The Priory Hospital Middleton St George

Quality Report

Middleton St George
Darlington
DL2 1TS
Tel: 01325 333192
Website:www.priorygroup.com/nhs/locations/priory-hospital-middleton-st-george

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

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

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

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

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

Summary of findings

Contents

Outstanding ☆

The Priory Hospital Middleton St George

Services we looked at
Acute wards for adults of working age and psychiatric intensive care units.

Summary of this inspection

Background to The Priory Hospital Middleton St George

The Priory Hospital Middleton St George is a 101-bedded hospital that provides 24-hour support seven days a week for people aged 18 years and over with mental health problems, personality disorders or both. It is registered with the Care Quality Commission to provide the following regulated activities:

- assessment or medical treatment for people detained under the Mental Health Act 1983
- treatment of disease, disorder or injury.

The hospital director is the registered manager who has been in post since 2014.

Patient accommodation comprises:

- Dalton Ward – locked rehabilitation ward for 13 women
- Hazelwood Ward – locked rehabilitation/personality disorders ward for 10 women
- Linden Ward – locked rehabilitation 15-bed ward for men
- Oak Ward – acute admission 12-bed ward for women
- Thoburn Ward – acute admission 22 –bed ward for both women and men.
- Chester Ward – psychiatric intensive care unit 12-bed ward for women.

There have been 10 inspections carried out at the Priory Hospital Middleton St George. The most recent inspection took place in September 2018, following which the hospital was given an overall rating of outstanding. However, the Chester Ward, the focus of this latest onsite inspection, has only been open since March 2019.

Referrals for the Chester Ward are accepted on the authorisation of the responsible funding authority and in accordance with NHS commissioning guidelines. Referrals to the ward are received from a wide range of services, including;

- acute psychiatric inpatient units
- high dependency units
- Section 136 suites
- criminal justice services such as the police, courts and prisons and
- community mental health services.

Referrals are accepted 24 hours a day, seven days a week.

The multidisciplinary approach to treatment delivery is aimed at; rapid stabilisation of symptoms, crisis resolution, risk reduction, relapse prevention and promotion of recovery. The expectation for patients who are admitted to the ward should be for a length of stay which does not exceed eight weeks.

Our inspection team

The team that inspected the service comprised one Care Quality Commission inspector, two Care Quality Commission assistant inspectors, a specialist advisor consultant psychologist and a specialist advisor nurse.

Why we carried out this inspection

This was a responsive inspection of the Chester Ward, a psychiatric intensive care unit, because we had concerns about the welfare of patients on the ward based on information we received via notifications from the provider, the local authority and the police and a complaint from a patient. We also had concerns that the provider was not always making statutory notifications to the Care Quality Commission or safeguarding referrals to the local authority when required. The ward had not been previously inspected since it opened in March 2019.

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we asked the provider to send us details of all incidents that had been reported across all the wards on the site during June and July 2019. We also reviewed intelligence we held about the Chester ward.

During the inspection visit,

- we looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients on the wardand two carers
- spoke with the ward manager and business, quality and performance manager
- spoke with six other members of staff, including a clinical lead, consultant psychiatrist, nurses, healthcare assistants and a psychologist
- attended and observed a multidisciplinary meeting and patient consultation
- looked at nine patients' care and treatment records
- carried out a specific check of the arrangements for the management of medicines on the ward
- looked at a range of policies, procedures and other documents relating to the running of the service
- looked at the safeguarding referrals that had been made across the wards for the two months prior to our inspection and cross referenced them with the statutory notifications the provider had sent to the Care Quality Commission.

What people who use the service say

We spoke with five patients and two carers during our inspection. Carers said that staff were kind, caring, supportive and respectful towards them and their loved ones and provided advice when it was requested.

Patients who spoke with us were unhappy on the ward due to being legally detained under the Mental Health Act and having a ban on smoking cigarettes imposed upon them. However, the provider had received satisfaction surveys from five patients that had been discharged from the ward. The results of these surveys were positive in relation to the care and treatment the patients had received, including in relation to the way they were treated by staff on the ward. The only negative feedback identified via the surveys was in relation to three patients who felt the quality and choice of food could be improved which the provider was addressing.

A carer told us they were given a good level of information about their loved one's progress.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles and were able to give examples to demonstrate their knowledge accordingly. At the time of our inspection, 86% of staff had completed their mandatory Mental Health Act training.

There was an onsite mental health act administrator from whom staff could access administrative support and legal advice about the Act and who also undertook routine checks and audits to ensure that staff adhered to the Act.

The provider had policies and procedures in relation to the Act that staff could access via the provider's intranet.

Patients had access to information about independent mental health advocacy via posters on noticeboards within the ward. There were also posters that told informal patients that they could leave the ward of their own free will.

We saw evidence in patients' care records that staff explained to patients their rights under the Mental Health Act in a way they could understand it and repeated their rights when appropriate. We also saw evidence that staff sought the opinion of a second opinion appointed doctor when necessary.

Staff encouraged patients to access their Section 17 leave when it had been approved. Staff stored copies of patients' detention papers and associated records correctly and in a way that ensured they were available to all staff who needed to have access to them.

The ward had not been subject to any Mental Health Act monitoring visits by the Care Quality Commission because it had only been open since March 2019.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good understanding of the Act and the five statutory principles and were able to give examples to demonstrate their knowledge accordingly. At the time of our inspection, 89% of staff had completed their mandatory Mental Capacity Act training and 96% of staff had completed their mandatory deprivation of liberty safeguards training.

The provider reported that no deprivation of liberty safeguards applications had been made since the ward had opened in March 2019.

An onsite mental health act administrator provided staff with administrative support and legal advice about the Mental Capacity Act and the use of deprivation of liberty safeguards. The mental health act administrator also undertook routine checks and audits to ensure that staff adhered to the Act.

