St Andrew's Healthcare

St Andrew's Healthcare - Womens Service

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?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location improved. We rated it as requires improvement because:

- Across all services, the provider was challenged to ensure staffing numbers met the needs of patients and we found in some cases, patient activities had been cancelled or postponed. There was a high use of regular bank staff and agency staff.
- Staff had not always followed the provider's policy on patient observations in two services. We found gaps in observation records.
- Therapy provision on wards for people with a learning disability was below establishment and affected the delivery of therapeutic activity. One of the long stay or rehabilitation wards, which supported patients with secondary needs associated with disordered eating, did not have access to a specialist dietician.
- Staff did not always ensure that the privacy and dignity of all patients was respected and maintained. Staff did not always demonstrate the values of the organisation when supporting patients.
- Environments on wards for people with a learning disability or autism wards were not always maintained due to untimely responses to complete repairs and manage estates issues.
- One seclusion room did not have a shower and whilst the provider had made progress in the processes to plan, fund and source a shower in the seclusion room, it remained without a shower.
- Two services did not make timely repairs to the environment when issues were raised.
- In two services, care plans did not always reflect how to manage patients with physical health issues. Staff on long stay or rehabilitation wards staff did not ensure patients had a care plan in place for the use of rapid tranquilisation. Staff on forensic inpatient or secure wards did not always undertake and record physical health observations following rapid tranquilisation.
- Blanket restrictions continued to be in place on most wards. In wards for people with a learning disability or autism, seclusion occurred in areas other than a seclusion room and staff did not always record it correctly in line with the MHA Code of practice. Staff on forensic inpatient or secure wards reported a high number of incidents that required restraint and staff did not undertake searches in line with the provider's policy.
- Not all staff in wards for people with a learning disability or autism knew how to find patient information on the electronic record.
- We found staff did not always safely manage medicines and act on audit results on three services we inspected.
- In three services, governance processes in place did not always ensure checks and audits were effective enough to ensure care delivery was improved. For example, gaps in environmental checks, long term segregation reviews, and medicines management checks were not followed up.

However:

- The provider had recently implemented a new system for calculating the right numbers of staff required, based on the acuity of patient need. This was enhanced with a bleep holder system which reviewed the real time staffing situation in addition to the electronic system. This meant senior staff could move staff to where need indicated it was higher on some wards. There were meeting three times in a 24-hour period to review staffing across all wards.
- When restrictive practices were used, there was a reporting system in place and there were comprehensive reviews to try and reduce the use of these practices. We noted ward teams had made improvements to reducing restrictive practice since our last inspection.
- The provider as part of a national pilot, had developed a new clinical model (co-produced with staff and patients), which was a blended approach including low and medium security.

Summary of findings

- Managers ensured that staff had relevant mandatory and specialist training, regular supervision and appraisal. Managers dealt effectively with poor practice and the provider had made significant improvement in following policy and procedure to deal with outcomes of investigations.
- People and those important to them, including advocates, were actively involved in planning their care. Multidisciplinary teams worked well together to provide the planned care.
- 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.
- Staff worked well with services and external organisations that provided aftercare to ensure people received the right care and support when they went home.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	Our rating of this service stayed the same. We rated it as requires improvement because: • Daily checks of the ligature cutters were not always completed. Staff recorded when ligature cutters were used but did not record when they were checked daily in line with their policy. • Patients had access, without supervision, to the main courtyard, however, there was a large opening in the ground of the courtyard that had been there for over 10 months without repair. • Staff did not follow the provider's policy and record all the medicines they had disposed of. However: • The ward environments were clean. The wards had enough nurses and doctors. Staff assessed and managed risk well and followed good practice with respect to safeguarding. • Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided. • The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. • Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Forensic inpatient or secure wards

Inadequate

Our rating of this service stayed the same. We rated it as inadequate because:

- Staff had not maintained patients' dignity. On Bracken ward we observed two incidents where staff had kept the door of the toilet ajar when observing a patient in the day area. Other patients on the ward could hear the patient in the toilet.
- The provider had not ensured that ward areas were always well maintained.
- Staff had not always followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.
- Staff had not ensured the physical security of Willow ward.
- Staff had not always recorded patient's vital signs (in line with the National Institute for Health and Care Excellence (NICE guidance) when using rapid tranquilisation.
- Staff had not always recorded in the patient's clinical records, the rationale for seclusion, or the time that a period of seclusion had ended.
- Staff had reported a high number of drug errors in Willow ward.
- Patients reported that they did not always have access to healthy snacks (e.g. fruit), that there was a lack of healthy food options on the menus.

However:

- The provider had removed 26 blanket restrictions following our last inspection.

Summary of findings

- 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.
- Staff developed a comprehensive care and personal behavioural plan for each patient that met their mental and physical health needs. All patients we spoke to stated that they had been involved in the development of both their care and behavioural support plans.
- Staff provided a range of care and treatment in line with best practice and national guidance (from relevant bodies e.g. National Institute for Health and Care Excellence (NICE)).Examples included National Institute for Health and Care Excellence (NICE) guidance on personality disorder, assessment and treatment, Antisocial personality disorder: prevention and management and self-harm: assessment, management and preventing recurrence.
- Staff took part in a range of clinical audits, benchmarking and quality improvement initiatives.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

- The wards did not always have enough nurses.
- Governance processes did not always ensure that ward procedures ran smoothly. Staff did not record all the medicines they had disposed of. Staff did not always ensure that both paper and electronic medicine records were accurate, up to date and correctly identify how staff should give medicines to patients.
- Staff did not always create care plans for physical healthcare conditions.
- Staff did not ensure that patients had a care plan in place for the use of rapid tranquilisation in line with policies and procedures.
- One ward team did not have access to a specialist dietician, which was required to meet the needs of patients.

However:

Summary of findings

- The service provided safe care. The ward environments were safe and clean. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service worked to a recognised model of mental health rehabilitation.

Wards for people with learning disabilities or autism

Requires Improvement

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.

Right Support

Summary of findings

The service did not meet the model of care set out in Right Support, Right Care, Right Culture. The service was on a hospital site with other mental health services and was designed to provide a service to 24 people over three wards.
People were supported by staff to pursue their interests.
The service worked with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative. Staff did everything they could to avoid restraining people. The service recorded when staff restrained people, and staff learned from those incidents and how they might be avoided or reduced.
The service gave people care and support in a safe, clean, well equipped, well-furnished and well-maintained environment that met their sensory and physical needs. However, some areas of the hospital, in particular the bathrooms and one seclusion room, required further work to meet these standards. The provider was in the process of obtaining funding for renovating the seclusion room.
People had a choice about their living environment and were able to personalise their rooms.
People benefitted from the interactive and stimulating environment, and the service endeavoured to make further improvements in providing sensory spaces for people on the wards.
Staff supported people to make decisions following best practice in decision-making. Staff communicated with people in ways that met their needs.
Staff supported people to play an active role in maintaining their own health and wellbeing.

Right care

Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care.
People received kind and compassionate care. Staff protected and respected people's privacy and dignity. They understood and responded to

Summary of findings

their individual needs. However, this was not always the case with night staff on Church ward. The management team was in the process of reforming the culture on this ward.
The service did not have enough appropriately skilled staff to meet people's needs and keep them safe, which meant some activities such as leave could not go ahead.
People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs. People who had individual ways of communicating, using body language, sounds, Makaton (a form of sign language), pictures and symbols, could interact comfortably with staff and others involved in their treatment/care and support because staff had the necessary skills to understand them.
People's care, treatment and support plans reflected their range of needs and this promoted their wellbeing and enjoyment of life.

Right culture

People received good quality care, support and treatment because staff were trained to support their needs. However, the service did not always have enough staff which meant that people's programme of support was not always delivered in time.
People were supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. This meant people received compassionate and empowering care that was tailored to their needs.
Staff knew and understood people well and were responsive.
People and those important to them, including advocates, were involved in planning their care.
Recommendations from external bodies were not always taken on board and these decisions were not always justified. This meant that staff did not always evaluate the quality of support provided to people and embed learning into practice.
People's quality of life was enhanced by the service's culture of improvement and inclusivity.

Summary of findings

Senior managers of the hospital and senior ward-based staff had taken steps to address a closed culture that was identified at our last inspection. This included reviewing blanket restrictions, revising professional boundaries, introducing new meeting structures and ward rules. Managers sought to embed a culture promoting transparency, respect and inclusivity. Our rating of this service improved. We rated it as requires improvement because:

- On Oak ward, we found water stains in bathrooms and showers where water had been left to dry, because the drainage was not sufficient enough to allow the water to flow away. Staff had not escalated these issues to estates management, leading to an unpleasant environment for patients.
- The seclusion room on Church ward did not have shower facilities. The provider had plans to improve this, but these had not yet commenced.
- The staffing on each of the wards did not meet the recommended establishment levels, this led to some people's Section 17 leave being postponed or cancelled. Also, staff were not always able to take their breaks and support the activities provision.
- People with physical health issues such as epilepsy, did not have appropriate care plans to manage bathing.
- Staff did not complete people's enhanced and general observations in accordance with the provider policy and we found numerous gaps in the observations' records.
- Staff did not record or review seclusions appropriately when a person was secluded outside of the seclusion room, for example in their bedroom.
- Some staff did not know how to access people's care records on the electronic records system. This meant staff could not find the most up to date plan of how to care for people using the service.
- We found some expired medicines in the clinic rooms on the wards, and that staff did not act on previous audits where this was found.

Summary of findings

- We found that staff were not aware of learning from complaints, incidents and internal and external investigations.
- The wards did not have adequate psychology and occupational therapy provision for people on the wards.
- On Church ward, staff behaviour did not always display the values of the organisation and people told us that attitudes of staff at night were not always kind and respectful.
- Not every ward had a dedicated sensory room, but access to one in the same building. Some rooms had sensory equipment that was available for people to use.
- The service did not have robust governance processes in place to ensure that due consideration was given to recommendations from external reviews and ensure that actions were followed up.

However:

- People's care and support was provided in an environment that was otherwise safe, clean, well equipped, well-furnished and well-maintained which met people's physical needs.
- People were protected from abuse and poor care. The service had appropriately skilled staff to keep them safe.
- People were supported to be independent and their human rights were upheld.
- People received kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs. People had their communication needs met and information was shared in a way that could be understood.
- People's risks were assessed regularly and managed safely. People were involved in managing their own risks whenever possible.
- When restrictive practices were used, there was a reporting system in place and there were comprehensive reviews to try and reduce the use of these practices.

Summary of findings

- People made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- People's care, treatment and support plans, reflected their sensory, cognitive and functioning needs.
- People received care, support and treatment that met their needs and aspirations. Care focused on people's quality of life and followed best practice. Staff used clinical and quality audits to evaluate the quality of care.
- The service provided care, support and treatment from trained staff and specialists able to meet people's needs. Managers ensured that staff had relevant training, regular supervision and appraisal.
- People and those important to them, including advocates, were actively involved in planning their care. A multidisciplinary team worked well together to provide the planned care.
- 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 were in hospital to receive active, goal-oriented treatment. People had clear plans in place to support them to return home or move to a community setting. Staff worked well with services that provided aftercare to ensure people received the right care and support when they went home.
- Staff supported people through recognised models of care and treatment for people with a learning disability or autistic people.
- Leaders had delivered a project to address poor culture found at the last inspection. We found culture had improved, and values of staff were better demonstrated between each other, their teams and caring for people.

Summary of findings

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Background to St Andrew's Healthcare - Womens Service

St Andrew's Healthcare Women's location has been registered with the CQC since 11 April 2011. The service does not have a registered manager in post but does have a nominated individual as required, and a controlled drugs accountable officer. At the time of the inspection, the provider had applied to change its registration with the Care Quality Commission to one location instead of multiple registrations across one site. A new application for a registered manager was in progress at the time of the inspection.

This location consists of four core services: acute wards for adults of working age and psychiatric intensive care units; long stay/rehabilitation mental health wards for working age adults; forensic/inpatient secure wards; wards for people with learning disabilities or autism.

St Andrew's Healthcare Women's location is registered to provide the following regulated activities:

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

This location has been inspected ten times. The last comprehensive inspection of this location was in July and August 2021. The location was rated as inadequate overall and placed into special measures. Safe was rated as inadequate, effective rated requires improvement, caring rated inadequate, responsive rated requires improvement and well led rated as inadequate.

Urgent enforcement action was taken following the previous inspection because of immediate concerns we had about the safety of patients on the forensic inpatient or secure wards, long stay or rehabilitation mental health wards for working age adults and wards for people with learning disabilities or autism. We imposed conditions on the provider's registration that included the following requirements:

- that the provider must not admit any new patients without permission from the CQC;
- that wards must be staffed with the required numbers of suitably skilled staff to meet patients' needs;
- that staff undertaking patient observations must do so in line with the provider's policy;
- that staff must receive required training for their role and that audits of incident reporting are completed.

Following this inspection, we wrote to the provider on 9 May 2022, to vary one condition to allow, from 10 May 2022, that St Andrews Healthcare Women's service may admit up to a maximum of 1 patient per week to each ward without seeking permission from the Commission. The admissions cannot be carried over to following weeks should an admission not occur. All other conditions outlined in the section 31 notice of decision from July 2021 remained applicable. The provider was required to provide CQC with an update relating to these conditions on a fortnightly basis.

We also issued requirement notices for breaches of the following regulations:

- Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care.
- Regulation 10 Health and Social care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect.
- Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.
- Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.
- Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

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- Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.

At this inspection, we found that the provider addressed most of the issues from the last inspection of 2021. However, safe staffing (a national challenge in the ongoing pandemic of COVID-19) and gaps in observations records remained an issue on forensic inpatient wards and remained a breach of regulation 12 and 18. In addition, at this inspection, we identified breaches in regulation 10, 12, 15, 17 and 18 but are related to different issues from the last inspection in 2021.

The overall rating for this service has improved to requires improvement. At this inspection, wards for people with a learning disability or autism and long stay or rehabilitation wards for adults of working age have improved the overall rating from inadequate to requires improvement. Psychiatric intensive care service has remained the same as requires improvement. Forensic inpatient or secure wards have remained as an overall rating of inadequate. As a result of the ratings, this location remains in special measures.

The following services and wards were visited on this inspection:

Acute wards for adults of working age and psychiatric intensive care units:

- Bayley, a psychiatric intensive care unit with 10 beds for women.

Forensic inpatient/secure wards:

- Maple ward, a 10-bed medium 'blended' secure service for women.
- Willow ward, a 10-bed medium 'blended' secure service for women.
- Bracken ward, a 10-bed medium 'blended' secure service for women.

This service was one of three hospital sites chosen by NHS England to pilot a blended setting of medium and low security levels, to reduce overall length of stay in hospital.

Long stay / rehabilitation wards for working age adults:

- Silverstone ward, a longer term high dependency rehabilitation unit for women over 18, with emotionally unstable personality disorder (EUPD) and disordered eating, 12 beds.
- Naseby ward, a longer term high dependency rehabilitation unit for women over 18, providing comprehensive dialectic behaviour treatment (DBT) with a diagnosis of borderline personality disorder (BPD), 12 beds.
- Watkins House a longer term high dependency rehabilitation unit for women over 18, six beds.
- 37 Berkeley Close, a community rehabilitation unit for women over 18, three beds.

Wards for people with learning disabilities or autism:

- Oak ward, a 10-bed medium secure service for women with learning disabilities and/or autistic spectrum conditions
- Church ward, a 10-bed low secure service for women with learning disabilities and/or autistic spectrum conditions
- Sycamore ward, a 4-bed medium secure enhanced support service for women with learning disabilities and/or autistic spectrum conditions.

What people who use the service say

We spoke with 34 patients and 10 carers.

Summary of this inspection

Wards for people with a learning disability or autism: people said that they felt well supported by kind, caring and engaged staff who were interested in their well-being and did their best to provide them with the support they needed. People told us that staff tried their best to accommodate leave and took them out on group outings, but they did not always have sufficient staff to carry out some activities. Four people told us that they liked the food but that the options could be improved.

Long stay or rehabilitation wards: Patients told us they felt safe. Two patients told us that they felt the service had aided their recovery more than any other and that staff that staff were generally kind, caring and took the least restrictive approach. They told us that staff only used restraint when it was needed, and patients were given a debrief afterwards. However, one patient told us that staff did not always consider the impact on patients who witnessed the use of restraint. Two patients told us that they felt the service could benefit from more staff as staff tend to focus more on the patients with the highest support needs. Three patients told us that the ward had several bank staff. One patient told us that the regular bank staff were caring and understood their needs, but two patients told us that bank staff were not responsive to their needs. Patients were involved with their care plans, had good access to physical healthcare and had access to activities organised by the Occupational therapist. Two patients told us that they often had to wait a while for repairs to be carried out, we saw that patients frequently raised repair issues during community meetings.

Forensic inpatient and secure wards: all patients told us that they had received advice regarding their medications. Six out of nine patients said they had been involved in their care planning. Four patients told us that there was a lack of health food options and that the quality of the food was variable. Two patients described the furniture as uncomfortable. However, six patients told us that there were often not enough staff on the ward, another patient said the number of staff on duty on the day of inspection was 'fake' adding that 'half the staff don't work on this ward'. One patient told us that 'the staff we have are amazing'. Three patients told us that their planned activities had been cancelled. Two patients told us that their escorted leave had been cancelled.

Psychiatric intensive care unit, we spoke to four patients. The patients' comments were overwhelmingly positive with lots of activities in the unit particularly, pamper sessions where they could get their nails done and access foot spa's. The unit had a shared electronic device which patients could use to make video calls and a shared phone. Patients could also use their own phones to check emails. One patient felt the unit was the safest place ever, and staff were always available when needed but were always busy. Patients were given leave to attend church for private prayers. One patient was pleased with the physical health doctor visit, however, was told by staff to use mouthwash but their preference was dental floss. They were also not offered a dental appointment. Risk items were only removed if the patient had informed a staff member and were kept in locked lockers. One patient was not involved in their care plan.

We spoke with five carers.

