St Matthews Unit

Quality Report

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Date of inspection visit: 22 to 24 March 2016
Date of publication: 16/05/2017

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 have not rated this service. We found that:

- The Unit was registered to provide care and treatment to a variety of individuals with different needs and risk profiles. There were patients detained under the Mental Health Act including restricted patients, patients managed under the Deprivation of Liberty Safeguards, informal and voluntary patients. The Unit also provided personal and nursing care to people assessed as requiring social care provision. However, the unit did not enforce a strict separation between the carrying on of the regulated activities which related to the hospital and care home. This meant that the Unit provided care and treatment on both floors to people who had very different assessed needs.
- The layout of the building meant there were blind spots on the wards preventing staff from seeing all patients. Some mirrors had been fitted to reduce the risk but they had not been fitted in all required areas. The Unit had significant numbers of ligature points (a ligature point is a place to which patients' intent on self- harm could tie something to harm themselves) throughout the interior and garden. The ligature risk assessment was not comprehensive and did not include the ligature risks in the garden.
- The wards were mixed sex, and did not comply with Department of Health guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice. Bedrooms for men and women were not in

Summary of findings

separate parts of the wards and bedroom doors were left unlocked, meaning patients could walk past, or into, other patients' bedrooms. Bathrooms on the wards were not clearly designated for men and women. Staff told us the facilities were unisex. The Unit did not have a women-only lounge or day room, as required.

- The Unit had six double bedrooms with just a curtain separating beds.
- Some drawers in patients' rooms did not lock. Three patients we spoke with told us they had their possessions go missing or stolen from their room.
- One clinic room was visibly dirty.
- The wards were not in a good state of repair in some areas. Carpet on the stairs had come away from the floor, some furniture was in a poor state of repair, a wall had been damaged on one ward, and curtains were dirty.
- On the day of the inspection The Unit had two qualified nurses and 20 healthcare workers caring for 51 patients. This covered both Hazel and Birch wards. Managers had not considered skill-mix in setting their staffing numbers.
- The Unit had a high staff turnover of staff leaving.
- The Unit kept an internal incident and accident log, which showed they were under-reporting patient safety incidents to the Care Quality Commission and to the local authority. We saw no evidence that learning was shared following some incidents.
- Patients told us that staff spoke to each other in languages other than English at times.
- Staff did not keep patient files and information secure. During the inspection, they left unlocked a door to the nurses' office where they stored the files.
- Care plans were not holistic or recovery oriented.
- There was a lack of psychological therapies available to patients.
- We found gaps in supervision records of up to four months.
- The pay phone for patients to make external calls from was in a public area.
- Staff did not know about any recent complaints made or the outcome of investigations into them.
- The Unit did not have a risk register. The management team did not robustly manage potential risks to the service.

However:

- The provider had recently implemented a recruitment and retention strategy action plan. At the time of inspection, the hospital had met its planned complement of qualified nurses and healthcare assistants.
- Staff sickness levels were low.
- Escorted leave and activities were rarely cancelled because of staff shortages.
- The overall completion of set mandatory training for staff was over 89%. This included safeguarding of vulnerable adults training.
- Patients and carers gave mostly positive feedback about the care they were receiving and the way staff treated them.

Summary of findings

Contents

St Matthews Unit

Services we looked at

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

Summary of this inspection

Background to St Matthews Unit

The St Matthews Unit (The Unit) was a 58-bedded service that operated over two floors. At the time of the inspection the Unit was registered to provide:

- treatment of disease, disorder or injury
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- accommodation for persons who require nursing or personal care.

The ground floor, Hazel, had 23 bedrooms, and was designated as a hospital that provided rehabilitation services to people who were either detained under the Mental Health Act 1983, or were voluntarily staying at the hospital. The upstairs, Birch, had 31 bedrooms and was designated as a care home.

At the time of inspection, The Unit had 21 people on Hazel and 30 people on Birch.

At the time of inspection, there was a registered manager.

St Matthews Unit had been registered with the CQC since 1 October 2010. Prior to this inspection the Care Quality Commission had inspected the Unit four times since its registration. We had last inspected the Unit on 12 April 2013 and found it to be compliant across the six assessed outcomes inspected.

At this inspection of March 2016, we found that people who were assessed as needing personal or nursing care in a residential care home were cared for on the same floors as those who were detained under the Mental Health Act. CQC had therefore assessed this service against the standards which are relevant to an independent rehabilitation hospital. We did this because of the distribution of patients detained under the Mental Health Act across both floors. The higher care standards must apply in order to ensure the safety of this vulnerable group of patients.

