Mill Garth

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
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.

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

Summary of findings

Overall summary

We rated Mill Garth as good because:

- All patients were protected from potential harm and abuse. The service had enough staff with the right training and support to deliver safe and effective care. Regular assessment of environmental risk ensured facilities and equipment were safe for patients and staff.
- Staff provided care and treatment that was effective, recovery focussed and met the individual needs of patients. Care was planned collaboratively between patients and the multidisciplinary team, this approach was consistent and positive. Staff adhered to the Mental Health Act Code of Practice.
- Staff inspired confidence in patients and carers. Staff treated patients with kindness and dignity. Relationships were built on a mutual respect for each other. Patients felt safe using the service and carers believed the service achieved positive outcomes for patients.
- The service was responsive to the needs of all patients. The service had a wide range of facilities and activities to meet the individual needs of patients. Staff monitored and measured therapeutic activities for effectiveness. The service had received no formal complaints.
- The governance systems in place ensured the delivery of safe and high quality care. Leadership was good and the service promoted an honest and open culture. Staff felt supported and listened to. The service embraced carer and family involvement.

Summary of findings

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Services we looked at

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Mill Garth

Mill Garth is a 21 bed locked rehabilitation and recovery service for men aged 18 years and over, who have complex mental health issues. At the time of the inspection, five patients were admitted to the service who were all detained under the MHA.

Mill Garth registered with the Care Quality Commission in March 2016. At the time of our inspection, a registered manager was in place and had been since the service opened in December 2016. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010. A condition of allowing a provider to register is that they must ensure that an individual who is registered as a manager in respect of that activity manages the regulated activities.

Following the successful merger of two providers in December 2016, Mill Garth now forms part of Priory Healthcare.

Mill Garth is registered with the CQC to carry out the following regulated activities:

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

Our Mental Health Act reviewer has not visited the service. The CQC has not previously inspected Mill Garth.

Our inspection team

Team leader: Joanne White, Mental Health Hospitals Inspector, Care Quality Commission.

The team that inspected the service comprised two CQC inspectors, which included the team leader, one pharmacist specialist and one special adviser who was an occupational therapist.

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.

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with the registered manager

Summary of this inspection

- spoke with seven other staff including; two qualified nurses and two nursing assistants, lead occupational therapist, consultant psychiatrist and activities co-ordinator spoke with the regional head of quality improvement
- spoke with the lead for the Mental Health Act and Mental Capacity Act
- attended and observed one multi-disciplinary business meeting and one staff meeting
- looked at all five care and treatment records of patients
- carried out a specific check of the medication management at the service
- reviewed five staff personnel files
- spoke with four other staff members from administration, housekeeping and catering
- spoke with two carers of people using the service
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Feedback we received from patients using the service was wholly positive. Patients told us they felt safe, happy and well cared for. Patients described staff as very kind and could approach them with any concern. Patients spoke highly of the catering team and described the food as 'the best bit'.

Patients described how they were involved in planning their care and were clear about treatment goals. Patients liked the range of activities that were available and valued the support staff provided when they went out in the community. Patients did not identify any improvements the service could make.

We spoke with two carers of patients using the service. Carers told us staff were respectful and helpful. Communication was good and carers felt they could openly express their views and opinions with the service. Although one carer did feel that procedures prevailed occasionally, rather than a common sense approach. Carers felt the service had positive outcomes for patients.

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

We rated safe as good because:

- All areas of the service were clean, well maintained and furnishings were good. Environmental safety checks had been completed and included a ligature point audit and fire risk assessment. Staff completed regular checks on the emergency call system and radio communication system.
- The service had enough staff with the right training to facilitate therapeutic activities with patients. Staff were able to access a range of mandatory training opportunities and additional specialist training. The average attendance rate at mandatory training by staff was 96%.
- All staff we spoke with during the inspection confirmed they were able to use the electronic incident reporting system and were aware of their responsibilities to report incidents. The service had not reported any serious incidents.
- Staff undertook patient engagement and observation in a respectful and dignified manner and demonstrated the least restrictive approach to patient care. All patients told us they felt safe.

However:

- One high-risk ligature point was not recorded on the completed ligature point audit.
- Emergency medicines were not stored in tamper proof containers.

Are services effective?

Good

We rated effective as good because:

- All care plans were comprehensive, person centred and up to date. The evidence base was clearly referenced and reflected current approaches to care and treatment.
- Long-term physical health conditions were effectively monitored and managed and referrals were made to specialist services.
- Multidisciplinary team work extended beyond the service to include community GPs' and care co-ordinators.
- Staff were experienced and qualified to undertake their roles. Staff were supported to maintain their professional registration and disclosure barring checks were in place for all staff.

Summary of this inspection

- Mental Health Act and Mental Capacity Act requirements were met by the service, all documentation was complete and patients were supported in decision making.

