# Appletree

## Quality Report

Frederick Street North
Meadowfield
Durham
DH7 8NT
Tel:01913782747
Website: http://www.cambiangroup.com/

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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

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

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

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

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

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

# Summary of findings

## Overall summary

This was a focused inspection in relation to concerns raised about Appletree. Ratings have not been given for this inspection.

We found the following issues that the provider needs to improve:

- Staff did not always carry out the necessary screening and monitoring of patients following the administration of rapid tranquilisation, or those receiving high risk medications.
- Staff did not always complete documentation on patients' physical healthcare accurately or in full.
- There were discrepancies in the management of medicines that had not been identified by Appletree's audit processes.
- Staff placed restrictions on patients that were not proportionate to the risk of harm.

However, we also found the following areas of good practice:

- Compliance with staff training was high and newly recruited staff underwent a series of employment checks, an induction and a probationary period.
- Staff reported safeguarding concerns as required and worked closely with the local safeguarding authority.
- Staff worked closely with community teams and the patients' families to plan for their discharge.

# Summary of findings

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# Appletree

**Services we looked at:**
Long stay/rehabilitation mental health wards for working-age adults

# Summary of this inspection

## Background to Appletree

Appletree is a 26 bed rehabilitation unit for females with mental health needs. At the time of inspection, Appletree had 25 patients. It provides services to patients who may be detained under the Mental Health Act 1983. It is run by CAS Behavioural Health Limited and is situated in its own grounds in Meadowfield, close to the city of Durham

The hospital had a registered manager and a controlled drugs accountable officer in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is ran.

Appletree has been registered with the CQC since 26 September 2012. Appletree was initially run by Cambian Healthcare Limited, before moving to CAS Behavioural Health Limited in June 2017. It is registered to carry out two regulated activities; assessment or medical treatment for persons detained under the Mental Health Act 1983, and treatment of disease, disorder, or injury.

Appletree has been inspected by the CQC three times since it was registered in 2012. At the last inspection on 24 May 2016, we found that Appletree was not meeting all the Health and Social Care Act (Regulated Activities) Regulations 2014. We issued the provider with one requirement notices for this service. This related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 17 HSCA (RA) Regulations 2014 Good governance

## Our inspection team

**Team Leader:** Jayne Lightfoot, Inspector (Mental Health) Care Quality Commission

The team that inspected the service comprised four CQC inspectors which included the team leader, a CQC pharmacist inspector and a CQC inspection manager.

## Why we carried out this inspection

We carried out this inspection in response to concerns raised about Appletree. Concerns were raised in respect of staffing levels and staff training, available activities and discharge planning, the use of face down restraint, the management of medicines and the management, attitudes and behaviours of staff.

We also took the opportunity to find out whether Appletree had made improvements since our last focused inspection on 24 May 2016.

When we last inspected Appletree, we rated it as good overall. We rated Appletree as good for safe, requires improvements for effective, good for caring, good for responsive and good for well led.

Following the previous inspection, we told Appletree that it must take the following actions to improve:

- The provider must ensure that all policies reflect the requirements of the revised Mental Health Act code of practice as stated in annex B of the code.

We issued the provider with one requirement notice for this service. This related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 17 HSCA (RA) Regulations 2014 Good governance

Ratings have not been given for this inspection.

# Summary of this inspection

## 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?

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 16 patients who were using the service and three carers of patients
- spoke with the registered manager
- spoke with 16 other staff members; including doctors, nurses, occupational therapists, and psychologists
- spoke with the independent mental health advocate
- gained feedback from one commissioner
- attended and observed the morning staff meeting and the morning patient meeting;
- looked at six care and treatment records of patients, including their physical healthcare files
- looked at the medication records of seven patients
- looked at eight staff personnel files
- looked at a range of policies, procedures and other documents relating to the running of the service, specific to the concerns raised.

