

Burnside Care Limited

The Priory Hospital Market Weighton

Inspection report

27 Holme Road
Market Weighton
York
YO43 3EQ
Tel:
www.burnsidecare.co.uk

Date of inspection visit: 21, 22 & 23 February 2022
Date of publication: 08/04/2022

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?

Requires Improvement



Are services caring?

Good



Are services responsive to people's needs?

Requires Improvement



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it. Although, this hospital was not a specialist service for people with a learning disability, they did provide care for five patients with a learning disability or autism. We have therefore applied this guidance.

Our rating of this service went down. We rated it as requires improvement because:


- People's risks assessments and management plans were not robust to assure staff of the patient's safety.
- People could not access assistance if required in an emergency in the occupational therapy building.
- People did not have clear goal orientated plans for discharge and did not have access to all the required specialists and therapies suitable to ensure they did not spend longer than necessary in hospital.
- The facilities were not suitable to promote the treatment, privacy and dignity for people with mobility difficulties.

However:

- People's care and support was provided in a clean, well-furnished and well-maintained environment.
- The service had sufficient, appropriately skilled staff to keep them safe.
- People were protected from abuse and poor care. Staff followed good practice with respect to safeguarding and minimised the use of restrictive practices.
- Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- People received kind and compassionate care from staff who protected and respected their privacy and dignity.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.
- People and those important to them, including advocates, were actively involved in planning their care.

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 	See overall summary for details.

Summary of findings

Contents

Summary of this inspection

Background to The Priory Hospital Market Weighton	5
Information about The Priory Hospital Market Weighton	6

Our findings from this inspection

Overview of ratings	8
Our findings by main service	9

Summary of this inspection

Background to The Priory Hospital Market Weighton

The Priory Hospital Market Weighton is an independent mental health hospital providing long stay rehabilitation for up to 15 male patients. It is located in a rural town between the cities of Hull and York.

The hospital is registered to carry out the following regulated activities:

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

At the time of the inspection, the hospital had a registered manager who had been in place for five months.

The hospital had one ward providing care and treatment for patients with severe and enduring mental health conditions, learning disabilities, those who could be on the autistic spectrum and those who may have complex presentations with behaviours that challenge. At the time of the inspection, there were 13 patients at the hospital, 12 of whom were detained under the Mental Health Act and one patient on a Deprivation of Liberty Safeguard. There were five patients with a diagnosis of a learning disability or autism.

We last inspected the Priory Hospital Market Weighton in February 2018. At that time, the service was rated overall outstanding. We rated good in the safe and effective domains and outstanding in the caring, responsive and well-led domains.

What people who use the service say

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with one person to tell us their experience

We spoke with eight patients who were staying at the hospital during our inspection. They told us they liked the staff and were treated well. They told us that they felt staff listened to them and involved them in their care.

Two patients told us they needed more therapies and activities and there was little to do, especially on a weekend. One patient told us they do not get 1:1 time with their named nurse. Three patients were unclear what their plans for discharge were and what was expected of them to achieve this.

We spoke with the family members of five patients who were staying at the hospital. They were positive in relation to staff treating their family members with dignity and respect. They told us they were invited to multi-disciplinary meetings to discuss their family member. However, two relatives told us the hospital did not have enough activities to keep the patients active, or that staff did not provide enough encouragement to promote independence.

Summary of this inspection

How we carried out this inspection

Our inspection team comprised one lead CQC inspector, one team CQC inspector, one medicines inspector, one CQC mental health act reviewer, one specialist advisor who was a registered nurse and one expert by experience.

The team included members with specialist experience in learning disabilities and autism.

During our inspection, we:

- Toured the care environments and observed how staff were caring for people.
- Received feedback from five carers and/or relatives of people who were staying at the service.
- Spoke with eight people who were using the service.
- Received feedback from the independent advocate working with people in the service.
- Interviewed ten staff including: the registered manager, consultant psychiatrist, clinical psychologist, registered nurses, support workers, occupational therapy assistant and auxiliary staff.
- Observed one handover meeting.
- Observed one Mental Health Act meeting.
- Reviewed eight care records.
- Completed a specific check of medicines management.
- Reviewed a range of documents and policies in relation to the running of the service.

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:

We told the provider that it must take action to bring services into line with three legal requirements.

