best practice in treatment and care

- Clinicians worked with the National Institute for Health and Care Excellence (NICE) guidance relating to managing refeeding programmes, and were able to describe how this was incorporated in their work 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. The hospital had links with local health care providers. Staff liaised with Norfolk and Norwich hospital gastroenterology department for advice, and Beating Eating Disorders (BEAT) a national charity for eating disorders in Norwich. Staff worked with the local community Eating Disorders (NCEDS) team to establish a smooth transition from inpatient to community care.
- We found guidance on the staff notice board around the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN). This was best practice guidance in treatment and care of patients with eating disorders. Staff told us they followed this guidance but had not received any training. Daily practice did not demonstrate MARSIPAN guidelines were followed.
- Psychological therapies were available to patients in line with NICE guidelines as part of their treatment plan.

Requires improvement

# Specialist eating disorder services

Patients were offered weekly therapies with creative motivational scrapbooks, storytelling, body image group and mindfulness (anxiety management) groups. In addition individual self-expression sessions were offered a professional massage therapist, yoga and relaxation sessions, and various forms of art and music.

- Occupational therapy groups included supporting patients with activities with daily living meal preparations, snacks and meals out, shopping, public transport skills, exercise. All these were aimed at increasing a patient's independence and nutritional rehabilitation.
- Patients were encouraged to make appointments at their local doctor's surgery in order to promote independence. Patients were supported to access specific physical healthcare services including dentists and opticians.

**Skilled staff to deliver care**

- Patients had access to a wide variety of clinical skills and experience from the MDT (multi disciplinary team) which included psychiatrists, counsellor/ psychotherapist, nurses, dietician, occupational therapists and support workers. The service advertised for a clinical psychologist.
- Staff undertook mandatory training. Topics included: oxygen management, infection control, medicine management, safeguarding children and adults, food hygiene, equality and diversity and responding to emergencies.
- Staff received additional training that was specific to eating disorders service. Staff attended courses which included the annual eating disorder network conference, motivational interviewing in eating disorders, managing challenging situations, setting firm boundaries consistency and consequences. In addition, there were monthly training sessions led by the clinical coordinator counsellor/psychotherapist.
- The hospital induction programme was being re-designed in line with the care certificate standards. The care certificate aims to equip staff with the knowledge and skills which they need to provide safe, compassionate care. However, a standard induction was available to new staff.
- Agency staff new to the hospital received an induction by the ward nurse to where they were allocated to work.
- Staff supervision took place regularly and in line with the provider's policy. Staff appraisals took place annually. In the last twelve months 100% of staff had received appraisals. This meant staff had access to protected time to discuss their development and any clinical issues.

**Multi-disciplinary and inter-agency team work**

- MDT (multidisciplinary team) meetings took place daily in order to review patients care. There were weekly patient reviews.
- Comprehensive handover meetings took place at the start of each shift to ensure information about patients daily presentation was communicated to staff.
- Staff communicated with other agencies such as local eating disorder teams and social services to co-ordinate patient treatment and discharge.

**Adherence to the MHA and the MHA Code of Practice**

- Forty per cent of staff were trained in the Mental Health Act (MHA).
- The ten patients at Newmarket House were informal. Newmarket House does not admit detained patients.

**Good practice in applying the MCA**

- Forty per cent of staff were trained in the Mental Capacity Act (MCA).
- Staff were assessing patient's capacity to make decisions but the assessment used was limited. If a patient does have capacity to make some decisions about the care and treatment that they receive then this needs to be evidenced with a clear MCA assessment that follows the five principles of the MCA 2005.

## Are specialist eating disorder services caring?

Good

**Kindness, dignity, respect and support**

- Staff interacted with patients in a positive way that treated patients with compassion. We saw examples

where staff sat beside patients for long periods talking quietly, reassuring them. Another example where a staff member was running a group therapy session ensuring everyone was involved at every stage.

- Staff were aware of individual need and specific patient preferences.
- Patients told us that they had good relationships with staff. The occupational therapist and cook were identified as particularly kind, caring and supportive staff members.