One carer told us 'at the moment it's great, the social worker is fantastic, and that there were regular updates from staff. A second carer told us that staff 'keep us up to date', adding that they attend meetings and speak to both the social worker and care coordinator regularly. A third carer told us that staff inform them of any issues, that staff 'keep them in the loop, and described the service was 'totally and utterly amazing'. However, one carer told us that there had been problems with communication, adding that 'no one had sought the families' opinion'. Two carers told us there were not enough staff on the ward and one carer raised concerns regarding the number of male agency staff on duty at night.

Summary of this inspection

How we carried out this inspection

The inspection team visited services and wards between 5, 6 and 11, 27, 28, 29 April 2022 and 3 and 4 May 2022. During the inspection we:

- visited wards on every service and observed how staff cared for patients
- toured the clinical environments, including clinics and reviewed emergency equipment
- looked at the medicine management on the wards, including 43 medication cards
- spoke with 34 patients that were using the service
- interviewed 67staff and managers, including ward managers, clinical leads, doctors, nurses, healthcare assistants, psychologists, occupational therapists, technical instructors and social workers
- interviewed senior managers and the provider's quality improvement lead
- spoke with 10 carers
- sampled minutes of various ward meetings, attended handovers, environmental risk assessments, ligature risk assessments, 15 observation records, and community meetings
- observed episodes of care activities
- reviewed 42 patient care records
- reviewed policies and procedures relevant 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 provider 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:

Acute wards for adults of working age and psychiatric intensive care units core service:

- The provider must ensure all maintenance issues leading to a risk of harm to patients and staff are repaired in a timely manner. Regulation 15(1(e).
- The provider must ensure ligature cutters are checked daily in line with their policy. Regulation 15(1)(c).
- The provider must ensure staff record all medicines disposed of in line with their policy. Regulation 12(1) (2(g).
- The provider must ensure effective governance processes are in place to ensure managers are able to identify if staff are following policies and processes in place. Regulation 17(1) (2(a)

Forensic inpatient/secure wards core service:

- The provider must always ensure staff respect patients' privacy and dignity at all times when providing care and support. Regulation 10(1).
- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. Regulation 12(1)(2)(a)(b)(c).
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. Regulation 18(1).
- The provider must ensure that patients have access to escorted leave and activities. Regulation 18(1).

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- The provider must ensure that staff record patient's vital signs following administration of rapid tranquillisation, in line with the providers' policy. Regulation 12(1)(2)(a)(b).
- The provider must ensure that staff undertake patient searches in line with patient care plans and the provider's policy. Regulation 12(1)(2)(a)(b).
- The provider must ensure that the revised leadership and governance arrangements support the delivery of high-quality, person-centred care, operate effectively and address risk issues. Regulation 17(1)(2)(a).
- The provider must review the remaining blanket restriction, to ensure that any restriction is individualised, and risk assessed. Regulation 12(1)(2)(a).
- The provider must ensure action is taken to reduce the number of assaults and injury on staff. Regulation 12(1)(2)(a)(b).
- The service must ensure that that the environment is well maintained and fit for purpose. Regulation 12(1)(2)(a)(b)(d).
- The provider must ensure that all staff who observe patients whilst in long term segregation, are fully engaged in the process of patient observations. Regulation 12(1)(2)(a)(b)(c).
- The provider must ensure that seclusion records are completed and the required safeguards are in place in line with the Mental health Act Code of Practice. Regulation 17(1)(2)(a).

Long stay / rehabilitation wards for working age adults core service:

- The service must ensure that staff complete physical healthcare plans for all patients that require them. Regulation 12(1)(2)(a)(b)).
- The service must ensure that staff complete rapid tranquilisation care plans for all patients that require them. Regulation 12(1)(2)(a)(b).
- The service must ensure that all staff receive the required mandatory training. Regulation 12(1)(2)(c).
- The service must ensure that both paper and electronic medicine records are accurate, up to date and correctly identify how staff should give medicines to patients. Regulation 17(1) (2)(c).
- The service must ensure that staff keep a record of all medicines that they dispose of, in line with its policy. Regulation 17(1)(2)(d).
- The service must ensure that there is a full multi disciplinary team and enough staff with the right skills are available to meet the assessed needs of patients. Regulation 18(1).

Wards for people with learning disabilities or autism core service:

- The service must ensure that its premises provide an appropriate environment for both staff and people on the wards, including showering facilities for those in seclusion. Regulation 15(1)(c)(e).
- The service must ensure that staffing levels are in line with the minimum establishment levels for each shift across all three wards. Regulation 18(1)).
- The service must ensure that its medicines audits are effective, and that staff implement findings from audits so that expired medicines are disposed of in a timely manner.. Regulation 12(2)(g).
- The service must strengthen its governance processes so that recommendations and learning from internal and external reviews and investigations, for long term segregation are embedded. Regulation 17(1)(2)(f).
- The service must ensure that people's observations are carried out in accordance with the provider policy and that observation records are completed accordingly. Regulation 12(1)(2)(a)(b).
- The service must ensure epilepsy risk assessments and care plans include how to care for a person when bathing. Regulation 12(1)(2)(a)(b).
- The service must ensure that all staff continue to receive mandatory training in supporting people with a learning disability and/or autism. Regulation 12(1)(2)(c).

Action the service SHOULD take to improve:

Summary of this inspection

Forensic inpatient/secure wards core service:

- The service should ensure that staff on all wards are in receipt of an annual appraisal. Regulation 18(1)(2)(a).
- The service should ensure that all new equipment is risk assessed and PAT tested prior to distribution. Regulation 12(1)(2).

Long stay / rehabilitation wards for working age adults core service:

- The service should ensure that each ward has its own supply of resuscitation equipment. Regulation 12(1)(2)(f).
- The service should ensure that maintenance issues are reported to the maintenance team in a timely manner. Regulation 15(1)(e).
- The service should ensure that there is a cleaning record for every clinic room and clinic area. Regulation 15(1)(a)(2).
- The service should ensure that all clinic equipment is cleaned regularly and that cleaning records are accurate and up to date. Regulation 15(1)(a)(2).
- The provider should continue to review restrictive practices on a regular basis, in line with its clinical treatment model. Regulation 12(1)(2)(a)(b).
- The provider should consider ways to improve communication with and the involvement of parents and carers, in relation to their relative's care. Regulation 17(1)(2)(e).

Wards for people with learning disabilities or autism core service:

- The service should review its model of service delivery against the principles set out in the current Right Support Right Care Right Culture guidance. Reg 17 (2)(a).
- The service should ensure seclusion which takes place in a space other than a seclusion room is also recorded, reviewed and safeguards put in place in line with the Mental Health Act Code of Practice. Regulation 12(1)(2)(a).
- The service should ensure that all its staff, substantive, bank and agency, are familiar with the online records system and know how to find pertinent information related to a person's care, for example care plans and risk assessments. Regulation 12(1)(2)(a).
- The service should ensure that any learning from incidents, complaints, internal and external investigations and clinical reviews is shared widely with staff so that learning can be embedded in practice. Regulation12(1)(2)(a)(b).
- The service should continue with its endeavour to recruit into psychologist and occupational therapist vacancies on the wards so that people can have the benefit of a full multidisciplinary team of professionals in their care. Regulation 18(1).
- The service should continue in their endeavour to challenge negative staff attitudes at night, particularly on Church ward, and embed a culture of compassionate and dignified care and support. Regulation 13(1).
- The service should continue to deliver on their plans to embed least restrictive practice and providing people with access to keys for their bedrooms and lockers. Regulation 12(1)(2)(a).
- The service should continue to deliver on their plans to provide sensory spaces for people. Regulation 9(1)(a)(b).
- The service should ensure that any sterile dressings are regularly audited so that out-of-date dressings can be disposed of before use. Regulation 12(1)(2)(g).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Inadequate	Requires Improvement	Inadequate	Good	Requires Improvement	Inadequate
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Wards for people with learning disabilities or autism	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

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

Are Acute wards for adults of working age and psychiatric intensive care units safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

The ward was safe, clean, well equipped, furnished, but there were issues with maintenance and accuracy of the environmental checks.

Safety of the ward layout

Staff completed environmental risk assessments and environmental checks. However, the documented checks did not always accurately reflect the findings. The ward had five ligature cutters in various locations. Staff said they were checked daily however on checking the content of the box, the logbook had evidence of cutters being used and replaced, but no evidence of a daily check. This meant we were not assured that they were safe to use in an emergency.

The main courtyard was accessible to patients without escort; however, the ground had been damaged with a hole left in it at the far end of the courtyard without repair for over ten months. There was an increased potential risk of physical injury to patients due to the opening on the ground. Details of the damaged ground in the courtyard were not included within the environmental audits. The manager escalated the incident a second time when we brought it to their attention.

Staff could observe patients in all areas of the ward, and there were ceiling mirrors in the corridor and bedrooms to support staff observing patients.

The ward complied with guidance on eliminating mixed sex accommodation. All rooms were single occupancy, had ensuite bathrooms and was a female only ward.

Staff had mitigated the risks of potential anchor points. Television cables and PlayStation kits were locked inside the TV cabinet in the quiet room where only patients who had been individually risk assessed were given access when safe to do so.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff were equipped with alarms and personal radios to call for support and assistance from peers when needed.

Maintenance, cleanliness, and infection control

The ward was clean, and well-furnished.

There was no recent Patient-Led Assessments of the Care Environment (PLACE) (2018) for the location for cleanliness and for condition, appearance, and maintenance. There had been a change to the process due to the COVID-19 pandemic, but the provider communicated with wards that a smaller audit called 'PLACE-lite' audit was still required. The need to clean all frequently touched surfaces every two hours, was not consistently followed by staff.

Staff did not always make sure the cleaning records were up to date. Cleaning records in place at the time of inspection showed that frequently touched areas required wiping down every two hours. This was a requirement for wards areas in isolation due to COVID-19. However, at the time of the inspection there was no outbreak on the ward, and 2-hourly cleaning as not necessary. There were some gaps in these recordings, but showed areas had been cleaned frequently. Staff stated they completed fridge temperature checks daily but during the inspection no records could be found to evidence these checks.

Staff followed infection control policy, including handwashing.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet, and washing facility including a shower, and two clocks; one on the outside of the room, one on the inside.

There were three viewing monitors so staff could see inside of the seclusion room. This removed the risk of blind spots. The seclusion room had soft furnishings, a bed, and a window that allowed natural light into the room and could be opened slightly for fresh air without a risk to safety.

The service used the extra care suite on the same ground floor of the seclusion room to isolate patients' with COVID-19. Staff used a mobile dividing wall to maintain privacy at the suite if both facilities were in use simultaneously.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic room had adequate space for clinical activities and medical examination of patients.

Staff checked, maintained and cleaned equipment. The clinic room was visibly clean and tidy. The clinic records showed weekly and monthly audits of the cleaning records by a senior nurse.

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.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Nursing staff

The service had enough nursing and support staff to keep patients safe. The service implemented the Mental Health Optimal Staffing Tool (MHOST) in January 2022. Managers used this to judge the levels required to meet patient need. The Mental Health optional staffing tool (MHOST) was used to calculate the right staff skill mix per shift based on the acuity of the ward. Staff used the electronic observation tablet which gave prompt reminders on when to observe patients. This supported patient safety. The service had seven staff members including two registered nurses and five healthcare assistants per shift.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift with the MHOST tool.

Due to the introduction of the MHOST tool at the end of January 2022 statistics around staff vacancy rates are measured differently. This resulted in an apparent increase in vacancy rates from 1 in January 2022 to 6 in March 2022. This was due to the MHOST tool including enhanced support staffing in the staff establishment figure.

At the time of the inspection the manager told us there were two registered nurses' vacancies and five healthcare assistant vacancies.

Managers limited their use of agency staff and requested bank staff familiar with the service. The service had high rates of bank cover whilst establishments were being recruited to.

Managers made sure all bank staff had a full induction and understood the service before starting their shift.

The staffing turnover rate over a six-month period increased by 4% in January 2022.

Managers supported staff who needed time off for ill health with the use of bank staff to fill their shifts. Staff were able to work flexible shifts consisting of long days, early or late shifts or on a part time basis.

The average sickness levels between October 2021 and March 2022 were 10% with a peak of 15% in January 2022 due to COVID related sickness.

The ward manager could adjust staffing levels according to the needs of the patients using the MHOST tool.

Patients had regular one to one sessions with their named nurse. This was recorded within all patient care plans viewed.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Multi-disciplinary staff supported the ward to ensure escorted leave was facilitated for patients.

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 other services such as acute hospitals or when a patient had transferred or discharge to another ward, hospital or service.

Medical staff

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover. There were consultants and doctor cover from other directorate divisions in the hospital.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. Basic mandatory training for all staff included basic life support, disengagement, safeguarding, fire safety, infection control amongst other training. Staff had completed and kept up to date with their mandatory training. The overall mandatory training completed by staff in the last six months was 97% or above and was 98% at the time of the inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers used dashboards to monitor training compliance, and this was reported monthly at governance meetings.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing behaviour that challenged. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed six patient care records. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed regularly, including after any incident and before they were discharged.

On admission, staff used referral paperwork to prepare risk assessments for patients and were reviewed along with the patients during the ward rounds and multi-disciplinary team meetings with patients, and at the monthly clinical governance meetings.

Staff used a recognised risk assessment tool, the historical risk -20 (HCR–20), which is a 20-item structured clinical guide for the assessment of violence risk. The service also used Health of the Nation Outcome Scale (Mental Health). The provider had a risk management policy which outlined how risk management was assessed in line with best practice guidance, for example, 16 Principles of Best Practice in Best Practice in Managing Risk (Department of Health 2009), Positive and Proactive Care: reducing the need for restrictive interventions (Department of Health 2014).

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. While awaiting COVID-19 test result for new admissions, patients were cared for in the extra-care suite before joining their ward of admission.

Staff identified and responded to any changes in risks to, or posed by, patients. There were no CCTV cameras in the ward areas. Staff used body cameras to manage risk behaviours and to improve working practices. Patients could request to view individual footage of an incident that involved them at any time. All data was stored for 30 days.

Staff followed St Andrew's Healthcare Women's Service policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patients were searched by a pat down on admission, and their belongings were kept in lockers. Patients were individually risk assessed for items such as razors and depending on individual risk, presentation and history, items were returned after use and were not stored in bedrooms.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Restraint and seclusion were used after all other least restrictive practices had been attempted. This included verbal de-escalation and the use of alternative spaces on the ward such as the quiet room and bedrooms. Staff reviewed the use of restrictive interventions daily during their multi-disciplinary huddles. The multi-disciplinary team reviewed restrictive interventions data monthly during clinical governance meetings and escalated any increases or trends to the divisional governance meeting.

Staff were trained in the management of actual and potential aggression (MAPA).

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation and monitored patient's physical health post administration in line with the provider's policy.

The service had six patients who were cared for in long-term segregation between October 2021 and January 2022 over eight episodes. The long-term segregation area was used on three occassionsto quarantine newly admitted patients in line with COVID-19 guidance. The five other occasions used long-term segregation for risk reasons, or a care planned reason. There were no patients being cared for under long-term segregation at the time of our inspection.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff followed best practice when using the seclusion room and the extra care suite including the guidance of the Mental Health Act and Code of Practice; and if a patient required long-term segregation in the extra care suite, this was terminated by staff when it was safe to do so.

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. Safeguarding training for staff followed national guidance. All staff were required to complete level one and level two safeguarding training. Qualified staff members were also required to complete safeguarding level three training.

Staff kept up to date with their safeguarding training. Staff had completed all levels of training, including level 3 which was done online.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults at risk of harm and worked with other agencies to protect them. Patients with bruises on the ward had body maps completed to record where the bruises were on their body, and information shared where appropriate, with the Local authority Safeguarding team and the Police.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes. At the weekly safeguarding meeting, incidents were reviewed, and lessons learned were shared in the monthly staff bulletins, daily ward and divisional level meetings.

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 including bank staff could access them easily. Agency staff were rarely used. The service used a combination of electronic and paper records. Staff used an electronic tablet, which was in a trial phase, to record security checks of the environment and patient observations.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer and store medicines. Staff did not always use records effectively when disposing of medication. 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.

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. The pharmacist attended the ward fortnightly to ensure there was enough medication and that they were, in-date.

Staff did not always store and manage all medicines and prescribing documents safely. Electronic prescribing was in place. Emergency medicines were checked fortnightly by staff. The nurse in charge held the keys to the clinic room which was locked when not in use. Spare keys were stored securely. However, staff did not follow the providers policy for recording discarded medication.

Staff followed national practice to check patients had the correct medicines when they were admitted. Staff completed medicines reconciliations on admission.

Staff learned from safety alerts and incidents to improve practice.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Consultants reviewed and completed care plans for patients on high-dose antipsychotics. There were no patients on high dose antipsychotics at the time of our inspection.

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.

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. Incidents of falls, allegations, infection control, and duty of candour were reported on the incident reporting system and copied to the electronic care records of patients. The service had an average of 58 incident reported per month in the last six months with 63 incidents reported in March 2022. The top three categories of incidents included incidents of physical aggression and violence (150 incidents in the last 12 months), self-harm (73 incidents in the last 12 months) and verbal aggression (30 incidents in the last 12 months). Lessons learned were shared as red alerts and sent out by emails to staff. They were also discussed at daily ward handover meetings and divisional governance meetings.

Staff raised concerns and reported incidents and near misses in line with the provider policy.

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 incident by talking to staff after the incident and recording this on the incident reporting system.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. If the patient gave consent, their families were involved in the investigation.

Staff received feedback from investigation of incidents, an email with a red alert was sent out to all staff, and lesson learned printed and put on the notice board for staff to view.

Staff met to discuss the feedback and look at improvements to patient care. At staff meetings, feedback was discussed and areas of improvement on patients' care.

There was evidence that changes had been made as a result of feedback. The views of patients on enhanced observations were obtained on how to support them in the toilet areas.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Are Acute wards for adults of working age and psychiatric intensive care units effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans at multi-disciplinary meetings and when patients' needs changed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed six patient care records which demonstrated good practice.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had access to physical healthcare and supported 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 long-term segregation daily audits and Care plan audits were provided for enhanced monitoring support and observation support by staff which did not go beyond 2-hours at a time in line with previous regulatory recommendations.

Staff delivered care in line with best practice and national guidance.