Since this inspection, the provider moved all detained patients from the location and applied to remove the regulated activity assessment or medical treatment for persons detained under the Mental Health Act 1983. This variation of registration has since been granted and the service has ceased to be a hospital.

Our inspection team

Inspection Manager: Lyn Critchley

Team leader: Hannah Lilford.

The team that inspected the service consisted of one inspection manager, three CQC inspectors, a Mental Health Act reviewer, a pharmacy inspector, an inspection assistant and a specialist advisor.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of this inspection

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

During the inspection visit, the inspection team:

- visited the St Matthews Unit and day centre, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 12 patients who were using the service
- spoke with the registered manager and one of the ward managers
- spoke with 16 other staff members, including doctors, nurses, occupational therapists, senior healthcare workers and healthcare workers
- collected feedback from 17 patients using comment cards
- spoke with three family members and carers of patients
- looked at six care and treatment records of patients
- looked at 10 medication records
- carried out a specific check of the medication management on the ward
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

- Twelve patients said they were happy living at the St Matthews Unit. Most patients said staff treated them with respect and were kind.
- Patients felt their physical health needs were being met.
- Carers or family members said staff treated patients with dignity and respect, and acted upon any requests.

However:

- Two family members and carers told us that staff did not involve them in the patients care or developing care plan. They did not know what treatment patients had.
- Two patients said staff sometimes spoke to each other in languages other than English.
- One patient, who was sharing a bedroom, said he would like his own room and a key but there were no room keys left.
- Another patient, who was also sharing a bedroom, said he did not like this because his roommate did not like him watching his TV at night.

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?

We have not rated this service. We found that:

- The layout of the building meant there were blind spots on the wards preventing staff from seeing all patients. Some mirrors had been fitted to reduce the risk but they had not been fitted in all required areas.
- The Unit had significant numbers of ligature points (a ligature point is a place to which patients' intent on self- harm could tie something to harm themselves) throughout the interior and garden. The ligature risk assessment was not comprehensive and did not include the ligature risks in the garden.
- The wards were mixed sex, and did not comply with Department of Health guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice. Bedrooms for men and women were not in separate parts of the wards and bedroom doors were left unlocked, meaning patients could walk past, or into, other patients' bedrooms. Bathrooms on the wards were not clearly designated for men and women. Staff told us the facilities were unisex. The Unit did not have a women-only lounge or day room, as required.
- We found one bedroom door was propped open with a chair.
- The Unit had six double bedrooms with just a curtain separating beds.
- Three patients told us they had their possessions go missing or stolen from their room.
- The ward décor was tired in places. Some furniture was in a poor state of repair, a wall had been damaged on Hazel ward and curtains were dirty.
- Staff had left items, such as bin bags and razors, which were a potential risk to patients in unmonitored areas.
- Staff did not keep patient files and information secure. During the inspection, they left unlocked a door to the nurses' office where they stored the files.
- Both clinic rooms were small. The clinic room on Hazel ward was visibly dirty. The carpet and the Controlled Drug cupboard were not clean. Surfaces in both rooms were cluttered.
- There was no emergency medication, including no anaphylaxis kits for staff to use when administering depot injections in accordance with Resuscitation Council guidelines.
- On the day of inspection, The Unit had two qualified nurses and 20 healthcare workers caring for 51patients. This covered both Hazel and Birch wards.

Summary of this inspection

- The Unit kept an internal incident and accident log, which showed they were under-reporting patient safety incidents to the Care Quality Commission and to the local authority. We saw no evidence that learning was shared following some incidents. We saw no evidence that they made changes following investigations into incidents.
- The service had no policy regarding safeguarding children from abuse who visited the hospital.

However:

- The Unit had an environmental risk assessment, which was last completed in January 2016.
- There were no current staff vacancies against the provider's planned staffing.
- No shifts had been left unfilled between October 2015 and December 2015.
- Overall, the provider's planned mandatory training rate was over 89% completion for all staff.
- A local GP practice provided physical healthcare checks and interventions for each patient on admission.
- The provider submitted data that showed there had been four incidents of restraint on three separate patients between June 2015 and December 2015. None of these was prone restraint.
- Staff undertook a risk assessment for patients within 36 hours of admission, and updated them.

Are services effective?