**The involvement of people in the care they receive**

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- We saw evidence that patients were given a variety of information on admission to the service. This included information about therapeutic programmes, consent to treatment and restrictions. The patients' information pack were not welcoming or user-friendly. This needs review around complaints and compliments, mobile phones and restrictions.
- Where patients completed a care plan, it was clear that they had been involved in the planning and creation of their care.
- Independent advocacy services were available to patients and information about this was displayed on noticeboards for example Norfolk Community Advice Network. Patients told us they knew where and how to access advocacy services, although most staff interviewed were not aware of local advocacy services.
- Patients took part in regular group support and community meetings with staff. We saw evidence that patients were given an opportunity to provide feedback and ideas for improvement for the service. Patients told us staff were sensitive to their needs. Patients had asked for a choice of fancy and plain cakes and this was now part of the menu plans. One patient told us they asked for a further therapy session with a clinician and this was provided.
- There had been a patient survey in 2014. Improvements were made around information prior to admission, assessment and admission being less rushed, more therapeutic group sessions, patient relationships with new group protocols. The patient survey action plan did not include timescales although managers told us the action plan was complete.
- Family members and carers were involved in patient care. Family therapy was offered to all families and carers. The hospital provided the carers support group with information meetings - recovering from eating disorders and body image in March and May 2015.

## Are specialist eating disorder services responsive to people's needs?

(for example, to feedback?)

Requires improvement

**Access and discharge**

- The average bed occupancy for the hospital was 94%. Patients' length of stay was between four and eight months. There were two out of area placements in the last six months.
- In the last six months, there had been no delayed discharges within the hospital.
- Clinicians made links with the patient's primary home care team, to continue with their recovery as an outpatient. Staff used the Wellness Recovery Action Plan (WRAP) for discharge planning to assist patients returning home, work or education. Staff worked with Eating Matters in Norwich. Families could receive support when patients were being discharged.

**The facilities promote recovery, comfort, dignity and confidentiality**

- The hospital did not have a full range of rooms and equipment to support treatment and care. There was a lack of quiet rooms for patients to meet their visitors. We saw patients and their visitors talking in the hallway and walking around the large rear garden. Managers told us there were two additional indoor areas available in the lodge and therapy unit. Patients and their visitors were not aware they could use these rooms. The clinic room was the nurse manager's office and was also used as a general meeting room and a thoroughfare to the general manager's office. This limited range of rooms and equipment was not included on the risk register. An extension to the building to extend the general manager's office had recently been completed, but had not addressed the lack of a designated clinic room.

Requires improvement

# Specialist eating disorder services

- Nutritional rehabilitation was a vital element of recovery at Newmarket House. Staff told us the dietician assessed the patients' nutritional needs and developed a safe refeeding programme. However, there was no evidence of nutritional assessments, which affected patients care, health and wellbeing. Nutritional monitoring is essential for this patient group.
- There were extensive choices of freshly prepared and cooked meals. Menus were changed regularly and were available on line for patients, parents and carers to try out. Some fruit and vegetables were grown in the hospital garden by patients.
- Staff provided patients with support and supervision before, during and after meals. Patients were provided with drinks and snacks at set times as part of their treatment plan. They were able to access the kitchen at other times to make drinks.
- Access to outside lawn space was available to all patients, with seating areas provided. Smoking was permitted in the garden area only.

**Meeting the needs of all people who use the service**

- The hospital was situated in a victorian house, a portable ramp provided wheel chair access to the ground floor. There was no lift. The bedrooms were located on the first floor via a long staircase. These meant patients who were frail may not be able to access the first floor safely. The provider should consider how the needs of people with physical disability can be best managed in the building.
- A variety of information was available to patients on the wards.
- Staff were able to access support from interpreters as and when required.
- The kitchen provided a comprehensive range of food to meet the dietician's guidance and cultural diet needs.
- Staff supported patients to access places of worship in the community

**Listening to and learning from concerns and complaints**

- In the last 12 months, the service had recorded no complaints. Patients told us that they knew how to complain.
- The complaints procedure in the patients information pack was lengthy and not user friendly. There was no information on how to raise a compliment. The hospital did not make it easy to raise concerns or complaints. Complaints were not used as an opportunity to learn. Following our inspection the complaints procedures were being reviewed.

## Are specialist eating disorder services well-led?

Requires improvement

**Vision and values**

- Staff told us about the vision and values of the organisation. They were dedicated to the treatment and recovery of those affected by eating disorders. The multidisciplinary team used a combination of therapies in a caring and structured way. Patients could develop and practice living skills. Newmarket House was a large house, and provided a homely environment for patients to receive care and treatment.
- Staff knew the management team well and senior managers regularly worked on the ward alongside staff.