Staff made sure patients had access to physical health care, including specialists as required. Staff identified patients' physical health needs and recorded them in their care plans. Physical observations were recorded on the electronic care records of patients. Staff made sure patients had access to physical health care including specialists as required and physical health care needs were identified and monitored appropriately

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

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the weekly Threshold Assessment Grid (TAG) tool to review severity of patients' mental health

needs, a fortnightly Clinical Global Impression (CGI) tool which measured symptom severity and response to treatments, and a fortnightly Health of Nation Outcome Scales (HoNOS) tool which measured a more in-depth assessment of patients' behaviour, impairment, symptoms and social functioning. The psychiatric intensive care unit crisis plan was reviewed by the care coordinator every week.

Staff used technology to support patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. 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 access to a full range of specialists to meet the needs of the patients on the ward. The multi-disciplinary team included nurses, doctors, psychologists, social workers and occupational therapists.

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.

Managers gave each new member of staff a full induction to the service before they started work. Managers supported staff through regular, constructive clinical and management supervision of their work. There was preceptorship programme for nurses, monthly clinical supervisions and three-monthly management supervisions. The average clinical supervision uptake from October 2021 to March 2022 was 97%. Staff told us the weekly reflective practice sessions had not taken place due to lack of maternity cover for the psychologist who ran the session.

Managers supported staff through regular, constructive appraisals of their work. Some staff told us they had not received an annual appraisal. The provider submitted information that showed all eligible staff had received an annual appraisal due as of March 2022.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff had the opportunity to attend training to enhance their skills such as quality improvement training, non-medical responsible clinician training, the "Transform programme" a six-month leadership programme for band 6, the "Aspire programme" a University blended career development, the "Evolve programme" for managers. The MSc Apprenticeship Clinical Associate programme for psychologist was due to commence.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff attended regular team meetings which took place weekly. We saw minutes of these meetings which had agenda items that covered staffing, serious incident reviews and shared lessons learned.

Multi-disciplinary and interagency teamwork

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

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. The ward teams had effective working relationships with other relevant teams within the organisation and with outside of the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. In addition to the nursing handovers, there were daily handovers in the mornings where nursing staff provided information to the multi-disciplinary team for the past 24 hours or the weekend.

Staff made sure they shared during the handover and daily huddle meetings clear information on patients care and treatments which had occurred. Information regarding incidents, risks, safeguarding, medication changes and admissions/ discharges.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Staff told us they maintained contact with external agencies including care co-ordinators, on site general practitioner's (GPs), dentists and advocacy services who were invited to ward reviews and community meetings, if appropriate. The independent advocate was available at the weekly community meetings.

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.

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.

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 stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. The independent advocate was available to patients every week at the community meetings.

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

Staff regularly assessed patients in seclusion, to ensure they were secluded for the shortest time possible. There were no patients in seclusion on the day of our inspection.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's 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.

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. Capacity to consent to treatment was obtained at admission, recorded in care plans and then regularly reviewed. Staff attempted to support and engage patients in decision processes before deciding that a patient did not have the capacity to do so.

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. Staff recorded this in the care plan which was then captured via a 'my voice dashboard'.

Are Acute wards for adults of working age and psychiatric intensive care units caring?

Good

Our rating of caring stayed the same. We rated it as 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 saw staff talking with patients at the dining area. Staff told us the social care assistant contacted carers and families of patients on admission for background information on patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. There were information leaflets on the notice boards which explained mental health problems and treatment options for patients. Information could be provided in other languages when required, and there was access to interpreter services.

Staff directed patients to other services and supported them to access those services if they needed help. Patients were given access to regular advocacy services at the weekly community meetings. There was a General Practitioner and dentist service on site, and nurses from the Physical health team attended the wards to carry out physical health checks on patients. One patient told us she was able to use the ward phone to contact Care Quality Commission to raise concerns.

Patients said staff treated them well and behaved kindly. We observed staff behaving kindly towards patients.

Staff understood and respected the individual needs of each patient. Patients told us they had been provided with meals that met their dietary needs. They were satisfied with the activities they received from the occupational therapy team. There were food choices for patients.

Patients told us they were pleased with the access to daily walk which improved their physical health. Other patients told us how staff helped them to slowly build trust with people again and were treated as human beings.

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.

Staff involved patients and gave them access to their care planning and risk assessments. Patients were given copy of their care plan and were involved where possible, in planning their care. Staff recorded patient involvement in the patients' own words. Patients were given hand-held device to capture their views in their own care plan. This initiative was part of a quality improvement project on the ward. Due to the nature of the ward, patients were often too unwell at the time of admission to participate in the initial care planning process. Staff ensured that once patients were able to, they involved them in care planning.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Staff made sure patients understood their care and treatment. Staff supported patients to understand their rights. There was independent advocacy service accessible to patients on the ward.

Staff involved patients in decisions about the service, when appropriate. Staff facilitated a monthly patient forum meeting where patients gave views about care, how the service was run and to give opinions and ideas on service development. Actions from each meeting were clearly recorded in minutes and actions were reviewed at subsequent meetings.

The service gathered feedback from patients using 'My Voice' a survey of views about care. It used ten questions about care and the results showed an improvement in patents experience since July 2021 from an average score of 8 to 9 out of ten in January 2022.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients gave feedback during weekly community meetings, the monthly patients' forum, via the pocket quality improvement device and at ward rounds.

Staff made sure patients could access advocacy services. There were information leaflets of advocacy services on notice boards in the ward areas. We saw that advocates attended the patient's review meeting.

Involvement of families and carers

Staff informed and involved families and carers appropriately**.** The social care assistant contacted carers and families of patients on admission for background information on patient involvement.

Staff enabled families and carers to give feedback on the service they received.
There were information leaflets on how to complain on the notice boards, and on how to give feedback on the service. However, during the tour of the ward area, 'You said, we did' section on the notice board was empty.

Staff provided carers with information about how to access a carer's assessment. There were information leaflets at the entrance into the ward, to get carers support and assess the needs for someone with a mental illness who is 18 or over by the local authority.

Are Acute wards for adults of working age and psychiatric intensive care units responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Patients were admitted to the psychiatric intensive care unit when their mental health needs could not be managed on an acute ward, or they required a more intensive approach for stabilisation.

Patients could be admitted from anywhere in the country although the majority were mostly from within the local area with some patients from out of area placements or from other wards within St Andrew's. Patients ready for discharge were supported to return home with aftercare support and local community crisis team involvement if necessary. Discharge planning was put in place with aftercare meetings with other professionals. Patients accessing the community were supported to become independent in doing so with shadow leave, where staff would observe patients at a distance to support patients to become independent and confident in accessing the community on their own.

Bed management

The ward had ten beds, but at the time of the inspection, there were seven patients.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay on the ward was 44 days. The actual length of stay on Bayley Unit ranged from two to 365 days.

Beds were available when needed for patients living in the catchment area.

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

When patients went on leave there was always a bed available when they returned. The responsible clinician reviewed patients before they went home or to the community for leave.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning. Patients were discharged in late afternoon.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and took action to reduce them. Patients had delayed discharge because the home team wanted the patient to access unescorted leave before discharge, or there was the absence of acute beds in the patient's local area, until a suitable placement was found.

Discharges were planned with patients, care coordinators and the home team to reduce risks. This included making transport arrangements for patients and discussing the discharge plan with the family.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff held section 117 aftercare meetings with other professionals to plan shadow leave for patients and to plan to support patients' needs in healthcare, social care and supported accommodation on discharge.

Staff supported patients during referrals and transfers between services – for example, if they were transferred back home or moved elsewhere in the hospital or stepped down.

All planning took place with the family. Patients on home leave, community leave or section 17 leave, were reviewed by their doctor with a view to discharge where safe to do so. Patients were supported to go to community placements and supported living if this was their preferred choice.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported 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.

Each patient had their own bedroom, which they personalised with pictures, wall papers and interior decorations.

Patients had a secure place to store personal possessions. Patients had lockers to keep items which were not allowed in the bedrooms. There were no safe storages in the bedrooms.

Staff and patients had access to the full range of rooms and equipment such as a clinic room to examine patients, activity and therapy rooms, and a quiet room to support treatment and care.

The service had quiet areas and a visitor's room where patients could meet with visitors in private.

Patients could make phone calls in private. Patients had their own mobile phones, and access to the ward phone for private calls.

The service had an outside courtyard that patients could access easily. Patients could access this without staff supervision.

The service offered a variety of good quality food. Patients had access to food choices. The ward had designated staff to serve meals to avoid using staff who were on shift to care for patients.

Patients' engagement with the wider community

Staff had not supported patients with activities outside the service, such as work, education. The manager told us there was minimal access to education and work due to the security of the environment and short stay nature of the ward. Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and the wider 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, advocacy and cultural and spiritual support.

The service made adjustments for disabled patients – for example, by ensuring disabled people's access to premises and by meeting patients' specific communication needs. The bedrooms have disabled access, and there was a disabled access toilet facility.

Staff made sure patients could access information on treatments, local services, patients' rights and Patients Advisory Liaison Service (PALS) and complaints were available on the notice boards.

The service provided information leaflets 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.

Patients had access to spiritual, religious and cultural support. There were chaplaincy services for all faiths provided at the community meetings, and there was an on-site church.

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. The service clearly displayed information about how to raise a concern in patient areas. There were information leaflets on how to raise a concern or complain on the notice board of the bedroom corridor.

Staff understood the policy on complaints and knew how to handle them. The manager told us a night staff member recently made a complaint about 'as and when required' medication' for a patient. The medication was reviewed and stopped to the benefit of the patient. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. Managers tried to reach a resolution at ward level, if this was not achieved then the charity complaints teams and PALS were involved. Forced medication, objection to detention and lack of access to desktop to access emails were identified themes from recent complaints.

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

Patients received feedback from managers after the investigation into their complaint.

The service had received one complaint and 16 compliments in the last six months. Records showed actions taken following the complaint and timely communication with the complainant.

Managers shared feedback from complaints with staff and learning was used to improve the service. Lessons learned were shared at staff meetings and divisional governance meetings.

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

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as 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.

The Senior Managers were visible in the service and approachable for patients and staff. Staff told us that senior managers visited the wards especially at nights to encourage and support night staff.

Vision and strategy

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

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 service had implemented a provider-wide 'six-C' project to address the blame culture with staff and encourage clear communications with patients, carers and families. This was to address other findings in the last inspection report and improve the quality of care provided to patients on Bayley Unit.

Staff told us that they felt listened to and were able to raise concerns without fear.

Staff felt positive and proud about working for the provider and their team.

Staff told us they knew how to use the whistle-blowing process and the role of Speak Up Guardian.

The service had a few resources available for staff to provide feedback during debrief following an incident, staff and handover meetings. Lessons learned were shared in the same medium and through red alerts sent to staff, and divisional governance meetings.

Governance

Our findings from other key questions demonstrated that governance processes did not operate effectively. Staff did not always follow policies in place and managers did not have a process in place to check this. The environmental audits did not identify the hole in the courtyard and the medication audit did not identify disposed medication not being recorded effectively. This increased the risk of patients being exposed to harm without managers being aware.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

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. The manager had access to performance charts which detailed the ward performance in areas such as supervision, all clinical and non-clinical audits, seclusions, incidents, staffing, wellbeing measures and staff leave. Performance was measured each month and comparisons made with trends reviewed.

Each area of performance was rated green, amber or red according to performance. Managers also had access to integrated performance reports and patient safety framework process control charts which were produced monthly. They monitored performance areas such as infection prevention control, incidents, safeguarding, complaints, falls and seclusions. These dashboards showed trends in incidents.

The provider had engagement in a 'buddy forum' with a local mental health trust, following the last inspection. The purpose of this forum was to review quality, risk and improve oversight of performance in the service.

Information management

As members of quality network (QN-PICU) and National association (NA-PICU), staff collected and analysed data on outcomes and performance and engaged 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.

The provider regularly had engagements with the Local NHS Trust to participate in peer reviews. and the provider took part in crisis pathway meetings with other services and local organisations, but because of COVID-19 restrictions, these were put on hold.

Current bed management relationship was ongoing to support patients who needed a PICU bed.

The provider had access to follow-up maternity support with patients with post-partum psychosis following childbirth.

Learning, continuous improvement and innovation

The provider had implemented projects aimed at improvement for both patients and staff. These included the 'six Cs', the electronic observation tablet to aid staff when providing enhanced patient observations, and 'My Voice' dashboard.

Bayley unit was working towards full Accreditation for Inpatient Mental Health Service in Psychiatric Intensive Care Unit (AIMS-PICU) and was currently a certified member of the National Association of Psychiatric Intensive Care and Low Secure Unit (NAPICU) and the Quality Network for Psychiatric Intensive Care Unit (QNPICU).

Inadequate

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

All wards were safe, clean, well equipped, well-furnished and fit for purpose. However, all wards had not been well maintained.

Safety of the ward layout

Staff had completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. There was a central staff office from which the day and bedroom areas could be observed. A staff member was always on duty in the day and bedroom areas.

The wards were female only and therefore complied with single sex accommodation guidance.

There were potential ligature anchor points in the service. Most staff knew about any ligature anchor points and mitigated the risks to keep patients safe. However, two staff members told us that they had not seen the wards' ligature risk assessment.

Patients had access to nurse call systems in their ensuite bathrooms. Staff had easy access to alarms. The provider had recently acquired a new alarm system which most staff reported was better than the previous system. However, two staff reported that adequate numbers of staff were not always available to respond to an alarm. One staff member gave an example of where only two staff members responded to one incident where the alarm had been activated. Staff were therefore unable to manage the incident safely, in line with training and the provider's policy.

Maintenance, cleanliness and infection control

Inadequate

Forensic inpatient or secure wards

Ward areas were clean and well furnished; however, two patients described the furniture as uncomfortable. Following inspection, the provider advised that managers have been in liaison with the patients to seek their views on new furniture. We noticed that unlabeled staff food was being stored in the patient's fridge, in the main kitchen. Ward areas were not always well maintained.

Patients told us about several ongoing issues with maintenance which had been reported and minuted in a community meeting. These issues included a blocked shower head, tumble drier not working, one patient reported that the heating in her bedroom was not working and patients reported that they were unable to use the bath as there was no plug. Further to our inspection, the provider shared documented evidence that these issues had been reported by staff and that the issues were in the process of being addressed. Further to this the provider has put in placed a preventative planned maintenance schedule.

We saw documented evidence that these issues had been reported by staff and that the issues had not yet been resolved.

Staff made sure cleaning records were up-to-date and the premises were clean. During inspection we saw that cleaning schedules had been fully completed but observed that the ward was clean, including the ward clinical and treatment room.

Staff followed infection control policy, including handwashing. The provider had ensured that robust infection, prevention and control measures were in place in relation to the prevention and management of Covid-19. All staff were bare from the elbow, staff were not wearing nail varnish or jewellery, Staff used hand gel on entry to the unit, following each activity and prior to any patient intervention.

Seclusion room (if present)

The seclusion rooms on each of the two wards allowed clear observation and two-way communication. They had a toilet and a clock. On the day of our inspection, there was a patient in the seclusion room on both Bracken and Willow wards. We reviewed three seclusion records, which had been completed in line with the provider's policy and the Mental Health Act Code of Practice.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs which staff had checked regularly. However, we noted that on Bracken ward, both glucose and adrenaline were kept in a separate locked medication cabinet. This could potentially cause a delay in the event of an emergency. The provider told us this was a standardised approach across all services and there had been no incidents which led to a delay in medication being available.

Staff had checked, maintained, and cleaned equipment. However, two staff on duty were initially not able to identify where the cleaning and checking of equipment had been recorded.

Safe staffing

The service had enough medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, had not ensured that there were enough numbers of suitably qualified, skilled and experienced nurse and healthcare assistants on the wards at all times.

Inadequate

Forensic inpatient or secure wards

Nursing staff

The service had not always had enough nursing and support staff to keep patients safe. Patients, carers and staff reported ongoing issues with staffing. During inspection six out of sixteen staff (37%), six out of nine (67%) patients and three out of five (60%) of carers interviewed raised concerns about a lack of staff. Two staff members told us that staff regularly had to remain on shift awaiting the arrival of staff for the next shift.

We reviewed data submitted by the provider in relation to staffing since the last inspection, as part of the conditions applied following the last inspection.

Although there was an improvement in the number of staff available to carry out assessed observations there remained occasions where observations did not have the correct staffing allocated. Between 27 September 2021 and 19 December 2021, 11% of all enhanced observations did not have the correct numbers of staffing. Between 30 March 2022 and 6 June 2022 16 occasions of enhanced observation did not have the correct numbers of staffing. Between 6 July and 3 August 2022, seven occasions did not have the correct numbers of staffing. Since 30 March 2022 there had been two incidents of self-harm to patients on arm's length observations rated as low or no harm between September 2021 and December 2021 there had been 21 incidents of self harm to patients on arm's length observations rated as low or no harm

Data submitted that related to planned versus actual numbers of staff on each shift showed that between 1 October 2021 and 11 November 2021, across 126 shifts, 13, (10%) did not have the numbers of staff required. This data was provided specifically for Maple and Bracken wards.

The service had varying levels of vacancies on each of the three wards. The vacancy rates on each of the three wards (as of 31 March 2022), were as follows; Maple ward four percent, Willow ward nine percent and Bracken ward 22%. The provider told us that the number of staff required per shift had increased in January 2022, with the introduction of a new safer staffing tool. The provider had an ongoing recruitment process in place, to address the current vacancy rates.

The service had low rates of agency nurses. The average agency nurse usage for the six-month period 01 October 2021 to the end of March 2022 was three percent. The provider had high rates of bank usage. The mean average bank nurse usage for the six-month period 01 October 2021 to the end of March 2022 was 22%. The highest bank usage was on Bracken ward in March 2022, where 29% of staff used were bank staff.

Managers limited their use of bank and agency staff when possible and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction to both the service and the ward and understood the service before starting their shift.

The service had reducing turnover rates. The average turnover rate in the six-month period 01 October to the end of March 2022 was just over two percent. The highest turnover rate in the six-month period 01 October to the end of March 2022, was on four percent on Maple ward in November 2021.

Managers supported staff who needed time off for ill health.

Levels of sickness were varied across the three wards. Between January and March 2022, sickness was mainly due to Covid-19. The highest average sickness rate for the three wards was 18% in January 2022, and the highest percentage sickness rate was 19% on Maple in October 2021. The average sickness rate in March 2022 was nine percent.