We have not rated this service. We found that:

- Care plans were not holistic or recovery oriented.
- There was a lack of psychological therapies available to patients.
- All medication, apart from Clozaril, came from a local pharmacy. This prescribing was undertaken by the GP and not the responsible clinician. This led to delays in patients receiving medication on occasion. The responsible clinician only prescribed Clozaril on a separate prescription dispensed at a separate pharmacy.
- We found gaps in staff supervision records of up to four months.

However:

- Staff undertook an assessment of patients within 36 hours of admission.
- Staff completed care plans in a timely manner.

Summary of this inspection

- Mental Health Act training and Mental Capacity Act training was included in the provider's corporate induction.

Are services caring?

We have not rated this service. We found that:

- Two patients said staff spoke to each other in languages other than English at times, which they did not like, as they could not understand what they were saying.
- Some patients said staff were not friendly towards them.
- Of the six care plans we looked at, there was no record in the care plan that patients had been offered a copy of their care plan, or if offered, had refused a copy.
- Two family members told us that they did not know about the patient's care plan or treatment needs, of any discharge plans, or therapy carried out on the ward.

However:

- Staff said that some patients could visit the ward for half a day before admission. On admission, staff gave them information about the ward and day centre activities and their individual timetables. Staff were assigned to show new patients around the wards.
- Most patients said the majority of staff were attentive and treated them well.
- Advocacy information was visibly displayed in the wards.
- Staff facilitated monthly community meetings and families were invited to join. Information from the meetings was displayed for patients to see on the notice board.

Are services responsive?

We have not rated this service. We found that:

- The Unit did not have clear admission criteria, leading to some patients' care being more restricted than necessary. At registration the provider confirmed they were operating two separate services, one hospital and one care home at The Unit. Despite this, the unit did not enforce a strict separation between the carrying on of the regulated activities which related to the hospital and care home. We found four patients detained under the mental Health Act upstairs in the care home and a patient subject to a community treatment order (CTO) within the hospital. This meant that the Unit provided care and treatment on both floors to people who had very different assessed needs.

Summary of this inspection

- Most patients requiring disabled access lived in the upstairs Birch ward. They could access the outside space only by using the lift with staff support.
- The pay phone for patients to make external calls from was in a public area.
- One patient said he asked for a bedroom key but staff said they did not have any spare keys. The provider reported that patients' access to room keys was a clinically based decision.
- Patients told us that some of the drawers in their bedrooms did not lock so they had nowhere secure to store their possessions.
- Staff did not know about any recent complaints made or the outcome of investigations into them.

However:

- There was a range of rooms available for patient activities and therapies. This included access to the day centre, which was considered part of The Unit.
- Patients had a choice of meals and most comments about the food were positive.
- Patients could make hot and cold drinks, and had access to fresh fruit daily.
- Patients knew how to make a complaint about the service. A box was in the reception area for patients to make a complaint or compliment about the service.

Are services well-led?

We have not rated this service. We found that:

- The Unit did not have a risk register. The management team did not robustly manage potential risks to the service.
- Although the provider developed a governance structure and used some performance indicators, we found that the process did not highlight a number of our concerns, such as environmental issues.
- The provider under-reported incidents to the Care Quality Commission and the local authority. It did not have a serious incidents policy. However, this was supplied following the inspection.
- We saw no evidence that management passed learning from incidents on to staff.
- Between January 2015 and December 2015, 41 members of staff left the Unit, a turnover rate of 31%.
- The staff survey showed 45% of staff, who answered, felt they were poorly rewarded and not valued for the job that they did.

Summary of this inspection

- On the day of the inspection The Unit had two qualified nurses and 20 healthcare workers caring for 51 patients. This covered both Hazel and Birch wards. Managers had not considered skill-mix in setting their staffing numbers.
- We found gaps in supervision of up to four months.

However:

- Staff knew who the most senior leaders of the organisation were and that they visited regularly.
- Staff sickness was low at under 7%.
- The provider reported that they had no harassment and bullying cases from staff members.
- Despite not feeling rewarded, staff said they enjoyed their roles.

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.