The provider had policies and procedures in relation to the Act that staff could access via the provider's intranet.

None of the patients on the ward at the time of our inspection lacked capacity.

There were posters on noticeboards within the ward informing patients about their right to an independent mental capacity advocate.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good

Notes

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

Good

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

Summary of findings

The overall rating for the hospital remains as outstanding. This inspection relates only to Acute wards for adults of working age and psychiatric intensive care units.

We rated this service as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and managed medicines safely.
- 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 team 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 were appraised. 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. 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.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However

- We identified an assault on a patient from the Thoburn ward, a ward for patients with acute mental health problems, during which they sustained a serious injury that had not been sent to the local authority as a safeguarding referral or as a statutory notification to the Care Quality Commission. The assault occurred whilst the patient was on leave from the hospital. The assault had not been recorded as a serious incident.
- Patients had limited access to quiet areas on the ward. If patients wanted to have some time to themselves, the only places they could go to were their bedrooms or the outside garden area. The acoustics of the ward caused noise levels to become amplified and echo throughout the ward which was not conducive to a therapeutic environment.
- Staff sickness on the ward was high. The average staff sickness rate between 19 March and 9 September 2019 was 21% which was much higher than the provider's sickness absence target of 5.5%.
- Staff supervision was below the provider's compliance target of 90%. At the time of our inspection, the average compliance with supervision was only 78%. Some elements of mandatory training

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

Good

were below the provider's 85% compliance target, including infection control, health and safety, safeguarding, data protection, learning and development and positive behaviour support.

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Good

We rated safe as good because:

- The Chester ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.
- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records.
- 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 physical health.
- The ward had a good track record on safety. Staff recognised incidents and reported them appropriately via the provider's internal reporting system. 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.

However

- We identified an assault on a patient from the Thoburn ward, a ward for patients with acute mental health problems, during which they sustained a serious injury that had not been sent to the local authority as a safeguarding referral. The assault occurred whilst the patient was on leave from the hospital. The assault had not been recorded as a serious incident.
- Staff sickness on the ward was high. The average staff sickness rate between 19 March and 9 September 2019 was 21% which was much higher than the provider's sickness absence target of 5.5%.
- Some elements of mandatory training were below the provider's 85% compliance target, including infection control, health and safety, safeguarding, data protection, learning and development and positive behaviour support.

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

Good

Safe and clean environment

Safety of the ward layout

Staff did regular risk assessments of the care environment. We saw evidence that ligature points had been identified, recorded, risk rated and were appropriately mitigated.

The main office used by staff overlooked most of the ward. Any blind spots were mitigated with mirrors, so staff could see around corners.

Staff had easy access to alarms and patients had easy access to nurse call systems in their bedrooms.

Chester was a female only ward and as such, it complied with the Department of Health guidance on eliminating mixed-sex wards.

We reviewed documentation and certificates in relation to the safety arrangements for the ward and found these were in date and appropriate. Tests in relation to electrical wiring, personal appliances, water hygiene and gas and fire safety had been completed.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well-maintained. Cleaning records were up to date and demonstrated that the ward areas were regularly cleaned.

Staff within the service adhered to infection control principles, including handwashing and the disposal of clinical waste.

Seclusion room

The seclusion room on the ward allowed clear observation and two-way communication and had toilet and handwashing facilities and a clock. The room was well ventilated, and the bedding was anti-ligature.

Clinic room and equipment

The clinic room on the ward was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it clean. Any 'clean' stickers were visible and in date.

Safe staffing

Nursing staff

There were adequate numbers of staff to deliver safe care and treatment. At the time of our inspection, the establishment numbers of staff on the ward were:

- eight whole time equivalent nurses
- 34 whole time equivalent healthcare assistants
- one whole time equivalent doctor
- 0.5 whole time equivalent occupational therapist
- one whole time equivalent assistant occupational therapist
- one whole time equivalent assistant practitioner

The vacancy rate for registered nurses was 15% and 28% for healthcare assistants. There was also a 50% vacancy rate for psychology. At the time of our inspection, psychologist input was being provided on a sessional basis.

The provider used its own tool known as the staffing ladder to calculate the numbers of each discipline required to deliver safe care and treatment on the ward. The minimum number of care staff was:

- two nurses and one healthcare assistant during the day and one nurse and two healthcare assistants during the night based on one to six patients
- two nurses and healthcare assistants during both day and night shifts based on seven to eight patients
- two nurses and three healthcare assistants during the day and two nurses and healthcare assistants based on nine to 10 patients and
- three nurses and healthcare assistants for both day and night shifts based on 11 to 12 patients.

During our inspection, the number of nurses and healthcare assistants for the eight patients that were on the ward were in line with these minimum requirements.

The ward manager was able to adjust staffing levels daily to meet the needs of patients such as increased observation levels or behaviours that challenge. The ward deployed agency and bank nursing staff to maintain safe staffing levels. The ward used regular bank and agency staff, so they were familiar with the patients and with how the ward operated. Agency and bank staff went through an induction programme when they first started working for the provider. Staff who spoke with us said there had been no instances in which the ward had been short-staffed.

Since the ward opened in March 2019, 118 shifts had been covered by bank or agency staff. There were no occasions when shifts were left uncovered.

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

Good

Staff sickness absence rate was high on the ward. Between 19 March and 9 September 2019, the average sickness absence rate was 21% which was much higher than the provider's sickness absence target of 5.5%. The provider monitored sickness absence on the ward and there were no trends identified. There had been some periods of long-term sickness absence due to health conditions but there were also some staff who were being managed under the provider's sickness absence management procedures. The average staff turnover rate for this period was 3%.

