Elysium Healthcare No.2 Limited

St Neots Neurological Centre

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

St Neots Hospital provides long stay and rehabilitation wards for adults with severe and enduring mental health needs. It specialises in caring for patients with complex and co-morbid mental health and physical health conditions, including progressive neurological conditions and patients in the latter stages of their diagnosis.

We carried out this unannounced inspection as a follow up to a focused inspection that took place July 2020 and to review those parts of the service that did not meet legal requirements at that visit. We also carried out this inspection as we had received a number of recent whistleblowing concerns from staff at the hospital.

At the previous inspection we did not rate this service. The most recent comprehensive inspection was completed in August 2019 when we rated this service as good in all areas.

St Neots Neurological Centre provides long stay and rehabilitation wards for adults with severe and enduring mental health needs. There are 4 wards in the hospital on the same site Willow, Cherry, Rowan and Maple.

We rated it as requires improvement because:

- There were no cleaning records for the clinic room and no cleaning records for clinical equipment, so no evidence to show that these areas and equipment were being cleaned regularly between patients.
- Risk assessments for patients moving into the hospital often took a few months to be written and added to the computer system.
- The hospital had not followed procedures after rapid tranquillisation for one patient. We were not able to find records to show that the patient had been observed afterwards and that the doctor had been informed.
- Clinic rooms had out of date dressings and the grab bag had items not stored correctly.
- Patients did not all have a discharge plan where appropriate.
- The inspection team witnessed 2 staff speaking to each other in their first language in front of patients and not all staff were wearing name badges.
- Care plans did not include spiritual needs for some patients who were at end of life.
- Staff training was not at an acceptable compliance level of 75% on 6 occasions.
- Staff did not always follow the hospital medication policy and procedure when recording medication.
- It was not clear in one patient's prescription chart and care plan who had several medications for the same mental health condition, when to use which.
- The restrictive hospital environment resulted in patients sharing communal bathing facilities and quiet areas were limited.

However:

- The service had enough nursing and medical staff, who knew the patients and received good training to keep people safe from avoidable harm. Staff on shift and on induction told us that the training they received by the hospital was very thorough and there was a comprehensive training programme for additional non mandatory training, which all staff could access. Managers used a training matrix to record mandatory training and used a traffic light system to alert managers when training had not been completed.

Summary of findings

- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. We observed a planned restraint, the patient was treated with dignity and respect, given choices and the process was well managed from start to end and staff avoided restraint using de-escalation techniques.
- Staff told us each staff member had a password to access patients records, regular agency staff had a password and temporary agency could access the system using a one-time password.
- Staff told us they received a debrief after serious incidents, this happened every morning at the hand over meeting. Carers told us managers investigated incidents promptly and thoroughly.
- Staff discussed recent incidents during team meetings and lessons learnt posters were displayed on a quarterly basis in the hospital and in reception areas and included actions taken.
- Staff managed physical health efficiently including using The National Early Warning Score to record any changes in patients' well being and assessed the physical and mental health of all patients on admission.
- Care plans were holistic, goal orientated and reflect change. Care plans included physical and mental health, moving and handling, medication, finances and end of life plans, nutrition and communication. Each patient had a different person-centred model of care and a Meaningful Care Plan. Care plans were reviewed regularly through multidisciplinary discussion and updated as needed.
- The hospital had a full multidisciplinary team 1 consultant neuropsychologist, 2 occupational therapists, 1 assistant psychologist, 1 physiotherapist, 1 social worker, 1 speech and language therapist and 4.6 therapy assistants. The therapy team were able to provide a full range of activities and therapies both in the ward and in the community.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to St Neots Neurological Centre

St Neots Hospital provides long stay and rehabilitation wards for adults with severe and enduring mental health needs. It specialises in caring for patients with complex and co-morbid mental health and physical health conditions, including progressive neurological conditions and patients in the latter stages of their diagnosis.

St Neots Neurological Centre has been registered with the Care Quality Commission under its current owner Elysium Healthcare since December 2016 for:

- Assessment or Medical Treatment for Persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

At the previous inspection we found issues with staff not following care plans, multi-factorial falls assessments not always being completed and actioned, airflow mattresses not always being inflated correctly, agency workers not always having access to hospital computers and systems, cleaning schedules on wards not always recorded and no effective systems for all staff to be able to raise concerns. During this inspection the provider demonstrated that improvements have been made in most of these areas.

What people who use the service say

Patients told us staff were kind, respectful and polite. They felt safe, enjoyed the food and there were enough activities to keep them occupied, although some were at too lower level for them. Some patients told us they didn't like the food, would like their shower to work and found the ward noisy at night as chairs were dragged across the floor.