## What people who use the service say

Patients had mixed views on the care and treatment received at Appletree. Some patients felt the staff were respectful and polite and genuinely cared about them. Others felt staff were not always respectful and sometimes ignored them. Carers reported that most staff were friendly and polite.

# 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?

This was a focused inspection in relation to concerns raised about Appletree. Ratings have not been given for this inspection.

We found the following issues that the provider needs to improve:

- Staff did not always carry out the required observations following administration of rapid tranquilisation.
- Medicine stock records did not always match medication administration records.
- Patients had restricted access to bathroom facilities that was not a proportionate response to risk of harm. Staff had not documented the reasons for this restriction or reviewed it in line with the provider's policies.

However, we also found the following areas of good practice:

- Compliance with staff training was high, with an overall rate of 98% at the time of inspection.
- Staff worked closely with the local safeguarding authority and reported safeguarding concerns as required.

### Are services effective?

This was a focused inspection in relation to concerns raised about Appletree. Ratings have not been given for this inspection.

We found the following issues that the provider needs to improve:

- Staff did not always carry out the necessary screening and monitoring of patients receiving high risk medications.
- Staff did not fully and accurately complete the required documentation on patients' physical healthcare. Patient records did not always evidence that they had accessed the recommended interventions for their physical healthcare needs.

However, we also found the following areas of good practice:

- The provider's national and local policies were compliant with the Mental Health Act revised Code of Practice 2015.

### Are services caring?

This was a focused inspection in relation to concerns raised about Appletree. Ratings have not been given for this inspection.

We found the following areas of good practice:

# Summary of this inspection

- We observed staff treating patients with kindness and respect during our visit.
- Carers reported the majority of staff were polite and helpful.

However, we found the following issues that the provider needs to improve:

- Patients had mixed views about the care and treatment they received. Some felt staff genuinely cared while others felt staff ignored them.

## Are services responsive?

This was a focused inspection in relation to concerns raised about Appletree. Ratings have not been given for this inspection.

We found the following areas of good practice:

- Staff worked closely with community teams and the patients' families to plan for discharge.
- Staff provided access to a range of activities and facilities.
- Staff dealt with complaints in line with the provider's policies.

## Are services well-led?

This was a focused inspection in relation to concerns raised about Appletree. Ratings have not been given for this inspection.

We found the following issues that the provider needs to improve:

- Staff morale was varied. Some staff felt well supported while others felt they were not listened to.
- The arrangements and responsibility for monitoring the physical healthcare of patients were not clear.

However, we also found the following areas of good practice:

- Appletree had a whistleblowing policy and staff could raise concerns through an external company.

# 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.

During this focused inspection, we reviewed Appletree's compliance with the Mental Health Act in relation to a previous breach of regulation. We found that both the provider's policies and the local hospital procedures were compliant with the Mental Health Act revised Code of Practice. All staff had received training in the Mental Health Act at the time of inspection.

We also found that consent to treatment documentation was in place as required and medicines were prescribed in accordance with the Act.

## Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review Appletree's compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards during this focused inspection.

# 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 Environment

Staff had access to equipment for monitoring patients' physical health. This included an electrocardiogram machine, scales, blood pressure machine and equipment to take blood.

The clinic room was clean and tidy. We checked emergency equipment and found there were adequate supplies of oxygen and a defibrillator with adult pads. Ligature cutters and adrenaline were available and staff knew where to locate them in an emergency. This was in line with guidance from The Resuscitation Council UK.

### Safe staffing

CAS Behavioural Health Ltd identified a minimum safe staffing level for Appletree of one qualified staff member and four unqualified at all times. A review of staffing rotas from January 2017 to July 2017 showed that all shifts had been staffed to the minimum safe levels or above. However, staff and patients gave mixed feedback about whether they felt Appletree was sufficiently staffed to meet the needs of the patients. Feedback from staff was that they were often short staffed which left less time to spend with patients. During our inspection, we saw sufficient staff to deliver nursing care and undertake additional activities with patients.

