CareQuality Commission

The Priory Hospital Nottingham

Quality Report

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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

Ratings

Overall rating for this location	Outstanding	☆
Are services safe?	Good	🟢
Are services effective?	Outstanding	☆
Are services caring?	Outstanding	☆
Are services responsive?	Good	🟢
Are services well-led?	Good	🟢

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.

Summary of findings

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

Overall summary

We rated The Priory Hospital Nottingham as outstanding because:

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment of each patient and care plans reflected patients' views. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice and worked well to involve patients in decisions about their care by informing them of their treatment options. Staff engaged in clinical audit to evaluate the quality of care they provided and learned from these to improve their practice.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients, families and carers in care decisions to make sure patients were active participants in their care and treatment.
- The service provided safe care. The ward environment was safe and clean. The ward had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- 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. We saw evidence of effective working with teams external to the organisation and had positive feedback from these organisations about the quality of the communication from the hospital.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Patients were discharged promptly once their condition warranted this.
- The service was well led, managers were actively engaged in supporting the staff and patients on the ward and the governance processes ensured that ward procedures ran smoothly.

However:

- Although staff maintained equipment well, staff did not record when clinical equipment was cleaned. Staff reported they cleaned all clinical equipment before and after every use, but had not recorded this.
- The blood glucose monitoring machine calibration was not part of the external audit company's audit schedule and there were no records to suggest this machine had been calibrated. However, this did not present an immediate risk to patient safety as the machine was less than 12 months old and therefore was not yet due for calibration.

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Background to The Priory Hospital Nottingham

The Priory Hospital Nottingham provides acute inpatient mental health care for up to 14 men and women. The hospital was full at the time of our inspection.

The hospital receives referrals from two neighbouring NHS Trusts.

The registered activities for The Priory Hospital Nottingham are:

- Accommodation for persons who require treatment for substance misuse, assessment, or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures and treatment of disease, disorder, or injury.

There was a registered manager at the hospital at the time of our inspection.

The Care Quality Commission last inspected the hospital on 11 January 2016 and rated the hospital as good in all domains. Following our previous inspection, the provider was informed it should take the following actions for improvement:

- The provider should ensure that supervision records are completed in order to ensure staff are being supported and issues are identified in a timely manner.
- The provider should ensure that stock is replaced following checks on emergency equipment.
- Staff should be provided with specialist training to meet the needs of patients on an acute ward.

Our inspection team

The team that inspected the service comprised two CQC inspectors and one specialist advisor who was a nurse.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with two family members of people who were using the service
- spoke with the registered manager and the director of clinical services for the hospital
- spoke with six other staff members; including doctors, nurses, occupational therapist, therapist and healthcare workers
- received feedback about the service from care co-ordinators or commissioners
- attended and observed a multi-disciplinary meeting

Summary of this inspection

- looked at four care and treatment records of patients
- carried out a specific check of the medication management and

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with three patients who were using the service at the time of our inspection. All of the patients told us they felt safe on the ward, had been fully involved in decisions about their care and treatment and felt supported by staff. Patients said staff were kind, respectful and compassionate towards their needs and went the extra mile to support their care and treatment. Two of the patients and two of the family members we spoke with said this was the best hospital they had ever received care in. They said staff provided a wide range of activities on the ward that were suitable to their recovery goals and that activities were never cancelled. All of the patients we spoke with had been oriented to the ward as part of their admission and said staff had given them information about their rights, how to complain and how to access an advocate, as well as other information about the hospital and treatments on offer. Patients told us staff worked hard to involve their families and carers in decisions about their care and always obtained their consent to do so.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good ●

Our rating of safe stayed the same. We rated safe as good because:

- The hospital was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- 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 only after attempts at de-escalation had failed. The hospital did not have a seclusion room. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. 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.

However:

- Although staff maintained equipment well, staff did not record when clinical equipment was cleaned. We did not see any 'clean' stickers on the clinical equipment. Staff reported they cleaned all clinical equipment before and after every use, but had not recorded this. The hospital managers added the cleaning of all clinical equipment to the weekly cleaning audit of the clinic room during our inspection.
- The blood glucose monitoring machine calibration was not part of the external audit company's audit schedule and there were

no records to suggest this machine had been calibrated. However, this did not present an immediate risk to patient safety as the machine was less than 12 months old and therefore was not yet due for calibration. The hospital manager addressed this concern immediately during our inspection.

Are services effective?

Our rating of effective improved. We rated effective as outstanding because:

Outstanding ☆

- Staff undertook thorough and holistic assessments of 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 the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a wide 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 went above and beyond to support patients to live healthier lives through a range of initiatives that all staff were engaged in.
- All staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking 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 needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills and share best practice. 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 excellent working relationships with other relevant teams within the organisation and with relevant services outside the organisation. The provider ensured that the systems to manage and share the information that was needed to deliver effective care were fully integrated and provided real-time information across teams and services.
- 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. The provider actively monitored and reviewed consent practices and records to improve how patients were involved in making decisions about their care and treatment.

- 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.

Are services caring?   Outstanding ☆

Our rating of caring improved. We rated caring as outstanding because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. The hospital had a store of spare clothes, female sanitary products and other items to offer to patients in need of these items, particularly on admission to the hospital. Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients' emotional and social needs were seen as being equally as important as their physical needs.

