Roseberry Park

Quality Report

Marton Road,
Middlesbrough,
TS4 3AF
Tel: 01642837300
Website: www.tewv.nhs.uk

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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

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

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

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

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

Overall summary

We did not rate this inspection.

During the inspection we reviewed the provider's action plan relating to restrictive practice.

- At the inspection in March 2014, we found people had restrictions in place regarding the use of telephones and visits; these were not in response to individual risk. During this inspection we found that patients were no longer supervised during phone calls and visits unless indicated on their risk assessments
- At the inspection in March 2014, people told us about their meal time experience and said that if they did not attend for meals on time they were not offered a hot meal and would be given a sandwich. During this inspection we found that patients always had access to a hot meal even if they had missed the meal time.
- At the inspection in March 2014 we found that the hospital did not always treat people in the least restrictive manner and often enforced boundaries with actions that could be seen to be punitive. For example staff told us that aggressive behaviour spitting and hitting staff was regarded as physical assault and would lead to a person having their leave cancelled. During this inspection we found that there was a positive culture on the wards and actions were no longer seen as punitive.

Summary of findings

- At the last inspection in January 2015 we found that blanket restrictions continued to be in place on some wards. For example, on Merlin, Linnet, Lark and Newtondale wards, patients were subject to routine rub down searches following a period of unescorted leave. These were not carried out on the basis of the risks presented by individual circumstances. During this inspection we found searches were no longer carried out routinely.
- During the inspection of the learning disability forensic inpatient/secure wards at Roseberry Park Hospital in March 2014 we found there was a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010: Safeguarding people who use services from abuse. During this inspection we found learning disability forensic inpatient/secure wards were no longer in breach of this regulation.

Summary of findings

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Summary of this inspection

Our inspection team

The inspection team consisted of one Care Quality Commission inspector and one Care Quality Commission inspection manager.

Why we carried out this inspection

We inspected this core service as part of a focused inspection into the use of restrictive practices. Roseberry Park was inspected in March 2014 and we found the provider to be in breach of regulation 9 and 11 of the health and Social care Act 2008 (regulated activities) Regulations 2010.The provider was re inspected in January 2015 and was found to still be implementing its action plans around the use of restrictive practice. This was a focused inspection to ensure the action plan had been implemented. Therefore only aspects relating to the restrictive practice were inspected during this focused inspection.

How we carried out this inspection

During the inspection visit, the inspection team:

- Visited eight out of the 11 learning disability forensic wards at the hospital and looked at the ward environment.
- Spoke with six patients who were using the service.
- Spoke with the director of operations, the deputy medical director, service leads and ward managers.
- Spoke with six other staff members; including doctors, nurses, and support workers.
- Looked at eight care and treatment records of patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Roseberry Park

Roseberry Park Hospital provided inpatient services for the assessment, treatment and rehabilitation of people with mental health needs, learning disabilities and problems with substance misuse. Care was provided in wards of between 4 and 20 beds.

It was registered to provide the regulated activities of;

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

What people who use the service say

Patients told us that things had improved, and that there were less 'rules' than before. Patients reported that staff were friendly and professional and that they discussed restrictions with them in their multidisciplinary reviews.

Patients told us that they would like access to their mobile phones on the wards.

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.

Forensic inpatient/secure wards

Summary of findings

Following our inspection in March 2014 the trust undertook a review of all potential restrictive practices. It established a restrictive practice working group which consisted of all ward managers, heads of service, modern matrons and clinical directors, along with the security manager and clinical leads. At the time of this inspection the group had met on three occasions.

The Mental Health Act code of practice 2015 states that providers who treat people who are liable to present with behavioural disturbances should focus primarily on providing a positive and therapeutic culture;

- Providers should have governance arrangements in place that enable them to demonstrate that they have taken all reasonable steps to reduce the misuses and misapplication of restrictive practices.
- Restrictive practices, when required, should be planned, evidence based, lawful, in the patients best interest, proportionate and dignified.

The service had made changes to the way it approached restrictive practice and a number of restrictions had been removed. Where restrictions were needed, these were individually risk assessed.

As part of the restrictive practice group a framework was developed which described the procedural arrangements for the ward to providing the least restrictive practice. When individuals required a greater level of restriction the framework provided managers with clear guidance around documentation and reviews.

Restrictive practices that were in place were recorded monthly and broken down by ward; this was reviewed during senior team meetings. We saw evidence of reviews in meeting minutes.

At the inspection in March 2014 we found people had restrictions in place regarding the use of telephones and visits which often meant people were supervised during phone calls and visits. We looked at the risk assessments in place and found they did not provide a rational for the restrictions in place. People we spoke with told us they did not know why they were being supervised for phone calls and visits and did not understand their rights regarding privacy and restrictions. During this inspection patients were no longer supervised on the phone or during visits, unless there was an individual need. Care records demonstrated that where such restrictions applied comprehensive risk assessments and care plans were in place.

Care records demonstrated that individual searches and room searches were only carried out where risk had been identified. We saw a comprehensive care plan was in place for a patient who presented a risk of arson and required room searches to ensure no items which could start a fire were available.

Weekly multidisciplinary team meetings reviewed restrictions that were in place. The multi-disciplinary team (MDT) considered if the restrictions needed to continue and what would need to change for the restriction to change.

At the inspection in March 2014 people told us about their meal time experience and said that if they did not attend for meals on time they were not offered a hot meal and would be given a sandwich. Staff told us this was due to food hygiene regulations. We found this practice restrictive as the rules did not take into account people's complex behaviours that may have meant they were unable to attend lunch or dinner. Patients may have also been attending visits or other appointments that meant they were not able to attend the mealtime.

During this inspection staff reported that restrictions around having a hot meal outside of meal times had been addressed through keeping a stock of food on the ward. This meant if patients missed meal times staff could still prepare them something hot if they wanted. We observed the kitchen cupboards to have a range of items available.

Safe wards (an internationally recognised project covering planning, compromise, positive environments and reduction of incidents and degree of harm) had been implemented across the service. This had been successful in reducing the number of violent incidents and staff reported that this had helped change the

Forensic inpatient/secure wards

culture on the wards. We did not see any evidence of punitive actions occurring, and patients and staff spoke of how things had improved and that there were not as many 'rules'. Staff reported the wards were calmer.

When walking around the wards we found courtyard doors were unlocked which allowed patients open access to the outdoor space. Bedroom doors were not locked unless patients had specifically asked them to be, and staff reported patients were free to go in their rooms at any time. Quiet rooms and activity rooms were open and patients did not need to ask staff to let them in. There was 24 hour access to the kitchen to make hot and cold drinks. Where there was a risk on the ward in relation to kitchen access, staff had to unlock the door to allow patient access.

Mobile phones were not allowed on the ward and could only be used whilst out on leave. The provider told us that this was because mobile phones with cameras can be used to take pictures and videos and could potentially breach patient confidentiality. This was a blanket restriction across the service. However, the trust were piloting a trial on one of the wards and we saw evidence in senior management meetings of an ongoing project to allow mobile phones whilst maintaining security. There was evidence of patient involvement in the decision to allow mobile phones from the patient restrictive practice representative.

Access to personal laptops remained a blanket restriction across the services. There was one patient that had been allowed their laptop as part of a bespoke care package. The trust reported that they had concerns regarding security of access to the trust Wi-Fi. At the time of the inspection the trust were still considering alterative options around access to personal laptops and internet access.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that it progresses action to reduce the restrictive practice around mobile phones and personal laptops.