Apple Hill

Quality Report

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

Ratings

Overall rating for this location	Not sufficient evidence to rate
Are services safe?	Not sufficient evidence to rate
Are services effective?	Not sufficient evidence to rate
Are services caring?	Not sufficient evidence to rate
Are services responsive?	Not sufficient evidence to rate
Are services well-led?	Not sufficient evidence to rate

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

Inspected but not rated

- We found that some ward areas did not have environmental risk assessments in place. We also identified ligature risks that had been missed from the assessment completed. Some of the staff we spoke with were not able to recognise ligature risks in the areas where they worked.
- We found example of interventions that met the definition of physical restraint and seclusion, the staff working in the hospital failed to recognise these and were not recording them appropriately.
- Patients detained under the Mental Health Act are subject to additional restrictions and specific rights. We found that the staff working with detained patients had not been trained in the Mental Health Act. The hospital had identified this through audit but had failed to take any action to address this. The hospital had begun to admit patients before the staff team were trained.

However

- All patients had good access to physical healthcare in addition to their mental health care.
- There was a good standard of medicines management
- Staff worked with patients in a caring way and took time to understand how patients communicate.
- Care plans reflected people's preferences and advanced decisions about care.

Summary of findings

Contents

Not sufficient evidence to rate

Apple Hill

Services we looked at

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

Summary of this inspection

Background to Apple Hill

Apple Hill provides accommodation with nursing care for older people with dementia and assessment or medical treatment for persons detained under the Mental Health Act 1983.

Since July 2015 Apple Hill has been registered as a hospital providing care for people detained under the Mental Health Act.

It was planned that any detained patients would be admitted to Hurley ward if male, and Tedray ward if female. At the time of the inspection they had admitted the first detained patient five days previously. This patient was on Russell ward rather than Hurley ward due to his mobility issues.

Apple Hill was also still functioning as a nursing home, and the other people living in the hospital were referred to as residents.

The service can accommodate up to 41 people as follows:

Tedray Ward: four beds nominated for female inpatient care, also used for nursing care

Russel Ward: ten beds nominated for male inpatient care, also used for nursing care

Hurley Ward: ten beds for nursing care for men

Regatta Ward: ten beds for nursing care for women

Walbury Ward: seven beds for nursing care for men.

Apple Hill has a registered manager in post and a nominated accountable officer.

This service was previously inspected on 7 March 2014. At that time we found it was compliant with all regulations.

Our inspection team

Team leader: Clement Feeney

The team that inspected the service comprised an inspection manager, three CQC inspectors, a Mental Health Act Reviewer and a specialist advisor in mental health nursing.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with two carers of people using the service;

Summary of this inspection

- spoke with the registered manager, operations director, and clinical nurse lead for the hospital;
- spoke with 16 other staff members; including doctors, nurses, occupational therapist, psychologist and support workers;
- looked at 20 care and treatment records of patients;
- carried out a specific check of the medication management on all five wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

People we spoke with were positive about the care they received and the activities they were able to take part in.

Carers we met and spoke with told us they liked the openness of the service to family visitors and that they were pleased they were able to meet their family in privacy or in communal areas, according to the person's preferences.

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?

Not sufficient evidence to rate

- Not all areas had risk assessments and we identified many ligature risks
- Staff were not able to recognise ligature risks in the areas where they worked
- Staff were not aware when they were using physical restraint and seclusion. The provider told us that restraint, segregation and seclusion were not used at Apple Hill, however many staff told us that they used "light touch" restraint, including holding people's arms to calm them down and guide them to their bedrooms when the person was agitated or aggressive.

However:

- Individual risk assessments of patients were good.
- Staffing levels were sufficient to safely manage the patients.
- There was a good standard of medicines management.

Are services effective?

Not sufficient evidence to rate

- Care plans were good and the provider was carrying out effective pre-admission and post-admission assessments.
- All patients had good access to physical healthcare in addition to their mental health care.
- A good range of professionals were available to meet people's needs.

