The Whitepost Health Care Group

Shrewsbury Court Independent Hospital

Quality Report

Whitepost
Hill Redhill
Surrey
RH1 6YY
Tel: 01737 764664
Website: www.whitepostgroup.co.uk/

Date of inspection visit: 11 - 13 August 2015
Date of publication: 14/04/2016

This report describes our judgement of the quality of care at this hospital. 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 hospital	Requires improvement
Long stay/rehabilitation mental health wards for working age adults	**Requires improvement**

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- While the hospital had processes in place for assessing the ligature points on the wards, it had not identified all ligature points and had not put in place appropriate management plans according to the risks identified. Outside spaces did not have a ligature assessment.
- Patients were left unattended in the annexe where it had been assessed that staff needed to supervise the area at all times.
- There were blanket restrictions on the wards for example, patients had to use polystyrene cups.
- Environmental risk assessments were not always completed in a timely way on the wards.
- Staffing levels were not set at a safe level using a recognised tool. Staff worked alone for periods of time and some staff were left to work alone for a whole shift. Staffing levels meant patients could not always have their escorted section 17 leave, there was not always a registered nurse on shift.
- Staff did not outline observations that are more intensive in care plans. They did not adhere to the observation policy for two-to-one observations.
- Staff were required to go through management to report safeguarding issues and were not clear of their role in safeguarding vulnerable adults.
- Patients were able to access a clinic room through an open window.
- No flumazenil was available in the hospital. Flumazenil counteracts the effects of benzodiazepine medication, used to help reduce anxiety.

However:

- Staff were equipped with alarms and patients had access to a call bell;
- risk assessments and management plans were completed;
- there were systems in place to minimise contraband such as illegal drugs coming onto the wards;
- medicines were managed well and there were excellent self-medication practices;
- incidents were reported and learning points fed back from senior management to the ward;
- Mulberry ward identified incidents and good practice in an end of day debrief for the staff.

Summary of findings

Are services effective?

Requires improvement

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

- There was inconsistent recording of patients' physical observations. Staff could not give assurance that physical observations had been carried out as prescribed by the doctor;
- handovers observed did not include all staff coming onto the shift, we found staff starting without being informed of patient risks;
- ward staff knowledge of the Mental Capacity Act 2005 and its five statutory principles to assess capacity was poor.

However:

- Patients had up-to-date care plans that reflected use of the recovery star and were evaluated regularly;
- patients had access to psychological therapies and occupational therapy;
- staff were able to access training for their professional development. Staff received supervision and appraisal regularly;
- the multidisciplinary team worked well together;
- there was good use of the Mental Health Act 1983.

Are services caring?

Good

We rated caring as **good** because:

- staff interacted positively with the patients, were respectful, polite and provided emotional support. Staff were knowledgeable of patients' histories and risk issues, and planned care in conjunction with the patients;
- patients were positive about staff attitudes and felt supported;
- there was positive feedback from families and they felt included in patient care;
- advance decisions were in place where appropriate.

Are services responsive?

Requires improvement

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

- There were no separate quiet areas on the wards outside of the patients' own bedroom;
- Oakleaf ward was a thoroughfare for staff needing to access Mulberry ward;
- there was restricted access to outside space. In the case of Aspen House, the outside space could be seen from the road outside the hospital. Oakleaf ward's outside smoking space was enclosed in metal mesh fence panels with a metal mesh roof, this could be seen from outside the hospital;

Summary of findings

- there were blanket restrictions in place that applied to patients without individual risk assessment, for example, patients were required to ask for plastic spoons and polystyrene cups;
- there were no areas outside of a patient's bedroom to store possessions. Not all patients had keys to their room so that they could lock away their possessions securely ;
- staff did not always facilitate weekend activities.

However:

- Staff moved patients on clinical grounds (to a different ward or hospital) and only in normal working hours;
- activities were available in the occupational therapy department, and patients helped to run a tuck shop;
- the hospital dealt with complaints promptly.

Are services well-led?

Requires improvement

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

- The hospital had systems in place to assess ligature points so that they could provide a safe environment for the patients, not all patient-occupied areas were assessed for potential ligature points. As a result the arrangements to identify risks and deal with them appropriately were not operating effectively.
- safeguarding incidents had to go through the hospital management, ward staff felt they were not able to raise safeguarding alerts;
- the hospital did not use a tool to work out safe staff-to-patient ratios;
- staffing levels reduced at weekends, the staffing levels on the wards meant that there was not always a member of staff around for patients. We found that patients were left unattended in the annex due to the lack of staff availability.
- staff worked on the wards alone at times.

However:

- Staff felt supported by the management team, morale was good and sickness rates were low;
- there was good compliance with mandatory training, supervision and appraisals
- staff reported ward based incidents appropriately, learning was fed back to the ward.

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Long stay/ rehabilitation mental health wards for working-age adults	Requires improvement 	We rated Shrewsbury Court Independent Hospital as requires improvement because: - While the hospital had processes in place for assessing the ligature points on the wards (places to which patients intent on self-harm might tie something to strangle themselves), it had not identified all ligature points and did not have appropriate risk management plans in place; - blanket restrictions were in place across the hospital rather than restrictions based on individual patients' needs; - staffing levels meant there was not always a safe number of staff deployed on the wards. Staff often worked a shift alone and there was not always a qualified member of staff available. Patients were not always able to have escorted community leave due to the lack of staff; - we found staff had left patients locked in an area alone; - one of the clinic rooms was accessible through an open window; - individual staff members could not raise safeguarding alerts directly; they had to raise them with senior management first; - there was inconsistent recording of patients' physical observations and staff could not give assurance that physical observations were carried out as prescribed by the doctor; - knowledge of the Mental Capacity Act 2005 and its five statutory principles to assess capacity was poor; - there was restricted access to outside space. In the case of Aspen House, this was viewable from the road outside the hospital. Oakleaf ward's outside smoking space was enclosed in metal mesh fence panels with a metal mesh roof. However: - Staff interacted positively with the patients, were respectful, polite and provided emotional support .Staff were knowledgeable of patients' histories and risk levels. Staff planned care in conjunction with the patients, patients were positive about staff attitudes and felt supported;

Summary of findings

- there was positive feedback from families and they felt included in patient care
- advance decisions were in place where appropriate;
- there was excellent management of medicines and some excellent practice of self-administration of medicines;
- patients had access to occupational therapy and psychological therapies;
- there was regular supervision and appraisal for staff and there was good compliance with mandatory training.