At the time of inspection, Appletree had four staff vacancies, two qualified and two unqualified and no staff on long term absence. The vacancies were being actively recruited to and were filled with the use of bank staff. Appletree used bank staff who were familiar with the hospital and patients and did not use agency staff. In May 2017, an average of 12% of shifts was covered by regular bank staff, with this ranging from between 8 and 15% each month since January 2017.

Some staff reported that therapy and treatment groups could get cancelled when they were short staffed and stated this had happened quite frequently since January 2017. Other staff reported they weren't aware of activities being cancelled. Appletree monitored the provision of activities and leave as part of their key performance indicators each week. The hospital aimed to offer 25 hours of meaningful activity each week and monitored how many patients were active by 10am each day. Appletree was performing on target hitting between 84 and 100% each week in all of these areas in the four weeks prior to inspection.

Appletree had a staff turnover rate of 30% as of June 2017, which included bank staff. This flagged as red on the hospital's electronic dashboard, which monitored their compliance with key performance indicators. Most staff and patients acknowledged there had been regular changes within the staff team but did not identify ways in which this had impacted on patient care. Reasons given for leaving over the previous six months included promotion, changes in personal circumstances, transfer to another CAS Behavioural Health Limited hospital and comments that the job was not for them.

Compliance with staff training was high at Appletree, with an overall compliance rate of 98% at the time of inspection. Appletree had an induction training package called achieve. This included electronic learning modules on topics such as safeguarding adults, information governance, infection control, the Mental Capacity Act and the Mental Health Act Code of Practice. Depending on the job role staff then attended additional mandatory training. Staff had a six month induction period, with three months to complete the achieve package. As at June 2017,

compliance with mandatory training in most areas was at 98 to 100%.The exception to this was restraint training which had a compliance rate of 91%. Appletree were moving to the management of actual or potential aggression model and staff were receiving this training at the time of inspection.

All staff had attended training in emergency first aid at work, oxygen training, oxygen therapy and electrocardiogram training, all of which were mandatory courses. Emergency first aid at work training included basic life support skills and automated external defibrillator. The Resuscitation Council (UK) recommends immediate life support training as a minimum standard for staff that deliver or are involved in rapid tranquilisation, physical restraint, and seclusion. The four training courses delivered at Appletree met these required training standards. Nursing staff had also recently been trained to take blood.

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

Staff had undertaken significant work on reviewing restrictive practice since our last inspection. The hospitals in the North East, including Appletree had led on a restrictive practice review that was being rolled out at other CAS Behavioural Health Limited hospitals across the country. This included the development of a reducing restrictive practice group. This group was working on developing a strategy on reducing restrictive practice involving the use of a self-assessment checklist and reviewing the restrictive practice policy and procedure. The minutes of this meeting identified a list of actions to be undertaken within specific timeframes and had last met on 20 June 2017.

At a local level, Appletree reviewed restrictive practice weekly and recorded this in a restrictions review booklet. Staff discussed patients' capacity, shop leave, visits, garden access during the evening, access to aerosols, access to cutlery, ability to have glass items in their bedroom, level of searching and unsupervised access to certain areas within the hospital. This was done on an individual basis and we saw evidence within the minutes of patients' restrictions being increased or decreased depending on the risk they posed to others and themselves. Staff and patients identified certain risk items that were again based on their individual circumstances. Patients could chose to place these risk items in a risk box for their own safety or staff could remove them if they felt they posed a risk of harm to the patient. The manager told us risk items were placed in lockable cupboards within the hospital.

During the inspection, two patients told us that staff had removed risk items from their bedroom and locked them in their en-suite bathroom, therefore restricting access to their bathroom. They felt this was used as a punishment and stated staff reported this was due to storage difficulties within the hospital. We saw one patient bathroom that was locked during our inspection. Staff initially told us this was care planned due to this patients individual risk behaviours. We reviewed this patient's care record and found that the current care plan and risk assessment did not identify the locking of the bathroom as an agreed strategy to manage risk. This bathroom was unlocked during the day we were there. Staff later told us this had occurred in response to an incident two days prior to our inspection in order to safeguard the patient. This had not been discussed in the morning meeting as a restriction placed on that patient and was not mentioned in the restrictions review meeting.