How we carried out this inspection

The team that inspected the service comprised of 2 CQC inspectors, an Expert by Experience, a Nurse Specialist Adviser and an Occupational Therapist Specialist Adviser.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the hospital, reviewed the quality of the ward environment and observed how staff were caring for patients;
- spoke with 13 staff members on the wards, 6 nurses, 6 health care assistants and a cook;
- spoke with 2 team managers who were responsible for the 4 wards;
- spoke with multidisciplinary team members doctor, consultant, physiotherapist, speech and language therapist, therapy lead, senior assistant psychologist and 2 occupational therapists;
- spoke to the hospital director;
- spoke with 16 patients and 2 carers on the ward and 2 carers on the telephone;
- observed 2 multidisciplinary team meetings;
- reviewed meeting minutes and audits of the service;
- observed posters on display in the ward and reception areas;
- reviewed 11 records of patients;
- reviewed 28 prescription charts;

Summary of this inspection

- reviewed policies and procedures relevant to running the service;
- reviewed legal status paperwork for patients;
- toured all 4 clinic rooms;
- carried out a tour of each ward including the kitchens and outdoor spaces.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The hospital must ensure that cleaning records are kept for the clinic rooms and the equipment in the clinic rooms (Regulation 17(1)(3)).
- The service must ensure that clinic room equipment is cleaned after each patient use (Regulation 12(1)(3)).
- Every patient must have a risk assessment which is completed in a timely manner once patients have been admitted. (Regulation 12(1)(3)).
- Staff must follow the hospital's policies and procedures after using rapid tranquilisation for a patient (Regulation 12(1)(3)).
- The service must ensure the clinic rooms are checked for expired dressings on every ward in the clinic rooms and that equipment in the grab bag is stored correctly (Regulation 12(1)(3)).
- All patients care plans must have a discharge plan if identified as a need. appropriate, or if not, a reason documented to say why this is not required (Regulation 9 (1)(3)(b)).

Action the service SHOULD take to improve:

- Staff should not talk in their first language on the wards in front of patients, if this is not English.
- Care plans should include any spirituality wishes for patients at the end of life and where patients did not have any identified, this should be reflected in the care plan.
- The service should ensure that training for all staff is at an acceptable level of compliance, Level 1 safeguarding adults and children mandatory training for permanent staff compliance was 73%, there were also 5 courses for bank staff that were below 75% compliance.
- Staff should follow hospital medication policy and procedures when recording medication.
- The service should ensure that if several medications have been prescribed for a patient for the same mental health condition, prescription charts and care notes clarify when to use which, either individually or in combination.
- The service should ensure that the 2 ensuite showers on Rowan ward are in working order.
- Care plans for patients who had been given covert medication, should record a capacity assessment and a best interest meeting.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

Are Long stay or rehabilitation mental health wards for working age adults safe?

Requires Improvement

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. However, we observed that whilst clinic rooms were clean, clinic room equipment was not always clean and the 2 ensuite showers on Rowan ward were not working due to water pressure difficulties.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Environmental risk assessments were present for all wards, completed in November 2021 and due for review November 2022. Any significant hazards identified were listed with a control measure.

Staff could observe patients in all parts of the wards. All wards were open plan and the bedrooms were sited from a main corridor. Any areas of the ward that were not visible by staff were mitigated with mirrors.

The ward complied with guidance and there was no mixed sex accommodation. Cherry and Maple wards were female only and Rowan and Willow wards were male only.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Ligature risk assessment had recently been completed and people using the service were individually risk assessed with appropriate mitigation in place. Staff described how they escorted patients with identified risks in the garden due to known ligature risks.

Staff had easy access to alarms and patients had easy access to nurse call systems. Central alarms were visible on every ward in the corridors and central points around the ward and staff carried alarms. Patients who were in their bedrooms had access to an alarm to call staff. In the communal lounges and bathrooms there were patient alarms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. The ward areas were clean, and furniture generally in a good condition. The 2 ensuite showers on Rowan ward were not working due to water pressure issues.

Staff made sure cleaning records on the wards were up-to-date Cleaning records were up to date in the wards, 2 ward kitchens, Assisted Daily Living kitchen, patients' toilets and bathrooms.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

Clinic rooms were tight for space and we found there was no room for patient examination or a couch, staff completed patient examinations in their bedrooms.

Staff checked and maintained equipment. There were up to date records of daily equipment checks of mattresses and falls monitoring equipment.

There were no cleaning records for equipment in the clinic room and no stickers to show cleaning had been carried out. Staff told us observation equipment is not cleaned between patients only once a day. The clinic rooms and cupboards were clean however, the Willow ward medicine trolley was observed to be visibly dirty.

We asked staff to show us these cleaning records, but they were not able too.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The hospital had 19 registered nurses and 37 healthcare workers in post.