Requires improvement

Shrewsbury Court Independent Hospital

Detailed findings

Services we looked at:

Long stay / rehabilitation wards for working age adults

Detailed findings

Contents

Our inspection team

Team leader: David Harvey

The team was comprised of two inspectors, one inspection manager, one specialist adviser, one pharmacist inspector, two Mental Health Act reviewers and one expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example, as a carer.

There were two new CQC members of staff shadowing the 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?

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 six wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 13 patients who were using the service;
- spoke with the team leaders of the wards;
- spoke with 16 members of staff including registered nurses, support workers, consultant psychiatrists, an occupational therapist, pharmacist and consultant psychologist;
- interviewed the registered manager with responsibility for the service;
- interviewed the clinical services manager;
- interviewed the Mental Health Act administrator;
- collected feedback from patients, families and stakeholders using comment cards;
- looked at the treatment records of patients;
- carried out a specific check of the medication management on all six wards;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- observed two clinical team meetings;
- observed two shift-to-shift handovers;
- observed the multidisciplinary team handover;
- completed a Mental Health Act records review on all detained patients.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Long stay/rehabilitation mental health wards for working age adults

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

Information about the service

Shrewsbury Court Independent Hospital is a 50-bed independent rehabilitation hospital based in Redhill in Surrey. The hospital provides assessment, care, treatment and rehabilitation for patients with enduring mental illness. These patients may or may not be detained under the Mental Health Act 1983.

The hospital offers care and treatment for both male and female patients in a locked environment. The hospital does not use seclusion in its care practice. Seclusion refers to the supervised confinement and isolation of a patient, away from other patients.

The hospital consists of six different care areas:

- Lavender Place is a seven-bed locked assessment ward for working age females, there was an annexe with an extra four beds off of the main ward.
- Aspen House is a 13-bed locked slow stream recovery and rehabilitation ward for males with enduring mental health problems.
- Maple ward is a nine-bed open intensive rehabilitation ward for adult males recovering from enduring mental illness.
- Oakleaf ward is a nine-bed locked assessment ward for working age males.
- Fern cottage is adjacent to the main hospital building and is a three-bed house for patients who are more independent and have successfully completed a period of treatment and rehabilitation within Shrewsbury Court.
- Mulberry ward is a five-bed slow stream open ward for women.

Shrewsbury Court Independent Hospital registered with the CQC in September 2012. We have inspected the hospital once previously in August 2013. We deemed the hospital compliant against the previous inspection methodology. We did not inspect the hospital on all outcomes at that time.

Regulated Activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Registered manager - Joseph Nkonde

Long stay/rehabilitation mental health wards for working age adults

Summary of findings

We rated Shrewsbury Court Independent Hospital as **requires improvement** because:

- While the hospital had processes in place for assessing the ligature points on the wards (places to which patients intent on self-harm might tie something to strangle themselves), it had not identified all ligature points and did not have appropriate risk management plans in place;
- blanket restrictions were in place across the hospital rather than restrictions based on individual patients' needs;
- staffing levels meant there was not always a safe number of staff deployed on the wards. Staff often worked a shift alone and there was not always a qualified member of staff available. Patients were not always able to have escorted community leave due to the lack of staff;
- we found staff had left patients locked in an area alone;
- one of the clinic rooms was accessible through an open window;
- individual staff members could not raise safeguarding alerts directly; they had to raise them with senior management first;
- there was inconsistent recording of patients' physical observations and staff could not give assurance that physical observations were carried out as prescribed by the doctor;
- knowledge of the Mental Capacity Act 2005 and its five statutory principles to assess capacity was poor;
- there was restricted access to outside space. In the case of Aspen House, this was viewable from the road outside the hospital. Oakleaf ward's outside smoking space was enclosed in metal mesh fence panels with a metal mesh roof.

However:

- Staff interacted positively with the patients, were respectful, polite and provided emotional support .Staff were knowledgeable of patients' histories and risk levels. Staff planned care in conjunction with the patients, patients were positive about staff attitudes and felt supported;
- there was positive feedback from families and they felt included in patient care
- advance decisions were in place where appropriate;
- there was excellent management of medicines and some excellent practice of self-administration of medicines;
- patients had access to occupational therapy and psychological therapies;
- there was regular supervision and appraisal for staff and there was good compliance with mandatory training.