- The provider must ensure that patients' risks assessment and management plans are robust, detailed and accessible. **(Regulation 12 - Safe Care and treatment)**
- The provider must ensure that staff, patients and visitors have access to an alarm in all areas of the hospital. **(Regulation 12 - Safe Care and treatment)**
- The provider must ensure patients have access to the specialists required, including Occupational Therapy, to meet their needs and support them to pursue meaningful activities that relate to their recovery and discharge planning. **(Regulation 9 - Person Centred Care)**
- The provider must ensure the premises and facilities support the comfort, privacy and dignity of those patient with mobility needs. **(Regulation 15 - Premises)**
- The provider must ensure that patients' have individualised and detailed discharge plan with timescales and clear steps a patient needs to take for rehabilitation. **(Regulation 9 - Person Centred Care)**

Summary of this inspection

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The provider should ensure staff have easy access to IT equipment.
- The provider should consider adequate space for staff to use during breaks, or for staff administrative duties.

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	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement



Safe	Requires Improvement	
Effective	Requires Improvement	
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

The ward was clean, well-furnished and well maintained. There were potential safety risks in the ward environment which the service had not fully mitigated.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of the ward. This included an annual ligature audit which staff had updated immediately prior to our inspection. Staff had identified potential ligature anchor points throughout the ward at all levels. These had been mitigated based on the knowledge of the patient group. The hospital ward had blind spots. Meaning the patients could easily access points to ligature in unobserved areas. At the time of our inspection, there were no patients in the hospital who were at risk of ligaturing; the hospitals admission criteria meant that such patients were not admitted. There had been no incidents of harm by means of ligaturing. However, there was a potential for patient's risks to change or the possibility that new patients admitted to the ward had not effectively had their risks identified. We reviewed eight patient's risk assessments and found them to be not sufficiently robust to provide assurance that all risks were fully explored and considered. All patients were on low observation levels and patient's rooms did not have viewing panels. As the mitigation of the ligature points was based on knowledge of the patient group as a whole on not through individual risk assessments, we could not be assured that that there was not a potential risk.

Patients, staff and visitors did not always have easy access to nurse call systems. In the main hospital there were alarm points on all walls, this included access to alarms from a patient's bed. However, there were no personal alarms for people to use if needed. Patients, staff and visitors would need to rely on the wall alarms. The hospital had an occupational therapy house which was not part of the main building. This was used for meetings and activities. Staff were often alone in the building with patients. This building did not have wall alarms. Staff carried out risk assessment prior to patients using this building to determine if use of the building was appropriate. Staff told us they would use a telephone if assistance was needed while in this building. Lone working policies were not used. However, this still meant that patients could not raise an alarm if needed if they were in the occupational therapy building. There were plans of maintenance works to the building to take place the month following our inspection. This included redecoration and damp proofing. However, installation of alarms was not in their current plans.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Maintenance, cleanliness, and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

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.

The service had enough nursing and support staff to keep patients safe. There was always one experienced staff member in the ward area. They had vacancies for one nurse and seven support workers at the time of our inspection. These gaps were filled by bank staff. The service did not use agency staff for patient care.

Staff turnover and sickness rates were low. The hospital's sickness rate was 1.1% and their turnover rate was 32%, below the organisation average of 40%. This equated to 12 members of staff leaving in the 12-month period prior to our inspection.

Managers accurately calculated and reviewed the number and grade of staff for each shift and could adjust staffing levels according to the needs of the patients.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

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. Medical staff for out of hours cover was provided on a rota basis with medical staff from a similar nearby independent hospital.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The service had an overall compliance rate of 86%.

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

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. Due to the pandemic, the face-to-face element of the reducing restrictive intervention breakaway training was at 55%, this figure also included auxiliary staff. However, the hospital had recently trained staff from the service to deliver this training in house. Staff were booked to complete the full course by March 2022.

Assessing and managing risk to patients and staff

Staff assessed patient risks. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. However, risk assessments were not robust.

Staff used recognised risk assessment tools. They had recently introduced the Short-Term Assessment of Risk and Treatability tool. At the time of inspection, not all staff had been trained to use this tool. They also used the organisational risk assessment tool which was a briefer risk screening document. This was the document newer staff would be directed to. Some patients also had Historical, Clinical and Risk Management - 20 (HCR -20) assessments in their files from previous providers. Staff at the hospital did not use this tool; these were therefore not kept up to date. We reviewed eight patient records. Five of these records were limited in detail about the nature of the risks. For example, one risk stated risk to self and others but with no context. Assessments did not include clear risk management plans. The assessments had been printed so staff had quick access. However, in printing some content had been cut off and the copies were extremely small to read. This meant we could not be assured that all staff, especially newer staff who were less familiar with the patients, would have a clear understanding of patient's risks or how to manage them. This was due to possible confusion in the risk assessment used, limited detail and lack of easy and clear access to the information.