We spoke to the independent mental health advocate who reported that two patients had previously raised this concern about their risk items being placed in the bathroom and it being locked. This had been raised by the advocate with staff, who at the time stated it was due to storage issues within the hospital.

These patients stated they had to use communal bathroom areas instead. We checked one communal bathroom on the first floor during our visit and found it to be locked. The registered manager stated it was not normally locked and had been done by staff in response to our unannounced visit. One patient told us this bathroom was often locked and they had to ask staff for the key.

Following our inspection, the provider commenced an internal investigation into these matters. They concluded that en-suite bathrooms were being locked and that belongings deemed to be a risk were being placed in them. Recommendations were made such as additional staff training on least restrictive practice, staff supervisions to discuss the issue and en-suite bathrooms to be included in the weekly restrictive practice review meetings. Appletree reported that they had cascaded the outcome of this investigation to all staff, had clearly identified storage areas for risk items and had begun staff training and supervision.

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

The number of restraints for the previous three months was as follows: five in April, seven in May and 14 in June. The majority of those in June involved one patient. One staff member reported that incidents appeared to happen more frequently recently, possibly due to changes in the patient population. The electronic incident reporting form was completed for each restraint; however in seven of the instances in June 2017, the associated monitoring form was not present in the file or marked as being completed. Staff found these in an archive file and they were presented to us. Some of the electronic incident reporting forms contained limited detail in the narrative about the restraint. A review of the nurses' monthly meeting minutes showed that in February 2017, the issue of missing information on the incident reporting forms was discussed and nurses were reminded to ensure all required information was present before signing them off.

All staff reported prone restraint rarely occurred, however patients reported this was a frequent occurrence. We reviewed restraint data for the three months prior to inspection, during which there had been one recorded prone restraint in June 2017. This prone restraint was detailed in full on the electronic incident reporting form.

We checked the arrangements for the safe management of medicines. We reviewed seven patient medication records and spoke with nursing staff responsible for medication management.

Medicines were supplied by a pharmacy contractor under a service level agreement. We checked medicines stored in the clinic room and medicine refrigerator and found they were stored securely with access restricted only to authorised staff. Medicines fridge temperatures were recorded daily. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, managed, and recorded appropriately. We saw evidence of routine checks and reconciliation of controlled drug stocks at the service.

We found there were adequate supplies of medicines to meet the needs of patients. Staff carried out medication stock checks, which reconciled the quantity of medication dispensed at the service with that ordered from the pharmacy. During our inspection, we found discrepancies in records which did not balance with the number of doses signed as administered on the medicine charts. In addition, stock records stated medicines had been wasted but they had been signed as given on the medicines chart.

We reviewed three audits which covered medicines management from April, May and June 2017. All of these audits had failed to detect the shortfalls we found during our inspection. Two medicines errors had been recorded since April 2017. One patient stated during interview that they had experienced a medication error where they were given the wrong medication. We saw this error had been documented as required and addressed in supervision with the staff involved. The provider had also notified CQC about the error at the time it occurred.

We reviewed minutes from the monthly nurse's meetings from January 2017 to June 2017. In June 2017, the minutes stated that medication errors were an issue and letters of concern had been issued to nurses. All nurses were given guidance in relation to accountability and responsibility, with Nursing and Midwifery Council hearings printed out for all nurses to read to ensure they understood the seriousness of potential over/under dosing. The frequency of medication stock checks had been increased to mitigate the likelihood of errors. Nurses were reminded to complete all documentation in relation to medicines management.

A policy was in place for the monitoring of patients following rapid tranquilisation, which was in accordance with national guidance. We reviewed records and found observations had not been carried out or recorded as set out in the policy in seven out of eight occasions where rapid tranquilisation had been used. In addition, where patients had refused observations their level of consciousness had not always been recorded. This meant there was a risk of harm because staff had not checked patients for adverse effects.