Long stay/rehabilitation mental health wards for working age adults

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

Inadequate

Safe and clean environment

- Aspen House was set out in a cross shape with bedrooms positioned off the main corridor and off the lounge. There was CCTV to monitor unstaffed areas. Lavender Place had a corner mirror to observe an unstaffed area.
- Two bedrooms on Aspen House had an ensuite bathroom. There were two toilets on the ward for the rest of the patients to use. Staff locked one of the toilets. At the time of the inspection staff had to escort patients to the shower on Oakleaf Ward due to construction work taking place. Maple ward had two showers and one toilet to share between nine patients.
- The toilets on Mulberry ward were locked. This meant that the patients did not have free access. This was a blanket restriction across the ward and not associated with individual patient risk.
- Staff carried out an assessment of ligature risks on each ward, the assessments concentrated on patients' bedrooms. We found outside spaces were not assessed for ligature risks. There was limited assessment of ligature points in communal areas.
- On Aspen House, we found that there were ligature risks in the garden that had not been included in the assessment. The ligature assessment stated "no action" for risks that were identified on the ward. It did not identify that the toilets in the corridor had ligature risks despite the exposed pipes and wires underneath the sink, taps and a pull cord for the light. There were no identified ligature risks in the lounge/dining room area on the assessment.
- Of the three members of staff we interviewed on Aspen House, none were able to identify ligature points on the ward. Staff were not aware of ligature points. We interviewed three staff members and heard that only one was aware of a patient at risk of self-harm by ligature on the ward.
- A monthly environmental risk assessment on Maple ward had identified the taps as ligature points each month since February 2015 and, each month, had asked for them to be changed, but no action had taken place.
- Mulberry ward checked the environment for ligature points daily. We reviewed the ligature assessment and found it incorrectly identified boxes and baskets on the floor as ligature points. The bath on Mulberry ward had grab rails that were ligature points. These were not included in their ligature assessment.
- All patients in the hospital used the garden outside Mulberry ward. There was no ligature assessment of this area and we found that trees, a water feature, benches, window restrictors and railings were all ligature risks. A set of white doors led to the boiler room under the hospital. Here, there were pipes on the ceiling, bricks and a tank. The keys in the lock meant we were able easily to enter this area from the garden.
- On Lavender Place, the observation mirror was a ligature risk. Staff did not include this in their assessment. Exposed wires in the garden area of Lavender Place were ligature risks. A staff member on Lavender Place was not able to tell us what a ligature point was.
- There were ligature points in the Oakleaf assisted bathroom. The assessment did not identify the taps, exposed pipes, radiator and shower fixings.
- Staff were able to tell us where the ligature cutters were stored. For Aspen House these were stored in the clinic room off the ward. This could lead to a life-threatening delay in an emergency.
- Wards were single sex and each patient had their own bedroom. Oakleaf ward was the only area with full en suite facilities.
- Oakleaf, Maple and Mulberry wards appeared clean and well maintained. The corridors were clutter free. There was a cleaner visible on the wards each day.
- Aspen House appeared tired and in need of decoration. There was paint peeling off the walls and the handrail was not secure down the main corridor. The low level of the ceiling and the lighting made areas of the ward feel enclosed and dark. There was only room for six patients to sit around the television in the lounge and two spaces

by the dining area television. Lavender Place appeared tired with paint peeling off the walls in some areas. The communal area of Lavender Place appeared clean and well maintained.

- Staff were supposed to undertake environmental assessments monthly. The last environmental risk assessment for Aspen house was complete in April 2015.
- Staff had emergency alarms. There were alarm identification points on the wall for staff to identify the location in the hospital an emergency was happening. Each ward allocated one member of staff to respond to an alarm if raised.
- Patients' bedrooms and bathrooms had call points in order for them to call staff if needed.
- The bathroom on Mulberry ward had a call point on the wall. We were concerned this was not sufficiently close to the bath for the patients to use if they needed to call for assistance.
- The office on Lavender Place had a stable door, which was open at all times. We found it to be open when staff were not present. Inside the office the ward security cupboard, which contained risk items such as lighters, was unlocked. This gave opportunity for patients to lean through and obtain items that compromised patient safety. This also meant that there was little dignity and privacy when staff were speaking about patients in the office. The patient board, which contained confidential patient information, was in view.

Safe staffing

- There were inconsistent staffing levels on the wards. Aspen House had staffing levels set at four in the day and two at night. We found that often there were only three members of staff on a full shift and one member of staff working 9am to 5pm as opposed to the full shift. This was the case during the inspection when reviewing rotas and speaking with staff. Senior management told us that staffing levels were set by budget considerations and not by a staffing level tool. However we found extra staff were brought in according to risk. We saw that the staff to patient ratio increased according to observation levels.

- During our visit to Lavender Place, we found that staff had left the patients unattended. The patients reported that this often occurred. Staff were not around to support the patients' mental and physical needs and in the event of an emergency they would not have been able to assist the patients. For example, if there was a fire. Lavender Place had a separate area for four patients in an annex on the first floor of the building. One staff member occupied this area each shift. On three occasions during our visit, we found the annex was unstaffed. On one occasion we found that observations were not completed. The ligature assessment for the annex indicated that an additional control measure for this area was for staff to supervise the area at all times.

- There were no ward managers on the wards. Team leaders were included in the staffing numbers so were required to lead shifts as well as run the ward.
- Bank staff were familiar with the wards. The hospital tried only to use agency staff familiar with the wards but this was sometimes not possible. Lavender Place had a high reliance on agency staff due to increased observations.
- Temporary staff who had not worked in the hospital before had a brief induction to the ward. This included orientation to the layout of the ward, fire points and observation levels. Maple Ward recorded the orientation. Aspen House reported that there was no record kept of such inductions.
- Staff often worked alone at break times. Mulberry ward had occasions when there was only one member of staff working on the ward for the whole shift. There were times when there was no registered nurse on a shift. Mulberry ward staff often worked on other wards to cover when there were staffing shortages. This meant increased duties for the staff member left alone on Mulberry ward because the patients were reliant on staff for money, personal care and there were often disagreements between patients that could escalate if not addressed. Staff told us that one patient posed a fire setting risk on the ward and staff were concerned the risk could not be mitigated with only one person on the ward.
- Staff interviewed stated that patients could have one-to-one time with their named nurse when they were on shift.
- Patients said that at times they were not able to go on escorted leave due to the staffing numbers. Staffing levels at the weekend reduced so it became very difficult to facilitate escorted leave. Ward staff provided those activities facilitated by the occupational therapy department on weekdays, at the weekends.