- Feedback from patients and the family members of patients using the service was overwhelmingly positive and two patients and family members reported this was the best hospital they had ever received care and treatment in. Patients and their family members said that staff went the extra mile to support their care needs.

- Staff actively involved patients in care planning and risk assessment and sought their feedback on the quality of care provided. We saw evidence that staff had developed care plans in collaboration with patients and the patients' input and preferences were clearly indicated in the plans. Staff ensured that patients had easy access to independent advocates. Staff ensured that they understood patients' communication needs to thoroughly involve them in their care and treatment.

- Staff informed and involved families and carers in an exemplary way. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. Family members and patients we spoke with reported excellent communication between the hospital and family members and gave examples of several occasions where staff had gone above and beyond to support family members and keep them updated. These relationships were highly valued by staff and promoted by leaders. The hospital

employed a patient services coordinator who was heavily involved in liaison with patients' family members and acted as a single point of contact for family members when they contacted the hospital.

Are services responsive?

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

- Staff managed patients' admission and discharge well. 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.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient 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 a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all people who use 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.

Good ●

Are services well-led?

Our rating of well-led stayed the same. 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.

Good ●

Summary of this inspection

However:

- We noted the cleaning audits and current governance systems did not cover the cleaning or calibration of all clinical equipment within the clinic room. However, managers immediately rectified this during our inspection.

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.

- As of 31 July 2018, the provider had trained 95% of staff in the Mental Health Act. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were.
- The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.
- The hospital had introduced a form that the speciality doctor completed with patients on admission, to record that the doctor had explained the proposed treatment plan to the patient and whether the patient consented to what was proposed. We noted this as good practice. We suggest that staff training should underline that such a record does not replace the need for statutory consent to treatment forms, where appropriate, or for patients' consent or lack of consent to be kept under constant review.
- Patients had easy access to information about independent mental health advocacy. An independent advocate attended the hospital once a week to support patients. The advocate met weekly with the director of clinical services to discuss any actions the hospital needed to take to assist patients.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. We saw examples of how patients were empowered to exercise their rights under the Act both on admission to and during their time at the hospital.
- Staff ensured that patients could take Section 17 leave when this has been granted. Section 17 leave is permission for patients detained under the Mental Health Act to leave the hospital.
- Staff requested an opinion from a second opinion appointed doctor when necessary.
- Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. Section 17 leave forms were completed on paper and scanned on to the electronic system. When we reviewed the electronic care notes system, we saw these had all been uploaded.
- The service displayed a notice to tell informal patients that they could leave the ward freely.
- Care plans referred to identified Section 117 aftercare services to be provided for those who had been subject to section 3 of the Mental Health Act.
- The Mental Health Act administrator completed monthly audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. The Mental Health Act administrator attended handover from Monday to Friday and shared information or updates with staff as and when required.

Mental Capacity Act and Deprivation of Liberty Safeguards

- As of 31 July 2018, the provider had trained 93% of staff in the Mental Capacity Act. Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles.
- The hospital had not made any Deprivation of Liberty Safeguards applications during the period 1 February 2018 to 31 July 2018.
- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.
- Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.
- Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.

Detailed findings from this inspection

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

- The service had arrangements to monitor adherence to the Mental Capacity Act. The Mental Health Act administrator audited the application of the Mental Capacity Act and acted on any learning that resulted from it. In addition, compliance with the Mental Capacity Act was part of the hospital's quality walk around schedule and was reviewed approximately every two months.

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	Good	☆ Outstanding	☆ Outstanding	Good	Good	☆ Outstanding
Overall	Good	☆ Outstanding	☆ Outstanding	Good	Good	☆ Outstanding

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

Outstanding ☆

Safe	**Good**	🟢
Effective	**Outstanding**	☆
Caring	**Outstanding**	☆
Responsive	**Good**	🟢
Well-led	**Good**	🟢

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

Good 🟢

Safe and clean environment

Safety of the ward layout

- Staff did regular risk assessments of the care environment to review the ligature risks and environmental risks associated with the building. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Staff had mitigated the risks associated with potential ligature points adequately. All patient areas were fitted with anti-ligature fittings and the hospital had seven designated safe rooms used by patients who presented a higher risk of harming themselves. Patients were individually risk assessed for their access to these rooms.
- Although the ward layout did not allow staff to observe all parts of ward, the provider had installed blind spot mirrors and used closed-circuit television to reduce the risk of patients not being able to be seen. The hospital used observations based on individual risk assessment to reduce the risks associated with not being able to observe all parts of the ward.
- The ward complied with guidance on mixed-sex accommodation. For example, all bedrooms were ensuite and there was a female-only lounge that staff and patients confirmed was only used by female patients. Staff offered male patients the use of another meeting room for a male-only space.

- Staff had easy access to alarms and patients had easy access to nurse call systems. An alarm was activated during our inspection and we saw staff responded quickly. Staff we spoke with told us the response to alarms was always fast and staff and patients said they felt safe on the ward.

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 cleaned regularly.
- Staff adhered to infection control principles, including handwashing.