We reviewed the safeguarding concern log from January 2017 to July 2017. We found no concerns with the safeguarding processes at Appletree. There had been 10 alerts raised by Appletree during this time. Patients had individual safeguarding files, of which we reviewed four. They contained each alert raised about that patient and Appletree worked closely with the local safeguarding authority.

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

## Are long stay/rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

**Assessment of needs and planning of care**

We reviewed six treatment records during the inspection. All contained a comprehensive assessment of patient needs. Patients had separate physical healthcare files, which contained care plans, clinical notes, test results and communication with hospitals and GP's. Care records showed that staff used a variety of monitoring tools for physical health, however physical health monitoring for patients was inconsistent. It was difficult to discern from care records what the rationale was for implementing or ceasing physical health monitoring. We found in one patient record that they had a physical health care plan for one diagnosed condition, but not for another.

The health improvement plans were not always completed accurately or in full. Staff had not always identified the appropriate interventions on the health improvement plan based on the patient's needs and there was conflicting information in the files. For example, one patient had a body mass index of greater than 25 but this had been rated as green which would suggest no further action was required. However, the document stated that recommendations for a patient with a body mass index of over 25 were advice and support with diet and exercise, to make a referral to external weight management and to consider a medication review. There was no evidence in this file of these actions being taken.

**Best practice in treatment and care**

Staff told us about a range of interventions offered to patients in terms of weight management, such as support to make healthy lifestyle changes and healthy food choices. We saw activities available to patients to promote a healthy lifestyle, such as exercise and a planned healthy shop and cook session.

We found evidence in care records of patients being supported to regularly attend their GP or local hospital for routine treatment for physical health matters such as skin and thyroid conditions. Three patients reported that staff did not always respond quickly enough to gain access to outside healthcare when they felt unwell and one carer felt that their relative had waited too long to access a GP appointment for blood tests. All other patients we spoke with stated they were supported to attend appointments when they needed them and had no concerns about this. We saw a patient attending hospital and another attending the opticians on the day of our visit. There was evidence in care records of patients attending appointments for health reasons outside of the hospital and attending the acute hospital in an emergency.

Appletree's procedure for physical health stated that patients will have a physical examination, blood tests, electrocardiogram and physical health monitoring conducted by the hospital in line with national guidance. The procedure stated that this will include monitoring for metabolic syndrome, high dose antipsychotics and medications such as Clozapine and Lithium. The provider informed us that the physical healthcare policy was being revised at the time of inspection and would be circulated to all sites by the end of August 2017. However, we found physical health monitoring was not always carried out in accordance with national guidance for patients prescribed antipsychotic medicines

The Head of Care told us nursing staff were responsible for completing each patient's health improvement profile and that the doctor was responsible for requesting and reviewing blood tests. We reviewed two health improvement profiles and found no evidence an electrocardiogram had been performed as required for either patient. A further example was an instance where a patient had a high pulse rate and the recommended action was to conduct an electrocardiogram, of which there was no evidence in the file. In addition, staff had indicated some parameters were normal when other physical health records indicated they were not. Where parameters such as weight and blood pressure were identified as abnormal, no further action had been recorded. We asked how the service managed blood tests which are regularly required for patients taking antipsychotic medicines. We were shown a document which indicated these tests were not up to date.

Staff used the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) to monitor the side effects of patients receiving antipsychotic medication. We reviewed the use of this scale for eight patients, reviewing a total of 27 completed scales. Only two of these scales were fully

completed with an overall risk score identified. The risk score is needed to determine if action is required in relation to side effects therefore this scale was not being used as intended to support clinical decisions.