Inadequate

Forensic inpatient or secure wards

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The provider had introduced a new staffing tool; mental health optimum staffing tool (MHOST) in January 2022. This staffing tool identifies the number of staff required per shift based on patient acuity and activity levels. Managers told us that following the introduction of the new staffing model, there had been several gaps in required staffing levels per shift. This has been reported above.

The ward manager could adjust staffing levels according to the needs of the patients. However, staff reported that staffing was not always at optimum levels. Therefore, it was not always possible to meet the required number of staff per shift. The impact of this was a reduction in activities, activities being cancelled and members of the multidisciplinary team having to cancel activities to undertake patient observations. We were told that at times staff had not been available to respond to alarms on the ward, or across the unit.

Patients usually had regular one to one session with their named nurse. However, some staff and patients reported that on occasions one to one sessions had been rearranged due to staffing levels.

Patients' activities were sometimes cancelled when the service was short staffed. Three patients reported that they had experienced their escorted leave being cancelled and two patients reported that their leave had been cancelled.

Managers had not always ensured that staffing levels, met the identified optimum staffing levels to carry out physical interventions. We were told that the service therefore did not always have enough suitably trained 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. Staff and managers attended a daily staff 'huddle' meeting where key information was exchanged.

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.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The average mandatory training rate across all three wards for March 2022 was 93%.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training included a range of different courses including life support (basic and intermediate), safeguarding children and young people, safeguarding adults (levels one, two and three, Mental Health Act and Mental Capacity Act, food hygiene, infection control, self-harm and suicide prevention.

Managers monitored mandatory training and alerted staff when they needed to update their training. They used dashboards to monitor staff compliance with training.

Inadequate

Forensic inpatient or secure wards

Assessing and managing risk to patients and staff

Staff had not always assessed and managed risks to patients and themselves well. They had not always achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion 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 / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff reviewed patients' risk assessments in multi-disciplinary meetings and in the daily staff huddle meetings.

Staff used a recognised risk assessment tool START, which integrated into the patient's electronic health record. Staff also completed specific risks assessment as required, for example. The historical risk -20 (HCR–20), which is a 20-item structured clinical guide for the assessment of violence risk.

Management of patient risk

Staff generally knew about any risks to each patient, however had not always acted to prevent or reduce risks. Staff told us that this was mainly due to low staffing levels and a low level of response to alarms. The number of incidents of physical aggression across all three wards between 01 January and 31 March 2022 was 69. Of these incidents 24 resulted in no harm, 36 low level harm and eight in moderate harm. The total number of incidents in the last 6 months was 793, compared to a three-month period at the last inspection when we reported 721 incidents between 1 April 2021 to 30 June 2021.

During inspection, we were informed of several staff injuries. We reviewed incident data from 01 January and 31 March 2022 for Bracken ward and saw documented evidence four staff injuries. Staff also informed us of further incidents where staff had been injured during the previous weekend.

Staff could not observe patients in all areas of the wards. The provider had installed mirrors and CCTV in ward communal areas in order to mitigate risks. Staff had not always followed the provider's policy for patient observations. Documentation had not always been completed and we found gaps in recording and absence of staff signatures. This issue had also been identified as a concern in a provider wide clinical audit of patient observations, which the provider had undertaken in their 2021-22 audit.

Staff had not always followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. On inspection we were told of two patients who had self-harmed via ingestion. In both incidents, patients had secreted items, and hadn't been searched on return to the ward. However, following inspection the provider shared incident data relating to incidents of ingestion. This data indicated that all items used by patients were either permitted or not restricted on the wider ward. The provider had undertaken a follow up audit of patient searches between 24 January and 10 February 2022, which confirmed partial implementation of their action plan. However, documentation and application of the policy remained a high risk.

Inadequate

Forensic inpatient or secure wards

Staff had not always ensured the physical security of the ward. On Willow ward we observed two incidents where ward doors had not been securely locked. The first incident related to the main ward door and the second incident related to a door in the corridor outside the main ward area. This was reported to the nurse in charge of the ward.

Use of restrictive interventions

Managers had taken active step to address the number of restrictive interventions. The provider had removed ten out of sixteen restrictions following our last inspection. However, at the time of our inspection six blanket restrictions remained in place. The provider told us that they had plans in place to review and remove move the remaining restrictions. However, we were informed that staff had reported feeling overwhelmed with the number and speed of changes in practice. Following our inspection, we received a written summary which stated that only one blanket restriction was remaining.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The provider had a quality improvement initiative in place to reduce the number of blanket restrictions. The provider also had an ongoing quality improvement project aimed at reducing patient restraint. 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.

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

Staff had not always followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We found evidence that on both the 03 and 04 April 2022, Staff had not monitored the patient's physical health following administration of rapid tranquillisation.

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 kept up to date with their safeguarding training. In addition to receipt of safeguarding training as part of mandatory training, staff had access to a safeguarding lead who provided ongoing advice and support to the team.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. All staff interviewed were able to describe a safeguarding concern and were aware of the role of the safeguarding lead and social work team in raising concerns with the local authority.

Staff followed clear procedures for child visits. All requests for child visits were risk assessed. No children were allowed on the wards. All child visiting took place in one of the two visitors' room off the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding lead for the service who supported ward staff. The safeguarding lead also provided one to one support and advice to ward staff.

Managers took part in serious case reviews and made changes based on the outcomes. For example, the provider had identified concerns recording physical health examinations not being undertaken following rapid tranquillisation. This was also identified by inspectors during our visit. The provider had recently reviewed its systems and processes and had commissioned a quality improvement project to examine the issue and introduce quality improvements to address the gaps in physical health recordings.

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 generally comprehensive, and all staff, including bank and agency, could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely.

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.

Staff followed systems and processes to prescribe and administer medicines safely. Staff followed systems and processes to prescribe and administer medicines safely. A copy of signed consent to treatment documentation was available in the clinic for staff, when giving out medication.

Staff had not always reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. We found evidence of two patients given rapid tranquillisation, who had not had their vital signs recorded in line with the providers' policy. This concern had been raised following a clinical audit of rapid tranquillisation which took place in August 2021. The audit findings identified that at the time of the audit only 25% of documentation evidence that patients had received physical health checks or had refused them. The service had an action plan in place to address this concern.

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

Staff generally completed medicines records accurately and kept them up to date. However, between the 12 October 2021 and 09 February 2022, 39 medication incidents had been reported. The highest number of medication incidents took place on Willow ward, where 34 (87%) of medication incidents were reported.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Inadequate

Forensic inpatient or secure wards

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service had generally 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. The provider had an electronic incident reporting system in place, which all staff could access.

During inspection we reviewed incident data and compared this against patient care records. Staff had raised concerns and reported incidents and near misses in line with the provider's policy. Incident data was detailed and contained an impact rating

Staff reported serious incidents clearly and in line with the provider's policy. The provider reported that during the time frame 12 October 2021 and 09 April 2022, there had been one serious incident on Maple ward.

The service had no never events on any wards.

Staff understood the duty of candour. Managers were able to outline the actions taken in response to an incident. They were open and transparent and gave patients and families a full explanation when things went wrong. We were informed by a patient that they had received a letter of apology and a verbal apology from staff, following a medication error.

Managers debriefed and supported staff after any serious incident. Staff told us that they received specific debriefing following incidents and that they could access one to one support if required.

Managers investigated incidents thoroughly.

Staff received feedback from investigation of incidents internal 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. An example of this was patients having access to mobile phone (including SMART phones), when it was risk assessed as safe.

Are Forensic inpatient or secure wards effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Inadequate

Forensic inpatient or secure wards

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, holistic and recovery oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff undertook an assessment of all patients prior to admission to ensure their suitability for the service. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care and personal behavioural plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed. All patients interviewed stated that they had been involved in the development of both their care and behavioural support plans. Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They generally ensured that patients had good access to physical healthcare and supported 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. This included treatments taking a trauma informed approach and dialectic behavioural therapy.

Staff delivered care in line with best practice and national guidance (from relevant bodies e.g. National Institute for Health and Care Excellence (NICE)). Staff delivered a range of therapies, depending on the patient's presentation. Therapies included 'trauma informed therapy', dialectic behavioural therapy and cognitive behavioural therapy.

Staff identified patients' physical health needs and recorded them in their care plans. Staff generally made sure patients had access to physical health care, including specialists as required. We saw evidence in the patient's care records of regular reviews by the physical health team. This included completion of a physical health check. Referrals to specialists (including dieticians, speech and language therapy, physiotherapy and dentists), had been made appropriately. The service also had close links with the local general hospital.

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

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

Inadequate

Forensic inpatient or secure wards

Staff used a wide range of recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included the health of the nation outcome score (HoNOS), clinical global impressions; recovering quality of life; and routinely collected behavioural data

Staff used technology to support patients, including access to tablets and laptops to access online dialectic behavioural therapy, and online meetings.

Staff took part in a range of clinical audits, benchmarking and quality improvement initiatives. The provider shared details of several quality improvement initiatives. The quality improvement initiatives currently underway in the service, were focusing on handovers, the monitoring of patients with a suspected head injury and physical observations following administration of rapid tranquillisation.

Managers used that results from audits to make improvements. We reviewed audits of patient care plans, advance statements and decisions, and patient searches. Managers had developed action plans to address all areas identified for improvement.

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 that permanent staff 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. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of the patients on the ward. The multi-disciplinary team included nurses, senior healthcare assistants, healthcare assistants, peer support workers consultant forensic psychiatrists, clinical forensic psychologists, psychology assistants, occupational therapists, occupational therapy assistants and social workers. Patients also had access to physiotherapy and education, and the ward received regular visits from a pharmacy.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care. However, there was high usage of bank and agency staffing on the wards.

Managers gave each new member of staff a full induction to the service before they started work. Managers and staff reported that all new staff attended both a provider and ward induction.

Managers supported staff through regular, constructive appraisals of their work. The average appraisal rate across the three wards as at 11 April 2022 was 82%. The highest appraisal rate of 100% was on Maple ward, and the lowest appraisal rate of 61% was on Bracken ward.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. The mean average of staff supervision across all three wards as of March 2022 was 88%. The supervision rates for each of the three ward areas for March 2022 was Bracken 93%, Maple 92% and Willow 80%.

Managers supported medical staff through regular, constructive clinical supervision of their work. Medical staff informed us that they received supervision from a senior member of the medical team who was identified as their clinical supervisor.

Managers generally made sure staff attended regular team meetings or gave information from those they could not attend. Managers e-mailed the outcome of meetings to members of the team, and minutes of the meetings were printed out and placed in the ward office. Any required actions were also discussed in supervision.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. During inspection we were informed that dialectic behavioural awareness training had been delivered to ward staff, and that patients had been involved in the delivery of the training.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

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. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff had access to reflective practice meetings which took at least on a monthly basis and more frequently where required.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Nursing staff had a handover at the commencement of each shift and multidisciplinary staff, during which information was shared about any risk issues and details of patient presentation.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams reported that they had effective working relationships with external teams and organisations. During inspection we were informed of links with a range of other services in order to share good practice.

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. Staff told us that e-learning was available, which was part of their mandatory training programme. At the time of our inspection 92% of staff had completed the training.

Inadequate

Forensic inpatient or secure wards

When a patient was placed in seclusion, staff kept records and generally followed best practice guidelines. However, staff had not always documented the rationale for a patient remaining in seclusion. We reviewed the records for one patient where it was not evident why the patient had remained in seclusion. This was brought to the attention of ward staff. The patient's seclusion had been terminated by the following day. We examined five seclusion records and found that in two records the time that seclusion was terminated had not been recorded.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient required long-term segregation.

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 independent advocate attended the wards at least weekly and we saw posters on the ward, which advised patients how to contact advocacy.

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 generally 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. However, two patients reported that in the past their leave had been cancelled.

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.

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 provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There were no deprivations of liberty safeguards applications made in the last 12 months.

Inadequate

Forensic inpatient or secure wards

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.

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 changes to practice when necessary.

Are Forensic inpatient or secure wards caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. However, staff did not always respect 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 not always discreet, respectful, and responsive when caring for patients. We observed two incidents where patients being observed by staff, used the toilet adjacent to the main day area. Due to the level of observation and identified risk, a nurse kept the door to the toilet ajar with their foot and were observed by patients and staff, to be issuing a set number of toilet paper sheets to the patient. Staff and patients in the main ward area could hear the patient using the toilet. Patient care plans indicated that this practice had been in place since August 2021. This was immediately reported to the provider who took steps to address the concern.

During our inspection, staff chaperoned all patients during their interviews. We spoke to the staff about this and were advised that the staff member was present due to the identified risks. Staff gave patients help, emotional support and advice when they needed it. We reviewed patient care records and found evidence of ongoing one to one sessions both planned and unplanned.

Staff supported patients to understand and manage their own care treatment or condition. Staff worked with patients to develop a personal behavioural support plan. These examined antecedents to certain behaviours and how the patients wanted staff to respond when they were exhibiting these behaviours.

Staff directed patients to other services and supported them to access those services if they needed help. Patients were directed to a range of services including the local general hospital, local authority services and voluntary organisations.

Inadequate

Forensic inpatient or secure wards

Patients said the majority staff treated them well and behaved kindly. However, two patients raised concerns regarding night staff. Patients had raised concerns about night staff with staff. Managers had investigated all concerns and taken appropriate actions.

Staff understood and mostly respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. However, no staff member had reported the practice of observing a patient when using the toilet in the main day areas, as an area of concern. 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.

Staff involved patients and gave them access to their care planning and risk assessments. All patients told us that they had been involved in the development of their care and behavioural support plans. Staff told us that all patients had been offered a copy of their care plans.

Staff made sure patients understood their care and treatment. During inspection all patients told us that they had been involved in the development of their care plans.

Staff involved patients in decisions about the service, when appropriate. The provider had involved patients in the review of the clinical model, and in the delivery of training.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients and staff told us that community meetings were regularly held on the wards. Minutes of the meeting showed that issues raised in community meetings were followed up at the next meeting.

Staff supported patients to make advanced decisions on their care. Patients had positive behavioural support plans in place. These plans included details of how staff should respond to deterioration in a patient's mental health, and how to prevent escalation of any risks.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved some families or carers. Of the five carers interviewed, three, stated that staff had communicated with them effectively. One carer told us that they had meetings with both the social worker and key worker. Another carer told us that 'it's great. I get regular updates from staff'.

However, two carers told us that they had not been kept informed. One carer told us that this was due to the service 'not having enough staff'.

Staff helped families to give feedback on the service. Families could provide feedback in care programme approach meetings, directly to the staff or manager or via the friends and family test.

Are Forensic inpatient or secure wards responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients. At the time of our inspection the mean average stay across the service was 446 days. The longest length of stay (1,310 days) was on Bracken ward and the shortest length of stay (27 days) was on Willow ward.

The service provided medium secure beds to patients from across the country. Therefore, the service had no out-of-area placements.

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. 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. Managers maintained performance figures relating to the patient's length of stay and delayed discharges.

Patients did not have to stay in hospital when they were well enough to leave. We found evidence of ongoing patient reviews. These included communication with other providers, care team from the patients' home area, commissioners and the Ministry of Justice.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We found evidence of patients working with the assisted transitional service, which supported patients toward discharge and up to one year following discharge. We found evidence of ongoing liaison between the provider and the patient's home team. Patient had ongoing six-monthly care programme approach meetings, to which carers, care coordinators and other providers were invited as required.

Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward generally supported 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.

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions.

The service had a full range of rooms and equipment to support treatment and care. However, patients could not access all the rooms. Some rooms for example the activities room and occupational therapy kitchens were kept locked due to the environmental risks present in the locked rooms.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could make phone calls in private.

The service had an outside space that patients could access easily.

Patients could make their own hot drinks and snacks and were not dependent on staff. However, some patients reported that the hot water was not always hot enough to make tea. Staff told us that the temperature of the water had been risk assessed in order to prevent staff or patients being scalded by boiling water.

The service offered a variety of food. The service provided a variety of food to meet the dietary and cultural needs of individual patients. Four patients told us that there was a lack of health food options, however the provider shared evidence of the four week menu cycle, which included healthy food and snacks.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education, and supported patients to engage in voluntary work when they were able to.

Staff helped patients to stay in contact with families and carers. Staff assisted patients to meet with friends and relatives remotely (via online meetings). Staff also facilitated family visits both on and off the ward.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff supported patients to arrange community visits to various locations.

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, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. During inspection we observed notice boards on each ward which contained information relating to complaints, advocacy and details of activities. We saw evidence that patients had their rights explained to them and that these were repeated six monthly.

The service had access to 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. Staff were able to access interpreters or signers when required.

Patients had access to spiritual, religious and cultural support. The service had a faith room and patients had access to religious leaders to meet their religious and spiritual needs.

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. During our inspection, we observed that 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. The provider shared complaint data, which showed that a robust system was in place for the management of complaints. Managers investigated complaints and identified themes. The data showed that of the seven complaints received in November 2021, four related to staff attitude and behaviour and three related to a lack of staff. All complaints had been thoroughly investigated and lessons learned had been identified.

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. During our inspection we observed examples of red alerts. These details of incidents and associated learning.

Inadequate

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They did not have a good overall understanding of the services they managed but were visible in the service and approachable for patients and staff.

Leaders had the skills, knowledge and experience to perform their roles. However, leaders did not have a good overall understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. During inspection, we were advised that the provider had undertaken a review of management structures within the service. However, at the time of our inspection, managers did not always have an adequate oversight of clinical delivery in terms of ensuring that patients' privacy and dignity had been maintained or that there were always safe staffing levels on the wards.

Managers had introduced a multidisciplinary morning huddle meeting at which all operational issues and risks were discussed. Managers also attended a daily service meeting to discuss operational and risk issues across the service. However, the recent changes were in their infancy.

We identified several improvements which had been implemented since our last inspection. On inspection we were informed that the provider had removed ten out of 16 blanket restrictions. Following our inspection, we received a written summary which stated that only one blanket restriction was remaining.