We reviewed the planned hours of nursing and actual hours worked for the month prior to our inspection because we had concerns that sickness absence and staff vacancies on the ward might be impacting on patient care. However, the information we reviewed showed that hours worked matched or exceeded those that were planned, and the ward used agency staff or deployed staff from other wards when required. This meant that patient care was not compromised. A qualified nurse was always in the communal areas of the ward and staffing levels allowed patients to have regular one-to-one time with their named nurse.

Staff who spoke with us said that the ward was never left short-staffed, so escorted leave and ward activities had not been cancelled due to staffing levels. There were enough staff to carry out observations and physical interventions such as restraint and seclusion safely and staff had been trained to do so.

Medical staff

There was adequate medical cover day and night. There was a medical response team on site which operated between 9am and 5pm which included either a doctor or an associate practitioner who were experienced in dealing with both mental and physical health emergencies. During out of hours, the service had an on-call consultant psychiatrist and associate practitioner to deal with such emergencies. The hospital was located approximately 25 minutes from the local acute hospital so if an ambulance was needed, it could get to the ward quickly.

Mandatory training

Staff had received appropriate mandatory training. Overall, staff on the ward had completed 88% of the various elements of training that the provider had set as mandatory. This included modules on managing violence and aggression, handling complaints, Mental Health Act, Mental Capacity Act and medicines management. The ward had only been open since March 2019, so some staff had mandatory training modules scheduled for completion later in the year. Elements of mandatory training that were below the provider's 85% compliance target included:

- data protection and confidentiality (76%)
- emergency procedures awareness (79%)
- fire safety (79%)
- immediate life support 87%)
- infection control (89%)
- introduction to health and safety (93%)
- my learning and development (83%)
- positive behaviour support (79%)
- safeguarding children (76%)
- safeguarding combined face to face full report (61%)
- safeguarding vulnerable adults (76%)

The provider had encountered difficulties in sourcing an organisation to deliver safeguarding training to staff which had caused delays in safeguarding training being rolled out. However, the provider confirmed that those staff yet to receive training were scheduled to complete it within the next three months.

At the time of our inspection, six of the eight qualified staff on the ward were trained in intermediate life support and 27 of the 28 unqualified staff were trained in basic life support. However, the three staff yet to undertake basic or intermediate life support training were scheduled to complete it within the next few months.

Assessing and managing risk to patients and staff

Assessment of patient risk

We looked at nine patients' care records, including all eight patients on the ward at the time of our inspection visit.

Staff completed a risk assessment of every patient on admission and updated it regularly, including after incidents. The electronic care records system automatically alerted staff when updates to risk assessments were due.

Staff used the provider's own risk assessment tool which was built into its care records system. However, the tool was similar to those recognised within mental health and included patients' risks to themselves and others, triggers, history and a range of other topics.

Management of patient risk

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

Good

Staff were aware of and dealt with any specific risk issues, such as allergies, risks of self-harm or suicidal ideation, trauma from historical experiences and behavioural triggers.

Staff identified and responded to changing risks to, or posed by, patients. Changes in risks and presentation were discussed amongst staff on duty, during handovers and multidisciplinary team meetings. Care plans and risk assessments were updated accordingly.

Staff followed good policies and procedures for use of observation and for searching patients or their bedrooms.

Staff applied restrictions on patients' freedom only when justified. Any restrictions were applied following a risk assessment of the patient and were regularly reviewed. An example included restricting access to certain areas of the ward where ligature points were present if a patient was known to be at risk of attempting suicide or self-harming. There was a list of banned and restricted items identified as being potentially dangerous to patients or staff which were appropriate for this type of service.

Most areas of the ward were locked due to presence of ligature points or potential risks of scalding, trips, slips and falls. Patients were given keys to rooms following a risk assessment.

Staff adhered to best practice in implementing a smoke-free policy. Cigarettes were not permitted on the ward but the use of vapes was allowed in patient's bedrooms and in the garden area following a risk assessment. Staff also offered nicotine replacement therapy to patients.

Informal patients were able to leave at will. At the time of our inspection, all the patients on the ward were detained under the Mental Health Act and the ward was locked. However, we saw signage on the ward that would notify any future informal patients about their right to leave the ward at will.

Use of restrictive interventions

The provider reported that between 19 March and 9 September 2019, there had been:

- five incidents of seclusion
- two incidences of long-term segregation (one patient only)
- 170 incidents of restraint which included one prone restraint
- 16 incidents of rapid tranquilisation

The Chester ward deployed staff from other wards to carry out restrictive interventions safely when required. Agency staff were also used to meet the needs of patients with behaviours that challenge.

At the time of our inspection, there was one patient who was receiving their care and treatment in an enhanced care suite which was segregated from the main ward until a forensic placement to meet their needs could be sourced. We spoke with staff assigned to delivering the patient's care and treatment, spoke with the patient themselves and looked at documentation around their care plan. We found the rationale for keeping the patient in a separate suite was justified as it protected both the patient and others from harm and abuse.

The provider had reviewed its policy on restrictive interventions and had taken the decision to cease the use of mechanical restraint in its psychiatric intensive care units.

The ward participated in the provider's restraint reduction programme. There were Safewards champions and a Safewards lead on the ward. Safewards is a model of care designed to reduce conflict and restrictive interventions within mental health inpatient settings. The Safewards champions and lead attended monthly meetings held on site which enabled them to access support and guidance on how to embed the full Safewards agenda. An audit had taken place on the ward in July 2019 which identified the following evidence that the ward followed Safewards approved practices:

- staff used positive language about patients within staff handovers and avoided terms that could be viewed as negative
- staff used soft-words during debriefs
- staff used recognised talk-down techniques as a method of de-escalation when patients' behaviours were heightened
- patients had their own 'getting to know you' files so staff had a clear understanding of patients' needs, preferences and interests.