The service had low vacancy rates for registered nurses. The vacancy rate across the hospital at the time of inspection was 2.65% registered nurses and 8.76% healthcare workers.

The service has high rates of bank and agency nurses. From the data provided, there was a high agency and bank staff use for nurses, for the period May to October 2022, a total of 576 shifts were covered in this way. The data showed us for all staff from 1 May to 31 October 2022, shifts were covered 45.3% by permanent staff, 11.9% by bank and 42.8% by agency.

The service has high rates of bank and agency nursing assistants. From the data requested there was high agency and bank for healthcare assistants for the period 1 May to 31 October 2022 a total of 4,324 shifts were covered in this way. The data showed us for all staff from 1 May to 31 October 2022 shifts were covered 45.3% permanent staff, 11.9% by bank and 42.8% be agency.

Managers requested agency staff familiar with the service. Most agency staff were known and had worked for the hospital for a long time and managers requested known agency staff as a priority. Agency staff were mostly used to provide extra hours for individual patients who require one to one.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Agency staff new to a ward were paired with permanent staff and were inducted onto the wards. Their agency profiles must show they have completed core training. They must have completed a comprehensive dysphagia competence and

were invited to attend specialist training as required. Managers were planning a mini face-to-face induction for agency staff and reviewing whether Mental Health Act and Mental Capacity Training should be face-to-face learning rather than online. Agency staff were block booked to maintain staff consistency, they attended team meetings and reflective practices, managers were reviewing whether regular agency staff should have supervision.

The average turnover rates for the hospital since May 2022 was 3%. The hospital had a number of new initiatives in place to retain staff.

Levels of short-term sickness were low. The average short-term sickness level May to October for the hospital had remained low 2.18%. However, the average long-term sickness rates May to October were 3.92%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. During the two days inspection, there were adequate staff at each grade for each shift.

The ward manager could adjust staffing levels according to the needs of the patients. Managers adjusted staff levels for the needs of the patients who were requiring additional one to ones.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Data for the hospital over the last 3 months demonstrated patients rarely had their activities cancelled.

The service had enough staff on each shift to carry out any physical interventions safely. Staffing levels at the hospital were good and the number of physical interventions from May to October were low.

Staff shared key information to keep patients safe when handing over their care to others. We observed a ward meeting that took place each morning with staff from each ward, each patient was spoken about in turn and detailed notes were recorded. Good practice was observed as the hospital used The National Early Warning Score 2 to record any changes in patients' physical wellbeing.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There was a specialist doctor and a consultant for the 4 wards within the hospital. The 2 ward managers and the hospital director were on call out of hours and the consultant was contactable by telephone in an emergency out of hours.

Mandatory training

Across the hospital 90% of permanent and 87% of bank staff were up to date with their mandatory training. However, there were 5 mandatory courses bank staff were below 75% compliance and Safeguarding Adults and Children C1 was 73% compliance for permanent staff.

Recruitment agencies were asked to provide the hospital with a profile for agency staff, listing mandatory courses completed within the last 12 months. However, there was no evidence that agency training was monitored for long term agency staff.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Staff on the wards and on induction told us that the training they received by the hospital was very thorough.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers monitored mandatory training and alerted staff when they needed to update their training. A training matrix was used to record mandatory training and a traffic light system to alert managers when training had not been completed.

Assessing and managing risk to patients and staff

Risk assessments were not always added to patients' files promptly when they moved into the service however, they achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff did not complete initial risk assessments for each patient in a timely manner. We reviewed 11 care records and 5 were not completed for some months after the patient had moved into the service. One patient's risk assessment was missing.

However, staff did use a recognised tool an acute risk matrix to monitor patients and although sometimes there was a delay in the initial risk assessment being written, were reviewed regularly thereafter and updated after an incident in the care notes. We reviewed 11 patient records - 9 had a risk assessment which had been regularly reviewed and patients had been involved in creating their risk assessment.

Management of patient risk

Initial risk assessments were not completed in a timely manner, so it was not certain staff knew about risks for new patients. However multidisciplinary team ward rounds took place every Wednesday face to face in the board room, patients were reviewed 4 weekly and new patients each week, patients and family carers were invited to attend. Multidisciplinary team meetings took place every morning, ward managers and one nurse from each ward attended in addition to other multidisciplinary team members and handover meetings with staff. During these meetings patient risks were discussed.

Staff could observe patients in all areas and staff followed procedures to minimise risks where they could not easily observe patients. We observed all wards were open plan and the bedrooms were sited from a main corridor. Any areas of the ward that were not visible by staff were mitigated with mirrors.

Use of restrictive interventions

Levels of restrictive interventions were low. For the period May to October 2022 there were 17 physical interventions.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We observed an incident on the ward, when a patient may have needed to be restrained, the patient was treated with dignity and respect, given choices and the process was well managed from start to end and staff avoided restraint using de-escalation techniques.