However

- Staff knowledge of the Mental Health Act and the Mental Capacity Act was inconsistent across the service.

Are services caring?

Not sufficient evidence to rate

- Staff worked with patients in a caring way and took time to understand how patients communicate.
- Staff intervened positively and sensitively to defuse difficult situations.
- Care plans reflected people's preferences and advanced decisions about care.

Are services responsive?

Not sufficient evidence to rate

- People had privacy when they wanted it, particularly with visiting family or friends.

Summary of this inspection

- Observation of people was kept to a minimum, and based on clear risk assessments
- The hospital was well equipped to support people with mobility difficulties
- Peoples dietary needs and preferences were catered for

However

- The service did not have a clear plan for supporting people whose first language was not English

Are services well-led?

Not sufficient evidence to rate

- Staff were not adequately trained to work with patients detained under the Mental Health Act, even though internal audits had identified this need. The hospital had begun to admit patients before the staff team were trained.

However

- The senior management team had systems in place to monitor many aspects of quality
- The hospital had a risk register to monitor safety issues.
- Staff received feedback on complaints and concerns that had been identified.

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 met with the MHA administrator who had been in post for three months. During that time they had prepared updates for policies to reflect the new status as a hospital and ensured that systems were in place for monitoring people detained under the Mental Health Act, and for making applications for hospital managers hearings and tribunals.

The detention papers for the one detained patient were in order and their rights had been explained following admission and a risk assessment carried out the day after arrival.

Two residents had been detained at a neighbouring NHS hospital, and were on a community treatment order (CTO), residing at Apple Hill in its function as a nursing home. One of these patients had very restrictive conditions attached to the CTO, as he was not allowed to leave Apple Hill without an escort. However we recognise that this restriction was to manage his safety.

Staff said that if an informal patient insisted on leaving the hospital, they would consider using sections 5(2) or 5(4) to ensure the patient was kept safe until a full MHA assessment could be organised. However if a resident who had capacity wished to leave, and staff were concerned about their safety, they would call the police to assess whether a section 136 was appropriate. We were concerned that this system was confusing for staff, particularly as MHA training had not yet been delivered.

The provider had developed a leave authorisation form for section 17 leave. This form did not include a method for recording whether the patient had been informed of the leave or had a copy of the form provided. We discussed this with the administrator, who agreed to consider amending the form.

The patients had access to advocacy including an independent mental health advocate to discuss issues relating to care and treatment under the Mental Health Act. Contact details for the advocate were on display throughout patient areas and advocacy leaflets were available.

However:

Many staff were unaware of the legal implications of the Mental Health Act for detained patients. Eight out of 20 of the staff working on the wards for people with mental ill health had not received training on the Mental Health Act before the provider began admitting people, and had still not received the training at the time of the inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that staff had a good awareness of the principles of the Mental Capacity Act (MCA) and were able to describe how they applied the principles in their work with patients.

The provider had carried out mental capacity assessments for all people using the service in relation to their treatment and consent to stay. Other decision specific assessments and best interests decisions were made and recorded, for example on covert medication, that is hiding a person's medicine in their food because they refused to take it but lacked capacity to understand the consequences of not taking it.

There were seven people subject to Deprivation of Liberty Safeguards (DoLS) in the units for people with mental health needs. The provider was effective at identifying the need for DoLs as part of their care planning and applying to the local authority for DoLS assessments and authorisations. The Mental Health Act (MHA) administrator managed the applications for DoLS and had a system for reviewing and renewing existing DoLS authorisations.

Residents who had capacity and were therefore not eligible for DoLS were deemed to be consenting to their stay. These patients were given the code to unlock the door to the garden so that they could go outside for a

cigarette. However it appeared they did not have the code to open the gate to exit the premises, and the grounds were behind large wooden gates which could only be opened from reception. It therefore seemed that these consenting patients were not free to leave should they choose to do so. We discussed with staff how this would be managed and they explained that they would keep consenting residents who were not safe to leave, through discussion and persuasion, and if they could not they would call the police as above.