We saw evidence that staff used restraint and rapid tranquilisation only after de-escalation had failed and used correct techniques. De-escalation techniques included the

use of distraction, verbal reassurance and grounding techniques. Staff had been trained in the use of restraint and managing violence and aggression and those who spoke with us said they were confident in the use of restraint.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. They were aware that this was not confined to physical restraint but also applied to any restrictions on a patient's liberty.

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation such as the use of physical observations following it being administered. Staff used seclusion appropriately and followed best practice when they did so. We reviewed seclusion records and found they were kept in an appropriate manner.

Safeguarding

At the time of our inspection, the overall compliance rate for safeguarding training on the ward was 67%. The training modules included:

- safeguarding children (76% compliance)
- safeguarding face to face full report (61% compliance)
- safeguarding vulnerable adults (76% compliance)

The ward had only been open for six months and staff were scheduled to fully complete their safeguarding training later in the year.

Staff could recognise possible signs of abuse and gave examples such as unexplained bruising, financial worries, change in presentation and becoming withdrawn.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. This included training in equality and diversity, seeking advice from the onsite safeguarding team, use of the provider's policy on harassment and discrimination and the use of observations on the ward so that any incidents of discriminatory behaviour could be appropriately and quickly dealt with.

Staff had not made a safeguarding referral to the local authority in relation to an assault on a patient on the Thoburn ward, during which they sustained a serious injury. The Thoburn ward was for patients with acute mental health problems. The assault occurred whilst the patient was on leave from the hospital. However, we reviewed other incidents that had happened within the wards across the Middleton St George site and saw evidence that staff had made safeguarding referrals in line with agreed arrangements with the local authority, so this appeared to have been a one-off oversight. However staff provided reassurance and support to the patient on their return to the ward. Staff carried out debriefs with the patient, supported them with the police investigation, undertook a welfare and health check and referred the patient to primary healthcare services.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff followed safe procedures for children visiting the ward. The provider had a policy on visitors to the ward which included visits by children which was also linked to the provider's safeguarding children policy.

Staff access to essential information

The provider used an electronic care records system. Staff who spoke with us said that they had access to all the information they needed to deliver safe care and treatment to patients which was in an accessible format. Patient information was also shared during handovers, multidisciplinary team meetings and ward rounds.

Medicines management

Staff followed good practice in medicines management. There were adequate processes for the transportation, storage and disposal, dispensing, administration, reconciliation and recording of medicines which were in line with national guidance. We checked medicines prescription charts for patients on the ward and found they were completed correctly and were easy to understand. Although the provider had a process for covering the use of covert administration of medicines, the practice was only used in exceptional circumstances throughout the wards on the Middleton St George site. None of the patients on the Chester ward were being given their medicines covertly at the time of our inspection.

Patients' medicines doses were reviewed during multidisciplinary reviews and there were systems in place to ensure the effects of medicines on patients' physical health were monitored.

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

Good

There were checks and processes in place to manage high dose antipsychotic prescribing, contraindications, drug interactions and allergies. 'As required' medicines were reviewed during weekly ward rounds and daily flash meetings. Flash meetings are short, focussed meetings to discuss any progress and developments and risk. The provider's medicines management policy also covered the use of novel, off-label or unlicensed medicines.

Patient's received specific advice about their medicines during multidisciplinary reviews, from the consultant psychiatrist and nurses and via information leaflets.

The provider had effective systems in place for the management of controlled drugs on the ward which were in line with national guidance. The physical health practitioner was the controlled drugs accountable officer.

Track record on safety

The provider reported that at the time of our inspection, there had been no serious incidents on the ward since it had opened in March 2019.However, there had been an incident in which a patient from the Thoburn ward, a ward for patients with acute mental health problems, had been assaulted by a gang of youths and sustained a serious injury whilst on leave. The provider had not classed this as a serious incident because they considered the impact and harm to the patient was only moderate.

We asked if there had been any adverse events on the ward since it opened. Staff told us about a medication error in which a nurse gave a patient an incorrect dosage of promethazine. The issue was dealt with accordingly by the provider.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report internally within the organisation and used the provider's electronic incident reporting system to do so. Examples of incidents that were routinely reported on the ward included violence and aggression, medicine errors, safeguarding issues and the use of restraint.

Staff understood what their responsibilities were under the Duty of Candour. The Duty of Candour legally requires all healthcare staff to be open and honest when things go wrong, offer an apology and full explanation and find ways to put the matter right. One Duty of Candour report had been made since the ward opened which related to an incorrect dose of medicine being administered to a patient.

Staff received feedback from investigations into incidents, both internal and external to the service and met to discuss the feedback. Incidents were discussed during multidisciplinary team meetings and daily meetings.

There was evidence that safety improvements had been made on the ward. An alert radio-based system had been installed within the main office on the ward which staff could use to call for security if any dangerous incidents occurred on the ward. This was operated during our inspection after a patient had ripped a control panel off the wall which left wires exposed. However, the electrical voltage was low so the risk of any serious injury as a result of this was low.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and quality improvement initiatives.
- 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 a range of skills need 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.

- 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 had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- 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 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.

However

- Staff supervision on the ward was below the provider's compliance target of 90%. At the time of our inspection, the average compliance with supervision was only 78%.

Assessment of needs and planning of care

We looked at nine patients' care records which included all eight patients that were on the ward at the time of our inspection.

Staff completed a comprehensive mental health assessment and physical health assessment of all patients on admission or soon after. We saw evidence that these assessments had identified allergies and included records of electrocardiograms, blood tests and information from patients' GPs.