- St Matthews Ltd had a Mental Health Act policy.
- Mental Health Act training was included in the provider's corporate induction. The Mental Health Act administrator did hold meetings with staff to provide some learning and support.
- Mental Health Act administrators completed a monthly audit to ensure that they applied the Act correctly.
- We examined five medical administration records of detained patients. All T3, certificate of second opinion forms were correct.
- Staff stated they read patients their rights under the Mental Health Act on admission and routinely afterwards. However, the MHA audit for February 2016 was completed for 11 patients, three of which were overdue being read their rights under the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act and Deprivation of Liberty Safeguards training was included in the provider's corporate induction but was not part of ongoing mandatory training.
- We interviewed staff and asked them about their knowledge of the Mental Capacity Act 2005. They appeared to have a basic understanding of capacity issues but could not give specific examples of how they would transfer this knowledge in to practice.
- Staff had assessed capacity to consent and recorded the outcome in patient files; however, these assessments were not detailed.
- At the time of inspection, 18 patients were awaiting DoLS assessments and five were awaiting DoLS assessment authorisation.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

- The last environmental risk assessment was completed in January 2016. This included identification of some ligature risks. However, the ligature risk assessment was not comprehensive. It did not cover the garden and did not detail actions to reduce or eliminate the risks. The Unit and garden had significant ligature points (a ligature point is a place to which patients' intent on self-harm could tie something to harm themselves).
- The layout of the building meant that there were blind spots meaning staff could not observe areas of the wards at all times to keep patients safe. There were some mirrors to reduce this risk but not enough to cover all the blind spots. The provider stated that staff would observe patients in these areas to mitigate this risk. However, during the inspection we saw patients in these areas who were not observed by staff.
- The wards were mixed sex and did not comply with Department of Health guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice. Bedrooms for men and woman were not in separate parts of the ward and staff left patients' bedroom doors unlocked, meaning patients could walk past, or into, other bedrooms because staff did not observe the bedroom corridor. There was no women-only lounge or day room, as required.
- All bedrooms included a toilet and hand basin but not all had a shower or bath. Other washing facilities on the wards were not clearly designated for men and women. Staff said the toilets and washing facilities on the wards were unisex.
- One door was propped open with a chair; this was a fire door and should remain closed.
- The wards had six double bedrooms in total. Curtains separated the beds.
- Three patients we spoke with told us that possessions had gone missing or had been stolen from their bedrooms.
- Each ward had a clinic room. The one on Hazel ward was small and visibly dirty. The Hazel ward clinic room controlled drug cupboard was not clean inside and the carpet was dirty. The small sink was full of empty medicine administration pots and a discarded spoon. On Birch ward, the clinic room was clean. Surfaces in both rooms were cluttered.
- Staff monitored fridge temperatures daily to ensure that medications were kept at the right temperature. In the clinic room on Birch ward, there was a pool of water at the bottom of the fridge and the medication boxes were wet.
- Resuscitation equipment was not located in either clinic room, due to size limitations. However, there was an emergency grab bag in the reception area. Staff carried out and recorded weekly checks to ensure the defibrillator was in good working order.
- No emergency medication was available. No anaphylaxis kits (used to treat severe allergic reaction)were available for staff to use when administering depot injections as required by Resuscitation Council guidelines.
- There was no British National Formulary (BNF) book for staff to refer to in either clinic room. The provider reported that they used the online BNF but there were no computers in the clinic rooms. This meant that staff would need to leave the clinic to check for information about medication.
- All medication, apart from Clozaril came from a local pharmacy. This prescribing was undertaken by the patient's GP and not the responsible clinician. The

responsible clinician only prescribed Clozaril on a separate prescription dispensed at a separate pharmacy. Staff kept medicines stored safely and securely, in locked cupboards in the locked treatment rooms. Controlled drugs were stored securely.
- Staff showed us a cleaning rota, which was updated at regular intervals throughout the day.
- However, the ward décor were tired in places. Carpet on the stairs had come away from the floor, some furniture was in a poor state of repair, a wall had been damaged on Hazel ward, and curtains were dirty.
- Staff had left black bin liners and a box of 200 razors in a bathroom on Birch ward, this room was unlocked and patients had unsupervised access to this room.
- Hand sanitizer stations were located throughout the wards.
- Equipment was well maintained. Portable appliance testing (PAT) test stickers were visible and in date.
- The wards had alarms located on walls and in patient's bedrooms. They were in working order so staff or patients could summon help when needed.