**Good governance**

- Mandatory training compliance was 96%. All staff received monthly supervisions and yearly appraisals.
- Shifts were covered by sufficient number of staff of the right grades and experience.
- Learning from incidents requiring investigation was poorly recorded with no monitoring or shared learning amongst the staff team. The arrangements for governance and performance management did not always operate effectively.
- There were no internal KPI's (Key Performance Indicators) made available to the inspection team to demonstrate how the provider monitored performance. There has been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance, including staff data.
- Managers told us improvements were taking place. For example, the ligature points action plan, care plans, welcome pack, buildings and refurbishment plan, and

staff induction was under review. However, some action plans did not include timescales for improvements and some recent changes to the hospital were yet to be embedded fully.

- We found the hospital risk register did not reflect the current risks to the hospital. For example, the clinic room, separate clinical fridge, the risk to patients posed by ligature points, clear lines of sight. Risks issues were not always dealt with appropriately or in a timely way.

**Leadership, morale and staff engagement**

- The staff 2014 survey showed that staff had some concerns about the hospital. The staff action plan confirmed improvements were made around, staff breaks, change of work tasks, working flexibly and personal harassment at work.
- Sickness and absence rates were 3% in the last twelve months.
- The service had one reported case of bullying and harassment. The management team investigated this in October 2015. Following our inspection the provider told us the allegations were not proven.
- Staff satisfaction was mixed. Most staff said there were good team work, mutual support and visible leadership.
- One staff member did not feel able to raise concerns without fear of victimisation and asked to remain anonymous. Managers agreed to review these issues generally with the staff group.
- Staff knew how to use the whistle-blowing process.
- Staff told us that they would like to receive feedback from incidents.
- Staff told us they received good training and development opportunities. However, staff had not received training on the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) to make them better equipped to care for patients.
- Most staff had worked at the service for several years and knew the patients and hospital well.

**Commitment to quality improvement and innovation**

- The provider participates in the Accreditation for Inpatient Mental Health Services (AIMS) Quality Network for Eating Disorders (QED). AIMS are accreditation schemes that have been approved by the Care Quality Commission (CQC). The hospital was accredited in most areas, with further work required around potential ligature risks and blind spots. The provider was taking action to make these improvements by January 2016 in order to gain accreditation.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

**The provider must:**

- remove or reduce the risk to patients posed by ligature points (places to which patients intent on self-harm could tie something to strangle themselves)
- complete maintenance work in all six bedrooms need to promote patients' comfort and recovery
- improve the clinic room in line with current legislation and guidance
- ensure that staff write care plans detailing the care patients need to manage risks appropriately for their health and safety
- ensure the nutritional and hydration needs of patients are met at assessment and on-going review
- provide rooms for patients to meet their visitors in private
- improve its oversight of the service by setting and monitoring key performance indicators.

### Action the provider SHOULD take to improve

**The provider should:**

- ensure that patients' care plans record when patients refuse to sign them and reasons for that
- ensure that staff assess patients' capacity to make decisions about their care adequately and recorded findings clearly in care plans
- ensure that staff are aware of advocacy services and can advise patients, families and carers
- ensure staff review restrictions, rather than place unjustified blanket restrictions on all patients
- ensure staff know how to report notifications and manage and record risks
- review the patient's information pack to ensure this is welcoming and friendly
- review complaints procedures so they are easy to access
- provide a fridge appropriate for storing medication
- provide staff with training on the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) to make them better equipped to care for patients.
- consider the suitability of the building for those who use the services with regards to access to the first floor.

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 |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The provider did not remove identified ligature risks and mitigate where there were poor lines of sight; and ensure the environment does not increase the risks to patients' safety.<br>The clinic room was not satisfactory and did not meet current legislation and guidance.<br>The care plans did not detail the care and treatment patients needed to manage risks appropriately for their health and safety.<br>This was a breach of regulation 12 2 (b) (g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs<br>We found a lack of nutritional and hydration assessment and on-going review.<br>This was a breach of regulation 14 (1) |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>We found maintenance work was needed in all six bedrooms.<br><br>There were insufficient quiet areas for patients to meet their visitors in private.<br><br>This was a breach of regulation 15 1(a) (c) (e) |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider did not have any key performance indicators (KPI's) to assess and monitor the effectiveness of the service.<br><br>This was a breach of regulation 17 (2) (a) |