Clinic room and equipment

- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. This had improved since our previous inspection.
- Although staff maintained equipment well, staff did not record when clinical equipment was cleaned. We did not see any 'clean' stickers on the clinical equipment. Staff reported they cleaned all clinical equipment before and after every use, but had not recorded this. We raised this with the senior management team during our inspection and the staff immediately amended the clinical room audit form to include daily cleaning checks of the clinical equipment.
- The provider used an external organisation to audit their clinical equipment. We noted that the blood glucose monitoring machine calibration was not part of this audit schedule and there were no records to suggest this machine had been calibrated. We raised this with the senior management team during our inspection who contacted the external organisation to

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

Outstanding ☆

ensure this was added to their audit schedule. The blood glucose monitoring machine was less than 12 months old and therefore a calibration was not yet required. The hospital has since ordered the required equipment to calibrate the machine internally and requested that the external company attended within a week to calibrate the machine. The hospital managers also ordered another new machine to be used as a 'back up', and the calibration of this machine was added to their own monitoring schedule.

Safe staffing

- At the time of our inspection, the hospital was awaiting the start date of a nurse who had been recruited to the one vacant nursing post. There were no other vacancies within the hospital. As of July 2018, staff sickness was at 2.1%. This had decreased further since our previous inspection when the figure was 2.3%.
- Managers had calculated the number and grade of nurses and healthcare assistants required and these staffing requirements were maintained on all shifts. The basic staffing levels were two qualified nurses and three healthcare workers on both day and night shifts. The senior management team could adjust staffing levels daily to take account of case mix and the observation requirements of the patients on the ward and we saw that staffing was increased appropriately according to this clinical need.
- When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. The hospital rarely used agency staff and we saw this amounted to around one shift per week. When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward.
- During our visit, a qualified nurse was present in communal areas of the ward at all times.
- Staffing levels allowed patients to have regular one-to-one time with their named nurse.
- Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. We saw an example where the ward had been short staffed due to staff sickness. On this occasion, the director of clinical services completed a nursing shift on the ward to support safe staffing numbers. Staff and patients said there were enough staff to support patient care and during our inspection we saw the staffing levels enabled staff and patients to interact and engage in activities.

- There were enough staff to carry out physical interventions, including observations and restraint, safely. As of July 2018, 97% of clinical staff had received training in the prevention and management of violence and aggression and all non-clinical staff had received breakaway training.
- Staff and patients said there were no concerns with the staffing levels at the hospital.

Medical staff

- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The hospital employed a consultant psychiatrist who worked at the hospital Monday to Friday between the hours of 9:00 and 17:00. A speciality doctor worked Monday to Friday 9:00 until 15:00. The hospital ensured medical cover was provided at all times through an on-call rota across the other sites within the region. The maximum time it could take a doctor to attend the hospital was up to one hour.
- Patients said they were always able to access a doctor to support their physical health needs.

Mandatory training

- Staff had received and were up to date with appropriate mandatory training.
- Overall, staff in this service had undertaken 98% of the various elements of training that the provider had set as mandatory. This had improved since our previous inspection.

Assessing and managing risk to patients and staff

- We looked at four sets of care records and saw that staff had completed a risk assessment of the patient on admission and updated this at least weekly, including after any incident. Staff used the provider's standardised risk assessment tool. It was evident that for patients who were referred from another service, staff used historical discharge summaries to support their care planning.
- We observed a multidisciplinary team review of a patient and their needs. We saw that consideration of the patient's risk was a central part of the review.
- Staff assessed patient risk before granting Section 17 leave. This is a section of the Mental Health Act (1983) which allows the Responsible Clinician to grant a detained patient leave of absence from hospital.

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

Outstanding ☆

Management of patient risk

- Staff were aware of and dealt with any specific risk issues, such as falls. The occupational therapist supported patients by completing assessments around their mobility and accessibility needs as and when required.
- Staff followed the provider's policies and procedures for use of observation, including to minimise risk from potential ligature points and for searching patients or their bedrooms. Staff explained when and how they searched patients for high-risk items and how they engaged patients in the search process. Patients who presented a risk to themselves or others had access to their bedroom monitored and restricted as required to maintain their safety.
- We saw that staff observed patients at irregular intervals in line with the provider's policy and if patients were observed by two staff members, staff made sure both staff members had signed the observation form. As of July 2018, 97% of staff had completed observation training.
- Staff applied blanket restrictions on patients' freedom only when justified.
- The hospital had recently implemented a smoke-free policy. We saw evidence that staff had offered and supported patients to access smoking cessation support and nicotine replacement therapy where appropriate.
- Informal patients could leave at will and knew that. Staff displayed a notice on the door to the ward to outline that informal patients could leave at their will.

Use of restrictive interventions

- During the period 1 February 2018 to 31 July 2018, there were four incidents of restraint on two different patients. None of these incidents involved face-down restraint or resulted in the use of rapid tranquilisation. The provider did not train staff to use face-down restraint. The prevention and management of violence and aggression training delivered to staff supported them to turn patients who took themselves down to a face-down position into a face-up position as soon as possible. The provider's policy highlighted that any face-down restraint needed to be reported as part of the incident reporting process and should instigate a team incident review. The number of reported face-down restraints was monitored centrally and followed up monthly.

- In addition to the prevention and management of violence and aggression training, the service had adopted the Safewards approach using soft words and talk downs and other strategies including identifying individual triggers for patients to reduce the need for restrictive interventions. Safewards is a model developed to support staff to manage and reduce conflict in psychiatric settings. We saw evidence the hospital had reduced its number of incidents since the introduction of the Safewards approach and saw a continuing downward trajectory in the number of incidents per month since the introduction of this approach.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- The hospital did not have a seclusion facility and reported no incidents of long-term segregation during the period 1 February 2018 and 31 July 2018.
- The service had not used rapid tranquilisation but had a policy that staff were aware of to ensure best practice was followed if rapid tranquilisation was used.

