Sturdee Community Limited

Sturdee Community Hospital

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of the service stayed the same. We rated it as requires improvement because:

- Medicines were not always safely managed.
- Patients did not always have regular one-to-one sessions with their named nurse.
- Staff did not always assess risk well.
- Patients and some staff raised concerns about the difficulty in communication at times due to a number of staff who do not speak English as a first language.
- Information systems were not always effective due to paper based systems which staff found difficult to navigate.
- Governance processes did not always work effectively to ensure good oversight of quality and performance data and that ward procedures ran smoothly. The processes in place did not always identify gaps in recording and whether care plans, risk assessments and risk management plans were in place or up to date.
- Audits in place did not always work effectively to monitor the quality and safety of care provided or ensure improvements were made where necessary.

However:

- Staff followed good practice to safeguard patients. Staff were able to recognise and report abuse appropriately.
- Staff knew what incidents to report, how to report them and they were appropriately recorded on the patient information system.
- Staff minimised the use of restrictive practices. Staff undertook patient observations and had good knowledge of individual patient risks.
- Staff were up to date with their mandatory training.
- Staff felt as though they were respected, valued and supported.

Following this inspection, we issued the service with a warning notice served under Section 29 of the Health and Social Care Act 2008. We found that the service was failing to comply with Regulation 17 Good governance.

We found the service had failed to operate effective systems or processes to ensure the compliance with the requirements of regulation 17. We found the service was not maintaining accurate, complete or contemporaneous records. We found issues with the governance of medicines and we found environmental issues that had been identified as previous issues had not been acted on.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to Sturdee Community Hospital

Sturdee Hospital is an independent hospital and is part of the InMind Healthcare Group. Sturdee Community Hospital provides assessment, care and ongoing treatment facilities including high dependency rehabilitation. The facilities are for female service users aged over 18 years who may be subject to an appropriate section of the Mental Health Act 1983 or within services voluntarily.

Although Sturdee Hospital is an independent hospital registered with the CQC as a mixed sex service, 35 bed, separated into small self-contained units for rehabilitation purposes. The service is currently operating as an all-female service with 24 beds available for use. All bedrooms are single en-suite bedrooms with shower facilities.

Sturdee Community Hospital has been registered with CQC since April 2011. The hospital has a nominated individual as required. At the time of inspection, there was no registered manager in place and the provider had notified CQC of this through the statutory notification process. The hospital director had recently left the service and the deputy hospital director was in an acting role. The director of services was due to register as the registered manager for the hospital.

Sturdee Community Hospital is registered to provide the following regulated activities:

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

The last comprehensive inspection of this location was on 9 August 2022 to assess the work the service had undertaken as a result of enforcement issued in November 2021 following a focussed inspection of safe and well-led. The location was rated as requires improvement overall with requires improvement in safe and well-led and good in effective, caring and responsive.

We undertook an unannounced focussed inspection based on some recent information of concern. We inspected the following key questions:

Are services safe?

Are services well-led?

We visited all 3 wards:

- Foxton ward is 7 bed admissions ward providing high dependency rehabilitation
- Rutland ward is a 15 bed ward providing high dependency rehabilitation
- Aylestone ward is a 9 bed ward containing independent flats providing open rehabilitation.

What people who use the service say

We spoke to 9 patients across all 3 wards. Patients told us that they did not feel as though the service provided was rehabilitation. Some patients told us that they did not always feel safe. They told us that at times it was difficult to communicate with staff as there were a high percentage of staff members who did not speak English as a first language.

Summary of this inspection

Some patients who had primary or secondary diagnoses of autism spectrum disorder (ASD) told us that the environment was not conducive to meet their needs. One patient found communication difficult at times. Some patients told us that they did not have access to or know what a personal alarm was. Patients spoke highly of the consultant and the occupational therapy team.