Records showed that training on MCA and DoLS was up to date for 88% of staff. Some staff we spoke with that had not had recent training were not clear on the implications of DoLS for the way they worked with people.

Notes

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

- We found that the provider did not adequately assess and manage ligature risks within the hospital, and that staff had poor understanding of ligature risks. The first person admitted as a hospital patient was admitted to Russell Ward, where no environmental risk assessment had taken place. We discussed this with the provider and a full ligature assessment of all wards was completed in the week following the inspection. The provider had one set of ligature cutters that the risk assessments said were onsite, but did not specify where they were stored. We found that they were kept on Warbury ward, which was used for elderly frail people rather than in one of the wards for patients with acute mental ill health with a higher risk of self-harm. This meant they would be hard to access in an emergency.
- Three of the five nursing and care staff we spoke to on the inpatient units were unable to identify of some of the ligature risks, including those identified in the ligature risk assessments. For example staff told us that particular rooms and ward areas were free of ligature risks, which we then found to contain ligature risks. These included wall mounted light fittings, wire opening restrictors on bedroom windows, taps and shower fittings in en-suite and communal bathrooms and a banister rail on a staircase that was not monitored by staff but used by patients visiting the garden. This meant that staff would not be able to safeguard patients at risk of suicide or self-harm via ligature points.
- However the provider had carried out an environmental risk assessment on Hurley and Tedray Wards as part of the registration process for hospital status. This risk assessment identified ligature risks and some rooms were refurbished to eliminate some risks and the provider created an action plan that stated how other risks would be mitigated when people at risk of self-harm were admitted. We found this to contain a good assessment of risks.

Safe staffing

Whole time equivalent (WTE)

Establishment levels: Qualified nurses (WTE): 12

Establishment levels: nursing assistants (WTE): 33

Vacancies: Qualified nurses (WTE): 0

Vacancies: nursing assistants (WTE): 3

Number of shifts filled by bank or agency staff to cover sickness, absence or vacancies in a three month period: 0

Number of shifts not covered by bank or agency staff where there is sickness, absence or vacancies in a three month period: 0

Staff sickness rate in a 12 month period: 1.6%

Staff turnover rate in a 12 month period: 2.1%

- Information provided to CQC by the service before and during the inspection gave a clear rationale for the staffing levels provided. We observed that the allocated staff on each ward were able to provide support that kept people safe and met their needs.
- The senior management team had regular discussions on the changing staffing needs of the service during transition from nursing care to hospital care.
- Staff told us that they were able to ask for extra staff on the wards when patient's needs changed, and that the management team would respond quickly to these requests.
- We saw arrangements for the induction of agency staff and bank staff. We saw that the registered manager

ensured that relevant background checks on each bank or agency worker were carried out before allowing them to work within the hospital. We saw that each ward had a list of agency staff approved by the registered manager to work on the ward.

Assessing and managing risk to patients and staff

- Three of the five care and nursing staff we spoke with on the inpatient wards were not aware when they were applying restraint or placing people in seclusion. The provider reported to us that restraint, segregation and seclusion were not used at Apple Hill, however many staff told us that they used "light touch" restraint, including holding peoples arms to calm them down and guide them to their bedrooms when the person was agitated or aggressive. Because these were not recorded as incidents of restraint or seclusion, the provider was not able to adequately review that the required safeguards to protect patients had been taken.
- The provider had not created any segregation between people receiving nursing care only and patients receiving hospital care. This meant that people presenting high levels of risk requiring hospital care were in a nursing environment where open visiting times were encouraged. Family carers visiting people who received nursing care had not been made aware of the increased risks from these patients and a patient assaulted a visiting carer during the inspection.
- We found that the provider was attempting to run two sets of safety procedures on the ward where detained patients were accommodated alongside those receiving nursing care. For example the provider had a list of controlled items that detained patients should not have free access to and a policy for searching detained patients, however there was a lack of awareness that the detained patients would be able to access these items when accommodated on a ward where other people were allowed these items and were not subject to the search policy.
- The provider had contracted with a pharmacy service to carry out regular audits of medicines management and to provide staff training on awareness of psychiatric medicines. We found that medicines management, including prescribing, storage and recording were of a high standard throughout the service.