Following the inspection, we asked for assurance from Appletree in respect of immediate action that would be taken to ensure the appropriate monitoring of patients' physical health and those on high risk medications. The provider informed us that in response to our concerns, medical staff had reviewed all 25 patients and devised a new schedulefor bloodmonitoring. The provider told us they had identified all patients who were prescribed rapid tranquilisation and were updating their care plan to identify what monitoring was required post administration. Further plans were in place for additional staff training and the development of systems and processes to ensure physical health monitoring was clearly identified for each patient.

**Skilled staff to deliver care**

Appletree had a range of mental health disciplines providing input to patient care and treatment. This included registered mental health nursing staff, support staff, a psychologist and occupational therapists. The occupational therapy team was fully staffed at the time of inspection. Prior to this where there had been vacancies in the therapy team, support workers had carried out activities with patients. All staff received an induction and underwent a probationary period.

All eight staff personnel files contained application forms, interview assessments, requests for disclosure and barring service checks and references. They did not all contain evidence of qualifications. The support worker job description stated that they should have GCSE Maths and English, or equivalent training or qualification, or be able to demonstrate the same. The manager reported it was not common practice to keep copies of qualifications in the staff files but they would have seen them at the interview stage. We saw evidence of nursing staff being registered with the Nursing and Midwifery Council.

A number of staff working at Appletree were related. CAS Behavioural health Limited has a policy and procedure on the employment of near relatives or partners within their hospitals. The policy stated that relationships between staff are to be identified on the appropriate form and held within staff personnel files. It also stated that staff who are related should not supervise each other. It placed no restrictions on staff who are related working the same shifts. We found that Appletree complied with this policy in the majority of cases; however we found that on one date, a staff member had provided individual formal supervision to two of their relatives. The majority of staff and patients did not raise concerns about the relationships between staff. The manager was dealing with a concern raised by a carer of one patient in relation to this, but this was an ongoing investigation at the time of our visit.

In all eight staff personnel files there was evidence of regular supervision. As at June 2017, 89% of staff had received supervision in the previous month. However, some staff reported that supervision lacked value. Staff also had access to regular team meetings, although some staff felt that issues raised were not always addressed. We found that where a complaint had been made or an error had occurred involving a staff member, this was addressed during their supervision. We found that when staff were placed under performance management, senior staff clearly documented the reasons for this and followed the provider's policy in addressing the concerns.

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

At the time of the last inspection, we found that the provider had not fully updated their policies to reflect the changes in the Mental Health Act revised code of practice. We reviewed this during this inspection. We found that all required policies at both a national and local level had been updated to reflect the changes in the 2015 Mental Health Act Code of Practice.

All staff had received training in the Mental Health Act at the time of inspection.

We reviewed consent to treatment documentation and found medicines were prescribed in accordance with the provisions of the Mental Health Act. Prescriptions for medicines to be given as or when required contained sufficient information to enable staff to administer them safely.

Patients had access to an independent advocate who visited the hospital regularly and was there on the day of inspection. The advocate raised any issues on the patients behalf with staff and reported the main concern that has been raised in recent months was the access to bathrooms.

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

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

### Kindness, dignity, respect and support

Patients had mixed views about the staff and the care that was provided. Some patients reported they got on well with staff who were very supportive. They felt staff were genuine and seemed to care about them. However, others felt that politeness and respect varied amongst the staff and that they sometimes felt staff ignored them. We observed staff treating patients with kindness and respect during our inspection and staff appeared to understand the needs of the patients during discussions with them. All three carers reported that the majority of staff were polite and helpful.

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

### Access and Discharge

Some patients reported they felt discharge planning was poor with a lack of communication between Appletree and the home teams. We reviewed the minutes of pre and post review meetings that were held by staff around the time of patient reviews. It was clear that Appletree liaised closely with home teams and there were detailed plans for discharge. These included discharge summaries sent to community staff, a stepped approach to discharge using overnight leave, the identification of patient goals with family involvement and a safety plan.