Safeguarding

- The provider had trained 98% of staff in safeguarding vulnerable adults and children. Staff knew how and when to raise a safeguarding concern and we saw evidence that staff did so when appropriate. Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies and we received feedback from an external team that the hospital had robust safeguarding processes. We saw that staff liaised with patients' community teams where appropriate, for example, on a patient's discharge, to handover safeguarding concerns. Staff reported positive working relationships with local safeguarding teams.
- Staff implemented safeguarding management plans as and when appropriate and we saw evidence these were effective in keeping patients safe.
- The provider had a safeguarding policy that staff were aware of.
- The hospital manager was the region's lead safeguarding officer and shared information with staff regarding all matters about safeguarding, including lessons learned. The hospital also had two designated

safeguarding officers. Staff we spoke with were aware of who the designated safeguarding officers were within the hospital and their role in supporting staff with advice and queries relating to safeguarding.

- Safeguarding was discussed as a standing agenda at clinical governance and multidisciplinary team meetings.
- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Staff followed safe procedures for children visiting the ward. Children could visit the hospital but did not have access to the main ward environment. The hospital had a room where children could meet with patients receiving care and treatment at the hospital. Staff liaised with social services regarding the suitability and safety of child visits to the hospital.

Staff access to essential information

- Staff completed most clinical documentation electronically. However, staff completed Section 17 leave forms and clinical nursing observations on paper and scanned this on to the electronic system later. The provider had plans to make all documentation electronic but this was not yet in place. To ensure paper documentation was scanned on to the electronic system in a timely and appropriate manner, the provider had introduced documentation quality walkarounds that took place during the year. These acted as an audit of the documentation and showed evidence that documentation was being completed accurately.
- We saw that all information needed to deliver patient care was available to all relevant staff, including agency staff, when they needed it and was in an accessible form. Medical staff had access to the electronic notes system of one of the local referring providers. This supported staff with ease of access to patient information as and when required, including for new referrals or admissions.
- However, when local bed managers made referrals outside day time working hours, night staff at the hospital did not have access to secure email accounts. This meant that making referrals to the service could be time consuming for local bed managers who used fax to send through confidential information.

Medicines management

- Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance. We saw several examples of this and patients told us how doctors and nursing staff gave patients information about their medication during multidisciplinary reviews and capacity assessments.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with national guidance, especially when the patient was prescribed a high dose of antipsychotic medication. For example, we saw the medical team had developed an additional monitoring form to support staff to monitor the physical health of patients who were prescribed anti-psychotic therapy.
- An external pharmacist visited the hospital weekly to support the management of medicines and completed monthly audits to generate actions where required. The hospital had not had any medication errors during the period 1 February 2018 and 31 July 2018. Staff said that when medication errors had occurred, they were reported through the provider's incident reporting process and lessons were learned.

Track record on safety

- The hospital had a good track record on safety. Staff managed patient safety incidents well.
- The hospital reported 18 serious incidents during the 12-month period 7 August 2017 to 30 July 2018. Most of these incidents related to the unauthorised absence of informal patients.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report, how to report them and did so when appropriate.
- 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.
- Staff received feedback from investigation of incidents, both internal and external to the service and met to discuss this feedback. We saw evidence that changes had been made as a result of sharing the feedback from incidents both within and outside of the hospital. Staff gave specific examples of times they had learned from incidents and made changes to their practice as a result.

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

Outstanding ☆

- Staff within the hospital were kept updated about changes to practice as a result of incidents through regular lessons learned and safety alerts that managers distributed through email and then printed copies off within the nursing office and the staff room. The hospital also had its own file for storing all information relating to lessons learned from within the service and other hospitals within the provider so staff could refer back to this in future.
- Staff and patients were debriefed and received support after a serious incident.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

Outstanding ☆

Assessment of needs and planning of care

- We reviewed four sets of care and treatment records. Staff assessed the physical and mental health of these patients on admission. As part of the physical health assessment, the speciality doctor conducted an electrocardiogram and took a baseline blood test for all new patients. Staff developed individual care plans which the team reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. We noted the care plans were detailed and covered each patients' social needs in addition to their mental and physical health needs.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. This included medication, psychological therapies and occupational therapy and activities. Patients had access to one to one and group-based sessions to support their mental health needs, including at weekends.
- Staff ensured that patients had excellent access to physical healthcare, including access to specialists

when needed. Following each patient's initial electrocardiogram and blood tests, the speciality doctor repeated these tests for any patient who remained in the service for more than three months and/or as required in line with medication regime. All patients whose records we reviewed had a physical health care plan that was reviewed weekly by the multidisciplinary team. In addition, patients had a one to one session with the consultant once a week to review their medication and physical health needs.