Track record on safety

- The provider reported 14 serious incidents in the 12-month period before the inspection. These all related to patient aggression towards other patients, apart from one incident related to a medicine administration error.
- We saw that reported incidents were properly reviewed and that the local safeguarding adults teams and commissioners were involved in investigations where this was appropriate. However these did not include episodes of restraint and seclusion, as staff did not recognise that they were using restraint and seclusion.

Reporting incidents and learning from when things go wrong

- Staff and senior managers we spoke with were able to outline how debriefing and learning took place following serious incidents. Staff told us that their line managers would debrief them either immediately following an incident if the staff member was upset, or in the handover meeting at the end of a shift.
- The assistant psychologist employed by the service was carrying out an analysis of all serious incidents within the service to help develop the provider's improvement plan for the service.

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

(for example, treatment is effective)

Assessment of needs and planning of care

- The care plans we reviewed showed that people had a good pre admission assessment of their needs and that this was updated within 72 hours of admission. All patients had an annual physical health check and ongoing monitoring of their physical health provided through the local GP service. People who were elderly and frail had access to a consultant geriatrician through the GP service.

Best practice in treatment and care

- Care records we reviewed contained some evidence of following National Institute of Clinical Excellence (NICE) guidance on assessing the effectiveness of the care people received, but this was not consistently used across the service.

- A new person centred planning model was being introduced to further promote people's involvement in their care, and this was evident in newer care plans.
- The assistant psychologist took part in care planning and had one to one time with patients, but access to NICE recommended psychological therapies was only available through referral to external agencies such as the Community Mental Health Team.

Skilled staff to deliver care

- The provider had a training program in place to support staff in the transition from nursing care to hospital. However, some staff we spoke with did not have up to date training on key aspects of their role. For example the provider showed us training records that stated that 96% of staff had received MCA and DoLS training, but 20% of the staff had not received training since the newest guidance of April 2014 was issued. That guidance had detailed significant changes in how the DoLS legislation was applied, therefore those staff did not have up to date training.
- The provider had ensured that a core group of staff had received training on mental health awareness and managing aggression before they began admitting patients under the mental health act, however most staff had not received this training and were not due to receive it before April 2016. We discussed this with the provider at the time of the inspection and the provider brought forward the training for managing aggression so that staff were trained in the week following the inspection. However this represented a half day from the four days training required for the staff working with inpatients.