Staff developed care plans that met the needs identified during assessment. Care plans considered the patient's history, triggers, early warning signs of potential heightened behaviours and goals, strengths and problems. Care plans were holistic, and recovery orientated. Staff updated care plans when necessary. The care records system automatically reminded staff when care plans were due to be reviewed and staff also updated care plans following incidents or when there were changes to patients' needs.

One patient had a specific care plan in place to manage a condition that meant their joints were easily susceptible to becoming dislocated. The care plan included safe techniques in relation to the use of physical interventions upon the patient and the need for staff to encourage the patient to wear their surgical appliance.

Best practice in treatment and care

We looked at nine patients' care records which included all eight patients that were on the ward at the time of our inspection.

Staff provided a range of therapeutic activities and interventions suitable for the patient group which were recommended by the National Institute for Health and Care Excellence. These included cookery, arts and crafts, mindfulness, use of the onsite gymnasium, relaxation, singing, outdoor games, reading, puzzles and a breakfast club.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Examples included onsite weekly visits by a GP and referrals to opticians, dentists and a dietician.

Staff assessed and met patients' needs for food and drink. Staff used fluid and food charts and responded to any issues identified. For example, drinks and meals could be fortified to take into account patients who were underweight.

Staff supported patients to live healthier lifestyles. Staff provided patients who smoked with nicotine replacement patches and a dietician provided advice about healthier food options.

Staff used recognised rating scales to assess and record severity and outcomes. These included the Secure Health of the Nation Outcomes Scales and the National Hydrotherapy Data Collection Project which is recognised by the Aquatic Therapy Association of Chartered Physiotherapists.

Staff used technology to support patients effectively. Patients had access to an onsite library which they could use to access online help such as dialectical behaviour therapy and advice on diet and nutrition.

Staff participated in clinical audits. These included weekly audits of care records, weekly pharmacy audits, weekly audits of Section 17 leave and annual audits of infection control.

Skilled staff to deliver care

The team included or had access to a range of specialists required to meet the needs of patients such as a consultant psychiatrist, GP, psychologist, dietician, pharmacist, occupational therapist nurses and healthcare assistants.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of the patient group.

Managers provided new staff, including bank and agency staff with appropriate induction. Topics included fire safety, completion of care records, the Mental Health Act and the use of restraint.

At the time of our inspection, the average compliance rate for supervision was 78% which was below the provider's target of 90%. Supervision enabled staff to discuss case management, reflect on and learn from practice, for personal support and professional development and to receive appraisal of their work. In addition to regular supervision, staff on the ward were able to access monthly reflective practice sessions which were facilitated by the onsite psychology team.

Staff on the ward received an annual appraisal. The appraisal compliance rate on the ward was 100% at the time of our inspection, although 15 of the 36 staff members were still working within their six-months probationary period and as such, were not yet subject to an annual appraisal.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.

Staff had access to specialist training for their individual role. A member of staff had undertaken specialist training in the Historical, Clinical, Risk Management 20 tool used for assessing risk and violence. The ward manager was also in the process of sourcing training for staff who had requested specialist training in motivational interviewing, smoking cessation, advanced mental health, addictive behaviours and autism.

Managers dealt with poor performance promptly and effectively. The provider had a performance management system in place which included a process for addressing staff performance issues. This system had been used to address a competency issue with a member of staff that had led to disciplinary proceedings.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings. There were daily multidisciplinary meetings held on the ward. We observed one of these meetings during our inspection visit. Staff knew their patients well and understood their needs, problems and sought advice from other professionals when necessary. The ward also held daily flash meetings which were short, focussed meetings to discuss any progress and developments and risk.

There were effective handovers between shifts and teams. There was a handover file on the ward and care records were regularly updated so staff were up to date about the health status of patients on the ward.

There were effective links and relationships with internal and external teams. For example, staff worked with primary healthcare services, social services, community mental health teams, care providers, advocacy services, families and carers to facilitate discharges, admissions and transfers to other services.

Adherence to the MHA and the MHA Code of Practice

Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles and were able to give examples to demonstrate their knowledge accordingly. At the time of our inspection, 86% of staff had completed their mandatory Mental Health Act training.

Staff had easy access to administrative support and legal advice about the Act from a Mental Health Act administrator who worked on the site. The Mental Health Act administrator also undertook routine checks and audits to ensure that staff applied the Mental Health Act correctly.

The provider had policies and procedures in relation to the Act that staff could access via the provider's intranet.

Patients had access to information about independent mental health advocacy. There were posters about advocacy services on noticeboards within the ward.

We saw evidence in patients' care records that staff explained to patients their rights under the Mental Health

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Good

Act in a way they could understand it and repeated their rights when appropriate. We also saw evidence that staff sought the opinion of a second opinion appointed doctor when necessary.

Staff encouraged patients to access their Section 17 leave when it had been approved.

Staff stored copies of patients' detention papers and associated records correctly and in a way that ensured they were available to all staff who needed to have access to them.

There were posters on noticeboards in each of the wards which told informal patients that they could leave the ward of their own free will.

Good practice in applying the Mental Capacity Act

Staff had a good understanding of the Act and the five statutory principles and were able to give examples to demonstrate their knowledge accordingly. At the time of our inspection, 89% of staff had completed their mandatory Mental Capacity Act training and 96% of staff had completed their mandatory deprivation of liberty safeguards training.

The provider reported that as at the time of our inspection, no deprivation of liberty safeguards applications had been made since the ward had opened in March 2019.

Staff had easy access to administrative support and legal advice about the Act, including deprivation of liberty safeguards from a Mental Health Act administrator who worked on site. The Mental Health Act administrator also undertook routine checks and audits to ensure that staff applied the Mental Capacity Act correctly.

The provider had policies and procedures in relation to the Act that staff could access via the provider's intranet.

None of the patients on the ward at the time of our inspection had been deemed to lack mental capacity.