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

Staff reviewed the programme every three months in response to patient feedback. Staff developed a therapy plan with each patient depending on their individual needs and knocked on patients doors each morning encouraging them to 'rise and shine'. Appletree monitored patient activity by reporting on 25 hours of meaningful activity for each patient every month. These included daily living skills, access to the community, a planned shop and cook system, household and gardening skills and group work. We saw patients engaging in activities during our inspection.

Patients had access to a gym and all equipment was in working order at the time of our visit. One staff member was also a personal trainer and some patients could use the gym on their own depending on their individual risk assessments. The community minutes mentioned a holistic therapist who visited the hospital and trips to Butterfly World and the beach.

### Listening to and learning from concerns and complaints

Patients stated they felt able to raise issues with staff but did not always feel they were addressed. There had been six formal complaints from patients or their relatives between January 2017 and July 2017, three of which related to staff behaviour and attitudes and one of which related to concerns about their care and treatment, including medication issues. We saw these complaints were addressed with the relevant staff members, either through supervision or through the performance management policy. One carer reported they were happy with the way their complaint had been addressed.

Learning from complaints was shared with staff in team meetings and individual supervision.

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

### Good governance

The arrangements and responsibility for monitoring the physical healthcare of patients were not clear. Staff were uncertain about who had responsibility for what and did not always follow Aoppletree's policies and procedures in monitoring the physical health of patients. Medication audits did not always identify issues. We found gaps in patients' physical health records and the electronic restraint monitoring forms. Staff reported supervision was not always meaningful and that despite the staffing establishment levels for Appletree being met, they often perceived the hospital as being short staffed. On the day of our visit, the hospital was sufficiently staffed.

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

**Leadership, morale and staff engagement**

Some staff felt morale was low, with comments including they didn't feel appreciated by managers, that achievements were not always recognised and that communication was not always good.

Other staff reported they received good support from senior staff and colleagues and felt able to approach them with any concerns.

Appletree had a whistleblowing policy and staff could raise concerns through an external company, which were then passed to the provider to be investigated. We reviewed management investigation reports in relation to previous whistleblowing concerns raised and found that actions had been identified and completed where required.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

**Action the provider MUST take to improve**

- The provider must ensure that staff carry out the necessary screening and monitoring of patients receiving high risk medications.
- Staff must carry out the necessary monitoring of patients following the administration of rapid tranquilisation.
- The provider must ensure there are clear arrangements for the monitoring of patients' physical health and that documentation is completed accurately and in full, with all recommended actions undertaken.
- Staff must ensure the proper and safe management of medicines.
- Staff must ensure that any restrictions placed on patients are proportionate to the risk of harm and the rational and timeframe for this is documented clearly in patients' records.
- Staff must ensure patients have access to bathroom facilities at all times.

### Action the provider SHOULD take to improve

**Action the provider SHOULD take to improve**

- Staff should ensure that they fully complete the electronic monitoring forms for restraint for each incident of restraint.
- The provider should ensure that any audits undertaken are effective in identifying action that staff need to take.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Staff were not assessing the risks to the health and safety of patients of receiving the care or treatment or doing all that is reasonably practicable to mitigate any such risks.<br><br>There were issues with the proper and safe management of medicines.<br><br>Staff did not carry out the necessary screening and monitoring of patients receiving high risk medications.<br><br>Staff did not fully and accurately complete documentation on patients' physical healthcare.<br><br>The arrangements and responsibility for monitoring the physical healthcare of patients were not clear.<br><br>Medicine stock records did not always match medication administration records.<br><br>Staff did not always carry out the required observations following administration of rapid tranquilisation.<br><br>This was a breach of regulation 12, 1, 2 (a) (b) (g) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Staff locked a patient's en-suite bathroom following an incident of self-harm. The bathroom remained locked once the risk to the patient had reduced. This was not a proportionate response to the risk of harm posed to the patient. |

This section is primarily information for the provider

# Requirement notices

The upstairs communal bathroom was also locked during our visit.

This restricted the patients' access to bathroom facilities.

This was a breach of regulation 13, 4 (b)