Multi-disciplinary and inter-agency team work

- The staff team included a part time consultant psychiatrist, a part time associate specialist, assistant psychologist, occupational therapist, an activity and hospitality co-ordinator and nursing and support workers. One support worker had responsibility for running activities set by the occupational therapist. This worker was waiting for their post to be filled in order to take on a full time OT assistant role. An external pharmacist and pharmacy technician were contracted to audit medicines. The provider was developing the team and reviewing the skills requirement of the team following the registration of the service as a hospital.
- Care records reflected the work of the multi-disciplinary team. For example there was clear input around the physical health needs of the more frail people using the service, nutritional support plans and schizophrenia care plans where appropriate.
- The GP gave clear written advice following visits to patients, and care plans were updated accordingly.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- We met with the MHA administrator who had been in post for three months. During that time they had prepared updates for policies to reflect the new status as a hospital and ensured that processes for tribunals and managers' hearings were also in place.
- The detained patient we reviewed had a T3 form on their medicine record to show that they were not able to consent to their treatment as required by the MHA. Paperwork relating to detention and community treatment orders (CTOs) were in order
- Some staff were not fully aware of the status of people subject to the Mental Health Act. For example we reviewed the care of a person on a CTO and discussed their care with the staff. Some staff were unaware that the CTO meant that the person was subject to restrictions under the Mental Health Act.
- Eight out of 20 of the staff working on the wards for people with mental ill health had not received training on the Mental Health Act before the provider began admitting people, and had still not received the training at the time of the inspection.
- We discussed the right of people to leave the house. People not subject to the Mental Health Act or DoLS were given the code to unlock the door to the garden so that they could go outside for a cigarette. However it appeared they did not have the code to open the gate to exit the premises, and the grounds were behind large wooden gates which could only be opened from reception. It therefore seemed that these consenting patients were not free to leave should they choose to do so.
- Staff said that if an informal patient insisted on leaving the hospital, they would consider using sections 5(2) or 5(4) to ensure the patient was kept safe until a full MHA assessment could be organised. However if a resident who had capacity wished to leave, and staff were concerned about their safety, they would call the police

to assess whether a section 136 was appropriate. We were concerned that this system was confusing for staff, particularly as MHA training had not yet been delivered Staff were not able to tell us what they would do if a person not subject to DoLS or the MHA asked to leave.
- The patients had access to advocacy including an independent mental health advocate to discuss issues relating to care and treatment under the Mental Health Act. Contact details for the advocate were on display throughout patient areas.

Good practice in applying the Mental Capacity Act

- We found that staff had a good awareness of the principles of the Mental Capacity Act (MCA) and were able to describe how they applied the principles in their work with patients.
- The provider had carried out mental capacity assessments for all people using the service in relation to their treatment and consent to stay. Other decision specific assessments and best interests decisions were made and recorded, for example on covert medication, that is hiding a person's medicine in their food because they refused to take it but lacked capacity to understand the consequences of not taking it.
- There were seven people subject to Deprivation of Liberty Safeguards (DoLS) in the in the units for people with mental health needs. The provider was effective at identifying the need for DoLs as part of their care planning and applying to the local authority for DoLS assessments and authorisations. The MHA administrator managed the applications for DoLS and had a system for reviewing and renewing existing DoLS authorisations.
- Residents who had capacity and were therefore not eligible for DoLS were deemed to be consenting to their stay. These patients were given the code to unlock the door to the garden so that they could go outside for a cigarette. However it appeared they did not have the code to open the gate to exit the premises, and the grounds were behind large wooden gates which could only be opened from reception. It therefore seemed that these consenting patients were not free to leave should they choose to do so. We discussed with staff how this would be managed and they explained that they would keep consenting residents who were not safe to leave, through discussion and persuasion, and if they could not they would call the police as above.
- Records showed that training on MCA and DoLS was up to date for 88% of staff. Some staff we spoke with that had not had recent training were not clear on the implications of DoLS for the way they worked with people.

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

Kindness, dignity, respect and support

- Staff we spoke with had a good understanding of the individual needs of the patients they worked with. They were able to discuss patients' care needs in detail and the types of activities and interventions that were helpful for them.
- All the interactions between staff and patients we observed were positive. At times the units were very busy due to the high level of patients' physical care needs, but we observed that staff were always calm and responded positively when patients sought their attention.
- When patients had visitors they were able to meet them in privacy, unless there were particular risks identified. Patients were able to spend time alone if they wished and staff carried out observations according to the person's assessed need.

The involvement of people in the care they receive

- Most of the people using this service had communication difficulties due to dementia or other impairments. Where people were able to express their opinions and wishes, these were reflected in their care plans. Where people were not able to communicate their wishes, there was evidence that family had been consulted and the persons previously expressed views and wishes had been taken into account.
- Care plans were updated regularly to reflect the providers developing understanding of the person's preferences as well as the person's changing needs.
- The provider was implementing the "My Shared Pathway" person centred planning model to make care plans more recovery focussed.
- People were offered copies of their care plans and staff recorded if the person accepted it.