How we carried out this inspection

The inspection team visited 3 wards between 28 and 29 November 2023. During the inspection we:

- visited and observed how staff cared for patients
- toured the clinical environment
- spoke with 9 patients who use the service
- spoke with 2 carers of people who used the service
- spoke with 18 staff including the nominated individual, a consultant, director of services, director of clinical services, a psychology assistant, occupational therapist, occupational therapy assistant, 5 nurses and 6 healthcare support workers
- spoke with the acting hospital director
- observed 1 morning meeting
- observed 1 therapy session
- reviewed 8 incident reports
- reviewed 10 patient records
- reviewed 15 patient medicines charts
- reviewed a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Action the provider MUST take to improve:

- The provider must ensure that care plans and risk assessments are personalised and updated regularly (Regulation 9(3)).
- The provider must ensure that medicines are managed appropriately and there are clear records in place for the transfer of medicines across the site. (Regulation 12(1)(g)).
- The provider must ensure that all patients are aware of how to access an alarm to alert staff in an emergency. (Regulation 12(2)(b)).
- The provider must ensure that there is sufficient outdoor furniture for patients to sit on. (Regulation 15).
- The provider must ensure that there are clear audits and action plans in place to monitor the quality and safety of care provided and to make improvements where necessary. (Regulation 17(2)(a)).
- The provider must ensure that the risk register reflects the current risks of the hospital. (Regulation 17)(2)(b)).
- The provider must ensure that cleaning records are completed contemporaneously and 7 days a week. (Regulation 17(2)(c)).

Summary of this inspection

- The provider must ensure that staff who are eligible are suitably trained in level 3 safeguarding adults. (Regulation 18(2)(a)).

Action the provider SHOULD take to improve:

- The provider should ensure that the fridge on Rutland ward is not overstocked. (Regulation 12).
- The provider should ensure that the use of agency staff is monitored. (Regulation 18).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Not inspected	Not inspected	Not inspected	Inadequate	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Inadequate	Requires Improvement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe	Requires Improvement
Well-led	Inadequate

Is the service safe?

Requires Improvement

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

Safe and clean care environments

All wards were generally safe, clean well equipped and fit for purpose but were not always well furnished or well maintained.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Monthly environmental audits were completed for all wards. However, we found that there were not always clear actions. For example, on the fire door audit from July 2023, there was a door on Aylestone ward that failed the check. There were no details of what had failed, what the action was or who was assigned the action, only that the carpenter had been informed. Other audits included water temperature, door guards and patient shower drains.

Staff could not observe patients in all parts of the wards. Wards were split across 2 floors and the nursing office did not allow all parts of the wards to be observed, however staff were in the communal areas at all times. Staff knew where the blind spots were and how they were managed. Blind spots were mitigated using parabolic mirrors and closed circuit television cameras (CCTV) were in place throughout the ward, grounds and garden areas.

The wards complied with guidance and there were no mixed sex accommodation. The hospital was for females.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Managers had completed ligature risk assessments for each ward, and these were on display in the nursing office, along with a heat map of ligature points. All staff wore ligature cutters on their person and there were a pair in the nursing office of each ward.

Staff had easy access to alarms, however patients did not have easy access to nurse call systems. Staff carried personal alarms in case of an emergency. There were no call systems in place in patient bedrooms, so the service had given patients a personal alarm to carry. We saw evidence of this in some patient records where patients had signed to consent to carrying a personal alarm. However, when we spoke to patients, some had not been given an alarm, and some knew nothing about carrying a personal alarm. We were not assured that patients would be able to inform staff if there was an emergency whilst in their bedrooms, with no alarm system or personal alarm in place. Following our inspection, the service informed us that nurse call buttons had been installed in each patient bedroom.

Maintenance, cleanliness and infection control

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Ward areas were clean, generally well furnished and fit for purpose, but were not always well maintained. There was new wipeable furniture in place that could easily be cleaned. There were some maintenance issues on Rutland and Aylestone wards. On Rutland ward, there was a window that was boarded up where the glass had been broken approximately 2 weeks prior to our inspection. This was on the maintenance log, but it was noted that a board was in place as a temporary measure with no indication as to when the window would be fixed or if new glass had been ordered. The service informed us that the window was fixed following our on-site visit. There was a large damp patch on the stairwell to the first floor on Rutland ward, which maintenance had installed a vent to support air flow and were due to replaster and repaint the wall. This was placed on the risk register on 24 November 2023 with initial action taken, but the maintenance team had identified that further action was needed to be taken to resolve the issue. There was no outdoor furniture for patients to sit on, other than seating in the smoking hut, which made it unpleasant for those patients who did not smoke. We reviewed maintenance logs and could see that numerous issues such as toilets blocking, and broken furniture were regularly reported and action had been taken.