Staff using rapid tranquillisation. Out of the 28 prescription charts we reviewed, in one incident, staff did not follow the hospital policy and procedure after using rapid tranquillisation. We were not able to find a completed post rapid tranquillisation observation sheet and the doctor was not informed of the incident.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. From data in the hospital of all permanent staff 73% level 1, 100% level 2 and 88% level 3 were up to date with safeguarding adults and children mandatory training. In all agency profiles, agency staff must have completed mandatory courses within the previous 12 months. This included safeguarding adults and children level 3.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff told us and demonstrated they understood how to keep patients safe.

Managers took part in serious case reviews and made changes based on the outcomes. There was evidence of lessons learnt after an incident and the hospital displayed posters throughout the hospital for each quarter which showed actions taken as a result.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Staff told us clinical notes were available on office computers and laptops in the ward. We observed bedrooms had personal folders with care plans, This Is Me folder, Occupational Therapy equipment records, and these were up to date.

Records were stored securely. Staff told us each staff member had a password to access patients records, regular agency staff had a password and temporary agency had a short window of time to access the system using a one-time password. The hospital were reviewing this process to establish if this could be further improved for temporary agency staff access.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines but staff were not always following these systems and processes. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely but did not always follow systems and processes for storage and administration of medicines. We found expired dressings on every ward in the clinic rooms and a grab bag with McGill forceps which were not stored in their sterile packaging.

Staff completed medicines records accurately and kept them up to date. Staff learned from safety alerts and incidents to improve practice. Staff completed medicines records accurately and kept them up to date. We observed an entry on a prescription chart had been crossed out but not initialled. The manager immediately commenced an investigation, we received a copy of the outcome and were satisfied that the hospital took the appropriate action to ensure that lessons were learnt from this incident.

Staff stored and managed all medicines and prescribing documents safely However, there was some inconsistency in the storage of asthma medication, with some wards storing this on the medicine trolley and some storing it in the fridge.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service ensured people's behaviour was not controlled by excessive and inappropriate medicines. 28 prescription charts were reviewed. On one chart a patient was given several medications for agitation or severe agitation and from the information available there was no clarification seen as to when to use which as and when PRN medicines either individually or in combination.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff complete physical health observations twice a day using National Early Warning Score 2 and repeated observations if a patient has a low score.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with trust policy. Staff accessed the incident database to report incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Managers debriefed and supported staff after any serious incident. Staff received a debrief after serious incidents, this happened every morning at the handover meeting. We saw the hospitals Incidents and Untoward Occurrences Policy which included guidance to managers on how to debrief staff following serious incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Staff discussed recent incidents during team meetings and lessons learnt posters were displayed on a quarterly basis in the hospital and in reception areas and included actions taken.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised and holistic.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Mental health assessments were documented as part of the care plan. The doctor told us that all new admissions were discussed at weekly ward rounds and daily ward rounds which included patients' mental health. We attended a ward round meeting where patients' mental health and physical health was discussed.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. In care plans it was recorded that patients had a full physical check on admission. There was a good relationship with the local GP surgery who visited every Tuesday to see patients on the wards. There was a physical health care lead nurse who worked for the GP surgery but was based at the hospital. Staff carried out physical health observations with patients twice a day.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. There were comprehensive care plans for patients' who had complex physical care needs and mental health needs. Care plans were holistic, goal orientated and reflected change. Care plans included physical and mental health, moving and handling, medication, finances and end of life plans, nutrition and communication. Each patient had a different model of care and a Meaningful Care Plan, for one patient this included the patient's choice to attend a local church on Sunday and if unwell to access an online service. In the 11 care plans reviewed, however we did not see spirituality wishes in care plans for patients at their end of life, the hospital told us these patients did not have any spirituality wishes, this should be reflected in the care plan.

Staff regularly reviewed and updated care plans when patients' needs changed. We reviewed 11 care plans, care plans were personalised, holistic and recovery orientated. The care plans we reviewed had extensive input from multiply professionals; speech and language therapy, occupational therapist, dietician, doctors and physiotherapists. Care plans were always updated following incidents or changes.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. The hospital had a full multidisciplinary team, patients had access to 1 consultant neuropsychologist, 1 assistant psychologist, 1 physiotherapist, 1 speech and language therapist, 4.6 therapy assistants, 1 social worker and 2 occupational therapists. Patients had a Meaningful Week Care Plan which listed patient needs, aims and interventions. The hospital used recognised outcome measures.

Staff delivered care in line with best practice and national guidance. Care was being delivered in the least restrictive way, staff took time to find out patients views and choices.