Management of patient risk

Staff mostly knew about any risks to each patient and acted to prevent or reduce risks. However, this was mostly due to the familiarity and stability of both patients and the staff group. This information was not documented in a clear and easily accessed format. The hospital did not have clear risk management plans detailing the steps required to minimise or mitigate the risks patients posed.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff discussed incidents during handovers and records were updated accordingly.

Staff could not observe patients in all areas of the wards. They followed observational procedures with the level dependent on multi-disciplinary decisions. At the time of our inspection, all patients were on either hourly checks day and night or intermittent checks four times each hour.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Managers completed an annual self-assessment of restrictive practices. The hospital had an ethos of positive risk taking. The audit and our observations showed no blanket restrictive practices. Staff attended organisational forums for recovery and rehabilitation where restrictive practices were discussed

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. In the 12 months prior to our inspection, staff had restrained patients on three occasions.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

The hospital did not use rapid tranquilisation or seclude patients. No patients were in long term segregation.

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. Staff were 82% compliant in their completion of the organisation's e-learning on safeguarding adults, and 88% for safeguarding children. There were 62% of the staff up to date with the combined safeguarding face to face learning; managers were waiting for further dates to increase this.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff discussed safeguarding in handover meetings, team meetings and through clinical governance processes.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The hospital had a safeguarding lead and an organisational lead.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There had been five referrals in the 12 months prior to our inspection. All five were managed locally after discussion with safeguarding.

Staff access to essential information

Staff did not always have easy access to clinical information.

All Records were stored securely.

The hospital used electronic care records. However, there was limited IT access in the main ward area meaning staff did not always have easy or quick access. To mitigate this, staff used printed copies for some documents such as risk assessments. However, we observed some printed copies that were in very small print with some information missing in the printing.

The organisation was due to embark on a large project to replace and increase their IT provision.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely Where appropriate, medicines were labelled with individual's name.

Staff learned from safety alerts and incidents to improve practice. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers maintained patient safety, investigated incidents, and shared lessons learned with the whole team and the wider service.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff worked alongside prescribers to ensure the principles of STOMP (stopping over-medication of people with a learning disability, autism, or both) were followed.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety. There had been no serious incidents in the 12 months prior to our inspection.

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. They understood the duty of candour.

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. Managers fed back learning from incidents across the organisation through governance meetings, team meetings and in handovers.

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

Requires Improvement 

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 and updated as needed. Care plans were personalised and holistic.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed eight patient records. All records were in date, personalised and holistic. However, they did not contain clear goals for people to progress in their rehabilitation.

Staff regularly reviewed and updated care plans when patients' needs changed.

The service had not had an occupational therapist in place for the seven months prior to our inspection. This meant patients did not have an up to date evidenced based assessment to address their occupational functioning.

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 and support for self-care. 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.

Staff provided a range of care and treatment suitable for the patients in the service. They delivered care in line with best practice and national guidance.

Staff understood patients positive behavioural support plans and provided the identified care and support. The service provided care to four people with a learning disability. The hospital's psychologist had developed positive behavioural support plans for these patients. We reviewed these plans and found them to be of good quality. Staff followed the plans to provide the detailed care.

Staff identified patients' physical health needs and recorded them in their care plans. They made sure patients had access to physical health care, including specialists as required. Patients were registered with a local GP practice. They referred patients to specialists as required such as speech and language therapists, diabetic nurses and orthoptists.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

One patient had been diagnosed with stomach cancer. Staff collaborated with the range of specialists required in the patient's care; this included Macmillan nurses.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff took part in clinical audits. They carried out routine care plan reviews. Staff also recently participated in an organisational audit as part of their pledge to stop the over medication of people with a learning disability, autism or both.

Skilled staff to deliver care

The ward team did not include or have access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure staff working on the ward had 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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

The service did not have a full range of specialists to meet the needs of the patients on the ward. The team consisted of doctors, nurses (half of whom were learning disability nurses), a psychologist and support workers. However, the ward had not had an occupational therapist in place for seven months. Managers had been actively seeking recruitment into this role. A potential candidate had been identified and was due to commence the role in May 2022. There were two assistant occupational therapists who assisted patients in recreational activities such as baking, arts and crafts. We reviewed eight patient records. These patients had not received a current assessment of their occupational functioning. Patients did not receive sufficient specific and personalised interventions to progress their rehabilitation. One patient told us they would like more therapies and rehabilitation activities. Another told us they spend too much time watching TV and there was nothing to do on a weekend. We spoke with five patient's family members. They told us they felt their loved ones needed greater encouragement for exercise and meaningful activities.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care.