- All patients whose records we reviewed maintained their registration with their local general practitioner and the staff at the hospital liaised with them, particularly during the patient's admission and discharge.
- The hospital had easy access to the local emergency departments if patients required emergency treatment or the support of an emergency paramedic.
- Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration as and when required.
- Staff, including managers, went above and beyond to support patients to live healthier lives. For example, the hospital participated in smoking cessation schemes, relaxation groups, yoga sessions and other health promotion initiatives including 'healthy January' in which patients had been encouraged to participate in a five mile walk with staff and 'mental health awareness week'. Patients we spoke with were aware of these initiatives and spoke positively about the impact they had on their recovery. We saw that the patient's initial physical health assessment included checking whether the patient had accessed screening for cancer and whether there were any issues relating to substance misuse.
- Staff used recognised rating scales to assess and record severity and outcomes. We saw evidence that all staff were actively engaged in activities to monitor and improve quality and outcomes.
- Staff participated in clinical audit, benchmarking and quality improvement initiatives.
- The hospital had recently applied for their accreditation for inpatient mental health services (AIMS) and was awaiting the outcome of this at the time of inspection.

Skilled staff to deliver care

- Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff

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

Outstanding ☆

with appraisals, supervision and opportunities to update and further develop their skills. As of 31 July 2018, all staff had received an appraisal. Managers provided an induction programme for new staff.

- Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. The provider combined managerial and clinical supervision. The percentage of staff that had received regular supervision was 97%. We reviewed the quality of the supervision records and saw that these had improved since our previous inspection.

- Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. The team included or had access to the full range of specialists required to meet the needs of patients on the ward. The multidisciplinary therapeutic team included a consultant psychiatrist, a speciality doctor, nurses, healthcare workers, a humanistic-approach therapist, a psychotherapist, an occupational therapist and an activities coordinator.

- Managers provided new staff with appropriate induction, including the care certificate standards for healthcare assistants. New starters at the hospital completed a corporate provider-level induction before beginning several modules of face to face and online learning designed to provide staff with the relevant skills to support the patient group.

- Managers ensured that staff had access to regular team meetings. The hospital held quarterly team meetings for all staff. The hospital director chaired these meetings and held them at two different times of the day so that day and night staff could attend. The hospital held monthly clinical staff meetings for nurses, healthcare workers, therapy staff and medical staff and monthly support services meetings.

- Clinical staff participated in weekly reflective practice sessions. Reflective practice in health means developing critical thinking skills by reflecting on an area of practice and looking to improve it. It helps to engage in continuous learning and to gain insight into yourself or your practice.

- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. For example, the hospital director also met with all new starters after their first month of employment to review their progress and identify

specific areas of support required. Members of the multidisciplinary team were also encouraged to attend profession-specific conferences to support their professional development.

- Managers ensured that staff received the necessary specialist training for their roles. For example, the provider had trained a healthcare worker in phlebotomy and one of the therapists had been supported to attend dialectical behaviour therapy training. Staff could access specialist training through the provider's training resource. For example, staff within the hospital had requested some training around substance misuse, specifically focused on legal highs and this was delivered through the provider's internal resource. This had improved since our last inspection.

- Managers dealt with poor staff performance promptly and effectively and had positive working relationships with the provider's human resources team to support with this element of their role.

Multi-disciplinary and inter-agency team work

- Staff held regular and effective multidisciplinary meetings. The multidisciplinary team met every morning from Monday to Friday and held two review meetings each week to allow every patient to have their care and treatment reviewed weekly.

- Staff shared information about patients at effective handover meetings within the team. Although we did not observe a handover meeting, staff we spoke with told us that all staff actively contributed to these handover meetings and they provided an opportunity to share key messages.

- The hospital team had effective and collaborative working relationships, including good handovers, with other relevant teams outside of the organisation, such as community mental health teams and local authority services. We saw local community mental health teams attended patients' multidisciplinary review meetings on a regular basis and played an active part in their care and treatment planning to deliver more joined-up care to patients. Staff used a holistic approach to planning patients' discharge to other services and began planning for discharge at the earliest possible stage with a range of other organisations.

- We received feedback from an external team about the quality of the communication with the hospital. The team reported the communication from the hospital to be exceptional, accessible and timely.

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

Outstanding ☆

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

- As of 31 July 2018, the provider had trained 95% of staff in the Mental Health Act. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were.
- The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.
- The hospital had introduced a form that the speciality doctor completed with patients on admission, to record that the doctor had explained the proposed treatment plan to the patient and whether the patient consented to what was proposed. We noted this as good practice. We suggest that staff training should underline that such a record does not replace the need for statutory consent to treatment forms, where appropriate, or for patients' consent or lack of consent to be kept under constant review.
- Patients had easy access to information about independent mental health advocacy. An independent advocate attended the hospital once a week to support patients. The advocate met weekly with the director of clinical services to discuss any actions the hospital needed to take to assist patients.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. We saw examples of how patients were empowered to exercise their rights under the Act both on admission to and during their time at the hospital.
- Staff ensured that patients could take Section 17 leave when this has been granted. Section 17 leave is permission for patients detained under the Mental Health Act to leave the hospital.
- Staff requested an opinion from a second opinion appointed doctor when necessary.
- Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. Section

17 leave forms were completed on paper and scanned on to the electronic system. When we reviewed the electronic care notes system, we saw these had all been uploaded.
- The service displayed a notice to tell informal patients that they could leave the ward freely.
- Care plans referred to identified Section 117 aftercare services to be provided for those who had been subject to section 3 of the Mental Health Act.
- The Mental Health Act administrator completed monthly audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. The Mental Health Act administrator attended handover from Monday to Friday and shared information or updates with staff as and when required.