Safe staffing

- On the day of inspection, The Unit team consisted of two qualified nurses and 20 healthcare workers during the day shift and two qualified nurses and 12 healthcare workers for night shifts. The team covered both Hazel and Birch wards. The ward manager said they were able to offer additional support when short staffed. The ward manager said additional staff could be called in to cover staff absences by agreement with the unit's registered manager. An occupational therapist, four day centre staff and a psychologist were part of the team, and not included in the numbers of ward staff.
- The provider had not used a recognised tool to estimate the number and grade of nurses needed on each shift. The provider was however piloting this at another hospital.
- Managers said there were no vacancies after carrying out a recent recruitment and retention drive.
- The provider submitted data that showed four shifts had been covered by bank staff between October 2015 and December 2015. No shifts had been left unfilled.
- Qualified nursing staff spent two hours each morning in the clinic room, preparing the morning medication. This meant there was no qualified staff in the communal areas to support healthcare workers to help patients complete their morning routine.
- Staff did not have regular one-to-one time with their named patients as recommended by the National Institute for Health and Care Excellence.
- The Unit had 31% staff turnover between January 2015 and December 2015, which amounted to 41 members of staff leaving.
- Staff sickness was under 7% between January and December 2015.
- Escorted leave and activities were rarely cancelled. Some patients were able to use the day centre to take part in activities.
- A local GP practice checked patients' physical health and met their physical healthcare needs. The ward had physical health monitoring equipment available.
- Senior medical staff provided 24/7 medical cover. There was no on-call rota but senior medical staff could be contacted at any time.
- The mandatory training compliance rate was 89% for all staff.
- Managers showed us a copy of the induction plan that all staff had to complete at the start of their employment. Most staff said they had completed their induction within three weeks. However, one staff member we spoke with had not yet had their corporate or local induction and had no date for when their induction would be taking place. This member of staff had been working on the wards for several weeks.

Assessing and managing risk to patients and staff

- Managers told us they did not use seclusion or segregation. If a patient did not respond well to verbal de-escalation, staff would use distraction techniques such as encouraging them to attend the day centre, where risk allowed.
- There had been four incidents of restraint on three separate patients between June 2015 and December 2015. None of these were prone restraint.
- The managers said restraint was used as a last resort. Staff confirmed this and said that they used verbal de-escalation techniques with patients. We observed staff supporting a patient to leave the dining area by physically guiding them. Staff did not record in patients' notes when they had required staff assistance to move between areas of the ward.
- There had been no use of rapid tranquilisation between June 2015 and December 2015.

- Staff completed risk assessments for patients within 36 hours of admission. These assessments were updated routinely during ward rounds.
- Staff stored patient files and all information relating to patient care in the nurses' office. We found this door left unlocked, meaning that patients and visitors could access confidential information.
- Staff gave some voluntary patients a key fob to enter and exit the building.
- The provider had a patient and room search policy. This was due for review in March 2016.
- The provider had policies and procedures for observation. The ward manager said patients at risk of falls were always supported on one-to-one observations.
- Eighty-nine per cent of staff had completed training on safeguarding of vulnerable adults from abuse. Staff were aware of how and when to make a safeguarding referral. However, we found that some safeguarding issues raised by staff had not been reported to the local authority or CQC.
- The provider did not have a policy for safeguarding children from abuse who visited the hospital. Patients told us that if children visited the hospital, the visit would be held at the day centre.
- There were clear systems and processes for ordering and receiving medicines. Administered medication was recorded clearly on medication administration records (MAR), which were provided by the pharmacy. There were no omissions in the administration records. Medicines in stock matched the administration records and balances were accurate.
- Staff maintained accurate and up-to-date records for the receipt and disposal of medicines. MAR charts had handwritten additions or changes to them that had been checked and signed by a second member of staff. Patient allergies were clearly recorded.
- Staff kept medicines stored safely and securely, in locked cupboards in the locked treatment rooms. Controlled drugs were stored securely. Medicines requiring cold storage were kept in an unlocked monitored refrigerator in the locked treatment rooms.

Track record on safety

- The provider, St Matthews Ltd, said it did not currently have a policy on serious incidents as required by NHS England for services providing NHS-funded care. However, the provider sent one to us following the inspection.
- The Unit had submitted one safeguarding alert and 37 safeguarding concerns between February 2013 and December 2015. However, The Unit kept an internal incident and accident log, which showed they were under-reporting incidents to the Care Quality Commission and to the local authority. Entries in the log for October 2015 included eight patient-on-patient assaults and one patient absconding. Only one patient-on-patient assault was reported to the Care Quality Commission or the local authority.