Long stay/rehabilitation mental health wards for working age adults

- We saw that one person had an advanced directive relating to end of life care. This was very clear and signed by staff and family to acknowledge they understood the person's wishes.
- The provider had an arrangement for an independent advocacy service to visit weekly, and the contact details for the advocacy service was clearly displayed in the communal areas of the hospital.
- Community meetings for patients were held monthly. Issues raised at meetings were addressed and information on actions was displayed on "You Said…, We Did…." notice boards in communal areas.

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

Access and discharge

- The provider reported an average bed occupancy of 93% over the six months before this inspection. At the time of our inspection there were two hospital inpatients and 39 people receiving nursing care.
- The provider contracted two nurses to carry out pre-admission assessments for the hospital. Referrals came from the local NHS foundation trust and all admissions were planned. Discussions took place between commissioners and the provider on admission, and the provider reported there had been no disagreements about whether a person should be admitted and there was no pressure to accept an inpatient when the provider did not believe the placement to be appropriate.
- Due to the recent registration as a hospital, the provider had not needed to seek move on accommodation for inpatients and there were no delayed discharges.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had restructured the accommodation as part of the registration as a hospital so that all units provided single sex accommodation in line with the Mental Health Act code of practice. This had involved moving people between units. Patients and people needing nursing care were sharing the same unit to avoid further moves of patients. However this was challenging for the provider as these two different groups required different policies and procedures, for example in regard to room searches and access to mobile phones.
- Russel and Hurley Wards were designed as separate wards but operated as a single unit. Staff were concentrated on Russel ward where patient needs were highest with Hurley's communal areas used by patients seeking more privacy. Staff were always aware where patients were and kept an appropriate level of observation for people using Hurley Ward.
- Patients had access to their bedrooms throughout the day. Access to the grounds was via keycodes on doors. Most patients had access to the garden and grounds unescorted. A requirement for an escort was part of a risk assessment.
- The occupational therapy team had a comprehensive range of activities that people could take part in. Activities were adapted to people's needs and planned so that all staff, including night staff, could promote participation.
- The communal lounges had modern touch screen PCs with apps that were accessible for the patients to promote their choices, for example listening to music or social game playing.
- People had access to a telephone on each unit. The management team told us that people receiving nursing care would be able to use their own mobile phones if they were able, but they had not written a policy on use of mobile phones for patients detained under the Mental Health Act. This would create an issue on a unit where both inpatients and people receiving nursing care were accommodated.
- People were able to make food and drinks any time they wished, though most required staff support to do this. An unsupervised kitchen was available on Hurley Ward and staff were aware of who was on that ward at all times, so could supervise if required.
- Bedrooms were spacious and many people had personalised their rooms. One room had extra furniture so that the person could meet their partner in privacy when they visited.

Meeting the needs of all people who use the service

- Two of the two units were for inpatients. Tedray was on the ground floor and all of the people using this unit had mobility difficulties. Staff on this unit had moving and handling training and aids and adaptations were in

place to support people. Hurley ward was on the first floor and accessible via a stair lift. Ramps were available for wheelchair access on steps on the first floor. Communal bathrooms on both wards were accessible for people with limited mobility, for example hoists were available and the bathrooms had adequate space for a wheelchair and a hoist to be used.

- A multi-faith room was available for people to use and staff had helped people using the service to access local faith groups, where this was identified as a need. The catering team were able to meet a wide variety of dietary requirements for religious or medical needs.
- However the senior management team did not have access to interpreters in place and did not have facilities readily available to provide information in alternative languages.