Leaders were visible in the service and approachable for patients and staff. We were informed that managers were usually visible in the service and most staff knew who the most senior managers and executives in the organisation were.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

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

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Staff knew and understood the provider's vision and values and how they were applied in the work of their team. All staff interviewed were aware of the providers' vision and values and were able to describe these in practice. Staff informed us that the provider was currently developing a new five-year strategic pathway.

Inadequate

Forensic inpatient or secure wards

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Most 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.

Most staff told us that they felt positive and proud about working for the provider and their team. The provider was in the process of implementing cultural change project across the service. This project (based on six C's), focused to ensure effective communication, care planning, clear risk assessments, the clinical model, ensuring correct information records and the cleanliness of the wards. Staff told us that improvements had been made following our last inspection.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. However, despite this, staff continued to report whistleblowing concerns directly to the Care Quality Commission (CQC).

Most staff told us that they felt listened to, respected and valued as a member of the team. However, three staff members raised concerns about the culture on the ward. One staff member told us that managers had their favourites and another staff told us that there were cliques on the ward. This was not raised an issue by other staff members interviewed on the wards, who told us that their manager was supportive.

Managers dealt with poor staff performance when needed. Managers shared details of incidents, where actions had been taken to address concerns. This included taking disciplinary action where appropriate.

Teams worked well together and where there were difficulties managers dealt with them appropriately. We found that teams worked well together, and staff told us that they felt supported by their colleagues.

Staff appraisals included conversations about career development and how it could be supported.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The provider recognised staff success within the service. The provider held regular staff recognition events.

Governance

Our findings from the other key questions demonstrated that governance processes had not always operated effectively at team level or that performance and risk were always managed well.

The provider had a clear framework of what must be discussed at a ward, team or directorate level in team meetings, to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. There had been a review of the management structures and we were told that there was stronger clinical leadership on the wards. However, whilst it was evident that there had been a level of improvement in governance arrangements within the service, these were in the early stages of being implemented. Despite the recent changes in the management structure, we found that managers did not have adequate oversight of clinical delivery at ward level.

Inadequate

Forensic inpatient or secure wards

The provider told us about several actions they had implemented, in order to address identified breaches following our last inspection. However, several concerns and requirements identified following our inspection in July 2021 had not been addressed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. However, managers were not aware that staff had not maintained patient's privacy and dignity, when taking patients to the toilet in the main ward area. This is a continued breach of regulation.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance however, staff had not always fully acted on the results when needed. One audit showed that staff were not fully complying with the requirement regarding rapid tranquillisation. The audit identified that the lack of physical health monitoring was a high risk. However, despite the seriousness of these gaps, managers had not fully introduced systems and processes to ensure that practice had improved. The completion of physical health interventions was a further breach of regulation, which were identified at our last inspection.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. The provider had introduced a new model for identifying the required numbers of both qualified and non-qualified nurses required on duty. However, we found that there were ongoing issues with poor staffing levels across the service. Both patients, carers and staff reported ongoing issues with staffing. This had resulted in patients having escorted leave postponed or cancelled, and staff having to remain at work after their shift had ended

Managers had taken active step to address the number of restrictive interventions. The provider had removed 26 of 27 restrictions following our last inspection. A restrictive practice group was embedded and had involvement from patients.

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.

Managers collected a range of care delivery information, such as the safety framework and key performance indicators. The provider had access to a wide range of performance data, however we found that up to date data on the provider's current status in terms of appraisal was not readily available.

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register. The manager had access to performance charts which detailed the ward performance in areas such as supervision, all clinical and non-clinical audits, seclusions, incidents, staffing, wellbeing measures and staff leave. Performance was measured each month and comparisons made with trends reviewed.

The service had plans for emergencies – for example, adverse weather or an outbreak of Covid-19.

Information management

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

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. All staff had access to the patient electronic health record. Staff told us that the system was easy to use. Information governance systems ensured the security of patient records.

Managers actively collected and reviewed ward performance data. Managers told us about the ward safety dashboard (which looked at level of patient risk, leave status and risk factors), key performance indicators and results from clinical audits. Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. The service used systems to collect data from wards and directorates, however we were informed that some systems were burdensome for frontline staff.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

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.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used through the intranet, bulletins, community meetings, team meetings and newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients were involved in decision-making about changes to the service. Patients had been involved in refurbishments projects and had participated in staff interviews. The provider had strong links with several other providers including high secure hospitals. The service was part of the local strategic partnership and held ongoing engagement meetings with the local NHS Foundation trust.

Learning, continuous improvement and innovation

The service was actively engaged in quality improvement programmes using evidenced methodologies. Managers had ensured that the quality improvement initiatives aimed to address areas for improvement as identified by clinical audit. The service had introduced the Safe wards model. Safe wards is an evidence-based model aimed at reducing conflict and restrictive practice, by improving staff-patient relationships and safety.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

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

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

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. We reviewed the environmental risk assessments and ligature risk assessments for each ward and found that they were up to date and accurately identified risks. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Anti-ligature fixtures and fittings were in place on Silverstone and Naseby wards. Watkins House and 37 Berkeley Close were both step-down rehabilitation houses located off the main hospital site. Neither of these had anti-ligature fittings but staff had appropriately identified and mitigated potential ligature risks in the ligature risk assessments. Patients at Watkins House and 37 Berkeley Close had open access to all communal areas including the kitchen, lounge and garden. This could be supervised or unsupervised access, based on individual risk assessments. Staff told us that patients on these wards were generally at lower risk of self-harm than those on Silverstone and Naseby wards and we saw that patients had to be risk-free for three to six months to be admitted to these wards.

Staff could not observe patients in all parts of the wards. However, staff mitigated the risks to keep patients safe. Staff used mirrors and observation to reduce blind spots in high risk areas. Staff on Silverstone and Naseby wards kept some high-risk ward areas, such as the kitchen, locked. Staff on these wards supported patients to access locked areas supervised or unsupervised, based on individual patient risk assessments and levels of engagement in the therapy programme.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff had personal alarms and access to radios to request support when needed. Staff used personal alarms to gain assistance from staff on nearby wards. Radios were used to summon assistance from across the wider hospital site for emergencies. Nurse call systems were present in patient bedrooms and communal areas. Staff told us they could summon help when they needed to, and staff responded quickly to assist in an emergency.

Maintenance, cleanliness and infection control

Ward areas were clean and well furnished. Ward areas had enough storage and soft furnishings for patients. Staff made sure cleaning records were up-to-date and the premises were clean. Housekeepers cleaned the ward areas every day. Staff cleaned high- touch areas every two hours and kept a record of this. However, ward areas were not always well maintained. Patients told us that there was sometimes a delay in repairs being completed by the maintenance team. We saw that patients on Naseby ward had reported the same maintenance issue regarding the light in the stairwell not working seven weeks in a row. We saw that this issue was first raised in a community meeting on 1 March 2022, but a maintenance request was not completed until 3 May 2022.

Staff followed infection control policy, including handwashing. We saw that staff were bare below the elbow and wore appropriate personal protective equipment. Staff had access to handwashing basins and handwashing signs were displayed throughout the service.

Seclusion room

The Seclusion room was located on Naseby ward and was shared by Naseby and Silverstone wards. It allowed clear observation and two-way communication. The seclusion room was linked to a staff observation room by a window. The seclusion room had a window which allowed access to fresh air. It had ensuite facilities and a clock. Staff could alter the temperature of the room using a control panel in the observation room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Silverstone and Naseby wards each had fully equipped clinic rooms. Watkins House and 37 Berkeley Close were located in residential buildings and did not have a fully equipped clinic room. Instead, each had a small clinic area within the manager's office. They did not have an examination couch; patient observations took place in patient bedrooms with a chaperone. Each clinic area had a stock of emergency drugs and oxygen. Not all wards had an emergency bag containing resuscitation equipment. Resuscitation equipment was shared between Naseby ward and Silverstone ward and between Watkins House and 37 Berkeley Close. The provider had a resuscitation response matrix which set out the primary and secondary response areas for each emergency bag holder. Staff told us that they could access the emergency bags quickly enough in an emergency. Staff told us they knew which wards emergency equipment came from. There were no recorded incidents in relation to delays in accessing the emergency equipment. The provider told us they met the standards set by the UK Resuscitation Council in relation to the number of emergency bags available across the hospital.

Staff did not always clean equipment. The examination couch, examination lamp and medicine trolley on Naseby ward should have been cleaned daily and cleaning was marked as complete on the cleaning record, but we saw that the clean stickers on the furniture were out of date. However, we saw that staff completed daily and weekly checks of medical equipment.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe staffing

The service did not always have enough nursing staff. However, nurses and medical staff knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough nursing and support staff. We reviewed staffing data for the service over an eight-week period and found that the number of staff on shift did not always match the planned staffing levels. Naseby ward was planned to have two nurses on the night shift, but we found that only one nurse was on each night shift. This was because one of the two nurses allocated to the night shift regularly went to support other wards. However, we saw that the ward manager had increased the number of support workers during the night shift on Naseby ward to increase the overall staffing numbers.

Naseby ward also did not have an allocated nurse to respond to alarms in 40% of shifts over a ten-day period. We were concerned that there would not be enough staff to keep patients safe. However, Naseby ward had primary responders from five nearby wards and areas. Four out of the five nurses and support workers we spoke with on Naseby ward knew who the responders were and told us that staff responded quickly to alarms in emergencies. Two out of three patients we spoke with on Naseby ward told us that there were enough staff to respond to incidents and that staff managed incidents well.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers used the Mental Health Optimal Staffing Tool (MHOST) to calculate the number of staff needed, based on the needs of the patients. Managers could adjust staffing levels according to the needs of the patients. Ward managers and senior managers met to review staffing levels on every ward twice a day. Managers told us they could request extra staff if they needed to.

The service had high vacancy rates. We reviewed the vacancy rates for March 2022 and saw that 37 Berkeley Close had the highest vacancy rate of 53%, followed by Naseby ward at 20%. The number of vacancies increased for all wards in January 2022, following the implementation of the MHOST tool. Naseby ward was recruiting to vacant nurse and healthcare assistant posts at the time of the inspection. Silverstone ward and Watkin's House did not have any vacancies in March 2022.

Managers relied on the use of bank staff to cover vacancies. Silverstone ward reported the highest bank fill rate of 27% between October 2021 and March 2022. Managers requested bank staff who were familiar with the service and patients. All wards limited their use of agency staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Managers ensured that bank staff understood the specialist needs of patients at the service. For example, managers ensured that regular bank staff on Silverstone ward received training about nutritional awareness and mealtime support to ensure they understood patients' needs around disordered eating. Silverstone ward is a specialist rehabilitation ward for patients with a primary diagnosis of emotionally unstable personality disorder, alongside disordered eating.

The service had low turnover rates. The average turnover rate for Naseby ward between October 2021 and March 2022 was 2%, this was the highest turnover rate of all four wards.

Levels of sickness were reducing. Naseby ward had an average sickness rate of 14% between October 2021 and March 2022. The sickness rate had peaked in January 2022 at 20%. The ward manager informed us that the ward had been in isolation in January 2022 due to an outbreak of COVID-19. 37 Berkeley Close had the lowest average sickness rate at 7%.

Patients had regular one- to-one sessions with their named nurse. Patients knew who their named nurse was and told us that they had regular one-to-one sessions with them.

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 Members of the multidisciplinary team staff supported the ward by running activities when needed.

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. Junior doctors and consultants provided medical cover out of hours and at weekends. The wards had access to an out of hours pharmacist. Staff told us they had good out of hours support from duty doctors.

Managers could call locums when they needed additional medical cover.

Mandatory training

Not all staff had completed and kept up to date with their mandatory training. We found that only 67% (4 out of 6) staff at 37 Berkeley Close were up to date with their Basic Life Support training. However, we found that compliance for all other mandatory training courses was above 75% and the overall mandatory training compliance for the rehabilitation core service was 95%. The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they received automated emails to let them know when they needed to update their training.

Assessing and managing risk to patients and staff

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. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion 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. We reviewed seven patient risk assessments and found these were detailed and staff updated them after any incident. However, we found that staff on Naseby ward had not yet developed a thorough risk assessment for one patient who was admitted to the ward one week before our inspection.

Staff used a recognised risk assessment tool. Wards used the Short Term Assessment of Risk and Treatability (START) tool to assess risk.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff told us that they could find information about patient risk in risk assessments, care plans and positive behaviour support plans. Staff told us that they were told about any risks during daily handover meetings. Staff on Naseby and Silverstone wards used information about individual risk to assign patients to a Support Level, using a Support Framework. This framework that was used to determine the level of support each patient needs. Patients' access to areas such as bedrooms, the laundry room and the kitchen was determined by their Support Level and individual risk assessments. Patients were assigned a to Support Level between one (independent) and six (highest dependency). Staff used the Support Level Framework alongside a structured Dialectical Behavioural Therapy (DBT) programme, which aimed to provide patients with the skills to manage their emotions and minimise the risk of self-harm. The DBT programme aimed to achieve this by reviewing and reducing patients' Support Level over time, to gradually increase patient's independence and access to areas both on and off the wards.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff reviewed risk daily, in ward huddle meetings. Managers told us that they could ask the safer staffing matron for more staff at times where there was an increase in patient need and risk level on the ward.

Staff followed provider's 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 reducing. Staff had removed restrictions on patients' access to the courtyard and removed blanket restrictions around vaping times. Staff and patients told us that this was working well. Patients at Watkin's House and 37 Berkeley Close had unrestricted access to their bedrooms and all communal areas. The kitchen, laundry, communal toilets and dining rooms were kept locked on Silverstone and Naseby wards. Patients told us that staff would unlock these when required. Access to these areas and patient bedrooms and ensuite bathrooms was based on individual patient risk assessments and patient Support Level, patients were aware of the Support Framework. One patient told us that they could go to their bedroom at specific times during the day due to their current support level. Another patient told us that their ensuite bathroom door was kept locked, but staff would unlock it when needed. We observed weekly restrictive practice meeting on Naseby ward and heard that patients felt restrictions were proportionate and that staff balanced restrictions and safety well.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff on Naseby ward kept a restrictive practice log and invited patients to a weekly meeting to review this. Staff also regularly discussed restrictive practice at team meetings and daily ward huddles. We saw that staff had implemented a reducing observational care plan for one patient who was on 2 to 1 enhanced observation. The multidisciplinary team reviewed this plan every day and gradually introduced periods of 1 to 1 observation.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Episodes of restraint had reduced since our last inspection of this core service. The provider reported 891 episodes of restraint between October 2021 and March 2022. 453 of these took place on Naseby ward and 435 took place on Silverstone ward. Use of restraint on Silverstone ward had reduced significantly since January 2022. Restraint was used much less frequently at Watkins House and 37 Berkeley Close. There were three episodes of restraint at Watkin's House and no episodes at 37 Berkeley

Close for this period. Restraint was rarely used at Watkin's House and 37 Berkeley Close as the patients were at a lower risk of self-harm and of harm towards others and there were significantly fewer incidents in general. 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. Patients told us that staff used restraint as a last resort.

Staff did not always follow National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We reviewed one episode of rapid tranquilisation and found no evidence that staff had considered the use of oral medication instead. Staff told us that they had offered oral medicine to the patient, but there was no record of this. We also found that the patient did not have a care plan in place for the use of rapid tranquilisation. This was not in line with the provider's policy and NICE guidance. However, we saw that staff took other appropriate actions before and after they had used rapid tranquilisation, such as informing the doctor and monitoring the patient's physical health.

The seclusion room was rarely used by Silverstone and Naseby wards. The seclusion room had been used by patients on Naseby ward eight times since October 2021. It had not been used by patients on Silverstone ward in this time period. There were no incidents of long-term segregation on any wards between October 2021 and March 2022.

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. All staff were required to complete level one and level two safeguarding training. Qualified staff members were also required to complete safeguarding level three training.

Staff kept up to date with their safeguarding training. 97 per cent of staff had completed the mandatory level one and level two safeguarding training. 96 per cent of qualified staff members had completed level three safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff completed equality diversity and human rights awareness as part of their mandatory training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe. Children's visits had to be authorised by the social worker and visits took place away from the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The social worker told us that safeguarding awareness had improved with the introduction of a weekly safeguarding meeting.

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. The service used a combination of electronic and paper records. Staff had recently trialled recording observations electronically using a tablet device. Staff informed us that the trial had to stop due to poor wi-fi access and technical issues with the system. Staff returned to keeping paper records until the issues were resolved.

Records were stored securely. Paper records were stored in the staff office within a locked filing cabinet.

Medicines management

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff did not keep a record of the medicines they disposed of and did not always keep accurate patient prescription records. However, staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff did not always follow systems and processes to prescribe and administer medicines safely. Staff did not keep a record for the disposal of waste medicines. We saw that staff disposed of waste medicines in a blue bin, but staff did not keep a record of which medicines had been disposed. This was not in line with the provider's disposal of medicines policy. However, staff kept a record of the unused and expired medicines that they returned to the pharmacy.

Staff did not always complete medicines records accurately and keep them up to date. Staff did not always manage medicines and prescribing documents safely. We reviewed 17 electronic and paper patient medicines records. We found that staff had not accurately recorded the prescribed medicines in both the paper and electronic records for three patients. We were concerned that this could lead to staff making errors when giving medicines to patients.

Staff followed national practice to check patients had the correct medicines when they were admitted. Staff had checked that patients had the correct medicines when they were admitted in each of the medicine's records, we reviewed.

Staff learned from safety alerts and incidents to improve practice. Managers discussed safety alerts and incidents with staff during handovers and team meetings.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff did not over prescribe anti-psychotic medicines. Staff reviewed each patient's medicines regularly. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The provider reported 1521 incidents for this service between October 2021 and April 2022. Silverstone ward reported the most with 768, followed by Naseby ward with 660. The most common incident types for these wards were 'physical health' accounting for 655 of reported incidents and 'self-harm' accounting for 610. There were 76 incidents for this period for Watkins House, 51 of these incidents were categorised as 'physical aggression and violence'. There were no incidents categorised as 'physical health' or 'self-harm'. 37 Berkeley Close reported no incidents for this period.