Staff did not always make sure cleaning records were up-to-date, however the premises were noted to be clean. During our inspection, we requested to review cleaning records for all 3 wards. We were not given any records after April 2023 for Aylestone ward. Foxton ward were unable to locate their records and there were gaps in recording for Rutland ward. During the inspection, members of staff were observed to be retrospectively completing cleaning records, following the request to view them. The service provided copies of cleaning records after the inspection and there were a number of gaps in recording. For example, there were omissions in cleaning records for the bathrooms on Rutland ward from 10 to 20 November 2023, on Foxton ward from 14 to 19 November and 19 omissions for Aylestone ward during November 2023. Patient bedrooms were not cleaned on Aylestone ward from 20 to 24 November 2023 and from 20 to 26 November 2023 on Foxton ward. The stairs, corridors, reception and patient bedrooms on Rutland ward had omissions in recording from 13 to 17 November 2023. It did not appear that cleaning took place on the weekend, particularly Saturdays as there were consistent gaps in records. Cleaning schedules were placed on the risk register following our inspection as not being detailed enough.

Staff followed infection control policy, including handwashing. The service provided handwashing facilities in communal kitchen and dining areas and there were hand gel dispensers available on all wards. The infection control policy had been updated since the last inspection. The service conducted monthly infection control audits, however when issues arose, there were no details of who or when actions would be carried out to address them.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs, however staff did not always check these regularly. Emergency grab bags and oxygen were kept in the nursing office of each ward, and there was a clear sign for oxygen on the door. Emergency bags were required to be checked on a weekly basis. However, we found that there were some gaps in the recording of checking the emergency grab bag across all wards. For example, in October and November 2023, Aylestone ward had omissions from 3 October until 11 November 2023, Rutland ward had omissions from 7 October until 21 October 2023 and Foxton ward had omissions from 7 October to 11 November 2023. Therefore staff could not always be sure that the relevant equipment was in the bag, should an emergency arise. There was a medical emergency response local protocol and drills protocol in place. Staff carried out emergency drills on a monthly basis, with varied scenarios, at varied times of day.

Safe staffing

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. The service always had floating staff member in addition to those staff required to support patient observations, staff breaks and section 17 leave.

The service had high vacancy rates for nursing staff but no vacancy rates for unqualified staff. The service required 17.87 whole time equivalent (WTE) nursing staff and had 6.87 WTE vacancies (38%). The service were over established for healthcare support workers by 48.8%. They required 28.8 WTE and had 59 WTE in post. The service informed us that this was due to the number of enhanced observations required across the service. The service provided information that detailed the enhanced observations across all wards and staffing rationale. This indicated that the minimum number of healthcare support workers required to ensure all enhanced and general observations were supported was 20, in addition to nurses, per shift. There were 3 healthcare support workers and 1 nurse required per shift on Aylestone ward, 1 nurse and 6 healthcare support workers required on Foxton ward and 2 nurses and 11 healthcare support workers required on Rutland ward. The service met these numbers, however this was through the use of agency staff.

The service had high rates of bank and agency nurses and healthcare support workers. The data sent from the service did not split agency usage in nurses and healthcare support workers, but provided agency usage overall. From the period 1 August to 30 November 2023 there was a consistent use of agency of an average of at least 50% per month. In August 2023 an average of 63% of day shifts were filled by agency, 55% in September 2023, 51% in October 2023 and 52% in November 2023. The use increased during the night shifts with 65% in August 2023, 60% in September 2023, 66% in October and 53% in November 2023.

Managers did not limit their use of bank and agency staff and requested staff familiar with the service. We found that the use of agency staff was high and were told that there was previously no system in place to book agency staff and that any member of staff was able to do so. The director of services informed us that the process had now changed and only those at ward manager level and higher were able to book agency staff for shifts.

It was unclear why there were continued high levels of agency healthcare support staff booked for shifts when the service was over established for that role. This meant we were not assured that managers had oversight of staffing and the use of agency staff and vacancy rates for nurses.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We saw that 100% of agency workers had received their induction before working at the service.

The service had low turnover rates. From 1 June 2023 to 30 November 2023 there was a turnover rate of 6.84% across the service.

Levels of sickness were low. From 1 June 2023 to 30 November 2023, sickness had not been above 2% across the service.