Listening to and learning from concerns and complaints

- The provider reported that it had received 14 complaints in the 12 months prior to the inspection. Two complaints had been upheld and four partly upheld.
- Information on how to make a complaint was clearly displayed in communal areas. There were regular visits by an advocate to the service.
- Staff were able to describe the complaints process in detail and had received feedback on the outcome of previous complaints.

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

Vision and values

- The service was in transition from a nursing care home to a hospital at the time of our inspection. The leadership team were promoting a recovery focussed model that would encourage independence and lead to people being discharged to independent living. However they were also aware that the existing people receiving nursing care would require long term support. The two needs were reflected in different training programs for nursing staff and hospital staff.
- A core group of hospital staff had received initial training on the Mental Health Act and mental health care pathways following registration as a hospital, and these staff were very clear on the new model of care and the values that underpinned it.

Good governance

- The majority of staff in the hospital units were not due to complete training on mental health care until April 2016. This would be nine months after registration as a hospital and meant that the majority of staff in the hospital units were not prepared for patients detained under the Mental Health Act.
- We discussed this with the registered manager at the time of the inspection and some aspects of the training were brought forward and a briefing note on the different client groups was prepared for staff in the week following the inspection. However staff and patients could remain at risk due to the lack of training.
- All clinical audits were carried out by the clinical lead. This was due to a unit manager post being vacant. The assistant psychologist employed by the service was carrying out an analysis of all serious incidents within the service to help develop the provider's improvement plan for the service.

Leadership, morale and staff engagement

- Staff we spoke with were positive about the service and felt that they were able to maximise time spent with patients, particularly nursing staff. We observed that this was the case during the inspection.
- Staff felt confident to report safety issues and were able to relate actions that had been taken after reporting issues. Nurses were able to ask for safety issues to be placed on the hospital risk register.
- One unit had a vacancy for lead nurse. While the provider was recruiting to this post, staff told us that mangers were taking action to minimise the effects of the vacant post.
- When senior managers visited the wards during our inspection, we observed that staff, patients and carers were familiar with them and related to them well. We concluded that the senior management team would have spent time building up relationships with staff, patients and carers.
- In the six months prior to the inspection staff sickness was 1.6% of all shifts. This is low for this type of service.

Long stay/rehabilitation mental health wards for working age adults

- Staff turnover for the year was relatively high at 27.9%. Senior managers told us that this had followed management changes and registration as a hospital. Some staff were not comfortable with the new client group. The provider had been able to cover all recent vacant shifts from bank staff rather than using an agency, and this had provided some continuity and mitigated against the risks of using agency staff unfamiliar with the client group.

Commitment to quality improvement and innovation

- Senior managers told us that the main focus of the leadership team was to establish a good transition to a hospital service. They told us they were considering options for accreditation, such as the Royal College of Psychiatrists AIMS program of peer to peer reviews
- A series of clinical and non-clinical audits had taken place in the year prior to the inspection. Some identified issues had not been fully addressed, for example the training matrix identified numerous outstanding training requirements for staff. Other issues had been addressed, particularly medical records and care plans were improved, staff appraisals and supervisions had taken place and safeguarding concerns had been fully reviewed and closed.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure ligature risks are identified and where they cannot be removed, must be mitigated against. All nursing and care staff should be able to recognise ligature risks.
- The provider must ensure patients on long stay and rehabilitation wards must be cared for by adequately trained staff, that is staff who are aware of the care needs and legal status of patients and who are adequately equipped to manage the risks posed by and to patients.

Action the provider SHOULD take to improve

- The provider should be able to segregate inpatients from people receiving nursing care so that the policies and practices required to care for one type of client do not impact on the care of the other type of client.

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	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15** HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises. How the regulation was not being met: Patients and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate risk assessments with regard to ligature risks. This was a breach of regulation 15 (1) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18** HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Care and treatment was not safe for service users because staff did not have the appropriate support and training to enable them to carry out the duties they were employed to perform. This was a breach of regulation 18 (2)