Good practice in applying the Mental Capacity Act

- As of 31 July 2018, the provider had trained 93% of staff in the Mental Capacity Act. Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles.
- The hospital had not made any Deprivation of Liberty Safeguards applications during the period 1 February 2018 to 31 July 2018.
- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.
- Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.
- Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- The service had arrangements to monitor adherence to the Mental Capacity Act. The Mental Health Act administrator audited the application of the Mental Capacity Act and acted on any learning that resulted from it. In addition, compliance with the Mental Capacity Act was part of the hospital's quality walkaround schedule and was reviewed approximately every two months.

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

Outstanding ☆

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

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. We observed several interactions between staff and patients and noted that in all cases, staff were exceptionally compassionate, kind and sensitive to patients. The hospital had a store of spare clothes, female sanitary products and other items to offer to patients in need of these items, particularly on admission to the hospital.

- There was a strong, visible person-centred culture within the hospital that was highly valued by staff and promoted by managers. Staff supported patients to understand and manage their care, treatment or condition and directed patients to other services when appropriate.

- Patients said staff treated them well, behaved appropriately towards them and went the extra mile to support their care and treatment needs. Patients said staff always made time to support their needs, even when the hospital was busy.

- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs and supported these needs in innovative ways.

- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

- Staff maintained the confidentiality of information about patients. Information was kept securely on computers and the patient information board in the nursing office shut inwards to protect the confidentiality of patient information. We saw that when external visitors entered the nursing office, staff locked computers to make sure visitors could not see personal information about patients.

Involvement in care

Involvement of patients

- Staff used the admission process to inform and thoroughly orient and welcome patients to the ward and to the service. Patients were given a welcome booklet which contained a range of information to support patients during their admission. Staff allocated patients a named nurse soon after their admission and each patient had a primary therapist to encourage patients to develop a positive relationship with staff. Patients told us they had regular one to one time with their named nurse. On each shift, staff completed a board that was displayed in the communal area which outlined which staff members were on shift and what the planned activities were for the day.

- Staff involved patients in care planning and risk assessment. For example, in all of the care plans we reviewed, we saw evidence that staff had developed the care plans in collaboration with the patient and the patient's input and preferences were clear. Although care plans were not written in the first person, we saw that staff had involved patients in the development of the plans through the use of direct quotes and clear goals. In all of the care plans we looked at, patients had signed and been given a copy of their care plans. Staff involved patients in their clinical review meetings and supported patients to make choices about their care and treatment. Patients told us they were involved in their discharge planning.

- Staff involved patients when appropriate in decisions about the service, such as activities available on the ward.

- Staff enabled patients to give feedback on the service they received through surveys that patients completed upon discharge. We reviewed five of the most recent feedback forms and saw that the feedback was overwhelmingly positive, including that all five patients would recommend this service to a friend or family member. Staff also encouraged patients to feedback through other patient surveys such as safeguarding surveys, one to one sessions, clinical review meetings and community meetings and feedback forms handed out on discharge.

- We reviewed the minutes of the recent community meetings and saw that patients were involved in the meetings and were encouraged to give feedback on the care they received and make suggestions for improvement and activities. Patients received copies of

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

the minutes of these meetings. In addition, staff held a quarterly 'meet the team' meeting where staff and patients had coffee and cake and patients had an opportunity to talk with the senior managers in the hospital.

- The provider encouraged patients to give feedback on their experience of receiving care and treatment at the hospital through their bi-monthly quality walkarounds. This feedback was reported to the clinical team through clinical governance. Most of the feedback that staff received through this method was positive.
- Staff enabled patients to make advance decisions through the collaborative development of patient care plans. We saw care plans contained information about patients' preferences about their future care and treatment and how they wanted staff to support them.
- Staff ensured that patients could access advocacy and patients reported using this to good effect.

Involvement of carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. The family members we spoke with reported staff were approachable, accessible and willing to be flexible about the times and dates of clinical meetings to enable them to attend. Family members we spoke with and patients reported excellent communication between the hospital and family members and gave examples of several occasions where staff had gone above and beyond to support family members and keep them updated. One patient told us their family members were involved in their clinical review meetings through the use of conference call equipment.
- Staff explained patients' care and treatment needs, including medication, to family members when patients consented to information sharing. The hospital employed a patient services coordinator who was heavily involved in liaison with patients' family members and acted as a single point of contact for family members when they contacted the hospital.
- Although both of the family members we spoke with had not been directly involved in their relative's care planning, patients we spoke with told us and records we looked at showed evidence of family involvement in care plans. For example, we saw care plans that contained information from a patient's family member about their early warning signs.

- During our inspection, we observed family members/ carers visiting patients on the ward. We saw there was appropriate spaces for family members to visit patients on the ward and outside of the ward if preferred.
- Staff enabled families and carers to give feedback on the service they received through surveys, clinical review meetings or by speaking directly with staff.
- Neither of the carers we spoke with had been given 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 ●

Access and discharge

Bed management

- Average bed occupancy during the period 1 February 2018 to 31 July 2018 was 100%.
- The service had block contracted beds from two neighbouring NHS Trusts. This meant that patients were admitted from outside of the local area. From February to August 2018, the hospital admitted 11 patients who had a home address of more than 50 miles away.
- There was always a bed available when patients returned from leave.
- When patients were discharged, this happened at an appropriate time of day.
- The average length of stay for patients between 31 August 2017 and 31 July 2018 was 29 days.
- The hospital had close links with the local psychiatric intensive care units to enable patients to be transferred to these services if their clinical need increased. The provider did not have any male psychiatric intensive care beds within the region so the service liaised with the local national health service trust to use their beds as and when this was required. We saw examples of how this link worked in practice to support the smooth transition of patients.