Patients did not have regular one- to-one sessions with their named nurse. Care plans indicated a number of patients should have regular one-to-one sessions, however these were not always documented in patient records, nor was there a record to indicate that a patient was offered a one-to-one but declined.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. During our visit, we observed 1 patient utilising their section 17 leave and a group session and physical health clinics taking place. Patients spoke highly of the occupational therapy team since they had increased their staffing and felt they were more available. However, we spoke to 2 patients who gave recent examples of when they had leave or activities cancelled due to staffing.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff did not always share key information to keep patients safe when handing over their care to others. We reviewed handover folders which had a page for each patient on the ward. They indicated if any medicated taken as required (PRN) had been taken but did not offer any details regarding the patient and their presentation during the shift. We saw an example where there were no details completed and under the section for describing a patients' mental state and staff had written "manageable". We saw the word "manageable" had been used on several handover forms for several different patients.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The consultant worked 2 days a week but was able to respond and there was a full-time junior doctor in post. There was an on call place to provide support out of hours.

Managers could call locums when they needed additional medical cover. There was an on-call rota system in place.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. We reviewed compliance figures and there were no areas of training that had a compliance rate of below 85%.

The mandatory training programme was comprehensive and met the needs of patients and staff. Training covered a range of programmes and there was training provided in autism awareness (92.11%) and working with people with a learning disability (88.89%).

Administration staff were responsible for overseeing training compliance and monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, but did not always review this regularly, including after any incident. We reviewed 10 patient records and found 1 patient did not have a risk

assessment in place despite having moved wards and their observation levels increasing. We also found that 4 patients did not have a risk management plan in place and that 2 patients did not have an up-to-date risk management plan in place. We found that there was 1 patient who was self-medicating and did not have a risk assessment or care plan for this.

Staff used a recognised risk assessment tool. The service used The Short-Term Assessment of Risk and Treatability (START) risk assessment, which is a 20-item structured clinical tool to assess the level of risk for aggression and likelihood of responding well to treatment.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. There was a patient safety folder located on each ward which indicated what patients risks where, their triggers, any significant dates, any items they were restricted from using and if supervision was required or not. Patients also had positive behavioural support (PBS) plans in place to identify risks and triggers and how to support the patient individually. The service had recently introduced patient safety officer roles to ensure improved patient safety. However, we observed a group session where a lighter fell out of a staff members pocket on the chair where they were sitting, and they were not aware this had happened and should not have had this on their person.

Staff identified and responded to any changes in risks to, or posed by, patients. Incident analysis was completed every month to identify any themes and trends with incidents. There had been an increase in the number of incidents of violence and aggression by 65% from October to November 2023, however incidents had been on a downwards trend since June 2023.

Staff followed procedures to minimise risks where they could not easily observe patients. The service had CCTV in use and there were parabolic mirrors to aid observation where there were blind spots.

Staff followed the providers policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff told us that patients were searched when they returned from unescorted leave but not escorted leave. Some staff told us that patient bedrooms were searched every day, some told us every week and others told us that searches would take place based on intelligence. We reviewed the searching policy for the service which did not indicate a specific frequency of searching but that searches would be carried out based on any information of concern and, on the risk presented.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff told us that physical interventions were always a last resort after de-escalation techniques had been unsuccessful.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We reviewed 8 incident reports which stated de-escalation techniques had been used prior to any physical intervention being utilised.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff understood the principles and how to apply them within their role. Staff knew where they could get support and advice if needed.

Staff followed NICE guidance when using rapid tranquilisation. We reviewed rapid tranquilisation records and found that staff carried out physical observations following the administration of rapid tranquilisation and were recording them appropriately. During the morning meeting that was observed, staff reviewed the post monitoring information following an incident where rapid tranquilisation was used.

Safeguarding

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

The service had a safeguarding tracker in place which had 12 open safeguarding notifications from 7 July to 30 November 2023 that were awaiting closure from the local authority. All of these had been notified to CQC.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff we spoke with were aware of safeguarding procedures and would inform the nurse in charge.

Staff kept up-to-date with their safeguarding training. All staff were trained to level 2 safeguarding adults. Safeguarding adults level 1 training compliance was 97% and 87% for safeguarding children. Safeguarding level 2 training for adults and children was 98%. There was no training data received for level 3 safeguarding training, so we were not assured that any staff were trained to level 3, despite some staff being eligible.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had received training in equality and diversity and had a training compliance of 99%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. All staff we spoke with were aware of identifying any risks and who to contact should they need to do so.