There were posters on noticeboards within the ward informing patients about their right to an independent mental capacity advocate.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

We rated caring as good because:

- 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 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.
- Staff informed and involved families and carers appropriately.

Kindness, privacy, dignity, respect, compassion and support

We spoke with five patients and two carers during our inspection. Carers said that staff were kind, caring, supportive and respectful towards them and their loved ones and provided advice when it was requested.

The patients who spoke with us were unhappy on the ward, but this was because they were detained under the Mental Health Act and had a ban on smoking cigarettes imposed upon them. We observed staff interacting with patients in a kind, respectful, supportive and compassionate manner.

All patients were offered the opportunity to complete a satisfaction survey, either during their stay or on discharge from the ward. The provider had received satisfaction surveys from five patients who had been discharged from the ward. The results of these surveys were positive in relation to the care and treatment the patients had received, including the way they were treated by staff on the ward.

Staff supported patients to understand and manage their care, treatment and condition. We observed staff interacting with patients in a friendly, supportive and caring manner throughout our inspection.

Staff directed patients to other services when appropriate and supported them to access those services. We saw evidence in care records that patients had been referred to primary healthcare services such as GPs, dentists and opticians.

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Good

We observed a multidisciplinary team meeting and a consultation between a patient and the consultant psychiatrist during our inspection. During both these sessions, we observed how well the staff knew and understood the individual needs of each patient being discussed.

Staff who spoke with us said there was a culture of openness and transparency on the ward which meant if they had any concerns about disrespectful, discriminatory or abusive behaviour towards patients, they would be able to report these concerns without fear of reprisals.

Staff maintained the confidentiality of information about patients. Staff received mandatory training in data protection and confidentiality.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward. Patients were issued with a welcome pack which included information such as ward activities, mutual expectations, a map of the area, bus and train times and how to make a complaint. New patients were shown around the ward and introduced to staff and patients already on the ward.

We saw evidence in care records that staff routinely attempted to involve patients in discussions and decisions about their care and treatment and offered patients a copy of their care plan. However, in the majority of care records we looked at, we saw evidence that patients were reluctant to engage in these discussions and had refused to take a copy of their care plan, either because they were unhappy with being detained on the ward or were too unwell to engage in the process. However, during our inspection, we observed staff speaking with patients in a clear way that they understood.

Staff enabled patients to give feedback on the service they received. There were monthly community meetings on the ward during which, staff invited patients to give their feedback and make suggestions as to how the service could be improved. The provider had a complaints process that patients could use to make a complaint or raise concerns about their care and treatment. The provider ran annual patient surveys across all its services and patients could also complete satisfaction questionnaires on discharge from the ward.

Staff who spoke with us were unaware of any patients asking for help to make advance decisions such as refusing certain types of treatment since the ward opened in March 2019. However, staff said any such requests would be considered by the multidisciplinary team or the Mental Health Act administrator.

Involvement of families and carers

Staff informed and involved families and carers if the patient had given their consent for them to do so and provided them with support when needed. We saw evidence of this in care records and one carer said that they were given a good level of information about their loved one's progress. Families and carers were also invited to care reviews. However, the ward manager said this was problematic because some patients admitted to the ward were outside of their local area meaning families and carers had to travel long distances to get to and from the hospital.

Staff enabled families and carers to give feedback about the service they received via satisfaction surveys. Families and carers were issued with a carers' pack which included information about how to make a complaint or raise concerns.

Staff provided carers with information about how to access a carer's assessment.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

We rated responsive as good because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe.
- The food was of a good quality and patients had access to hot drinks and snacks at any time.

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

Good

- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However

- Patients had limited access to quiet areas on the ward. If patients wanted to have some time to themselves, the only places they could go to were their bedrooms or the outside garden area. The acoustics of the ward caused noise levels to become amplified and echo throughout the ward which was not conducive to a therapeutic environment.

Access and discharge

Bed management

The average bed occupancy between 19 March and 9 September 2019 on the ward was 46%. There had been 33 patients who had been admitted to the ward outside of their local area during this time. There was always a bed available when patients returned from leave. Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and in the interests of the patient.

When patients were moved or discharged, this happened at an appropriate time of day. We observed the transfer of a patient from the Chester ward to the Dalton ward, a rehabilitation ward for patients with complex mental health needs, during our inspection. This was done at a time when the patients on the Chester ward were settled and convenient for the patient concerned.

Discharge and transfers of care

Between 19 March and 9 September 2019, there had been one delayed discharge from the ward. The patient had been assessed as requiring a transfer to a forensics service and staff on the ward were awaiting confirmation of a bed being available.We saw evidence that the provider was proactive in its attempts to find a suitable placement to meet this patient's needs.

Staff planned for patients' discharge, including good liaison with care providers and social workers. We saw evidence within care records that discharge was considered and planned for from the point of admission to the ward.

Staff supported patients during referrals and transfers between services. Patients were supported to access primary healthcare services such as GPs and acute hospitals and were given assistance when being moved to a step-down placement.

The service complied with transfer of care standards. Referral forms and discharge documentation contained standard clinical headings to ensure all essential client information was shared with other health care services.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms on the ward which they were able to personalise. There were lockable storage cabinets under patients' beds that could be used to store possessions. All bedrooms on the ward were en-suite with anti-ligature fittings to mitigate the risk of patients attempting suicide.

Staff and patients had access to a range of rooms and equipment to support care and treatment. These included a fully equipped clinic room, art room, therapy room, multi-faith room and pressure relieving equipment and continence management aids.

Patients had limited access to quiet areas on the ward. There were no designated quiet areas on the ward so if patients wanted to have some time to themselves, the only places they could go to were their bedrooms or the outside garden area.The acoustics of the ward caused noise levels to become amplified and echo throughout the ward which was not conducive to a therapeutic environment. We raised this issue with staff and were told that managers were looking into ways to resolve it.