Reporting incidents and learning from when things go wrong

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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. All staff had access to the Datix incident reporting system and knew how to use this. There had been one serious incident since October 2021. The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed complaints data between October 2021 and April 2022 and saw that staff responded to complaints appropriately and apologised when things went wrong. Managers debriefed and supported staff after any serious incident. Staff told us that they were debriefed after serious incidents, including the use of restraint and rapid tranquilisation. Staff had access to regular reflective practice sessions. Managers shared learning with their staff about never events that happened elsewhere. Staff received feedback from investigation of incidents in team meetings, daily handovers and by email.

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

There was evidence that changes had been made as a result of feedback. For example, staff on Naseby ward removed restrictions on patients accessing the outdoor courtyard and vaping, based on patient feedback. Staff on Silverstone ward had changed the name of the ward based on patient suggestions.

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

Requires Improvement

Our rating of effective improved. We rated it as 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 through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed the care plans of 13 patients and found that each patient had a detailed mental health assessment in place soon after admission.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Patients on Silverstone ward had secondary needs related to disordered eating. Staff completed a pre-admission checklist to ensure that patients were medically stable prior to admission to the ward. Staff monitored patients' physical health at least every two weeks using the NEWS 2 tool and more frequently if this was needed. Staff monitored physical health appropriately after incidents. For example, we reviewed the records of one patient with an extensive history of headbanging and saw that staff completed neurological observations after each incident. Staff discussed physical health at the daily ward safety huddles. Staff were knowledgeable about physical health monitoring.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff did not always develop a comprehensive care plan for each patient that met their physical health needs. We reviewed the care plans of 13 patients and found that three patients on Naseby ward did not have care plan in place for a known physical health condition. Staff had not created a physical care plan for one patient with a history of seizures. Although this patient had not had a seizure since 2018, we were concerned that there was no plan in place for the possible re-occurrence of seizures. One patient had a history of blocked ear which required regular interventions. Staff had not documented this in a physical health care plan. Staff had not yet developed a physical health care plan for a newly admitted patient with type two diabetes. The patient had been on the ward for seven days at the time of our visit to the ward. However, staff did develop a comprehensive care plan for each patient that met their mental health needs.

Staff regularly reviewed and updated care plans when patients' needs changed. Staff updated care plans at weekly ward round meetings, or sooner if this was needed. Care plans were personalised, and recovery orientated. We saw that patients had been involved in the creation of care plans. Patients told us that staff worked with them to identify goals to include in their care plans. Patients told us that they saw their care plan and were offered a copy during ward round meetings.

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 multidisciplinary team on Silverstone and Naseby wards delivered a dialectical behavioural therapy (DBT) service for patients. DBT is a type of cognitive behavioural therapy that is specially adapted for patients with a diagnosis of emotionally unstable personality disorder. DBT is the treatment programme recommended for this patient group by The National Institute for Health and Care Excellence (NICE). Both wards had a structured therapeutic programme which offered individual and group DBT sessions, daily mindfulness and goal setting. Assistant psychologists and specially trained DBT assistants delivered these sessions. Each patient had an assigned individual therapist. Staff did not deliver the full DBT programme for patients at Watkins House and Berkeley Close as patients here had a diagnosis of severe mental illness, DBT is not the recommended treatment for this patient group. Instead, patients at these services accessed a variety of treatments based on their individual needs and specific mental health diagnosis.

Staff delivered care in line with best practice and national guidance. Patients had access to a variety of activities that were recovery focused such as meal planning and preparation, gardening, music and exercise. Patients with grounds leave were able to visit the onsite gym, swimming pool and café. Staff supported patients with community leave to access shops, cafes and leisure activities. Staff supported patients to build up their leave over time and worked towards preparing their own meals. Staff supported patients to access education and training. course. Patients were able to make suggestions for activities during community meetings and at the monthly patient forum meeting.

Each patient had a copy of their activity timetable and staff displayed timetables in communal areas. There were limited planned activities at the weekends, staff told us that patients tended to have visits or go on leave at the weekends. One patient told us that they felt more activities were needed, we also saw that patients had requested more weekend activities during a patient forum meeting.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff made sure patients had access to physical health care, including specialists as required. Staff told us how they use the National early warning Score (NEWS) 2 to monitor patients' physical health. We saw that staff monitored physical healthcare after incidents and after the use of rapid tranquilisation. Patients told us that they had good access to physical health care and that staff contacted the doctor if required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We reviewed the nutrition care plans for seven patients who required nasogastric feeding. We found these were detailed and staff reviewed them regularly.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff on Silverstone ward provided specific support for disordered eating, this included individual post-mealtime support and a group called body wise to discuss issues related to disordered eating and body image.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the Health of the Nation Outcome Scale and the Recovering Quality of Life scale. Staff on Silverstone ward used The Management of Really Sick Patients with Anorexia Nervosa to assess specific needs associated with disordered eating.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Audits were completed by the St Andrew's quality improvement team. The service participated in a quality improvement project to improve physical health monitoring after using rapid tranquilisation Managers used results from audits to make improvements. Managers and the head of operations reviewed the results of audits on a monthly basis.

Skilled staff to deliver care

The ward teams did not always have access to the full range of specialists required to meet the needs of patients on the wards. Silverstone ward team did not have access to a specialist dietician, which was required to meet the needs of patients. However, 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 did not always have access to a full range of specialists to meet the needs of the patients on the ward. The multidisciplinary team consisted of doctors, nurses, occupational therapists, social workers and DBT assistants, who were specifically trained to deliver the DBT programme on Silverstone and Naseby wards. We found that patients had not had access to a specialist dietician on Silverstone ward for six months. The ward manager told us that they had recruited a new specialist dietician who was due to start in June. St Andrew's Healthcare dietetics service had provided a weekly drop-in service in the meantime, but the ward manager told us that the service could not provide the same level of access for patients. The lack of a specialist dietician had initially led to some disruption in the delivery of the regular body wise group, but this group was now being delivered by the occupational therapist.

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. A total of 19 nurses had received nasogastric training on Silverstone and Naseby ward and there were enough staff on each shift to support patients who required nasogastric feeds. Managers told us that bank staff cannot work shifts on the ward unless they have met the mandatory training requirements.

Managers gave each new member of staff a full induction to the service before they started work. Naseby and Silverstone ward had developed grab-sheets for staff, which included information about patient preferences and risks. This ensured that new members of staff could see essential information about each patient at a glance.

Managers supported staff through regular, constructive clinical supervision of their work. We reviewed supervision data for the period between October 2021 and March 2022. The supervision rate for Watkins House was 98% and 96% for 37 Berkeley close. The supervision rate for Naseby ward was 82% and 79% for Silverstone ward. We saw that clinical supervision uptake had improved significantly for Silverstone and Naseby wards over this period. The overall clinical supervision compliance for the service was 89%. Staff also had access to group supervision and weekly reflective practice sessions led by an assistant psychologist. Managers supported staff through regular, constructive appraisals of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff told us that they also received important updates during handovers, through emails and the divisional newsletter.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. The service introduced a specialist three- day DBT course in June 2021. This course provided staff with an overview of the DBT programme. The course did not run between November 2021 and March 2022 due to COVID-19 but had recently restarted. All staff were expected to attend some or part of this, depending on their role. This was to ensure that all staff had an awareness of the aims and principles of the programme. Nurses on Silverstone and Naseby wards had received nasogastric training to ensure that they could meet the nutritional needs of the patients. The manager on Silverstone ward told us that regular bank staff now had access to training around meal support and portioning to ensure they understood the needs of the patients on the ward.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

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. Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Ward round meetings took place every fortnight, but the multidisciplinary team attended daily safety huddle meetings on each ward to review patient care. Staff told us that handover meetings provided useful and relevant information.

Ward teams had effective working relationships with other teams in the organisation. Staff on Silverstone ward told us that they had good communication with the St Andrew's Healthcare central dietetics team. Staff on Silverstone and Naseby wards had a regular joint supervision session. The service worked with neighbouring wards to ensure there were enough staff to support with nasogastric feeds.

Ward teams had effective working relationships with external teams and organisations. Staff kept in touch with commissioners and care coordinators and invited them to patient reviews. The service had good links to the local safeguarding team. The responsible clinician for Silverstone ward told us that they had good links with the gastroenterology and A&E departments at the local general hospital.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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. We reviewed Mental Capacity Act training data for each ward and found that 100% of staff at 37 Berkeley Close and Watkins House were up to date with their Mental Capacity Act training. 96 per cent of staff on Naseby ward and 92% on Silverstone ward were up to date.

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. Staff displayed advocacy posters and information in communal areas.

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. We saw evidence that patients were regularly informed of their rights under the Mental Health Act in the records we reviewed. 97% of staff at the service had completed Mental Health Act training.

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 and patients told us that section 17 leave was rarely cancelled.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We saw that copies of detention papers were present and complete in the patient care records we reviewed.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's 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**.** We reviewed Mental Capacity Act training data for each ward and found that 100% of staff at 37 Berkeley Close and Watkins House were up to date with their Mental Capacity Act training. 96 per cent of staff on Naseby ward and 92% on Silverstone ward were up to date.

There were no Deprivation of Liberty Safeguards applications made in the last 12 months.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Our rating of caring improved. We rated it as 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 and respectful when caring for patients. Six out of the eight patients we spoke to told us that staff were kind, supportive and understanding of their needs. However, two patients told us that they felt night bank staff did not pay enough attention to patients. One carer told us that they had raised a complaint about a bank member of staff who had fallen asleep during patient observations. We looked at the previous six months of complaints and this complaint was not within this timeframe. The ward managers on Silverstone and Naseby told us that they try to use regular bank staff who are familiar with the patients and their needs. One patient us that they felt that bank staff on Silverstone ward were now more responsive and understanding of their nutritional needs.

Staff gave patients help, emotional support and advice when they needed it. Staff supported patients to understand and manage their own care treatment or condition. Patients told us that staff listened to them and supported them to use the strategies they learned about in their therapy sessions.

Patients said staff treated them well and behaved kindly. The patients we spoke to were generally complimentary of the regular staff who worked on the wards. Patients told us staff were respectful, caring and approachable. We saw that staff interacted with patients in a friendly manner and appeared to have a positive rapport with patients. We saw that staff used appropriate humour to engage with patients.

Staff understood and respected the individual needs of each patient. One patient told us that a staff member went out of their way to support when they were feeling particularly anxious during a mealtime.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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. Staff showed patients around the ward and gave them a welcome pack with information about the ward. Patients on Silverstone ward had contributed to the welcome pack for patients.

Staff involved patients and gave them access to their care planning and risk assessments. Patients told us that they had seen their care plans and staff offered them a copy at every ward round meeting. Patients told us they were able to contribute to their risk assessments and staff involved them in goal setting.

Staff made sure patients understood their care and treatment. Patients understood their treatment programme and knew about their medication. Staff involved patients in decisions about the service, when appropriate. Patients were involved in the planning of ward-based events and activities. Staff kept patients updated regarding recruitment of staff during community meetings.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients and staff on each ward attended a weekly community meeting. This was chaired by patients and was well attended by both patients and staff. Issues raised by patients at the community meetings were fed back to the monthly patient forum meeting, this was attended by staff and patient representatives from each ward. We observed a community meeting on Naseby ward and saw that staff welcomed patients' feedback.

Staff supported patients to make decisions on their care. Patients told us that staff involved them in their care. One patient told us how staff had respected her decision not to involve her family in her care and treatment but had encouraged her to maintain contact.

Staff made sure patients could access advocacy services. Three patients told us that an advocate had supported them.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff did not always support, inform and involve families or carers. We spoke to three carers who each felt that staff could improve communication with carers and more could be done to involve carers in ward rounds and care review meetings. The social worker told us that the service was working to improve communication with carers. We saw that Silverstone ward had developed a carers guide and there were plans to invite carers to upcoming ward events. Two carers told us that staff enabled patient visits to go ahead and they were accommodating. There was a carer centre onsite where carers could access support and information, this had recently reopened after the COVID-19 pandemic.

Staff helped families to give feedback on the service. One carer told us that the social worker had helped them to make a complaint to the ward.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Good

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay was 551 days for Naseby ward, 428 for Silverstone, 565 for Watkins House and 213 for 37 Berkeley Close.

The service had a high number of out-of-area placements. Commissioners and care coordinators were invited to patient reviews.

Managers and staff worked to make sure they did not discharge patients before they were ready. Managers told us that the expected length of stay varied between 12 and 24 months. Patients on Silverstone and Naseby were expected to complete the DBT programme before discharge, which took six months. Ward managers told us that DBT was often more successful after two cycles of DBT. Patients were able to remain on the ward for longer than two years if staff felt they would benefit from further treatment.

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

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. One patient had moved from Watkins House to 37 Berkeley Close because this environment was more suited to their increased level of independence.

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. Three patients on Naseby ward had significantly longer than expected lengths of stay. One patient had a length of stay of five years. However, we saw that staff had made efforts to engage the patient in their treatment and had involved the patient's home team in discharge planning. Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We reviewed the discharge plans for five patients and saw that planning for discharge started soon after admission. One patient told us that they had weekly catch ups with their community care coordinator to discuss discharge planning. Ward staff invited community care coordinators and commissioners to discharge planning meetings. Patients did not have to stay in hospital when they were well enough to leave.

Facilities that promote comfort, dignity and privacy

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The design, layout, and furnishings of the ward supported 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. When clinically appropriate, staff supported patients to self-cater. However, not all patients could make hot drinks and snacks at any time and the food was not always of good quality.

Each patient had their own bedroom, which they could personalise. We saw that several patients had personalised their bedrooms. Patients were involved in decorating and completing artwork in the communal areas of the service. Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Patients had access to a communal lounge, a quiet room, therapy kitchen, therapy room and outdoor spaces. However, we saw that patient areas such as therapy rooms and dining rooms were sometimes used for staff meetings, which meant that patients could not access some rooms at times. These rooms were available for patients to use for their timetabled therapeutic activities. Patients told us they had access to a range of activities both on and off the wards and did not raise any concerns about their level of access to the communal areas on the ward.

The service had quiet areas and a room where patients could meet with visitors in private. Naseby and Silverstone each had visiting rooms located off the main ward and a quiet room for patients to use. Patients could make phone calls in private.

The service had an outside space that patients could access easily. Patients on Silverstone and Naseby wards had access to a courtyard area. Patients at 37 Berkeley Close and Watkins House could access the garden freely.

Patients could not always make their own hot drinks and snacks. The kitchen on Silverstone and Naseby wards was kept locked. Access to the kitchen was dependant on patient risk assessments, their Support Level and their progress within the therapeutic model. At the time of the inspection, no patients on Naseby ward were self-catering, or able to use the kitchen unsupervised, due to their Support Level. We saw that six out of nine patients on Silverstone ward were fed via a nasogastric tube and did not have unsupervised access to the kitchen. There was a drinks station on both wards that patients could access to make cold or warm drinks, flasks were available to do this, but patients did not have free access to a kettle. We observed a patient asking a staff member to make them a hot drink during our visit. Snacks were stored in locked cupboards in the communal lounge and patients had to ask staff to gain access. However, we saw that patients at Watkins House and 37 Berkeley Close had access to the kitchen at any time and were able to self-cater.

The service offered a variety of food. Patients could order a variety of meals and desserts. However, patients had raised concerns about food quality and lack of access to fresh fruit during community meetings and patient forum meetings. One patient reported that sometimes the food provided was not appropriate for the patients on Silverstone ward. For instance, some patients had been provided with low-calorie yoghurts which they had found distressing. We saw that ward staff had invited the catering manager to attend a community meeting, but they had been unable to attend so far. The head of nursing had been informed of food quality concerns. A four weekly menu cycle was available which has been created and approved by special dieticians. There was a daily vegetable soup option, salad option, fresh vegetables and steamed fish/meats. Fresh fruit and vegetable platters were available daily.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. Staff had recently supported a patient at Watkins House to apply for a college course. Patients had access to the Workbridge Centre and knew this was available to them. The Workbridge Centre is a place for patients to access vocational work skills.

Staff helped patients to stay in contact with families and carers. One patient told us that staff had helped her to maintain contact with her family and that this had led to the patient wanting their family to be involved in their care. Two carers told us that they had been able to visit patients regularly.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff supported patients with community leave to access the local shops and cafes and activities, such as bowling.

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, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There was one patient on Naseby ward who required nasogastric feeding. Despite the ward not specialising in disordered eating, the staff were able to meet this patient's specific needs. The ward manager ensured that there were enough staff trained to provide nasogastric feeds and the patient had a clear dietary plan in place. One patient on Silverstone ward was a wheelchair user. They were able to access all areas of the ward and had a wheelchair-accessible bedroom. All regular staff were trained to use the evacuation chair and evacuation mat to ensure the patient could be safely evacuated. Each patient had a personal emergency evacuation plan which considered their mobility and support needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The service had information leaflets available in languages spoken by the patients and local community. We saw that staff provided advocacy leaflets and discussed the treatment programme with patients during weekly community meetings.

Managers made sure staff and patients could get help from interpreters or signers when needed.

Patients had access to spiritual, religious and cultural support. Patients had access to a multi-faith chaplaincy and spiritual care team.

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. Patients were able to raise their concerns during community meetings and 1 to 1 sessions. There had been three formal complaints made by patients since October 2021. Patients received feedback from managers after the investigation into their complaint. The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes. We reviewed the complaints data between October 2021 and April 2022 and saw that managers responded to complaints in a timely way and shared lessons learnt from complaints with staff.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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. Managers and staff discussed learning from complaints at team meetings and in daily safety huddles.

The service used compliments to learn, celebrate success and improve the quality of care. Staff and patients celebrated success during community meetings by nominating a patient and staff 'star of the week'. Staff shared compliments during ward huddles and staff meetings.

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

Requires Improvement

Our rating of well-led improved. We rated it as 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.

Ward managers were knowledgeable about key issues and priorities for their wards. Staff told us that ward managers and senior managers were now more approachable and visible in the service and the head of nursing visited wards regularly. We saw that the head of nursing also attended the monthly patient forum meeting.

Vision and strategy

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

Staff members were able to tell us about the provider's values of Compassion, Accountability, Respect and Excellence. We saw that staff were compassionate and respectful in the way they supported patients. Staff told us that they now had more opportunities to share their thoughts about the strategy with senior leaders.