Managers supported staff through regular, constructive supervision of their work. The hospital had a compliance rate of 72% for up-to-date supervisions. Staff were able to attend self-reflection groups facilitated by the doctor. Medical staff participated in peer supervision with medical staff from a similar nearby independent hospital.

Managers made sure staff attended regular team meetings or gave information to those they could not attend. The hospital had a period without team meetings in the 12 months prior to our inspection. However, these had recently reconvened with the new managers arrival. We reviewed the last two months minutes showing good attendance and discussions including staffing, corporate updates, plans of work, incidents and lessons learnt, survey results and an opportunity for staff to discuss any concerns.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. They made sure staff received any specialist training for their role. Staff had completed training additional to the mandatory units, these included understanding autism, recovery approaches and managing behaviour that communicates distress.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. All disciplines of staff attended the meetings. These occurred weekly, the team discussed each patient in detail at least every four weeks.

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. Staff from the hospital attended the organisation's recovery and rehabilitation forums.

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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

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. On the ward, 88% of staff had completed the provider's training.

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 service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The service used two independent advocate providers for general advocacy and advocacy specific to the Mental Health Act and the Mental Capacity Act.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

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.

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.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

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. On the ward, 100% of staff had completed the provider's training which also included the Deprivation of Liberty Safeguards.

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

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

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.

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.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

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. They gave patients help, emotional support and advice when they needed it. Staff at all levels showed a genuine interest in patients. We observed staff displaying positive interactions at all times, engaging patients in conversations which were meaningful and individual to each patient.

Staff supported patients to understand and manage their own care treatment or condition.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

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 introduced patients to the ward and the services as part of their admission. As all admissions were planned, patients attended the hospital for visits prior to their admission with familiar staff from their previous placement.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff involved patients and gave them access to their care planning and risk assessments. However, patient's one to one work sessions with their named nurse were not clearly identified as they had been embedded in the patient's daily notes. This was recognised by the service who were acting to clearly show a patient's involvement. Patients gave us varied views of their involvement. Most patients were aware of their care plan and felt they were involved, and their views listened to.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). They had identified four patients requiring easy read care plans. These plans were reviewed monthly and updated as required. Staff included a statement in the files of five patients with a learning disability or autism diagnosis detailing how to communicate with them and the interventions to use.

Staff involved patients in decisions about the service, when appropriate. Patients were able to attend a daily morning meeting where they could discuss activities and concerns.

Staff made sure patients could access advocacy services. They used two services who visited the hospital regularly.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke with five family members who told us they were invited to multi-disciplinary meetings.

Staff helped families to give feedback on the service. The provider website had a compliments, comments, and complaints section for people to provide feedback.

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

Requires Improvement 

Access and discharge

Staff did not plan and managed discharge well.

The service had low out-of-area placements.

When patients went on leave there was always a bed available when they returned.

Discharge and transfers of care

There had been two patient discharges in the previous 12 months. There were three planned discharges for the months following our inspection. These were waiting for Ministry of Justice requirements to be satisfied, or for completion of community placement accommodation.

However, patients mostly stayed in hospital for a long time. They did not have discharge plans with clear stepped timeframes in place to support them to return home or move to a community setting. There were thirteen patients at the hospital at the time of our inspection. One patient had been at the hospital for 13 years, one patient for eight years and another for seven years. Three patients had been in the hospital for over two years. The shortest length of stay was six months. The hospital had one long term patient on end of life care; the hospital and patient were not considering transfer for this gentleman. Staff worked alongside Macmillan support to meet the patient's needs.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

We reviewed the records for eight patients. One record had detailed plans for discharge. The remaining records had either vague or no clear plans for discharge. Records did not identify recommendations for future placements as part of the admission process. They did not detail timely goals or steps a patient would need to take to progress. Two patients told us they did not know what their plans were or what was expected of them.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not support all patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were 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. They had a secure place to store personal possessions. Staff completed risk assessments for patients to have keys to access their own bedrooms. At the time of our inspection, all patients had their own keys and could access their rooms freely.

Staff used a full range of rooms and equipment to support treatment and care. There were quiet areas and a room where patients could meet with visitors or make phone calls in private. The hospital had a pool room and an allotment for patients to use.

The service had an outside space that patients could access easily. They could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. Four bedrooms in the ward had been sectioned away from the main bedrooms and contained a separate laundry room, lounge, and kitchen area. The area was to support patients in their independent living skills. This included a kitchen to support self-catering.