Staff access to essential information

Staff had access to clinical information, but it was not always easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were not comprehensive, however all staff could access them. The service used paper records for patient notes. These were not always updated to reflect patients' current presentation and were not always up to date. Staff told us that it was difficult to locate and update information at times due to the large amount of folders and paperwork. The service told us that they were due to move to an online system of patient records at the end of the 2023 and were already using an online system for incident reporting and prescriptions.

Records were stored securely. Records were located in filing cabinets that could be locked within the nursing office, which was locked at all times.

Medicines management

The service used systems and processes to safely prescribe and administer medicines, however they were not always stored and recorded correctly. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines and patient treatment plans were reviewed every month at ward round or sooner if necessary.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 15 prescription records and found these to be up to date and of good quality.

Staff did not always store or manage all medicines and prescribing documents safely. We found some individual patient medicines that were no longer in use but remained in the cupboard. For example, a clonazepam for one patient had been changed from tablet to liquid form in March 2023 but the tablets remained in the cupboard. We found that the medicines fridge on Rutland ward was overstocked. We found systems were not in place to audit and monitor the usage of 'Drugs liable to misuse'. A large amount of medicines were stored in the controlled drugs cupboard on Rutland ward. We were told staff from Foxton and Aylestone wards took medicines from Rutland ward, but there are no records of stock transfer to other units and no record of any counting of medicines. The medication management policy stated that the storage and usage of these medicines should be treated like that of controlled drugs. The quantities of boxes of these medicines meant there was a lack of oversight of stock control, which increased the risk of poor medicines administration. These findings were raised with the service on the day and immediate actions were put in place such as implementation of a DLM register, transfer documents and review of storage.

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

Staff learned from safety alerts and incidents to improve practice. There were monthly lessons learned bulletins and staff meetings and any immediate information could be shared verbally during handover or the morning meeting.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Regular medication reviews were in place for every patient.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. The physical health nurse reviewed patients' physical health in line with their care plan. There were regular physical health clinics on all wards, and we saw that patients had their physical health monitoring on a weekly basis using the National Early Warning Signs 2 (NEWS2) tool.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff knew what incidents to report and how to report them. The service used an electronic incident reporting system which all staff had access to. There had a been a review of the quality of incident reporting and training had been provided to staff to improve this.

Staff reported serious incidents clearly and in line with policy. For the reporting period 1 June to 30 November 2023 there were a total of 823 incidents reported across all 3 wards. Staff told us that they felt confident to report incidents. We reviewed 8 incident forms and found them to be of reasonably good quality. There were some inconstancies with reporting, with details of debriefs and follow up information not always recorded, and the patient level of observation was never included in the report.

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.

Managers debriefed and supported staff after any serious incident. Staff told us that they received a debrief after incidents had occurred and there were debrief folders in place for each ward which highlighted any areas of learning.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

We were not assured that leaders had the right skills, knowledge and experience to perform their roles, or have understanding of the services they managed. However they were visible in the service and approachable for patients and staff.

The leadership team had changed since our last inspection. At the time of inspection there was no registered manager in place as the hospital director had recently left. The deputy hospital director had been in the acting role since October 2023 with support from the director of services, who was in the process of registering as the registered manager. There was currently only 1 ward manager overseeing all 3 wards. This was due to 1 ward manager being on maternity leave and another ward manager going through the recruitment process. The service had recently introduced the role of Director of Clinical Services to strengthen the management team. However due to the concerns with the governance of the service and oversight of systems and processes, we were not assured that leaders had the right skills and experience or understanding of the service.

Most staff we spoke with said leaders were supportive, approachable, accessible and visible.

Managers met daily for the morning meeting and on a monthly basis for clinical governance meetings.

Culture

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Staff told us that they felt supported and respected from managers. However, staff told us that they were not kept up to date around changes in leadership at the service, especially in regard to the change in hospital director.

Managers dealt with poor performance when needed.

The service carried out a staff survey with 17 responses. There were no significant concerns raised and an action plan had been collated in response to the qualitative responses received.

Governance

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

The services current systems did not ensure that medicines that were classed as 'drugs liable to misuse' were monitored or audited or medicines no longer in use were removed from clinic rooms.