Long stay/rehabilitation mental health wards for working age adults

- An allocated staff member responded to emergency alarms. In the event of an alarm, there would be a member of staff leaving each ward. At the weekend when there were reduced staffing levels on duty on each ward, this would leave staff members in a vulnerable position with less staff around.
- Medical cover for the hospital was provided by sessional consultants, all patients were allocated a sessional psychiatrist for the duration of their stay. At the time of the inspection the hospital did not have a dedicated consultant to oversee the care of patients. The hospital did have a part-time medical director in post who did not provide medical care directly to patients.

Assessing and managing risk to patients and staff

- Staff assessed patient risk prior to admission to the assessment wards. Information gathered prior to admission helped form their assessment. Previous incidents recorded in the patients' records helped inform the risk management plans. However, two qualified staff on Lavender Place were not able to say if there was a risk assessment completed and stated that they had not seen them.
- Staff put measures in place when they identified particular risks. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments that we reviewed took account of patients' previous history, as well as their current mental state.
- Staff trained to use the historical clinical risk management-20 (HCR-20) assessment to assess the risk of violence. Staff on Maple ward assessed and managed violence risk using the HCR-20 assessment. For patients who did not pose a risk of violence, staff used Shrewsbury Court's own template for risk assessment. We found that this was complete across the board.
- Staff logged incidents in the patients file. Incidents on the ward helped create the risk management plans. For example, risk management plans were in place following incidents where patients smoked in their rooms and posed a fire risk.
- We found blanket restrictions were used on some wards in the hospital and were not adapted according to individual patient need. Patients on Lavender Place used polystyrene cups and plastic spoons to eat their cereal, as there were no bowls kept on the ward. Patients had to buy their own bowl to eat cereal from. Access to toilets was restricted on Aspen House and Mulberry ward due to locked doors. Staff at Aspen House said they did not lock the toilets routinely. However, the toilets were locked when we made further visits to the ward. Mulberry Ward, Aspen house and Oakleaf wards all locked food away. Staff locked outside space so patients were required to request to use the garden.
- Smoking times were restricted to two hourly for Aspen and Maple wards because they shared a garden. On Oakleaf, ward smoking times were hourly. Patients on Lavender Place had free access to their garden and could smoke throughout the day.
- Informal patients were able to leave the ward when they wanted. There was information about informal patients' rights displayed on the ward notice boards in the ward corridors.
- Staff told us that patients' observation levels changed according to risk. The patients' records confirmed this. However, we observed poor practice in care planning observations for a patient on two-to-one observations. Inspection staff asked to see a care plan on how to manage someone on these observations but staff were not able to produce it. Staff members walked away from the patient who was on two-to-one observation levels leaving one member of staff with the patient. Two-to-one observations require two staff members to be within arms-reach of a patient at all times.
- Staff searched and scanned patients using a metal detector following unescorted leave. This minimised the risk of contraband items coming onto the ward.
- Prior to the inspection, we found that there had been three incidents of physical restraint in the six months prior to inspection. Staff used verbal de-escalation techniques to manage incidents of aggression. They rarely used restraint. Verbal de-escalation prompts were on display in the offices of Oakleaf and Maple ward. However, when reviewing incident reports there was often not a clear indication of whether restraint had been used or not. We found that there were incidents that had been logged as a patient being 'escorted' to their bedroom or away from an incident. It was unclear

whether the patient was restrained whilst escorted to their bedroom or away from an incident. We were therefore not assured that incidents of restraint were being recorded effectively.

- Staff received two-yearly safeguarding of vulnerable adults e learning as part of their mandatory training package.
- We found safeguarding referrals were discussed within the multidisciplinary team (MDT) before a safeguarding alert was agreed and sent by the safeguarding lead for the hospital. The hospital managers informed us that the role of the MDT in the safeguarding process was to promote disclosure and reporting of safeguarding issues through identifying any events, occurrences and concerns that might not have been reported by individual practitioners, and ensuring that these were reported.
- Consistently across all wards, staff told us that the power to make referrals for safeguarding was out of their hands and that they must go through the MDT meeting first and through the safeguarding lead. Staff were not clear on the correct local authority for their safeguarding referrals. They were not clear on what constituted a referral to safeguarding. There was limited knowledge and understanding of the safeguarding process amongst the ward staff.
- Staff provided patients with appropriate information about their medicines. The pharmacist and ward staff discussed changes to patients' medicines, and mental health medicines information leaflets were available for patients. Most patients we spoke with confirmed they had received information about medicines and knew what they were for.
- During our inspection, we looked at the systems in place for managing medicines, spoke to staff involved in the administration of medicines and examined 31 medicine charts.
- An external contractor who provided a pharmacist visit once a week also provided medicines. The pharmacist conducted audits and we saw evidence of a monthly correspondence from the pharmacy contractor in the form of a newsletter to keep staff up to date. The pharmacist indicated on prescription charts, which people were on high dose antipsychotics to aid with monitoring.
- Medicines were stored safely and securely including those that required extra controls because of their potential for abuse (controlled drugs). All medicines were within date and most items for individual patients' use were appropriately labelled with the patient's name. However, Aspen house and Maple ward shared a clinic room in the communal corridor. We found that when the clinic room got too hot the staff were required to open the window to bring it down to 25 degrees celsius or below. The window opened onto a flat roof that was accessible from a window on a patient-occupied corridor. Staff in this corridor did not observe patients routinely so there was a risk that a patient could access the clinic room. We found the clinic room door was open on one occasion with no member of staff present. Patients could therefore have been able to access the emergency medication and risk items such as needles. We brought this issue to the attention of the registered manager immediately.
- Medication records contained the patient's photo for identification when staff administered the medication and the patients' allergy status was always available. There were no gaps in administration records.
- When 'as required' medicines were prescribed there were clear instructions recorded regarding the reason for the prescription and the maximum dose.
- Records were made of medicine refrigerator and clinic room temperatures on a daily basis and most of these were all within the expected temperature ranges. Staff took appropriate action when the temperature fell out of the required range.
- Emergency medications such as oxygen were available throughout the hospital and there were adrenaline pens within the hospital for use in an emergency. One location labelled as having an adrenaline pen available but it had previously been disposed of and not replaced although others were available within the hospital. There was no flumazenil available within the hospital for use in an emergency as indicated by the hospital's rapid tranquilisation policy. There was no intravenous fluid available for use by first responders.
- We checked consent to treatment forms (T2) for people. Current practice within the hospital stated that staff checked them at each shift handover; some forms had not been reviewed for the last two years. There was evidence that the visiting pharmacist had highlighted issues with the consent forms to hospital staff.