Staff identified patients' physical health needs and recorded them in their care plans. We reviewed 11 care records and, in each record, there was a detailed plan of patients' physical health care needs. Patients' with dysphagia were reviewed daily due to their risk of choking and aspirating and clear care plans were documented for these patients.

Staff made sure patients had access to physical health care, including specialists as required. Managers and the doctor told us there was a lead nurse for physical health care for the hospital, the local GP practice visited once a week. Staff told us they took patients to appointments at the local doctor, dentist and hospitals.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. In care plans, where required, there was a clear plan for patients needs for nutrition and hydration. In the main kitchen some patients had a special meal and there were food and fluid charts on the wall. The speech and language therapist and dietician provided advice and guidance to staff on dietary needs.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.There was a full therapy team who were able to provide a full range of activities and therapies both in the ward and in the community. There were 2 transport vehicles one which was wheelchair accessible and a designated driver to take patients out. Patients had access to a garden which was accessible from each ward. Activities include swimming, gym classes, meals out, shopping, visits to parks, a designated therapy kitchen and an activity cabin in the grounds of the hospital which is a valuable resource.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The hospital used the National Early Warning Score 2 to assess patients physical and health care needs and recognised outcome models for therapeutic input.

Staff used technology to support patients. Staff used teams for multidisciplinary team meetings which carers and patients were invited too.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Minutes of recent team meetings included staff discussions of improvement initiatives and recent whistleblowing concerns. Staff told us managers were very supportive of improvement initiatives.

Managers used results from audits to make improvements. There were action plans in place to follow up from audits. There were audits for grab bags for the 4 wards, however there was no action seen to address the McGill Forceps that we found not in their sterile packaging.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. The hospital had a full multidisciplinary team 1 consultant neuropsychologist, 2 occupational therapists, 1 assistant psychologist, 1 physiotherapist, 1 social worker, 1 speech and language therapist and 4.6 therapy assistants. This was a newly formed therapy team and offered a structured timetable which provided an enabling approach to maximise independence and recovery.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. In addition to mandatory training permanent staff had access to a wide range of non-mandatory training. The training covered physical health care, evacuation of people with mobility difficulties, psychology, Positive Behaviour Plans, Food safety, End of Life, National Early Warning Score 2, Safe Observations. Staff told us the training the hospital provided was "excellent". An agency proforma detailed mandatory courses that must have been completed within the previous 12 months. Agency staff told us everyone can have training if required.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers gave each new member of staff a full induction to the service before they started work. Face-to-face induction was taking place in the boardroom while we were on inspection. Staff told us on the induction, it was very impressive, lasted over a week and the training was undertaken by staff at the hospital. Staff have a 3 month probation period with a mid-point review.

Managers supported staff through regular, constructive appraisals of their work. Staff told us that they received regular supervision, appraisal and reflective practice. Agency staff attend team meetings and reflective practice and managers are considering regular agency receiving supervision.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Data told us that at the time of our inspection 95% of staff were up to date with their supervisions and 88% of all staff appraisals.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Minutes of team meetings were available in the ward offices for all staff to read.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff could ask for any additional training and there was a training board which outlined all training being offered in the coming months. Staff could train to become a trainer to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. There was a detailed plan of specialist training on offer for all staff.

Managers recognised poor performance, could identify the reasons and dealt with these. When staff had performed poorly, managers described the action they had taken to address these concerns. In forum minutes, there were discussions of poor performance with staff, and managers responded to say this was not acceptable.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended 2 multidisciplinary meetings, a weekly ward round and a daily ward meeting. Multidisciplinary meetings at the hospital were attended by occupational therapists, psychologist, physiotherapist, speech and language therapist, a nurse from each ward, specialist doctor or consultant. There were specialist learning disability, mental health and general nurses in the hospital.