Culture

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

Overall, staff spoke positively about the culture of the service and were proud to work at St Andrew's Healthcare. Staff told us that they felt respected and valued by the ward manager and that there were now more opportunities for staff to provide feedback and engage with the senior leadership team. Staff told us that they had opportunities to develop in their roles. The provider recognised staff success through staff awards. Staff and patient success was also celebrated during patient forum and community meetings.

Governance

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

We found that patient's prescribed medication was not always recorded accurately in paper and electronic records and no record was kept for disposed medicines on the ward. Staff did not follow aspects of the policy on disposal of medicines and did not ensure that patients who required rapid tranquilisation had a care plan in place for this, in line with the organisation's rapid tranquilisation policy. This meant systems and processes were not effectively followed to ensure safe administration and disposal of medicines.

However, there was a clear framework of what must be discussed in ward meetings and daily huddles, to ensure that staff were informed of essential information and learning from incidents was regularly discussed.

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 knew where to find information about patients' needs, preferences and risks. Staff told us that they had regular access to both group and individual supervision and reflective practice sessions. The service had a comprehensive audit programme.

Staff maintained and had access to the risk register at ward and directorate level. Staff concerns matched those on the risk register. The risk register was discussed and reviewed at the monthly divisional clinical governance meeting.

The manager had access to performance charts which detailed the ward performance in areas such as supervision, all clinical and non-clinical audits, seclusions, incidents, staffing, wellbeing measures and staff leave. Performance was measured each month and comparisons made with trends reviewed.

Information management

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

Managers regularly collected and reviewed data about performance, staffing and patient care and discussed areas for improvement with staff during team meetings. Each ward had its own quality improvement plan which was regularly reviewed by managers and senior leaders. Staff had easy access to essential information.

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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff were kept informed of things happening throughout the service through the intranet, emails and a divisional newsletter. Staff kept patients informed of changes through community meetings and the patient forum. However, carers felt that they did not receive regular communication about what was happening at the service. We saw the service was working on improving communication with carers.

Staff acted on the feedback they received. We saw that staff had removed restrictions on accessing the courtyard on Naseby ward and staff on each ward sought feedback from patients on the types activities and events they would like to have access to.

The service had good links with the local NHS Foundation trust and with other local mental health providers.

Learning, continuous improvement and innovation

We saw that the service was trialling 'e-observations'. This involved staff using an electronic tablet device to record patient observations, rather than using paper records. Staff on Naseby and Silverstone wards had been involved in the trial. Staff told us that they had experienced some difficulties with the trial due to possible internet and system issues.

Managers across the division had implemented the '6 C's culture change project'. The programme aimed to improve six key areas including communication, clinical model, care plans, risk assessment, recording, cleanliness and estates. Some areas of the project were well embedded. Staff were aware of the project and told us that communication both within their teams and from senior managers had improved. We saw that each ward had a clear and comprehensive clinical treatment model and staff created detailed risk assessments for patients. However, we found some issues with care plans, recording, cleanliness and estates during our inspection.

Requires Improvement

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

Some ward environments needed work to ensure they were safe, clean and well equipped to serve the people on the wards. Most of the wards were clean and furnished appropriately. However, staff did not always report issues relating to estates management so they could not always be addressed in a timely manner.

Safety of the ward layout

Staff completed and regularly updated thorough environmental risk assessments of all wards areas and removed or reduced any risks they identified. Risk assessments were completed annually, or sooner if new risks were identified. Staff completed weekly checklists of the environment and equipment.

Staff could observe people in all parts of the wards. Where the wards had any blind spots, these were mitigated with staff presence and the use of cameras and convex mirrors.

The ward complied with current NHS guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe. Each ward had a ligature risk assessment which was updated annually, and more regularly if any new risks were identified.

Staff had easy access to alarms and people had easy access to nurse call systems. We found that not all staff knew how to reset alarms. During our inspection, on Sycamore ward, several staff were not able to reset call alarms in a toilet without guidance from the inspection staff.

Maintenance, cleanliness and infection control

Requires Improvement

Wards for people with learning disabilities or autism

Ward areas were mostly clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. However, on Oak ward we saw that some bathrooms had dried water stains on the floors. This is where water had gathered and dried, leaving a stain on the floor. On Sycamore ward, we found dried water stains in a bedroom ensuite shower floor and a shared bathroom. Staff informed us that this was due to a drainage issues, but these had not been reported to the facilities and estates management team leading to an unpleasant environment for patients.

Staff followed infection control policy, including handwashing.

However, on Sycamore and Oak wards, the manual blood pressure monitoring machines were out of date for its' maintenance test, of which one had expired only in March 2022. There was no evidence of staff checking first aid boxes on a regular basis as we found out of date items that had not been replaced. For example, on Oak ward, we found six out of date sterile dressings in a first aid box.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

Staff were able to open and close any blinds in seclusion rooms to allow for clear observation and communication.

The seclusion rooms on Sycamore and Oak wards had been refurbished to ensure the environment was more appropriate for people's care.

The seclusion room on Church ward did not have any shower facilities. Staff tried to use other seclusion rooms in the building if a person required seclusion, however these were not always available. The provider was aware of the situation and had a renovation plan which included ensuite facilities. The architectural plans for the renovation dated back to March 2017. This means that the changes had been planned for a number of years, without any action being taken. The provider informed us that quotes for the works had been obtained and funding approval is progressing.

At the time of the inspection, there were four people being cared for in long term segregation. These people were supported by experienced staff and encouraged to enter the ward environment whenever possible as part of their reintegration programme.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

The temperature of the clinic room on Oak ward was now within the recommended range and monitored regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not always have enough staff to meet people's needs on a daily basis. Staff knew the people and received basic training to keep people safe from avoidable harm.

Requires Improvement

Wards for people with learning disabilities or autism

Nursing staff

The service did not have enough nursing and support staff to meet the needs of people using the service. We reviewed five weeks of rotas on Oak and Church wards and found that staffing levels were lower than required on two or three days per week. Staff told us that the lack of staffing impacted on their ability to take breaks, meet Section 17 leave requirements and provide activities for people on the wards. People we spoke with, told us they sometimes had their escorted leave or activities postponed due to short staffing. This was usually rescheduled as a group activity or when staffing was at establishment levels again. Some people had limited access and engagement in their community due to short staffing.

The service had increasing vacancy rates. The service had implemented a new staffing tool in January 2022 (Mental Health Optimal Staffing Tool) which converts acuity and dependency data into workload requirements. To meet the needs of people with higher dependency needs, wards had implemented greater support. The resulting staffing establishment levels were significantly higher than last year but had led to an increased vacancy rate for each ward.

The service made use of bank and agency nurses and nursing assistants until the vacancies were fulfilled by permanent staff. Agency use was very low across all three wards, and most vacant shifts were filled using regular bank staff. This meant that most staff attending the service were familiar with the wards and people they looked after. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had high turnover rates. However, this was primarily due to an effort to tackle a closed culture on Oak and Sycamore wards. The service had shifted to focus on recruitment and retention and was keen to slow the turnover rate.

Managers supported staff who needed time off for ill health. Levels of sickness were reducing.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward managers could adjust staffing levels according to the needs of people.

People had regular one-to-one sessions with their named nurse.

The service had enough staff on each shift to carry out any physical interventions safely. Staff also received support from the supernumerary bleep holder and clinical operations hub for any incidents or emergencies.

Staff shared key information to keep people safe when handing over their care to others. Staff held daily safety huddles and handovers.

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.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Requires Improvement

Wards for people with learning disabilities or autism

Staff had completed and kept up to date with their mandatory training. The staff compliance averaged at 92 per cent across the three wards in March 2022. The training was comprehensive and provided staff with a rounded introduction to basic life support, infection control, equality and diversity, safeguarding, fire safety and information governance among others.

The mandatory training programme was comprehensive and met the needs of people and staff. Staff had access to training on supporting people with a learning disability, autism or both. Since the introduction of this course in August 2021, only around 70% of staff across the three wards had been trained although more sessions had been planned for any remaining or incoming staff members.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to people and staff

Staff assessed and managed risks to people and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support people's recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of a person's risk

Staff completed risk assessments for each person on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool, the short-term assessment of risk tool (START). This was updated quarterly or sooner, following any incidents, if needed.

Management of a person's risk

Staff knew about any risks to each person and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, people. Staff had good knowledge and understanding of people's behaviours and moods. They used distraction and de-escalation techniques to manage and prevent risks**.**

The risk assessment for people with epilepsy was very detailed and comprehensive. We found that staff did not always record risk mitigations for when people with epilepsy were being bathed. For example, out of the four epilepsy care plans we reviewed, none had instructions for staff on what to do when a person was bathing and how to manage the risk of drowning. However, when we spoke with all staff, they were able to communicate clearly the risks, and understood how to manage the risks around seizures and drowning.

Staff used enhanced observations to minimise risks where they could not easily observe people. This meant that staff were required to check all people on the wards regularly to ensure they are safe and content. However, we found that

staff did not always complete all observations as required. We reviewed 24 observation records dated between July 2021 and March 2022 and found 11 records with gaps in recording. The longest gap for a person under care without observation was eight hours. Since August 2021, 20 incidents related to missed observations had been reported as Datix incidents. This meant that people were at risk of harm during the times when they should have been observed.

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

Blanket restrictions across the wards had reduced significantly. For example, people had free access to their bedrooms and food lockers. Staff were working on reducing restrictions around the use of mobile phones and outdoor access. People we spoke with told us they experienced more freedom on the wards. Staff worked with people to regularly review any blanket restrictions on the wards and these were discussed at community meetings. The remaining blanket restrictions were appropriate for the group of people and risks presented.

Use of restrictive interventions

Levels of restrictive interventions were reducing across all three wards.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep the person or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it. There had been 364 incidents of restraint on Oak ward, 185 on Sycamore ward and 30 on Church ward in the six months leading up to the inspection.

Staff followed NICE guidance when using rapid tranquilisation. There had been 22 incidents of rapid tranquilisation in the six months leading up to the inspection across all three wards, of which 19 incidents took place on Oak ward. These were mostly related to two people who had exhibited higher levels of acuity during their stay. Staff were able to describe the process they followed for rapid tranquilisation and completed all necessary physical health monitoring following its administration.

When a person was placed in seclusion, staff kept clear records and followed best practice guidelines. However, when people were secluded in their bedrooms, staff did not complete seclusion reviews and records appropriately. For example, the exact start and end time of seclusion was not always recorded and the nursing reviews for seclusion were not always carried out in a timely manner.

Staff did not always best practice, including guidance in the Mental Health Act Code of Practice, if a person was put in long-term segregation. For example, recommendations from external reviews were not always taken into account.

Safeguarding

Staff understood how to protect people 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.

Requires Improvement

Wards for people with learning disabilities or autism

Staff kept up to date with their safeguarding training. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give clear examples of how to protect people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. People we spoke with told us they felt safe on the wards.

Staff followed clear procedures to keep children visiting the ward safe. People and their loved ones had access to a family room near reception.

Managers took part in serious case reviews and made changes based on the outcomes.

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. However, some staff did not know how to access the care records.

People progress and care notes were comprehensive. We found that not all staff knew how to access electronic information related to people's care in a timely manner. Some staff we spoke with did not know how to find people's care plans. However, all staff had easy access to people's positive behavioural plans. These were printed one-page documents summarising all key information related to people's care and provision.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

When people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

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 person's mental and physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

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

Staff reviewed each person's medicines regularly and provided advice to people and carers about their medicines.

Staff completed medicines records. Staff stored medicines and prescribing documents safely. However, we found some expired medicines stored in the clinic rooms on two out of three wards. This meant that audits of medicines cupboards were not effective or fully embedded. Multiple pharmacy audits in the last six months also listed expired medication as an action for nursing staff, and this was not completed at the time of the inspection.

Requires Improvement

Wards for people with learning disabilities or autism

Staff followed national practice to check people had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice. Staff raised alerts and reported incidents when there were any errors relation to medication.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). They had held webinars and training sessions on achieving STOMP ethics within the service provided. Staff reviewed the effects of each person's medication on their physical health according to NICE guidance.

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 people's 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 people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. There had been no serious incidents at the service since August 2021.

Staff understood the duty of candour. They were open and transparent and gave people and families a full explanation if and when things went wrong. Staff gave an example of where a person's laundry items went missing and they apologised to the person and family members and tightened processes around access to the laundry room. We looked at five complaints and saw evidence that the service offered apologies to the complainants and/or their families.

Managers debriefed and supported staff after any serious incident. Managers investigated incidents thoroughly and tried to involve people and their families. We saw evidence of learning from lessons being cascaded to teams using 'patient safety action notices'. However, staff we spoke with were not able to give examples of recent lessons learnt and said they did not always receive feedback from investigation of internal incident.

Staff met to discuss the feedback and look at improvements to people's care. Staff had access to fortnightly reflective practice sessions with the learning disability lead and discussed any complex cases. There was evidence that changes had been made as a result of feedback.

Managers and staff were aware of the Learning from Deaths Mortality Review (LeDeR) Programme. Managers supported the review process and changes made from any learning shared.

Requires Improvement

Wards for people with learning disabilities or autism

Are Wards for people with learning disabilities or autism effective?

Good

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of people who would benefit. They worked with people and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

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

Staff had access to physical healthcare support on site. This included an onsite mobile physical health team, and a GP, and people were registered with this GP on admission. People had access to dentistry and the GP could refer people to appointments for age related clinics such as smear tests.

People had care and support plans that were personalised, holistic, strengths-based and reflected their needs and aspirations, including physical and mental health needs. People, those important to them and staff reviewed plans regularly together.

Care plans reflected a good understanding of people's needs, including relevant assessments of people's communication support and sensory needs.

Staff ensured people had up-to-date care and support assessments, including medical, psychological, functional, communication, preferences and skills. Support plans set out current needs, promoted strategies to enhance independence.

For people in long term segregation, these support plans were on display in the observation area, so all staff knew their preferences and risks. However, we found that staff did not show evidence of planning and consideration of the longer-term aspiration of each person in segregation. They did not always plan people's reintegration back onto the wards using an evidence and positive risk-based approach.

Best practice in treatment and care

Staff provided a range of treatment and care for people 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 people 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.

Requires Improvement

Wards for people with learning disabilities or autism

Staff provided a range of care and treatment suitable for the people in the service. For example, people had access to adaptive cognitive behavioural therapy, coping skills, sensory approaches, animal therapy and work opportunities.

Staff delivered care in line with best practice and national guidance.

Staff understood people's positive behavioural support plans and provided the identified care and support. People had a communication plan in place which met their needs.

Staff identified peoples' physical health needs and recorded them in their care plans. These were reviewed on a regular basis. Staff made sure people had access to physical health care, including specialists as required. People had an active role in maintaining their own health and wellbeing and this included access to primary care services. Staff examined people's body mass index (BMI) over time to recognise patterns for treatment and care. However, we found that staff did not effectively record these bathing protocols for people with epilepsy to manage and prevent the risks of drowning. We did find that staff knew and could describe how to prevent drowning and their responsibility in managing people's epilepsy conditions.

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

Staff helped people live healthier lives by supporting them to take part in programmes or giving advice. For example, one person had a plan to support smoking cessation and how this would be managed. People had access to an on-site gym and gym instructor.

Staff used recognised rating scales to assess and record the severity of peoples' conditions and care and treatment outcomes. For example, staff used Model of Human Occupation Screening Tool (MHOST), Health of the Nation Outcome Scales, Goal Attainment Scaling (GAS) and Clinical Global Impressions (CGI). Staff did not use any recognised psychology related outcome measures.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. This included quality, infection control, environment, clinic room and mental health act documentation audits. Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward teams had access to a range of specialists required to meet the needs of people 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 access to a range of specialists to meet the needs of the people on the ward, including doctors, nurses, psychology, occupational therapy and social workers. However, the psychology and occupational therapy provision for the wards was under establishment and part-time. Cover was provided from other areas, and the provider was working to recruit into vacant full-time posts.

People received good care as managers supported staff through regular, constructive clinical supervision of their work.

Requires Improvement

Wards for people with learning disabilities or autism

People felt more supported as staff now had access to relevant and good quality training in evidence-based practice. This included training in the wide range of strengths and impairments people with a learning disability and or autistic people may have, mental health needs, communication tools, positive behaviour support, sensory approaches, and all restrictive interventions.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. Managers recruited, trained and supported volunteers to work with people in the service.

Staff were supported to apply their training to people's individual needs. Updated training and refresher courses helped staff continuously apply best practice to the people they cared for.

If staff had to restrict people's freedom teams held debriefing meetings and reflected on their practice to consider improvements in care.

Staff were knowledgeable about and committed to using techniques which reduced the restriction of people's freedom. Any restrictions identified people's care plans were identified and developed in collaboration with them. For example, we saw that some people chose seclusion as a coping strategy and had this added to their care plan.

Staff had worked towards reducing restrictions on the wards and this had had a positive impact on the culture on the wards. For example, staff had opened corridor doors and improved people's free access to outdoor space and their own bedrooms.

Managers held regular staff meetings. However, not all staff were able to attend these due to short staffing on the wards. Managers ensured minutes from staff meetings were available for staff that could not attend.

Managers made sure staff received any specialist training for their role. For example, some staff had completed phlebotomy and preceptorship training. The provider had supported two staff members into clinical nurse leadership roles.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. The ward teams had effective working relationships with staff from services that would provide aftercare following people's discharge.

Staff held regular multidisciplinary meetings to discuss people and improve their care.

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care.

The ward teams had effective working relationships with staff from services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge. For example, teams worked with social workers, bed management and other healthcare providers.

Requires Improvement

Wards for people with learning disabilities or autism

People had health actions plans or health hospital passports that enabled health and social care services to support them in the way they needed.

Multidisciplinary team professionals were involved in or made aware of support plans to improve care.

Staff shared clear information about people and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with external teams and organisations, such as other hospitals, GP services and voluntary organisations for people's work experience.

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 people's rights to them.

Staff understood their roles and responsibilities and were able to explain people's rights to them.

People had easy access to information about independent mental health advocacy, and people who lacked capacity to make decisions for themselves were automatically referred to the service.

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

Staff could not always ensure people took their section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or the Ministry of Justice or both. This was often due to short staffing on the wards.

Staff stored copies of people's detention papers and associated records correctly, and staff could access them when needed.