Long stay/rehabilitation mental health wards for working age adults

- There was a comprehensive medicine policy and reference books for medicines information were available, however some books that were in use were out of date and therefore we could not ascertain that the most up to date information was always used.
- Staff reported medication errors. However, the pharmacist was not routinely involved in this process. The pharmacist provided training for staff on medicine issues regularly.
- Maple ward had a self-medication policy for all patients on the ward. Own medicines were kept in a locked cupboard in patients' bedrooms. Information of which medicines to take and at what time to take them was displayed on the outside of the cupboards. Patients asked staff for their medicines at the appropriate time. The qualified nurse held the keys for the cupboards and supported patients with the administration. We felt this was an example of good practice.
- Patients at risk of falls had this risk documented in their care plans. However, there was no documented evidence that a formal falls assessment had taken place.
- Children were not allowed to visit the wards. The occupational therapy area was the designated area for visitors where there were private rooms available.

Track record on safety

- The hospital did not have any adverse events to investigate at the time of the inspection. Information provided prior to the inspection revealed there had been six serious incidents between July 2014 and May 2015. The hospital had dealt with these appropriately.

Reporting incidents and learning from when things go wrong

- Staff we spoke with on all wards knew how to recognise and report incidents on the electronic incident recording system. The clinical services manager maintained oversight of all incidents and reviewed them with the MDT.
- A fortnightly incident review meeting took place to review incidents across the wards. Learning points from these were cascaded back down to ward level. We found these kept in a folder for staff to read and sign off when this had occurred.
- Debrief was used for patients and staff following an incident, this was included as a learning point for staff following the incident review meeting. Mulberry ward identified incidents and good practice in an end of day debrief for the staff.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Staff individually assessed patients' needs and created care plans from this assessment. Wards used the recovery star to provide nursing staff with information to formulate recovery focused care plans. Patients completed the recovery star to rate strengths and weaknesses to identify the support and treatment needed to enhance recovery. Patient's recovery stars were updated regularly. Staff recorded review dates for the recovery star and displayed them in the ward office as a reminder.
- Data received prior to the inspection showed that 67% patients had received a physical health check on admission to the hospital. Patients without a physical health check were found to have refused and this was documented in the notes.
- Patients with physical health issues had associated care plans. These identified the physical health need, contained objectives, a "what I will do" and "what the staff will do" section. However, we found that there was inconsistent recording of patients' vital signs across the wards. Staff did not routinely record the results of daily physical observations in a patient's notes. Therefore, there was no guarantee that these were being completed.
- Care plans in place reflected outcomes from the recovery star. The care plans each had a section with the staff approach to care and with what the patient was expected to do to make the care plan work. We found

that these contained patients' views. However on Lavender ward, the care plans were the same for each patient. This implied that staff had not considered individual patient need in the care planning process.

- Patients had an individual activity plan stored in their notes. We found that these were largely the same and based on the occupational therapy activities provided rather than individual recovery goals.
- Care records were held securely in electronic format on the record system Amigos. The hospital admin team scanned paper records into the system before destroying the originals.

Best practice in treatment and care

- Patients were able to access psychological therapies individually and with their families. An audit completed by one of the consultant psychologists showed that family psychological sessions were useful for the patients.
- The hospital employed a practice nurse who undertook yearly physical health checks for the patients. Instances where a physical health check had been refused by patients were well documented and stored securely in their notes. There was a ward doctor available in normal working hours.
- All wards used health of the nation outcome scales to record severity and outcomes. Staff recorded this on admission and then these were to be reviewed in the clinical team meeting intermittently. However, when reviewing records we found that staff were not routinely reviewing these.
- Staff evaluated care plans regularly. The dates for care plan evaluations were kept on the board in the offices of the wards. Care plan evaluation sheets were signed and scanned onto the electronic record system by the admin team. Staff recorded refusals to sign the care plan evaluation.

Skilled staff to deliver care

- The staff working on the wards came from a range of professional backgrounds including nursing, medical, occupational therapy, psychology and social work. An independent pharmacist visited the ward weekly.
- Staff told us they had undertaken training relevant to their role, including safeguarding children and adults, fire safety, life support techniques and the use of physical interventions. Records showed that most staff were up-to-date with statutory and mandatory training.
- Staff told us that they were able to access further training relevant to their role such as phlebotomy, electrocardiogram and historical clinical risk management-20. Staff told us that some support workers did medication training. Some staff had received training in professional boundaries, legal highs, oxygen management and root cause analysis. The care certificate course was available to support workers.
- There were several patients in the hospital with a dual diagnosis of mental illness and substance misuse. Staff had not received training in dual diagnosis. There were plans to have dual diagnosis training in the future.
- Staff received management and clinical supervision six weekly in order for them to talk through any issues they had on the ward, to review and reflect on their practice and the care of the patients. Staff had yearly appraisals. Information received prior to the inspection showed appraisal rates as 75%. Reasons for not having done appraisals were that there were staff on maternity leave and new staff that were not yet due an appraisal.
- There were regular team meetings across the wards; team leaders filed minutes for these meetings in the office for staff to access.
- The hospital addressed poor staff performance in qualified and unqualified staff. In the previous year, the hospital had terminated the contracts of five staff members because they had not met hospital standards in their induction period.