Patients and carers could attend ward meetings, they took place virtually. Each patient was discussed every 4 weeks and any new patients to the hospital discussed weekly. A patients' mental health, physical health, life skills, behaviour and any incidents were discussed. We observed, at the daily ward round every patient was spoken about, staff used The National Early Warning Score 2 to record patients' physical care needs using this tool and there was a discussion to agree a that a patient's son could bring his dog to visit.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Ward teams had effective working relationships with other teams in the organisation. Daily multidisciplinary team meetings were held each morning virtually for the whole hospital, ward rounds were held once a month face to face.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Ward teams had effective working relationships with external teams and organisations. Local doctors visited the hospital once a week and a nurse employed by the local doctor's surgery was based at the hospital. District nurses came in to deliver staff phlebotomy training. Care coordinators visited the hospital to assess patients for discharge to a new home. An approved mental health professional visited a patient in the hospital during our inspection.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Mandatory training included the Mental Health Act and the Mental Capacity Act. The compliance rate was 78% for permanent staff and 73% for casual staff. Some staff could not describe the Code of Practice guiding principles. Staff understanding these guiding principles means they can support patients in the least restrictive way.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The consultant was able to provide advice and support.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. In the information on each ward there was details displayed telling patients about the ward visits by a mental health advocate. An independent advocate visited every Tuesday. The hospital received a report following the advocates visit. Advocacy report themes were on the regular agenda and discussed at the hospital Operational Governance Meetings.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Data showed during August to October 2022 there were 176 planned section 17 leave taken and 2 in an emergency. Rowan ward had informal patients who could ask to leave the ward, individual risk assessments were put in place to respect this.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. In all wards there were posters informing informal patients they could leave the ward at any time.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Data showed overall 80% of staff were up to date with their training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Managers we spoke to had a good understanding of the Act and would contact the Mental Health Administrator or online training if they needed to increase their knowledge.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Managers shared the policy with us.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Mental Capacity Assessments were completed and were time specific. Evidence was seen for patients to determine whether they have the capacity to have their flu and COVID-19 vaccines and capacity assessments for finances, sharing information and nutritional modification needs. We did see a care plan for a patient on a section 2, who had been given covert medication, there was no best interest meeting and no recorded capacity assessment to show patient lacked capacity. The provider immediately carried out a capacity assessment for consenting to care and treatment and as the patient lacked capacity, a best interest meeting was held which included family.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. In all but one of the care plans we reviewed, where patients were deemed not to have capacity, there was evidence of best interest meetings documented with multidisciplinary team and family members who attended to determine decision.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We observed staff spending time with patients on a regular basis, actively engaging in an activity, sitting and listening to a patient and speaking to them in a kind and compassionate manner.

Staff supported patients to access a community car, taking time to make sure they were comfortable and had their seat belt secured, having fun and laughing with patients, playing games, singing, supporting to cook a meal in the Assisted Daily Living Kitchen.

However, on a ward 2 staff were speaking to each other in their own language in front of patients.

Staff gave patients help, emotional support and advice when they needed it. We saw managers and staff responding to patients' questions and taking time to answer those questions in an interested and caring manner.

Staff supported patients to understand and manage their own care treatment or condition. Staff directed patients to other services and supported them to access those services if they needed help. A patient told us staff supported her to go on holiday.

Patients said staff treated them well and behaved kindly. Patients told us the staff were kind, polite and respectful.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff understood and respected the individual needs of each patient. A patient told us they were supported in their room by staff as they preferred the solitude. One patient did tell us that the activities were of a lower level and they had made suggestions for activities they would like, that had not been taken up.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that patients had easy access to independent advocates.**

Involvement of patients

Staff involved patients and gave them access to their care planning and risk assessments. In records staff had read the care plan to patients and documented if they agreed to it, where the patient did not have capacity, their needs and wishes were taken into consideration. Records showed where patients had been involved in their care plans and where they had refused and when carers and advocates had been involved in care plans.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could give their feedback at the hospital community meetings. Staff used a white board to communicate with one patient.

Staff supported patients to make decisions on their care. Records show that staff discussed preferred needs with patients and these decisions were appropriately documented in the care plan.

Staff made sure patients could access advocacy services. An advocate visited all wards on a weekly basis and there were posters in each ward informing patients. The hospital received a report from the advocate, in this report patients said how much they value the opportunity to speak to the advocate.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers told us they were very pleased with the way staff do things, found staff are nice and there is good engagement with the family. A carer who stayed overnight while their family member was unwell, was made to feel welcome and comfortable by staff. Another carer was happy with communication, their nurse gave feedback every week and talked through any medication queries.

Staff helped families to give feedback on the service. Carers told us that if they raised anything or made a complaint then they would have a response straight away and the hospital would appoint someone to deal with the complaint.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Requires Improvement

Access and discharge

Staff worked well with services providing aftercare and managed patients' move out of hospital. However not all patients had a discharge plan and as a result, it was not clear if patients stayed in hospital when they were well enough to leave.

At the time of inspection, the hospital had an overall occupancy of 90%.

It was not evidenced that managers regularly reviewed length of stay for patients with no discharge date, to ensure they did not stay longer than they needed to. We did find evidence that some patients had a discharge plan in place and where a patient was ready to be discharged, discussion with external providers and professionals was well documented in the care plan. Of the 10 care plans we reviewed where a discharge plan would have been expected, we found only 2 but there was discussion of discharge in care notes. The provider had identified this was a short fall and there was a Quality Improvement Plan for every patient to have an active discharge care plan by the end of December. Meetings and correspondence had taken place to secure a new home for patients, in one case a lengthy wait while funding was agreed for an individual.

The service is a specialist service, and some patients are out-of-area placements. Some patients in the hospital were living away from family due to the specialist nature of the hospital. When patients moved out of the hospital staff told us their next move would be as close to family as possible.