Discharge and transfers of care

- In the period 1 January 2016 to 31 July 2018, there were no delayed discharges from inpatient wards.

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

Outstanding ☆

- Staff planned for patients' discharge, including good liaison with care managers/co-ordinators. We saw evidence that staff held detailed discharge planning meetings prior to a patient's discharge.
- Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital.
- All patients were given information about how to access crisis services upon being discharged from the hospital.

The facilities promote recovery, comfort, dignity and confidentiality

- All patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Patients could personalise their bedrooms. We saw that patients had been involved in the décor of the hospital, including having made several ornaments around the hospital, bird boxes and the hospital displayed several pieces of patient art work on the walls.
- Patients had somewhere secure to store their possessions. The hospital had a store room located off the reception area that was kept locked and was only accessible by nursing staff. Each patient had a box they could utilise for anything they did not wish to have on the ward and restricted items. Patients also had access to a lockable drawer in their bedrooms if they had been risk assessed to have access to this. There were clear processes in place to ensure patient monies were stored securely.
- During our inspection, the atmosphere on the ward was calm and comfortable. Patients and staff reported this was usual for the ward.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care. This included meeting rooms, therapy rooms, a clinic room, a large communal area and a de-escalation/quiet room. Staff at the hospital reported issues with access to space for therapies. There were quiet areas on the ward and a room where patients could meet visitors.
- Patients could make a phone call in private and staff completed risk assessments to support patients to use their own mobile phones in their bedrooms.
- Patients had access to a small outside space. The hospital recognised this area was small and had previously functioned as the hospital smoking shelter/

area. There were plans to improve this outside area. Patients who had access to the community were encouraged to use a larger garden that was not enclosed.
- Patients said the food was of good quality and were given a choice daily about their menu. Patients could make hot drinks and snacks 24/7.

Patients engagement with the wider community

- When appropriate, staff ensured that patients had access to education and work opportunities. The hospital encouraged patients to engage with the occupational therapy programmes to support patients to develop links with the local communities. For example, the occupational therapy department had developed links with local volunteering companies and a recovery college and supported patients to access these opportunities.
- Staff supported patients to maintain contact with their families and carers and to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

- The service made adjustments for disabled patients by completing a comprehensive assessment of patients' mobility and accessibility needs prior to admission. The hospital had a lift to access the first floor and had three accessible bedrooms with wider door frames on the ground floor to support patients with mobility aids.
- Staff ensured that patients could obtain information on treatments, activities, local services, patients' rights and how to complain. This information was displayed around the hospital and contained in the patient's welcome booklet which patients received on admission. This information was also reiterated to patients within their clinical review meetings.
- The hospital could provide information in an easy-read format if this was required by a patient. The hospital could also access speech and language therapy input through the provider if this was required by a patient receiving care and treatment at the hospital. Staff reported they had used communication cards in the past to support a patient to understand their care and treatment.
- Staff made information leaflets available in languages spoken by patients and ensured that staff and patients

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Outstanding ☆

had easy access to interpreters and/or signers. Staff had put a sign next to the information leaflets to make it clear to patients that all information leaflets were available in different languages upon request.

- Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. We also saw an example of how staff had supported a patient who did not like eating food from the hospital kitchen by offering cooking sessions to support the patient to make their own food.
- Staff ensured that patients had access to appropriate spiritual support. Staff encouraged patients to engage with their preferred spiritual support services in the local community but this was also available on request within the hospital for patients who did not have access to the community. Patients we spoke with confirmed this and the noticeboard and the welcome booklet offered to patients on admission contained information about how the hospital would support their cultural and religious needs.
- The hospital had three bedrooms that had been used for transgender or non-binary patients as the rooms were not part of a gender-specific area, thus remaining compliant with mixed-sex accommodation guidelines. These bedrooms were located closer to the nursing station to enable better observation of the bedrooms should this be required to keep patients safe.

Listening to and learning from concerns and complaints

- Patients knew how to complain or raise concerns. We saw this information contained within the patient welcome booklet given to all patients on admission.
- When patients complained or raised concerns, they received feedback.
- Staff protected patients who raised concerns or complaints from discrimination and harassment.
- The provider had trained all staff in how to handle complaints. Staff we spoke with knew how to handle complaints appropriately, received feedback on the outcome of investigation of complaints and acted on the findings.
- During the period September 2017 to February 2018, the hospital received seven complaints. Of these seven complaints, four were not upheld, two were partially

upheld and one was upheld. Staff handled the complaints process according to the provider's complaints policy and we saw evidence of change as a result of the outcome of the complaint.

- The service received 28 compliments during the period August 2017 to July 2018.

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

Good ●

Leadership

- Leaders had the skills, knowledge and experience to perform their roles.
- Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.
- Staff and patients told us and we saw that leaders were visible in the service and approachable for patients and staff. Staff and patients said the leadership team were on the ward daily and supported the team with ward-based tasks. Staff told us and we saw that the hospital manager's office door was always open to promote a culture of openness and encourage staff to approach them with any questions or comments.
- Leadership development opportunities were available, including opportunities for staff below team manager level. For example, the provider offered leadership and management training that both charge nurses within the hospital had completed.