Reporting incidents and learning from when things go wrong

- Staff were aware of what constituted a patient safety incident and how to report it. Incident reporting was completed on a paper record and given to the ward manager to carry out an investigation.
- Staff confirmed that the duty of candour was included in induction training sessions and had been discussed at team meetings. The duty of candour is a legal duty to inform patients honestly, give them reasonable support and apologise to them in writing if there have been mistakes in their care that have led to significant harm.
- Managers said feedback from incidents was discussed during staff handovers at shift changes or at the monthly team meetings. However, we noted incidents were there had been no feedback or learning shared with staff.
- Staff told us and we saw no evidence that changes had been made following investigations into incidents. However, as part of the quality improvement plan for The Unit, there were plans to produce a learning alerts newsletter for staff.
- Staff said that management did not debrief them after a serious incident. However, managers stated it was discussed during the handover.

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

- Staff undertook assessments of patient needs within 36 hours of admission.
- A local GP practice assessed patients' physical health needs when they were admitted. The ward had access to physical health monitoring equipment.
- Care plans we viewed were completed in a timely manner; however, they were not holistic or recovery-oriented. Care plans were task orientated rather than focussing on recovery.

Best practice in treatment and care

- All medication, apart from Clozaril, came from a local pharmacy. A GP and not the responsible clinician undertook this prescribing. This led to delays in patients receiving medication on occasion. The responsible clinician only prescribed Clozaril on a separate prescription dispensed at a separate pharmacy.
- We looked at 15 prescription charts and found that two patients were prescribed antipsychotic medication exceeding 100% BNF maximum dose. Otherwise, prescribing generally followed the National Institute for Health and Care Excellence guidelines.
- There was a lack of psychological therapies available to patients. The consultant psychologist led the psychology department for one day a week, and was assisted by a forensic psychologist, who was full time. Both worked across all sites run by St Matthews Ltd. At the time of inspection, there were two vacant posts for psychology assistants.
- Patients were assessed by the responsible clinician at the point of admission. Any psychological needs were identified and referred to the psychology department.
- Physical health needs were met by a local GP. Physical health was then followed up as part of the ward round every three months by the visiting GP.
- Staff used the outcome star as a tool to measure change and support patients' recovery.
- We saw two documented audits of the clinic room, including medication administration chart audits and a storage of medicines audit.
- Medication administration records contained all necessary information including patient name, date of birth and allergy status. Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medicine charts where required.

Skilled staff to deliver care

- The multidisciplinary team consisted of nurses, occupational therapists, doctors, health care workers, psychologists, and administrators.
- The provider had recently run a recruitment and retention drive due to a high staff turnover. Many of the staff had been employed for less than six months.
- The Unit provided data showing that 73% of non-medical staff had an appraisal between December 2014 and December 2015. Eighty-one per cent of staff who answered the staff survey said that they felt supervision was good or excellent. However, we found gaps in supervision records of up to four months.
- The provider had recently sourced further training opportunities for staff from an external training provider and was developing links with a local university.
- The Unit held regular team meetings with staff. However, team-meeting minutes were not disseminated to staff unable to attend, were not structured, and did not cover incidents or health and safety.

Multidisciplinary and inter-agency team work

- The medical director completed monthly ward rounds for patients from the local area.
- A local GP surgery did weekly ward rounds and completed health checks with patients. Patients were seen by the local GP every three months.
- The ward manager completed three handovers daily, which lasted for 15 minutes each. The handovers were attended by all available staff. We observed that the 15 minute handover was insufficient time to discuss 51 patients.
- The ward manager reported good working relationships with teams outside of the organisation, such as the local pharmacy, the GP surgery and the local authority.

Adherence to the Mental Health Act and Code of Practice

- The provider stated that they were operating two separate services, one hospital and one care home at

The Unit. Despite this, we found four patients detained under the mental Health Act upstairs in the care home and a patient subject to a community treatment order (CTO) within the hospital.

- St Matthews Ltd had a Mental Health Act policy and Mental Health Act training was included in the provider's corporate induction. The Mental Health Act administrator held meetings with staff to provide some training and support and completed a monthly audit to monitor that the Act was being applied correctly.
- We examined five medical administration records of detained patients. All T3 certificates of second opinion forms examined were correct.
- Staff said they read patients their rights under the Mental Health Act on admission and routinely after that but the Mental Health Act audit for February 2016 was completed for 11 patients, three of whom were overdue being read their rights.

Good practice in applying the Mental Capacity Act

- At the time of inspection, 18 patients were awaiting assessments for Deprivation of Liberty Safeguards (consideration of whether powers to restrict their freedom for their own protection or the protection of others was needed) and five were awaiting authorisation for safeguarding measures.
- Staff completed training in the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards at induction.
- We interviewed staff and asked them about their knowledge of the Act. They appeared to have a basic understanding of capacity issues but were unable to give specific examples of how they would use this knowledge in practice.
- However, staff had assessed patients' capacity to consent to their treatment and recorded the outcome in patients' files.