However, our review of six long term segregation care records demonstrated that adequate review of people's care was not happening as per the Code of Practice. For example, regular quarterly reviews by an external body were not always conducted. In addition, any recommendations made by an external hospital were not given due consideration and disregarded without justification.

Care plans included information about after-care services available for those people 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 people to make decisions on their care for themselves. They assessed and recorded capacity clearly for people who might lack the mental capacity to make certain decisions for themselves.

Requires Improvement

Wards for people with learning disabilities or autism

Staff empowered people to make their own decisions about their care and support and obtained people's consent in an inclusive way.

Staff ensured that an Independent Mental Capacity Advocate was available to help people if they lacked capacity to make decisions for themselves and they had nobody else to represent their interests.

Staff were aware of people's capacity to make decisions through verbal or non-verbal means, and this was well documented.

For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any decisions made on their behalf in their best interests.

Staff followed best practice on assessing mental capacity, supporting decision-making and best interest decision-making.

For people lacking capacity to make decisions about their medicines, staff followed best practice.

The service followed safe processes when giving people medicines covertly.

Staff respected the rights of people with capacity to refuse their medicines and ensured that people with capacity had the option to consent to receiving medicines.

Staff gave people all possible support to make specific decisions for themselves before deciding they did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision.

When staff assessed people as not having capacity to make decisions for themselves, they made decisions on people's behalf in their best interest and considering their wishes, feelings, culture and history.

People's freedom was restricted only when necessary and staff made applications for a Deprivation of Liberty Safeguards authorisation where needed, or a deprivation of liberty was made through a court process. There were no Deprivation of Liberty Safeguards application at the time of our inspection.

People were consulted and included in the decisions about the use of surveillance such as CCTV cameras.

Are Wards for people with learning disabilities or autism caring?

Good

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Requires Improvement

Wards for people with learning disabilities or autism

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

The general culture on the wards was kind, caring and nurturing. People spoke positively

about the physical environment and culture and said that staff tried to meet their needs, including sensory needs.

However, two people on Church ward we spoke with told us that staff at night did not always treat them kindly and sometimes slept while on duty. Managers were aware of these issues and were investigating the claims. Managers informed us they had a plan to resolve the staff attitude issues at night and were working to create a more constructive and responsive care environment.

Staff used appropriate styles of interaction with people. They were calm, focused, and attentive to people's emotional and other support needs and sensory sensitivities.

People felt valued by staff who showed interest in their well-being and quality of life. Staff showed warmth and respect when interacting with people.

People had the opportunity to try new experiences, develop new skills and gain independence. Staff supported people to access Workbridge, a local charity that helped people develop vocational confidence and skills and they had opportunities to work in the coffee shop, catering, horticulture, contracting and develop office skills.

Each person had a support plan that identified target goals and aspirations and supported them to achieve greater independence including skills development.

Staff knew when people needed their space and privacy and respected this. For example, people were given access to their bedrooms or a quiet space when they sought privacy.

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

Staff directed people to other services and supported them to access those services if they needed help. For example, they were able to access a dietician, dentistry or physiotherapy.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people.

Staff followed the policy to keep people's information confidential. They ensured the information was displayed and stored in a secure manner.

Involvement in care

Staff involved people in care planning and risk assessment and sought their feedback on the quality of care provided.

Requires Improvement

Wards for people with learning disabilities or autism

People were listened to, given time and supported by staff to express their views using their preferred method of communication. Staff on Oak ward had developed an easy read 'ward round' request form for people to fill in prior to attending. They could put any questions and comments to the care team which would be covered during ward round.

Staff took the time to understand and develop a rapport with people. Staff had decorated a 'likes and dislikes' board about themselves which was displayed on the wards for people to get to know them. In addition, the seclusion area of Oak ward had been personalised to support the likes of the person in seclusion. For example, we saw pet pictures from staff, music that could be piped and sensory lighting to support with de-escalation.

People were enabled to make choices for themselves. Staff ensured they had the information they needed. People had access to easy read versions of most leaflets and information packs on the ward.

Staff respected people's choices and wherever possible, accommodated their wishes, including those relevant to protected characteristics – for example, due to cultural or religious preferences.

People were supported to access independent, good quality advocacy.

People were empowered to make decisions about the service when appropriate and felt confident to feed back on their care and support. There was a suggestion box on the wards for people to provide feedback.

People and those important to them took part in making decisions and planning their care and in risk assessments.

Staff supported people to maintain links with those important to them. If a person was not from the local area staff supported them, in line with their wishes, to have regular contact with family, friends or an advocate. For example, people told us that they had regular contact by phone, video call and through posted cards and drawings.

Staff introduced people to the ward and the services as part of their admission.

Staff made sure people understood their care and treatment (and found ways to communicate with people who had communication needs). For example, some staff were trained in Makaton.

Staff informed and involved families and carers appropriately. They were involved in the multidisciplinary team meeting reviews and supported to input in the planning of care and treatment. The care plans reflected that families had been consulted.

Staff helped families to give feedback on the service. This was through informal feedback to staff or family and carer surveys.

Are Wards for people with learning disabilities or autism responsive?

Good

Our rating of responsive improved. We rated it as good.

Access and discharge

Requires Improvement

Wards for people with learning disabilities or autism

Staff planned and managed people's discharge well. They worked well with services providing aftercare and managed people's move out of hospital. As a result, people did not have to stay in hospital when they were well enough to leave.

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Discharge was usually not delayed for other than clinical reasons. However, for people in long term segregation, the reintegration and discharge planning was very dependent on them finding a bespoke placement. The provider took all appropriate actions to work with commissioners to highlight that a bespoke was required. They also tried to reintegrate people back onto the wards for short periods of time when it was safe to do.

Managers regularly reviewed people's length of stay to ensure they did not stay longer than needed. Data submitted by the provider showed that the length of stay ranged from 381 days to 1402 days, with an average length of stay being 908 days.

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

People were moved between wards during their stay only when there were clear clinical reasons, or it was in their best interests.

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

Staff carefully planned people's discharge and worked with care managers and coordinators to make sure this went well.

Staff supported people when they were transferred between services. They sometimes arranged 'sleepover' sessions where staff supported them to stay a few hours or night at their new placement to get used to the environment and other staff.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people's treatment, privacy and dignity. Each person had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and people could make hot drinks and snacks at any time.

The service's design, layout and furnishings supported people and their individual needs. This included noise-reducing furnishings and calm diffused lighting, which supported people with sensory sensitivities.

Each person had their own bedroom, which they could personalise. Staff had supported one person in long term segregation to personalise the whole corridor outside of this room. The person could see all their chosen images on the wall from within the room and this helped them feel calmer and more at home. However, people on Oak and Sycamore ward could not freely access their bedrooms and lockers without first asking for a key from staff. The ward manager had plans to change this and was in the process of procuring keys for every person, provided this was in line with their risk assessment.

Requires Improvement

Wards for people with learning disabilities or autism

People's care and support was provided in a safe, clean, well equipped, well-furnished environment that met people's sensory and physical needs. However, the environment was not always well-maintained as staff did not always report issues to estates management for addressing.

Staff used a full range of rooms and equipment to support treatment and care. The service had access to a number of therapy rooms, quiet spaces and gym. Church ward had its own sensory room. Oak and Sycamore did not have a dedicated sensory room. Instead, they had developed the 'chill zone' in collaboration with people and had access to a fully equipped sensory room within the same building.

The service had quiet areas and a room where people could meet visitors in private. This room was off the ward. All visitors, including children, had to adhere to medium security measures which included leaving bags and prohibited items before entering the airlock.

People could make phone calls in private. During our inspection, managers informed us about plans to introduce mobile phones to people on the wards. They had started with button phones and upgraded to smart phones based on risk assessment. Some access to phones was supervised based on a person's risk status.

The service had an outside space that people could access easily.

People' engagement with the wider community

Staff supported people with family relationships and community activities outside the service, such as work, education and family relationships. For example, people we spoke with volunteered with Workbridge to gain work and life skills through a range of vocational tasks.

Staff supported people to take part in their chosen social and leisure activities on a regular basis.

Staff gave people person-centred support with self-care and everyday living skills. For example, people had access to a gym on site and swimming sessions in the community.

People who were living away from their local area were able to stay in regular contact with friends and family using the telephone, online voice or video calls, and social media. One person was encouraged and supported with weekly sleepovers at their family's house.

Clear plans and placement goals were developed with commissioners to enable people to move back to their local community as soon as possible.

Staff ensured adjustments were made so that people could take part in activities.

People were supported by staff to try new things and to develop their skills.

Staff enabled people to broaden their horizons and develop new interests and friends. For example, people were exposed to a range of different activities on and off the wards including animal therapy, marble painting, cooking, gardening and arts and crafts.

Staff were committed to encouraging people, in line with their wishes, to explore new social, leisure and community-based activities.

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

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

Meeting the needs of all people who use the service

The service met the needs of all people – including those with a protected characteristic. Staff helped people with communication, advocacy and cultural and spiritual support. The physical environment was appealing and had some aspects to meet people's sensory and physical needs. For example, there were spaces with dimmable lights, acoustic panels and sensory equipment.

Staff used person-centred planning tools and approaches to discuss and plan people's care.

People learned everyday living skills, understood the importance of personal care and developed new interests by following individualised learning programmes with staff who knew them well.

Staff made reasonable adjustments to ensure better health equality and outcomes for people.

Staff identified people's preferences and appropriate staff were available to support people– for example, by having staff of people's preferred gender available to support them. We saw evidence of this happening on the wards.

People were supported to understand their rights and explore meaningful relationships. For example, one person was supported with weekly visits to their partner as staff recognised this was important to them.

People were supported with their sexual, religious, ethnic and gender identity without feeling discriminated against. The service met the needs of all people using the service, including those with needs related to their protected characteristics.

Staff offered choices tailored to individual people using a communication method appropriate to that person. Staff ensured people had access to information in appropriate formats, which included photographs, symbols, electronic devices, Makaton and easy read versions.

Staff used these methods to help people know what was going to happen during the day and who would be supporting them. However, one person told us that the font on the easy-read activities timetable was too small.

Staff spoke knowledgably about tailoring the level of support to an individual's needs.

People had individual communication plans that detailed effective and preferred methods of communication, including the approach to use for different situations.

Staff had good awareness, skills and understanding of people's individual communication needs. They knew how to facilitate communication and when people were trying to tell them something.

Staff worked closely with health and social care professionals and ensured people were assessed to see if they would benefit from the use of non-verbal communication aids.

Requires Improvement

Wards for people with learning disabilities or autism

People received individualised support such as tailored visual schedules to support their understanding.

Staff were trained and skilled in using personalised communication systems.

Staff made sure people could access information on treatment, local services, their rights and how to complain.

The service had information leaflets available in languages spoken by people and the local community.

Managers made sure staff and people could get help from interpreters or signers when needed.

The service provided a variety of food to meet people's dietary and cultural needs.

People had access to spiritual, religious and cultural support. The chaplain carried out regular visits to the ward and there was a multi-faith room on site. Religious leaders from other religions could be accessed on request.

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.

People and those important to them could raise concerns and complaints easily, and staff supported them to do so. In the month of March 2022, there had been two complaints of which one had been upheld and one was under investigation.

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them. For example, people were able to feedback about the service in weekly community meetings.

People, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in areas used by people.

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

Staff knew how to acknowledge complaints, and people received feedback from managers after the investigation into their complaint.

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. For example, following the complaint of a person on access to fresh air, Oak ward initiated a ward leave diary to ensure that time is allotted for each person to have access to leave and grounds for fresh air.

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

Are Wards for people with learning disabilities or autism well-led?

Requires Improvement

Wards for people with learning disabilities or autism

Requires Improvement

Our rating of well-led improved. We rated it as 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 people and staff.

Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs and oversight of the services they managed. Management and staff put people's needs and wishes at the heart of everything they did.

Leaders worked hard to instill a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish.

Managers were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say.

Leaders and senior staff were alert to the culture in the service and as part of this spent time with staff, people and family discussing behaviours and values. The ward managers were highly skilled and knowledgeable about their area of work. They provided good direction and strategy for the ward and sought to make improvements on the wards.

Managers worked directly with people and led by example.

Managers promoted equality and diversity in all aspects of running the service.

Vision and strategy

Staff knew and understood the provider's vision and values and how to apply them in the work of their team.

The provider had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible.

Managers set a culture that valued reflection, learning and improvement. They were receptive to challenge and welcomed fresh perspectives.

Culture

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

Requires Improvement

Wards for people with learning disabilities or autism

Senior managers of the hospital and senior ward-based staff had taken steps to address a closed culture that was identified at our last inspection. This included reviewing blanket restrictions, new meeting structures, new ward rules, dealing with poor staff performance and a culture awareness project. Managers ensured that staff understood the risks of a closed culture so that people received support based on transparency, respect and inclusivity.

Management sought to ensure that they set a culture that valued reflection, learning and providing genuine care to people in the service.

The provider invested in staff by providing them with quality training to meet the needs of all people using the service.

Staff felt able to raise concerns with managers without fear of what might happen as a result.

Staff felt respected, supported and valued by senior staff, which supported a positive and improvement-driven culture.

Governance

Our findings from the other key questions demonstrated that governance processes had improved since the last inspection. However, the service still required further work to ensure that performance and risk were managed well.

Governance processes were not always effective. Senior leaders did not always have governance practices in place to ensure that actions and recommendations from audits, reviews and investigations were followed up. For example, our review of six long term segregation care records demonstrated that adequate review of people's care was not happening as per the Code of Practice. Records reviewed on inspection found five of the records, only the initial three months' review was conducted by an external hospital. In the code of practice, regular three-monthly reviews by an external body are recommended. Following the inspection, the provider submitted documents to show one patient had received three monthly external reviews in line with the Code of Practice and three which did not. These were outside of the three month review by eight days.

In addition, we noted that where a recommendation was made by an external hospital, this was ignored without justification. We saw no evidence of consideration being given to the external recommendations that were not supported. In one case, the recommendation stated that the long-term segregation was no longer proportionate as the person's risk had significantly reduced. This was not taken under consideration by the multidisciplinary and management team.

The provider kept up to date with national policy to inform improvements to the service.

Staff did clinical audit, benchmarking and quality improvement work to understand and improve the quality and effectiveness of care. However, the findings were not always communicated to staff.

The management of records and recordings of surveillance ensured they were protected and stored safely.

There was a clear, recorded purpose for the use of surveillance supported by relevant assessment. The provider had a policy on the use of CCTV surveillance, and this was justified by the level of risk presented.

Management of risk, issues and performance

Requires Improvement

Wards for people with learning disabilities or autism

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

The manager had access to performance charts which detailed the ward performance in areas such as supervision, all clinical and non-clinical audits, seclusions, incidents, staffing, wellbeing measures and staff leave. Performance was measured each month and comparisons made with trends reviewed.

Staff were able to explain their role in respect of individual people without having to refer to documentation. They gave good quality support consistently.

Staff acted in line with best practice, policies and procedures. They understood the importance of quality assurance in maintaining good standards.

Information management

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

We found that the electronic recording systems for care plans and enhanced observations had not yet fully embedded. We found that the ability to upload information at multiple places in the electronic care records system meant that staff could not find information in a timely way. In addition, staff did not always carry out and record enhanced observations as required.

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.

The provider sought feedback from people and those important to them and used the feedback to develop the service. For example, in the blanket restriction reviews staff asked people what blanket restrictions they would like to address on the wards and supported them to think of other ways to address the risks. This led to a reduction in blanket restrictions from 58 to 12 on Church ward.

The service worked well in partnership with advocacy organisations/ other health and social care organisations, which helped to give people using the service a voice/ improve their health and life outcomes.

Learning, continuous improvement and innovation

The service was involved in some research initiatives relevant to the learning disability and autism pathway. For example, the team had presented at the Learning Disability Conference hosted by the Royal College of Psychiatry on the evaluation of outcomes in people's treatment methods.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not always ensured effective governance processes were in place to ensure managers were able to identify if staff followed policies and processes in place. • The provider had not always ensured that the revised leadership and governance arrangements supported the delivery of high-quality, person-centred care, operated effectively and addressed risk issues. • The provider had not ensured that seclusion records were completed and the required safeguards were in place in line with the Mental health Act Code of Practice. • The provider had not ensured that both paper and electronic medicine records were accurate, up to date and correctly identified how staff should give medicines to patients. • The provider had not ensured that staff kept a record of all medicines that they dispose of, in line with its policy. • The provider must strengthen its governance processes so that recommendations and learning from internal and external reviews and investigations, for long term segregation are embedded.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • The provider had not always ensured the privacy and dignity of those who used services was protected at all times.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not always ensured that wards were staffed with the required numbers of suitably skilled staff. • The provider had not ensured that there were sufficient staff to ensure patients always had access to escorted leave and activities. • The provider had not always ensured that there was a full multi disciplinary team and enough staff with the right skills were available to meet the assessed needs of patients.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider had not ensured all maintenance issues leading to a risk of harm to patients and staff were repaired in a timely manner. • The provider had not ensured ligature cutters were checked daily in line with their policy. • The provider had not ensured that its premises provided an appropriate environment for both staff and people on the wards, including showering facilities for those in seclusion.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not always ensured staff completed enhanced observations in line with their policies and procedures. • The provider had not ensured staff always recorded physical health of patients following rapid tranquilisation.

This section is primarily information for the provider

Requirement notices

- The provider had not ensured that staff always undertook patient searches in line with patient care plans and the provider's policy.
- The provider must review remaining blanket restrictions, to ensure that any restriction is individualised, and risk assessed.
- The provider must ensure action is taken to reduce the number of assaults and injury on staff.
- The service had not always ensured that that the environment was well maintained and fit for purpose.
- The provider had not always ensured that all staff who observe patients whilst in long term segregation, were fully engaged in the process of patient observations.
- The provider had not ensured that staff always completed physical healthcare plans for all patients that require them.
- The provider had not ensured that staff always completed rapid tranquilisation care plans for all patients that require them.
- The provider had not ensured that all staff received the required mandatory training.
- The provider had not ensured that medicines audits were always effective, and that staff implemented findings from audits so that expired medicines were disposed of in a timely manner
- The provider had not ensured epilepsy risk assessments and care plans included how to care for a person when bathing.
- The provider must ensure that all staff continue to receive mandatory training in supporting people with a learning disability and/or autism.