Vision and strategy

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Members of the leadership team successfully communicated key messages about changes to the service or the provider from the senior management team to the staff and patients on the ward where appropriate. Staff supervision and appraisals also included discussion that mirrored the provider's vision and values.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the

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

Outstanding ☆

service was changing. Staff did this through staff surveys, supervision, monthly clinical governance meetings, team meetings and fortnightly senior managers meetings.

- Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

- Staff felt respected, supported and valued in their roles and reported feeling happy in their work. The provider issued the last staff survey in March 2018 and 86% of staff participated in the survey. Whilst the majority of the feedback was positive, the senior management team had developed an action plan in response to areas for improvement from the staff survey results and we saw evidence of change as a result of this action plan.
- Staff felt positive and proud about working for the provider and their team and reported feeling respected by patients and staff.
- Staff felt able to raise concerns without fear of retribution and knew how to use the whistle-blowing process.
- Managers dealt with poor staff performance when needed. There were no open staff performance concerns at the time of our inspection. Teams worked well together and where there were difficulties managers dealt with them appropriately.
- Staff appraisals included conversations about career development and how it could be supported. The provider encouraged managers to engage in talent mapping to support staff with professional development.
- The service's staff sickness and absence were similar to the average for the provider.
- 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 through staff awards. The provider had a monthly awards scheme for staff which encouraged staff to nominate members of the team who had demonstrated the provider's vision and values. All staff who were nominated were recognised for this nomination by being given a small badge to wear. The provider also had long service awards to recognise the contribution of staff who had worked in the service for a long time.
- The provider had introduced a range of staff well-being initiatives as a result of learning from the previous staff

survey. For example, staff received a voucher on their birthday to thank them for their contribution to the staff team and every other month the provider gave staff the option of a free massage within working hours. During the Christmas period, the hospital had a Christmas advent calendar prize scheme that the hospital entered all staff into. Every day, a different staff member was randomly selected and awarded a small prize to thank them for their contribution to the team.

- The hospital had a well-being champion to support the staff well-being initiative.

Governance

- There were effective governance structures in place to ensure the hospital was safe and effective in delivering care that was suitable to the needs of the patient group. There were systems and procedures to ensure that the ward was safe and clean, that there were enough staff, that staff were trained and supervised, that patients were assessed and treated well and that the ward adhered to the Mental Health Act and Mental Capacity Act. The systems ensured that beds were managed well, that discharges were planned and that incidents were reported, investigated and learnt from.
- Managers had access to a dashboard to monitor the hospital's key performance indicators and had the appropriate support from administrators and human resources. The hospital manager completed a quality framework each month to report the hospital's key quality areas to the provider.
- 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 learning from incidents and complaints, was shared and discussed.
- Staff had implemented recommendations from reviews of incidents, complaints and safeguarding concerns at the service and provider level.
- Staff undertook or participated in local clinical audits. Overall, the audits were sufficient to provide assurance and staff acted on the results when needed. However, we noted the cleaning audits did not cover the cleaning or calibration of all clinical equipment within the clinic room. Managers immediately rectified this during our inspection.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

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

Outstanding ☆

Management of risk, issues and performance

- Staff maintained and had access to the risk register at site and provider level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register.
- The service had plans for emergencies including adverse weather or a flu outbreak.
- Where cost improvements were taking place, they did not compromise patient care.

Information management

- The service used systems to collect data from the within and outside of the hospital that were not over-burdensome 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, worked well and helped to improve the quality of care.
- Information governance systems included confidentiality of patient records.
- 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. Information was in an accessible format, and was timely, accurate and identified areas for improvement.
- Staff made notifications to external bodies, including CQC and the local authority safeguarding team as required.

Engagement

- 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, email updates and a lessons learned folder, as well as regular clinical, community and team meetings.

- 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 this feedback and used it to make improvements.
- Patients and staff could meet with members of the provider's senior leadership team to give feedback and were involved in decision-making about changes to the service.
- Senior leaders engaged with external stakeholders, including commissioners, local safeguarding teams and regulatory bodies.

Learning, continuous improvement and innovation

- Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes.
- The hospital had links with local universities to encourage nursing students to complete placements and mentorship programmes within the hospital.
- Staff were not involved in research at the time of our inspection. However, managers reported they would support staff who wanted to participate in research.
- Innovations were taking place in the service. For example, we saw the medical team had developed an additional monitoring form to support staff to monitor the physical health of patients who were prescribed anti-psychotic medication.

- Staff used quality improvement methods and knew how to apply them. Staff reported the senior management team were responsive to suggestions for improvement and felt they took action in response to quality improvement ideas.
- The hospital did not participate in any national audits relevant to the service.
- The hospital had recently submitted an application for their accreditation for inpatient mental health services (AIMS) and was awaiting the outcome of this at the time of inspection.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital engaged in several healthy living initiatives to support patients to live healthier lives. All the patients and staff, including the management team, were involved in these initiatives and we saw this was well-embedded in the care and treatment of patients at the hospital.

- The hospital went above and beyond to include patients and their family members in their care and treatment decisions.
- Members of the leadership team were very visible within the service and promoted an open and honest culture within the hospital.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure staff maintain accurate records of their cleaning schedule of the clinical equipment.

- The provider should ensure all clinical equipment is calibrated in line with manufacturer's guidance.