Governance systems had not identified that records were not always accurate, complete or contemporaneous. Patient records, risk assessments and risk management plans were not always up to date or in place when necessary. Cleaning records were not always up to date and were filled in retrospectively. Handover records did not always provide details of patient presentation.

Governance processes were not working effectively to identify areas that needed improvement. There were issues that were raised at the previous inspection that had not been actioned, for example, providing outdoor furniture and completing cleaning records 7 days a week. Audits in place did not always have clear action plans with who was assigned the action and how the action would be resolved. For example, in care plan audits there were comments such as 'action care plans that are due for review' or 'reoffer copy of care plan'.

Managers did not have effective oversight of staffing. There were issues with systems in place to monitor staffing. There were a high number of agency staff used despite the service being over established in healthcare support workers by 48%.

Paper based systems in place made it difficult to locate information. Staff found the systems frustrating and difficult to navigate and update information. The service informed us that patient records were due to move online by the end of the year.

There was a set agenda for clinical governance meetings which was set to the CQC's five domains of safe, effective, caring, responsive and well-led. There was an overall action plan in place, however it was unclear to see where the issues identified had come from and where the action plan and updates were discussed.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had an up-to-date risk register in place, but this did not accurately reflect the risks of the service. There were a number of risks on the risk register that were very low level and would be better suited to a maintenance log or an action plan following an audit. For example, 'bins are not in the dedicated store', 'foot operated clinical waste bin broken' and 'child visiting area not child friendly'. There was no indication how the risk rating was worked out, there was just a low or medium risk indicated. The service had no high risks on the risk register.

Managers did not have full oversight of risks to the quality of service delivery. Issues identified by this inspection were not reflected on the risk register, for example the high number of enhanced service user observations or service user acuity which led to the service pausing admissions was not on the risk register. It was not clear who was able to add items to the risk register.

The risk register was an item on the agenda for clinical governance meetings, but the minutes did not include any detail of discussion or review of the risks. For example, of the 40 risks on the risk register, 37 of these had been added between 19 to 30 November 2023 and there was no discussion documented at the clinical governance meeting that took place on 30 November 2023. The minutes stated "quality assurance portal review and updated weekly with current risks". Therefore, we were not assured that the risks added were appropriate for the risk register or were discussed and reviewed regularly.

Managers collected a range of care delivery information, such as key performance indicators. The service had access to a wide range of performance data such as training, supervision and appraisals.

Engagement

The service worked closely with external partners. There were good relationships with the local safeguarding team and commissioners.

Learning, continuous improvement and innovation

The service documented lessons learned in clinical governance meetings, incident analysis meetings and through incidents and debriefing. Lessons learned were shared via a bulletin on a monthly basis and through team meetings. Whilst it was clear that the service had a clear focus on learning lessons, there were a number of lessons learned identified during the October 2023 clinical governance meeting but these were not reflected in the October lessons learned bulletin.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not managed appropriately and there were not clear records in place for the transfer of medicines across the site. Not all patients were aware of how to access an alarm to alert staff in an emergency.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Ccare plans and risk assessments were not always personalised or updated regularly.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment There was not sufficient outdoor furniture for patients to sit on.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all staff who were eligible, were suitably trained in level 3 safeguarding adults.

Audits and action plans did not monitor the quality and safety of care provided to make improvements where necessary.

The risk register did not reflect the risks of the hospital.

Cleaning records were not always completed contemporaneously and 7 days a week.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Following the inspection, a warning notice was issued to the provider which told the provider areas which must be improved, in particular:** • Systems and processes did not always operate effectively and there was a lack of clear oversight of governance processes. • Systems were not in place to audit and monitor the usage of 'Drugs liable to misuse'. • Individual service user medicines that were no longer in use remained in the medicines cupboard. • Care plans were prescriptive and were not always up to date. • Regular 1:1 sessions with named nurses did not always take place as prescribed. • Cleaning records were not always contemporaneous and there were gaps in recording. • Handover reports were not always detailed and did not always use appropriate language. • Paper-based systems meant locating information was difficult at times for staff and it was unclear at times which information was the most up to date. • The risk register did not reflect the hospitals risks at the time of inspection and had a number of low level risks identified. • Audits did not always highlight issues or give clear detail of action that needed to be taken to address issues and improve the quality of care provided. • Environmental issues were not always acted on in a timely manner.