Managers and staff worked to make sure they did not discharge patients before they were ready.

There was an assisted Daily Living Kitchen for patients to learn independent living skills before they were discharged. There were kitchens on each ward where patients, after risk assessment, could use the kitchen independently to make drinks and snacks.

Patients were moved between wards during their stay only when there were clear clinical reasons or it was in the best interest of the patient. Each ward had its own specialism and patients tended to stay on a ward due to this.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The care notes demonstrated when patients discharge had been delayed. When patients were admitted, managers identified Care Pathways with external colleagues and Palliative Care Pathways with families, to ensure Advance Directives were documented with preferences clearly identified. Some patients stayed long-term in the hospital because the hospital could provide for their physical as well as their mental health needs and it was very difficult to find another suitable care setting.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not support patients' treatment, privacy and dignity. Each patient had their own bedroom, but they did not have en-suite bathroom only a toilet and a sink. They could keep their personal belongings safe. The hospital had limited quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. Patients were able to personalise their own rooms including their own paintings and pictures on the room walls.

Patients had a secure place to store personal possessions. Patients had cupboards and wardrobes to store belongings in their own bedrooms and could use the office safe for anything they wished to keep secure.

Staff used a full range of equipment to support treatment and care. The clinic rooms were too small to be used for patient examinations, staff examined patients in their own bedrooms. The ward lounges were used for activities and in Cherry and Rowan wards there was no separate dining area. There was a heated cabin outside that was used for activities, but it was also used for storage.

The service lacked quiet areas, but patients could meet with visitors in private in their bedrooms.

Patients could make phone calls in private. Staff told us patients were able to make phone calls in private using a mobile phone in their bedroom and if patients did not have a mobile phone there was a hospital one that patients could use.

The service had an outside space that patients could access easily. There were 2 outdoor areas which had benches and seats for patients to use. Both areas had a grassed area and the larger garden area accessed from Rowan ward which staff told us was used for outdoor events in warmer weather. We observed patients used the garden areas with staff.

Patients could make their own hot drinks and snacks and were not dependent on staff. We found some kitchens in wards were locked but were told this was because there were no patients who had low risks that could use it independently. Cherry ward had an open kitchen.

The service offered a variety of good quality food. Staff told us that there was a choice of foods on offer and that patients who requested a favourite food, this could be accommodated for them. In the kitchen we saw that 1 patient had requested dried fruit and fresh fruit and another patient a meal choice that they preferred. Some patients told us they liked the food on offer in the hospital, other patients said they did not like the food and would like more variety.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff helped patients to stay in contact with families and carers. Carers were invited to attend weekly ward rounds. We spoke to carers, and they told us they visited the hospital and staff made them feel welcome and kept them up to date with any changes in their family members well-being. Care plans documented when families were involved in best interest decisions, when patients lacked capacity and included how patients wished to keep in contact with their family.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Each patient has a meaningful care plan which describes what patients choose to do that week in the service and in the community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication and advocacy. In some patients care plans cultural and spiritual support was not mentioned.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospital was accessible for people with physical disabilities and mobility difficulties. Two wards were on the ground floor and 2 were on the first floor and there was a lift. The communal bathrooms had a wet room and bathing facilities were accessible for people with physical disabilities. Where required, care plans included a communication plan written by the speech and language therapist. The hospital supported individuals with complex health care needs and staff were given specialist training. The hospital employed learning disability, mental health and general nurses on the wards. The hospital had a high number of patients who had expressive dysphasia, the speech and language therapist had produced pictorial aids and white boards and used them to determine if a patient had capacity and to facilitate them making decisions for themselves.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The hospital had an independent advocate that visited the hospital every week. The advocate shared concerns with the hospital with patient's agreement.

The service had information leaflets available in languages spoken by the patients and local community. If patients speak a different language, the hospital would be able to provide a leaflet in their language.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. In care plans, the speech and language therapist detailed the dietary needs of individuals with the hospital dietician. In kitchens on the cupboard doors there were details of dietary needs for staff to follow.

In some patients care plans we saw they had access to spiritual, religious and cultural support. In all patients' end of life care plans we reviewed this information was missing, the hospital told us these patients did not have any spirituality wishes, this should be reflected in the care plan.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. We spoke to carers on the telephone and in person and they told us they knew how to complain, and their complaints were acted on promptly by managers.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff told us they knew what to do if someone made a complaint, they would record the details and talk to their manager.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. In Operational Governance minutes complaints were discussed and themes were identified. Managers investigate complaints, speak to any staff concerned, finalise with a report and action plan, feedback to patient, family and carers.