Patients had their own mobile phones and could use these to make a call in private either in their bedroom or in the garden area.

We saw evidence that patients had a variety of food options such as menus on noticeboards. However, the results of five patient satisfaction surveys indicated that three of the patients felt the food could be improved. As a result of this

feedback, the head chef attended ward community meetings to discuss patients' preferences and ideas for improving the variety and quality of food moving forward. Patients always had access to hot drinks and snacks.

Patients' engagement with the wider community

Although most of the patients on the ward at the time of our inspection had only been on the ward for a short time, staff still ensured patients had access to education and employment opportunities when this was appropriate. Patients were able to use an onsite library to learn about a variety of topics and occupational therapists devised activities that were designed to enhance patients' life skills. One patient was working in the ward's tuck shop to enable them to gain practical work experience to better their chances of employment in the future.

Staff encouraged patients to maintain contact with the people who mattered to them and who could support them with their care and treatment such as friends, family members, carers and home teams.

Meeting the needs of all people who use the service

The ward was designed to meet the needs of disabled patients or patients with mobility issues. All areas of the ward were wheelchair accessible and there was a designated bedroom that had been adapted to meet the needs of patients with disabilities or mobility issues. We also saw evidence within care records that specific care plans were in place to meet the needs of patients with a disability. Staff also met patients' communication needs by providing them with access to an interpreter, signer and providing information in different languages or easy-read format when required.

Patients were issued with a welcome pack on admission which contained information about treatments, local services, their rights and how to make a complaint.

Patients had a choice of food to meet their dietary requirements. These included healthy options for patients with weight issues or diabetes, gluten-free options, halal and kosher meats and vegetarian and vegan options.

Staff ensured that patients had access to appropriate spiritual support and there was a multi faith room on the ward.

Listening to and learning from concerns and complaints

There had been five complaints between 19 March and 9 September 2019. One complaint had been partially upheld by the provider and another two were still being investigated at the time of our inspection. The remaining two had not been upheld. All five complaints had been made by the same patient. None of the complaints had been referred to the Parliamentary and Health Service Ombudsman. There had also been four compliments received during this time.

Patients knew how to complain or raise concerns. There were posters on patient noticeboards which told patients how to complain and welcome packs issued on admissions also contained leaflets on how to make a complaint or raise a concern. When patients raised concerns or complaints, they received feedback. Patients also had access to independent mental health and independent mental capacity advocates who could raise complaints and concerns on their behalf.

Staff protected patients who raised concerns or complaints from discrimination and harassment. When complaints had been made about another patient, staff ensured both parties were closely monitored so that any potential of reprisals was mitigated, and observations were adjusted when necessary. If an allegation against a staff member was serious, managers considered whether to move the staff member to another ward or suspend them from duty until the investigation process was completed.

Staff knew how to handle complaints appropriately. Staff received feedback and lessons learned on the outcome of investigations into complaints. An example of this was following a complaint from a patient that whilst they were speaking, a staff member rolled their eyes which the patient took to mean the staff member was uninterested or bored. The complaint was investigated, and feedback was given to staff on the ward to be mindful of the use of body language when interacting with patients as signals could be misinterpreted and lead to resentment or friction.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However

- We identified an assault on a patient from the Thoburn ward, a ward for patients with acute mental health problems, during which they sustained a serious injury that had not been sent to the local authority as a safeguarding referral or as a statutory notification to the Care Quality Commission. The assault occurred whilst the patient was on leave from the hospital. The assault had not been recorded as a serious incident.
- Staff sickness on the ward was high. The average staff sickness rate between 19 March and 9 September 2019 was 21% which was much higher than the provider's sickness absence target of 5.5%.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Examples included nearly forty years' experience on working in the health and care sector, holding various roles in the past such as associate practitioners, registered mental health nurses and working in service redesign, public consultation and project work for NHS England.

Leaders had a good understanding of the ward and could explain how the team was providing high quality care.

Leaders were visible on the ward and approachable for patients and staff. The ward manager and clinical lead were available to provide advice, guidance and leadership and the hospital director and the business, quality and performance manager were onsite and visited the ward to speak to staff and patients.

Staff who spoke with us said that there were leadership development opportunities available for all staff, not just those currently in people management roles.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to their work. They were centred around respect, putting the patient first and supporting patients, families, carers and colleagues.

Staff had opportunities to contribute to discussions about the strategy of the service at clinical governance meetings, reflective practice meetings and during supervision and appraisal sessions.

Staff could explain how they were working to deliver high quality care. An example of this included the fact that there were Safewards champions on the ward. Safewards is a model of care designed to reduce conflict and restrictive interventions within mental health inpatient settings.

Culture

Staff who spoke with us felt respected, supported and valued within the service. Staff felt positive and proud about working for the provider and their team. There was no evidence of difficulties within the team, but staff said that if there were, they thought managers would deal with them appropriately.

Staff who spoke with us said they would feel confident in raising concerns without fear of reprisals and that there was an open and transparent culture within the service that encouraged speaking out. Staff had access to the provider's whistleblowing policy via the provider's intranet.

Managers dealt with poor performance promptly and effectively. The provider had a performance management system in place which included a process for addressing staff performance issues. This system had been used to address a competency issue with a member of staff that had led to disciplinary proceedings. Managers could also seek advice from the provider's human resources department about staff performance issues.

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

Staff reported that the provider promoted equality and diversity into its day to day work. Examples included policies, procedures and guidance on equality and diversity, bullying, harassment and discrimination, mandatory training in equality and diversity and the diverse make-up of the multidisciplinary team.