Multi-disciplinary and inter-agency team work

- Clinical team meetings were held monthly for each patient. The consultant psychiatrist, consultant psychologist, associate specialist, occupational therapist and staff nurse attended with the patient.
- We observed two clinical team meetings and found the staff communicated well with the patients, had a caring attitude and the staff involved families in the treatment.

The patients were included in discussion around medication, changing section 17 leave and discussed a discharge plan. Outcomes of the clinical team meeting were shared with community teams.

- We observed two handovers on Aspen House and on Lavender Place. The handover included patients' behaviour and mental state. They included discussion of any appointments off the ward and any physical issues they needed to follow up. We found that the shift-to-shift handover on Aspen House did not include all staff coming onto the shift and there was an instance where a support worker missed the handover. There was no further full handover provided for this staff member when they came onto the shift.
- Every morning there was an MDT meeting with team leaders from all wards, clinical services manager, occupational therapists, psychologists, psychiatrists and social workers. The purpose of the meeting was to share high-level issues on the wards across the hospital. The meeting appeared structured and involved discussion within the MDT about how to improve the care of the patients, how they were going to structure the day and fund trips and appointments.

Adherence to the MHA and the MHA Code of Practice

- Staff told us they had received training on the Mental Health Act (MHA) and the associated code of practice.
- The use of the MHA was good in the inpatient wards. The documentation we reviewed in detained patients' files was generally compliant with the Mental Health Act and the code of practice.
- Capacity assessments were completed on admission and reviewed intermittently by the responsible clinician. Capacity assessments were completed thoroughly. If a patient did not consent to treatment or did not have capacity to consent to treatment, then the capacity assessment and a form T3 (certificate of second opinion) were completed. The T3 form was attached to the patient's medication card.
- Patients were informed of their section 132 rights on admission and every three months. Staff told us that they did not routinely re-inform patients of their rights when aspects of their treatment, such as medication, changed. The ward nursing offices contained an information board that had the date each patient was due to be re-informed of their section 132 rights in order to remind staff.
- Administrative support was available from the Mental Health Act administrator in the hospital. The wards relied heavily on the administrator for scrutiny of the section papers and dates of renewal of sections and rights.
- Section 17 leave forms were not filled in according to the code of practice. We found that the forms were not filled in clearly and that there was not clarity around the meaning of escorted leave.
- Patients were able to access an Independent Mental Health Advocate (IMHA) every Thursday. The role of the IMHA was clearly displayed on the wards and on Mulberry ward; it was displayed in an easy read format.

Good practice in applying the MCA

- We interviewed staff and asked them about their understanding of the Mental Capacity Act 2005 (MCA), particularly the five statutory principles to assess whether someone has capacity to make a decision. We found staff had received training in the MCA, but only one member of staff across the whole hospital was able to recite the five statutory principles.
- Shrewsbury Court Independent Hospital had a policy for implementation of the MCA and Deprivation of Liberty Safeguards (DoLS). Staff were aware of the policy.
- We found capacity assessments on consent to treatment. We found DoLS assessments for two patients staying in the hospital, this was to assess their capacity to stay on the ward informally.
- Staff considered patients not to have capacity when they refused to engage with the capacity assessment. This meant that staff might have wrongly assumed patients lacked capacity.
- A patient who had refused to take an essential medication for the management of their physical condition had not had their capacity assessed around this decision. Therefore, staff were not able to ensure the provision of appropriate care and treatment for this patient based on a specific treatment issue.

Long stay/rehabilitation mental health wards for working age adults

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

Good

Kindness, dignity, respect and support

- We observed staff interact positively with the patients on each ward. Staff were respectful, polite and interacted with them to provide emotional support, practical support such as getting food and drinks, and going out to the shops for those that were not able.
- We spoke to staff about the care of the patients and they were knowledgeable of patient risk and of the history of the patients on their ward. Staff spoke of the patients in a respectful manner and, overall, were aware of individual patients' needs. However, two members of staff on Aspen House were not aware of the ligature risk posed by one of their patients.
- Most patients reported that they felt safe on the wards and that staff were friendly and worked hard for them. They were positive about staff attitudes and felt supported. We were told by patients that staff were respectful and worked well together, they knocked before going into bedrooms and that they were caring. However, patients told us that staff were very busy and staff were "run off their feet".
- Some patients complained that the toilets on the ward were often dirty. We heard that a patient was unhappy coming back from the shower wrapped in a towel when there were staff members of the opposite sex on the ward. Staff were not always around to let patients into the occupational therapy area.
- Some patients had keys to their bedrooms so that they could lock their possessions away; however, we heard that there was nowhere else to store their possessions safely. Patients told us that there had been an instance where money had gone missing and another patient had their mobile phone go missing.

The involvement of people in the care they receive

- Staff allocated a primary nurse to the patient on admission. Staff orientated patients to the ward through a tour and allocated a bedroom. There were patient information leaflets about the ward, which informed the patients of meal times, medication times and of the running of the ward's activities and clinical team meeting. We found that some patients were given information specific to their mental illness, which included what treatments were beneficial to them.
- Care planning was done in conjunction with the patient and there were clearly patients' own views included on the care plans we reviewed. For patients who were not willing or able to be involved in the care planning process we found that this was documented. For example when a patient refused to sign the care plan.
- Maple ward admitted patients as the final part of their care pathway through the hospital. The ward required patients to cook their own meals each day. Patients received money for individual items and to put towards general items such as bread and milk to keep the ward stocked for the week.
- Patients were able to access advocacy once weekly on a Thursday. While information regarding the advocacy service was clearly displayed in the wards, some patients were not sure how to access the advocate and told us staff had not offered advocacy support.
- We received feedback from families during the visit through the comment cards and letters. The feedback from families was unanimously positive with one family saying that the improvement they had seen was profoundly better than they had seen in previous services.
- Clinical team meetings highlighted to inspection staff that families were included. Family therapy was available if required.
- Nursing staff on the wards conducted community meetings weekly. Minutes were taken and actions were fed back to the senior management team for consideration. Mulberry ward kept minutes in the patient lounge. However, we found that other wards filed them in the office. Staff fed back actions to the patients in the following meetings rather than on the notice boards in the communal areas.
- Twenty five of the patients had completed a patient survey across the hospital; however, the results were not available during our inspection.
- We heard from patients that they felt comfortable to tell staff if they were not happy with something to do with their care.
- We found patients with advanced decisions in place. For example, some advance decisions stated which medication the patients would like to be treated with

Long stay/rehabilitation mental health wards for working age adults

should their mental health deteriorate again. We found that when advance decisions could not be made due to patient refusal to participate in the process, this was documented as such and that an attempt had been made.