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

Kindness, dignity, respect and support

- Staff interacted with patients who needed one-to-one observations and support. We saw staff interacting positively with patients throughout the ward.
- Two patients told us that staff spoke to each other in languages other than English at times, which they did not like, as they could not understand what they were saying.
- Most patients we spoke with said the majority of staff were attentive and treated them well. However, some patients said that staff were not friendly towards them.
- Staff said they were aware of patients' individual needs. However, the care and treatment records we reviewed did not reflect this.

The involvement of people in the care they receive

- We looked at six patients' care plans and none of the patients had been offered a copy of their care plan, as they should have been.
- Advocacy information was visible on the walls in the ward but patients we spoke with said they did not use advocacy services.
- We spoke to two family members or carers of service users, who told us that they were not aware of the patients' care plans or treatment needs, and they were not aware of any discharge plans or therapy on the ward. One family member of a patient told us that they did not understand their relative's legal status. Another relative was not aware that a DoLS application had been submitted.
- Staff facilitated monthly patient community meetings and ensured that information from the meetings was displayed for patients to see on the notice board. Families were invited to attend the monthly community meetings.
- We looked at minutes of the meetings and saw that patients had asked to have juice during the day and a quiet lounge. The provider approved and implemented these requests.

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

Access and discharge

- The Unit did not have clear admission criteria, leading to some patients' care being more restricted than necessary. At registration the provider confirmed they were operating two separate services, one hospital and

one care home at The Unit. Despite this, the unit did not enforce a strict separation between the carrying on of the regulated activities which related to the hospital and care home. We found four patients detained under the Mental Health Act upstairs in the care home and a patient subject to a community treatment order (CTO) within the hospital. This meant that the Unit provided care and treatment on both floors to people who had very different assessed needs. This also meant that some individuals were cared for in an environment that might be overly restrictive.

- Data provided by St Matthews Ltd showed that in November 2015 The Unit had six patients funded by NHS continuing healthcare, three patients on NHS-funded Nursing Care, 19 out-of-area patients funded by NHS continuing healthcare and 29 individual packages of funding care.
- Average bed occupancy was 97.5% between June 2015 and December 2016.
- The ward manager told us they aimed to keep at least one bedroom free so they could place a patient at short notice.
- Upon admission, patients were given a copy of the ward and day centre activities and their individual timetables.
- Managers told us that patients were not moved between wards during their stay in The Unit.
- There had been no delayed discharges.
- Patients' average length of stay varied. The shortest was six days and the longest 10 years and seven months.

The facilities promote recovery, comfort, dignity and confidentiality

- The Unit had a range of rooms to support patients to engage in a variety of activities and therapies. This included access to the day centre, which was considered part of The Unit.
- Patients could meet adult visitors in their bedrooms, at the day centre or in The Unit. Family members or carers told us they usually met patients in the day centre as there was more space.
- The pay phone for patients to make external calls was in a busy area and was not private. Not all patients were allowed mobile phones.
- Patients had access to outdoor space. However, most patients with mobility difficulties were treated in Birch ward upstairs, meaning they could access the outside space only by using the lift with staff support. Two carers of such service users told us that they did not think patients were getting the benefit of fresh air.
- Patients had a choice of meals and most comments about the food were positive. Specific dietary requirements were catered for. We saw patients ask for food different from what they had pre-selected because they had changed their mind, and staff accepted their requests.
- Patients could make hot and cold drinks and had access to fresh fruit daily. We spoke with a volunteer who visited The Unit a few times each week and who brought cakes and crisps in for the patients on a snack trolley.
- Patients told us they were able to personalise their bedrooms but many had not. Some patients had been given a key to their bedrooms, which staff told us was risk assessed individually. One patient said he had asked for a key but had staff told him they did not have any spare so he could not have one. The provider reported that patients' access to room keys was a clinically based decision.
- Most bedrooms had access to a lockable drawer. Some patients said the drawers did not lock.
- Patients had access to activities during the week and at weekends, including cooking, playing skittles, playing cards, and monthly pizza and disco nights.