The average staff sickness absence rate between 19 March and 9 September 2019 was 21% which was much higher than the provider's sickness absence target of 5.5%. The provider monitored sickness absence on the ward and there were no trends identified. There had been some periods of long-term sickness absence due to health conditions but there were also some staff who were being managed under the provider's sickness absence management procedures.

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

The provider recognised staff success within the service. Staff received immediate praise and thanks and their successes were also highlighted during supervision and appraisal sessions. There were also nominations for individual staff and team awards.

Governance

Governance systems on the ward were generally effective. Staff were trained and received supervision, patients were assessed and treated well, staff adhered to the Mental Health Act and Mental Capacity Act, beds management and discharge was effective, and the ward was clean, tidy and complied with infection control procedures.

However, an assault on a patient during leave from the hospital in which they sustained a serious injury was neither sent to the local authority as a safeguarding referral or as statutory notification to the Care Quality Commission, the latter of which is a requirement under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was 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 risks, safeguarding and learning from incidents and complaints, was shared and discussed.

Staff participated in clinical audits. These included weekly audits of care records, weekly pharmacy audits, weekly audits of Section 17 leave and annual audits of infection control. Improvements made as a result of these audits included the need for staff to clearly state on prescriptions what the form of medicine is being prescribed such as tablet or capsule and to ensure that staff always record in care records when a patient had refused to accept their physical health plans.

Staff understood the arrangements for working with other teams, both within the organisation and with external teams, to meet the needs of patients.

Management of risk, issues and performance

Staff had access to the risk register and were able to escalate concerns for inclusion in the corporate risk register. Staff concerns matched those on the risk register. The main risks on the ward were violence and aggression, impulsive behaviours and patients at risk of attempting suicide or self-harming.

The service had a business continuity plan in place for which included contingencies for emergencies which could affect the running of the service such as floods, loss of premises and adverse weather conditions.

At the time of our inspection, the ward had not been asked to make any efficiency savings since opening in March 2019.

Information management

The service used systems to collect data that were not overburdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system was adequate and helped to improve the quality of care.

Information governance systems included confidentiality of patient records. Staff received mandatory training in data protection and confidentiality. The provider's electronic care records system required a username and password for staff to access patient information.

Managers had access to information to support them with their management role. This included metrics such as supervision compliance, budget information, administration of medicines and staff conduct. This

information was in an accessible format and identified areas for improvement. Managers also attended multidisciplinary team meetings, so they were up to date with the progress patients were making.

Hospital managers did not always send notifications to external bodies when required. Under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, care providers are statutorily required to notify the Care Quality Commission about allegations of abuse, serious injury or incidents which the police are involved in. However, a statutory notification in relation to an assault on a patient on the Thoburn ward during which they sustained a serious injury whilst they were on leave had not been sent to the Care Quality Commission. The Thoburn ward is for patients with acute mental health problems. Hospital managers had not made a safeguarding referral to the local authority about this incident despite its meeting the local authority's threshold for doing so. However staff provided reassurance and support to the patient on their return to the ward. Staff carried out debriefs with the patient, supported them with the police investigation, undertook a welfare and health check and referred the patient to primary healthcare services.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider. Staff received information from their managers, through meetings and forums, bulletins and newsletters. Patients received information from the provider via community meetings with staff and the intranet. Staff sought patients' consent to share information with their families and carers.

Patients had opportunities to give feedback on the service through regular community meetings, surveys and attending multidisciplinary meetings. Managers and staff considered patient feedback and used it to make improvements.

Senior managers regularly engaged with staff and patients during quality walk arounds. These were quality audits which managers from other wards on the site and members of the senior management team attended. They allowed staff and patients the opportunity to provide feedback about the service to senior managers. Staff told us that senior managers were visible and approachable.

Directorate leaders engaged with external stakeholders such as commissioners and other care organisations. The ward was officially opened by the director of Public Health in the local area and commissioners were invited to open days at the hospital.

Learning, continuous improvement and innovation

Staff were given time and support to consider any opportunities for improvements and innovation during team meetings, reflective practice meetings and during supervision and appraisal sessions.

There was an example of innovative practice taking place on the ward known as the 'patient bus stop'. Staff had devised a simple but effective idea which comprised a row of three chairs designated for patients who were unable to verbally communicate their distress but wanted to be approached by staff for help and reassurance.

Staff on the ward were not involved in any research or accreditation schemes at the time of our inspection because the ward had only been open for six months. However, the provider intended to apply for a National Association of Psychiatric Intensive Care Unit accreditation for the service once the male psychiatric intensive care unit on the site had opened.

There were Safewards champions on the ward. Safewards is a model of care designed to reduce conflict and restrictive interventions within mental health inpatient settings.

Outstanding practice and areas for improvement

Outstanding practice

There was an example of innovative practice taking place on the ward known as the 'patient bus stop'. Staff had devised a simple but effective idea which comprised a row of three chairs designated for patients who were unable to verbally communicate their distress but wanted to be approached by staff for help and reassurance.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all incidents in which patients have been subjected to serious harm and abuse are recorded as serious incidents across all the wards on the Middleton St George site.
- The provider should ensure that all staff on the Chester ward receive regular supervision in order to meet its 90% compliance target.
- The provider should ensure that staff on the ward are compliant with all the modules of their mandatory training in order to meet its 85% compliance target.
- The provider should ensure that sickness absence on the Chester ward is managed effectively and in a supportive manner to encourage staff to return to work as soon possible.
- The provider should consider a solution to the noise levels on the ward caused by the acoustics, so the ward is conducive to a therapeutic environment, particularly given the lack of quiet areas on the ward for patients.
- The provider should consider exploring ways to further engage with families and carers of patients on the Chester ward who live long distances from the hospital to enable them to be involved in decisions about their loved ones' care and treatment.