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

Requires improvement

Access and discharge

- Average bed occupancy for the hospital was 96%.
- Staff kept patients beds open for them when they were on leave; as a result, they were able to access their bed at any point while on leave.
- Patients did not move wards unless it was justified on clinical grounds. A patient on Mulberry ward had previously relapsed and required more security on Lavender Place for a short period; staff transferred the patient back to Mulberry ward when appropriate. A patient we spoke with had been transferred from Maple ward to Aspen House due to deterioration in his mental health. If patients could not be managed inside Shrewsbury Court then staff arranged transfer to another hospital appropriate to their needs.
- The hospital admitted patients during normal working hours Monday to Friday. Patients were always made aware of a move between wards or outside of the hospital.
- The hospital reported prior to the inspection that there were three delayed discharges in the preceding six months. There was no information submitted about reasons or which wards they occurred on. However, there was a clear pathway for patients admitted to the hospital and discharge was planned. Patients moved through the hospital wards according to risk and were able to increase their level of independence as they progressed.

The facilities promote recovery, comfort, dignity and confidentiality

- The occupational therapy department situated on the first floor of the hospital facilitated activities. In the department, there was provision to supply supported cooking sessions, individual and group therapy rooms, a gym, art room, tuck shop and a pool room.
- We found that on Lavender ward, Aspen House, Mulberry and Maple wards there were no individual quiet areas outside of the patients' bedrooms.
- Access to Mulberry ward was through Oakleaf ward, which therefore became a thoroughfare for hospital staff.
- Each ward had access to a clinic room; however, there was no examination couch in the clinic room shared by Aspen House and Maple ward.
- Psychologists held their appointments in the occupational therapy area of the hospital.
- Patients were able to meet visitors in one of the rooms in the occupational therapy area.
- Patients had their own mobile phones on the ward. There was a pay phone in the main corridor by the occupational therapy area, which was broken. Maintenance were yet to repair the phone despite staff reporting it to them many weeks previous.
- Patients on Lavender Place had unrestricted access to outside space where they could smoke. Staff at Aspen House had to escort patients into the garden outside of smoking times. Maple and Aspen shared the garden due to construction work. This outside space could be seen from the road outside the hospital so did not protect patients' privacy and dignity. Fern Cottage had its own garden for the patients to access. The whole hospital used the garden outside Mulberry Ward.
- Oakleaf ward had no outside space other than an enclosed metal mesh area akin to a cage which patients used as a smoking area; this was visible from the road outside the hospital and therefore had an impact on patient dignity and privacy.
- Patients gave mixed reports of the food. The menus appeared varied with a selection of food each day. The menu was on a rolling four-week rota. The chef visited the wards weekly to gain feedback on the quality of the food. Patients were allowed to order takeaway food if they wished

Long stay/rehabilitation mental health wards for working age adults

- Hot drinks were available to patients. There were no snacks visible on Aspen House. Patients on Oakleaf ward and Lavender Place were required to ask for spoons and polystyrene cups, and there were no available bowls for cereal.
- Patients staffed the tuck shop in the occupational therapy area. Patients volunteered to help the running of the tuck shop, which sold, crisps, sweets, noodles and other snacks. There was free fruit available at the tuck shop.
- We saw very little personalisation of bedrooms around the hospital, however, there was evidence on Mulberry ward that patients were allowed to personalise their bedrooms.
- Patients had keys to their bedrooms. We heard from staff that all patients had keys; however, some patients said that they did not have keys. There were no areas on the wards outside of their bedrooms where patients could store their possessions securely.
- Activities were available throughout the week. Patients had an individual activity timetable based on the activities and psychological therapies available in the OT department. However, there was very little activity provided at weekends, nursing staff had to provide weekend activities. Staff did not always facilitate weekend activities due to the issues with staffing levels.
- Occupational therapists facilitated a planning meeting on each ward in order to communicate the day's activity schedule.

Meeting the needs of all people who use the service

- Oakleaf ward had an assisted bathroom and there were disabled adaptations to the bath on Mulberry ward. There were no disabled adaptations to patients' bedrooms. A lift was available for patients with mobility issues to use.
- Patient information on how to complain was kept on the wards with the leaflets. There were complaint sheets for patients to fill in and give to staff. Ward information leaflets were available.
- Information on medication was available from staff upon request. Communal areas had healthy eating information displayed clearly.
- Staff were able to access an interpreter if needed.
- The hospital planned for patients admitted with particular dietary preferences. For example, stocking halal and kosher meat.
- Faith representatives did not visit the hospital routinely. However, information was available to staff if a patient wanted to access spiritual support.

Listening to and learning from concerns and complaints

- Wards dealt with complaints; however, there was no evidence of these kept on the ward so we were not able to see improvements made because of the complaints.
- Patients we spoke with stated that they would address issues with staff before they escalated so there was no need to make a formal complaint.
- Shrewsbury Court Independent Hospital provided information prior to inspection regarding the number of formal complaints. There were 12 formal complaints in the 12 months leading up to the inspection. None of the complaints were upheld.