However, one patient's physical health had deteriorated since their admission and now required a large wheelchair. There was limited space throughout the hospital and no specifically adapted rooms. The patient's bedroom was not wheelchair friendly. The bathroom did not have a full hoist system for times when this was required. There was limited room in the dining area or lounges to accommodate a large wheelchair. This compromised the patient's privacy and dignity at certain times, for example, when staff gave medications and easily accessible toilet facilities. The hospital recognised that the ward was no longer appropriate for this patient's needs. They were working with commissioners for a bespoke placement in the community. However, two previous discharges had failed as unable to meet the patient's needs. This meant the facilities of the hospital were unable to promote dignity and privacy for patients with mobility difficulties.

Patients' engagement with the wider community

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

At the time of our inspection there were no patient's assessed as suitable to access external work opportunities or education. However, patients visited a service user supported work environment as preparation which included activities such as bowling, the cinema, museums, concerts and exercise.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Meeting the needs of all people who use the service

The service met the needs of most patients. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support the needs of most patients. However, it could not meet the needs for patients requiring wheelchairs due to the facilities and layout of the ward.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The ward had information boards in patient areas with a good variety of information.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. There were two patients on the ward who followed diets to support their cultural or dietary needs.

Patients had access to spiritual, religious and cultural support. One patient had regular visits from a priest.

Listening to and learning from concerns and complaints

The service received feedback from patients and acted on the concerns.

Managers told us complaints were mostly informally received from patients during morning meetings and discussions with staff. The service clearly displayed information about how to raise a concern in patient areas. Both patients and relatives knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. Managers investigated informal complaints and identified themes. They provided feedback appropriately.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers shared feedback from complaints with staff and learning was used to improve the service.

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.

Both staff and patients were confident in the leadership provided at the hospital. Leadership opportunities were available, and managers were developing staff and contingency plans to ensure ongoing leadership if managers became unavailable.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement



Vision and strategy

Most staff did not know and understand the provider's vision and values and how they applied to the work of their team. Staff members based on the ward could not tell us the vision or values of the organisation. All staff were able to describe positive behaviours they believed the ward demonstrated, such as person-centred care.

Managers were unable to give a well-defined rehabilitation model used for the service. Their aim was for the service to be more rehabilitation focussed for patients as a step down from secure forensic services. Their criteria for admission no longer included patients with learning disabilities or autism as their primary diagnosis or with high risks. They intended for patients to have short term stays for rehabilitation. This was recognised by the organisation with the hospital now being part of the organisation's rehabilitation network rather than their specialist learning disability network.

Culture

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

The most recent staff survey took place in October 2021. Most staff felt supported and valued and said they received constructive feedback.

Staff were recognised for their achievements in a monthly recognition scheme. The hospital produced a monthly wellbeing newsletter for staff. They had access to support for their own physical and emotional health needs through the organisation's wellbeing lead.

The service's staff sickness and absence rates were below the provider target. Staff did not report concerns in equality or diversity.

However, Staff comfort was compromised due to limited space within the hospital for staff to use for administrative work or a suitable sized room for staff to use during breaks. Members of the multi-disciplinary team did not have dedicated space for administration. Staff members only had the use of a small staff room suitable for no more than two people at any one time.

Governance

Our findings from the other key questions did not demonstrate that governance processes operated effectively at team level and that performance and risk were managed well.

The service had some systems and procedures in place. These ensured safe staffing levels, the safe management of medicines, staff training and supervision compliance and the adherence to the requirements of the Mental Health Act and Mental Capacity Act.

However, managers had not ensured that patients' risks or discharge plans were robust. We found risk assessments with limited detail and little or no management plans. We also observed plans for patients discharge to be deficient in clarity.

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. Staff could escalate concerns if required.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Information management

Staff did not collect analysed data about outcomes and performance or engage actively in local and national quality improvement activities.

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. We received positive feedback from commissioners with no concerns.

Learning, continuous improvement and innovation

The hospital was working towards AIMS accreditation standards. They had also participated in nationally driven initiatives and audits focussed on service improvement; STOMP audit, NHSE Schizophrenia Audit and the National Reducing Restrictive Practice Audit.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Patient's risk assessments and management plans were not robust, detailed and accessible.

Patients, staff and visitors did not have access to personal alarms in all parts of the hospital.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Patients did not have access to the specialists required, including Occupational Therapy, to meet their needs and support them to pursue meaningful activities that relate to their recovery and discharge planning.

Patients did not have individualised and detailed discharge plans with timescales and clear steps a patient must take for rehabilitation.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The premises and facilities did not support the comfort, privacy and dignity of patients with mobility difficulties.