Meeting the needs of all people who use the service

- The Unit was accessible to people who needed disabled access. However, most patients who needed it were in Birch ward upstairs, making it more difficult for them to go downstairs and take part in activities or go outside for fresh air.
- Information on treatment, advocacy, and how to make a compliment or complaint about the service was available in the reception area and on the ward. If patients needed interpreters, the ward manager said that it could be organised.
- We saw no information available for patients on local services, such as smoking cessation or in any languages other than English.
- Staff told us that local faith groups attended The Unit weekly and that patients had the opportunity to access spiritual support in the community.

Long stay/rehabilitation mental health wards for working age adults

Listening to and learning from concerns and complaints

- The Unit reported that eight complaints were received between December 2014 and January 2016. One was upheld by the provider. The upheld complaint was from a family member regarding short notice of a meeting. The complaints that were not upheld related to allegations of physical assault, abuse by a staff member, staff behaviour, unauthorised deprivation of liberty, medication, standard of care and short notice of a meeting.
- Patients knew how to make a complaint about the service. A complaints box was available in the reception area for patients to make a complaint or compliment about the service. One patient told us he had made a complaint about a staff member in the last month and had not yet received any feedback.
- Staff told us that if a patient wanted to make a complaint it would go to the ward manager for consideration. Staff were not aware of any recent complaints made or the outcome of investigations into any recent complaints.

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

Leadership, morale and staff engagement

- The Unit had 31% staff turnover between January 2015 and December 2015, which amounted to 41 members of staff leaving.
- Staff sickness was under 7%.
- There were no cases of harassment and bullying reported by staff.
- Staff knew how to use the provider's whistleblowing procedure. They said they were confident to use the procedure or to raise concerns with senior managers if required. The provider reported that The Unit had no whistleblowing concerns raised between July 2014 and October 2015.
- The ward manager said additional staff could be called in to cover staff absences by agreement with The Unit's registered manager.
- St Matthews Ltd gave us the results of a staff survey, which showed that 45% of staff who responded felt they were poorly rewarded and were not valued for the job that they did. The provider said it was enhancing the salary package to improve this.
- Twenty-seven per cent of staff who answered the survey said that they would rate St Matthews Ltd as an excellent place to work and 45% would recommend St Matthews Ltd as a good place to work.
- Some staff told us that they enjoyed working at The Unit due to the opportunity to work flexible hours and because they enjoying helping and supporting patients.

Vision and values

- The provider delivered corporate induction training which included the vison and values of the organisation.
- Staff said they knew who the most senior leaders of the organisation were and that they visited regularly.

Good governance

- The provider held monthly health and safety meetings, quality improvement meetings and managers' business meetings, and used some performance indicators to gauge team performance. The indicators included recording meaningful activities, sickness monitoring and recording, monitoring agency/bank staff use, Mental Health Act and Deprivation of Liberty Safeguards audit, and an infection control audit. The provider had an organisation-wide quality improvement programme but did not have a risk register specific to The Unit. We found that a number of our concerns, such as environmental issues, had not been highlighted through this governance process.
- At the time of the inspection, the manager told us that the hospital did not formally capture any feedback about the care provided at The Unit. However, following the inspection we were given the results of a survey from May 2015, which indicated a generally positive level of feedback. However, in relation to patient involvement, 40% of people did not feel fully involved in their care.
- St Matthews Ltd said it did not have a policy on serious incidents as required by NHS England. However, it supplied one to us following the inspection. Incidents were being under-reported to the Care Quality Commission and to the local authority safeguarding team.

Long stay/rehabilitation mental health wards for working age adults

- We saw no evidence that learning from incidents was disseminated to staff.
- At least 89% of staff had completed mandatory training. However, Mental Capacity Act, Mental Health Act, and Deprivation of Liberty Safeguards training were not identified as ongoing mandatory training, although included in corporate induction.
- A total of 73% of non-medical staff had received an appraisal of their work performance between December 2014 and December 2015. However, we looked at six staff supervision files and found gaps in supervision of up to four months.
- On the day of the inspection The Unit had two qualified nurses and 20 healthcare workers caring for 51 patients. This covered both Hazel and Birch wards. Managers had not considered skill-mix in setting their staffing numbers.
- The ward manager told us he had enough administrative support and authority to carry out his role.

Commitment to quality improvement and innovation

- The Unit had registered with Royal College of Psychiatrists for completion of the National Audit of Schizophrenia for 2015/16. They planned to register all other units the following year.
- The Unit did not participate in any accreditation schemes.
- The manager undertook some audits on training, sickness, supervision, the Mental Health Act, medication and record keeping but few other clinical audits.