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

Requires improvement

Vision and values

- Staff we spoke with had no sense that the organisation had prescribed values for them. They did, however, consistently say that they were there to deliver excellent care for the patients.
- We spoke with staff who said they felt supported by the hospital's senior managers. They regularly visited the wards and there was an open door policy. We heard that the senior managers were contactable by phone almost any time of the day.

Good governance

- Wards did not have ward managers, the team leaders for the wards were included in the staffing numbers so worked a mixture of days and nights. As a result, this did not free up time for a leader to work on the running of the ward.
- While the hospital had systems in place to assess ligature points so that they could provide a safe

environment for the patients, not all patient-occupied areas were assessed for potential ligature points. As a result the arrangements to identify risks and deal with them appropriately were not operating effectively.

- Mandatory training across the hospital was good and reached their target of 85%.
- Hospital targets of six weekly supervision were met across the wards. Staff were given both clinical and managerial supervision.
- The hospital did not use a tool to work out their staffing to provide a safe ratio of qualified and unqualified staff. We found that there was staff left alone on Mulberry ward. Lavender Place had a high reliance on agency staff. Staff left patients unattended in the annex. Staffing levels at the weekend were reduced. There was reliance on nursing staff to provide ward-based activities and for them to take patients out on escorted leave. This meant that there were occasions when one member of staff was left on the wards for up to nine patients.
- Staff regularly evaluated care plans with the patients, however, there was little in the way of clinical auditing on the wards to measure their effectiveness.
- Staff reported incidents appropriately using the electronic care records. We found that the reporting to safeguarding was taken away from the ward nurses and went through the MDT. Safeguarding should be the responsibility of every member of staff but staff at Shrewsbury Court Independent Hospital were not empowered to refer incidents to safeguarding. We found that there were very few safeguarding referrals. Staff received feedback from incidents through the incident review meeting.

Leadership, morale and staff engagement

- Sickness rates were very low for the hospital at 2%. The hospital did pay staff that were off sick. Staff told us that staff members came into work unwell as a result.
- We heard from staff that due to the presence of the senior management on the wards and their open door policy they felt safe to raise issues.
- There were no current whistleblowing cases. There were no bullying and harassment issues highlighted by staff.
- Staff we spoke with felt good about their job, they stated that seeing the patients getting better was fulfilling for them.
- The teams consisted of a variety of qualified and unqualified staff from a range of disciplines.
- Monthly team meetings allowed staff to discuss issues on the wards and give feedback about the service. The morning MDT meeting provided staff daily contact with the senior managers to highlight issues and feedback.

Commitment to quality improvement and innovation

- The hospital was not signed up to any national improvement programmes such as Accreditation of Inpatient Mental Health Services.

Outstanding practice and areas for improvement

Outstanding practice

- Maple ward had a self-medication policy for all patients on the ward. Staff locked the patient's medicines in a cabinet, which was secured to a wall in the patient's bedroom. Information about which medicines to take and at what time to take them was displayed on the outside of the cupboards. Patients asked staff for their medicines at the appropriate time. The qualified nurse held the keys for the cupboards and supported patients with the administration. We felt this was an excellent system of self-administration, using prompts to enable people to be independent with medication while remaining safe.
- We found patients with advance decisions in place. For example, staff supported patients to decide which medicine they would like to in the event of a relapse. Some patients refused advance decision so therefore staff documented the attempts.

Areas for improvement

Action the hospital MUST take to improve

- Ensure sufficient numbers of staff are deployed on the wards and ensure that patients are not left unattended. Staff left patients alone on the wards. Staff worked whole shifts alone.
- Ensure all ligature points in the hospital are identified and risks mitigated. We found the ligature assessments on the ward did not include all ligature points. There was no identification or mitigation of ligature risks in the outside spaces of the hospital.
- Ensure clinic rooms are secure at all times and not accessible by patients. We found a clinic room was accessible from a patient-occupied corridor.
- Ensure restrictions are related to individual patient risk. We found blanket restrictions were in place across the hospital.
- Ensure that patients are treated with dignity, we found that there was not free access to food. Patients had to drink from a polystyrene cup. Patients could be seen from the road by members of the public when in the smoking areas of two of the wards.
- Ensure flumazenil is available. Flumazenil counteracts the effects of benzodiazepine medication, used to help reduce anxiety.

Action the hospital SHOULD take to improve

- Ensure physical observations are recorded in the appropriate area of patient records so results are easily accessible to the team. We found there was inconsistency in the recording of physical observations, which meant staff could not evidence they were being completed at the prescribed intervals.
- ensure all staff are empowered to make safeguarding referrals and are aware of the local safeguarding authorities.
- ensure staff understand how to use the Mental Capacity Act 2005. We found knowledge of statutory principles was very poor despite training being provided.
- ensure there is somewhere safe and secure for patients to store their possessions.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment The hospital must assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks. Risks caused by ligature points on the wards and in the outside spaces were not identified and risks mitigated. While ligature assessments had been completed, we found that there were many areas that had not been assessed for their risks. This is a breach of regulation 12 (2) (a) and (b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014. Staffing

This section is primarily information for the provider

Requirement notices

Insufficient numbers of staff were deployed on the wards to ensure that patients' care and treatment needs were met.

This is a breach of regulation 18 (1).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

The hospital must ensure the proper and safe management of medicines.

The clinic room on the first floor next to Aspen House was accessible from the patient occupied corridor when the window was left open.

This is a breach of regulation 12 (2) (g).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

Flumazenil was not available in the hospital to counteract the effects of benzodiazepines.

This section is primarily information for the provider

Requirement notices

This is a breach of regulation 12(2) (f).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014. Dignity and respect Service users must be treated with dignity and respect. There were blanket restrictions in place across the hospital which were not related to individual patient risk. There was not free access to food. Patients on some wards had to drink from a polystyrene cup. Patients could be seen from the road by members of the public when in the smoking areas of two of the wards. This is a breach of regulation 10(1)