Managers shared feedback from complaints with staff and learning was used to improve the service. Any lessons learnt were shared in team meetings and minutes from team meetings are available in offices for all staff to read.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Requires Improvement

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders were experienced and knowledgeable about the service and knew their patients well. During an incident on one of the wards, leaders attended and fully supported the staff. Senior leaders were supportive of their managers and provided additional training where required.

Staff told us leaders were very visible in the service and approachable and that they took an active role in the operations of the hospital. Staff expressed the provider was incredibly supportive and open to service improvement. Leaders held forums with all staff to find out their views and to solve difficulties together.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff we spoke with were aware of the trust values and how these applied to their work in the team.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us that they felt valued, respected and supported. Leaders promoted equality and diversity in daily work. Leaders were creative in ensuring staff had opportunities for development and career progression. There was a speak up guardian and a process that was promoted to staff. Leaders' promoted opportunities for staff to speak up without fear however there is a culture in the hospital for staff to not raise concerns internally. Leaders are working hard to address this culture, so all staff feel able to raise their concerns internally. Leaders had held forum meetings with all staff and their Director of Culture visited in September, to give staff opportunities to raise any concerns.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and risks were not always managed well. However, performance was well managed

In the care plans we reviewed discharge plans were not always showing however the provider had identified this was a short fall and there was a Quality Improvement Plan for every patient to have an active discharge care plan by the end of December. When patients moved into the hospital risk assessments were found to take several months to be added to patients care files. There were no audits in place to ensure risk assessments were completed in a timely manner, after patients were admitted.

The hospital had a clinic room checks recording booklet for the clinic rooms that covered cleaning of clinics but not cleaning of clinic room equipment. Hospital audits did not pick up the expired dressings, equipment stored incorrectly in grab bags, and lack of cleaning records of equipment.

After inspectors identified all staff were not complying to the rapid tranquillisation policy, the hospital immediately ensured all staff were aware and trained on the policy and procedure to follow.

However, incidents were discussed in team meetings and lessons learnt from incidents were displayed in all areas of the hospital on a quarterly basis. Staff were provided with regular supervision and appraisal and any performance issues were managed swiftly and appropriately. There was a low rate of vacancies for nurses across the hospital and a full therapy and multidisciplinary team.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Personal emergency evacuation plans were all present, correct and up to date and ligature risk assessments on all wards. The fire doors were being replaced to fully comply with a recent fire safety audit. A full therapy team ensured that care plans provided detailed plans for staff to follow with each patient care and support. Joint weekly and daily teams ward meetings took place across all wards. Staff had regular team meetings, reflective practice, supervision and appraisals. Policies and procedures were up to date and staff both agency and permanent were able to access up to date face to face specialist training provided by staff on site.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had adequate laptops on site for their use. Agency staff were given log on details when they arrive which they must activate quickly to be able to gain access to the hospital IT systems. Leaders are reviewing this, and we agree that a better access system would enable agency staff to have quicker access when they require it. Elysium IT services and professionals provide guidance and support. There had been a new intranet launched for staff in September. There were Quality Involvement Projects in progress, one of which was considering launching one drive so that files are saved onto i Cloud.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

There are partnerships in place with external social care providers to ensure that patients had opportunities to move on from the hospital to more independent living where appropriate. The Independent local advocate visits the hospital once a week. Partnership working takes place with local commissioners to ensure that patients had the necessary funding to be able to move on from the hospital where appropriate. Partnership exist with the local doctor's surgery, who visited the hospital once a week, a nurse is based at the hospital part time and patients visited the local surgery for appointments. District Nurses from the local hospital trained staff at the hospital with specialist training. Approved mental health professionals visited the hospital to carry out reviews and mental health assessments.

Learning, continuous improvement and innovation

St Neots has been awarded outstanding in all areas by Headway who have developed an accreditation scheme open to providers who specialise in caring for individuals with an acquired brain injury. There is a Quality Improvement Plan which is discussed at each monthly operations meeting. Recently the hospital have sponsored individuals who wish to live and work from overseas as they were losing good staff to competitors who were offering sponsorship. Exit interviews are carried out for all staff and recruitment fairs including a recent one on a local bus. Up to date outcome models are used. Leaders are open to learning and continuous improvement and following high-level feedback from our inspection, took immediate action where they could, when we highlighted areas of concern.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance The hospital did not have any cleaning records for the clinic rooms and the equipment in the clinic rooms.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose There were no records to show the hospital cleaned equipment after each patients use. Risk assessments were not always completed in a timely manner once a patient was admitted. Staff did not always follow hospital's policies and procedures after using rapid tranquillisation for a patient. The service had expired dressings on every ward in the clinic rooms and the equipment in the grab bag was not stored correctly.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients did not all have a discharge plan if identified as a need, appropriate, or if not, a reason documented to say why this is not required.