  However:
- Some physical healthcare monitoring and blood test results for patients prescribed antipsychotic medicines had not been recorded in their clinical notes.
- Insufficient time was given to request a second opinion approved doctor for the purpose of assessing consent to treatment.

Are services caring?

Good

We rated caring as good because:

- Staff provided care that promoted the dignity and respect of patients.
- Staff had a thorough understanding of individual need. Patients were involved in planning their care and goals had a recovery focus.
- All patients that we spoke with gave positive feedback about their care and treatment. Patients told us they felt safe and supported by staff.
- Carers felt the service had positive outcomes for patients.

Are services responsive?

Good

We rated responsive as good because:

- Referrals to the service had a multidisciplinary assessment within four days.
- A rehabilitation and recovery focus was prominent throughout a patients care pathway.
- There were a range of facilities for patients to use, including kitchens for preparing meals and developing daily living skills. The large café area and garden promoted the social aspects of living in the unit.
- The service provided a weekly timetable so patients could plan ahead to include all parts of their care and treatment.
- Activity schedules took into account individual needs and preferences.
- The service recorded accurately the time patients engaged in activities.
- Patients knew how to make a complaint and felt confident to do so. The service had not received any formal complaints from patients or carers. The independent mental health advocate attended the service regularly to provide support to patients.

Summary of this inspection

Are services well-led?

Good

We rated well-led as good because:

- Morale was very positive across the multidisciplinary team. Teamwork underpinned this and was a positive support for joint decision making.
- Staff spoke highly about the senior management team. Lines of communication were open and honest within the service and staff felt listened to.
- Mandatory training and supervision were well supported and compliance rates were high.
- The registered manager had established lines of support within the service and these extended into regional support from the provider.
- Governance arrangements within the service provided assurance that care and treatment was safe.
- The service embraced carer and family involvement.

However:

- Initial assessment and risk assessment for patients was inconsistent.
- The bath hoist in the accessible bathroom had not been serviced since December 2013.
- The fire blanket and the fire extinguisher in the main kitchen did not display up to date service labels.

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.

The service employed a Mental Health Act administrator who provided guidance on the application of the Mental Health Act to all staff. The Mental Health Act administrator had responsibility for ensuring that all Mental Health Act documentation was accurate and complete.

We reviewed Mental Health Act documentation for all five patients; detention paperwork was completed accurately and up to date. The service had an organised system for storing detention paperwork, consent to treatment forms, approved mental health professional reports and second opinion approved doctor reports. This systematic approach ensured the Mental Health Act administrator and consultant psychiatrist had oversight for patients' ongoing detention.

The service had a multidisciplinary approach to managing and monitoring section 17 leave. A patients' primary nurse planned all section 17 leave in advance and made a written proposal to the consultant psychiatrist and the multi-disciplinary team. All patients had a care plan specifically relating to section 17 leave and this detailed the conditions and contingencies of that period of leave. Staff considered the therapeutic value and risks associated with section 17 leave and we saw detailed evidence of this in all care records.

At the time of our inspection, all staff had received training on the Mental Health Act and the 2015 Mental Health Act Code of Practice. Staff we spoke with had a good understanding of the Mental Health Act and the Code of Practice guiding principles.

All patients had their rights under the Mental Health Act explained to them on admission to the service.

Patients were able to access independent mental health advocacy and patients told us they were familiar with how to access this service.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had received training in the Mental Capacity Act. The provider had a policy to guide staff. The registered manager was the service lead for the Mental Capacity Act and provided support to staff. Staff we spoke with demonstrated a good understanding of the Mental Capacity Act, its five statutory principles and the definition of restraint.

At the time of our inspection, all patients admitted to the service were detained under the Mental Health Act. There had been no Deprivation of Liberty Safeguards applications made by the service since its opening. The provider had a policy to guide and assist staff to apply the Deprivation of Liberty Safeguards should they need to.

Staff had completed capacity assessments with patients when required, these were time and decision specific. Staff did not make decisions in isolation, consideration was given to all available sources of information and this extended to patients care co-ordinators. Staff recorded the outcome of assessment clearly and in detail in the patients care record.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Long stay/rehabilitation mental health wards for working age adults

Good

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

The layout of the unit did not allow all areas to be observed by staff or provide clear lines of sight. An environmental audit completed by the service in June 2017 had already identified the blind spots across the unit. This had directed the measures put in place to mitigate the risk to staff and patients. These included comprehensive care plans for observation specific to individual patient need and levels of staff presence in communal areas.

We saw completed and up to date ligature point risk assessments for the unit. A ligature point is something that a patient intent on self-harm could use to tie something to in order to strangle themselves. Senior management had undertaken these as part of the provider's audit cycle. We reviewed the documentation held by the service in relation to ligature points and this was comprehensive. Ligature risks associated with every individual room and communal area were recorded. Each ligature point had a risk rating of low, medium or high. Those risks with a medium or high rating required action to be taken or the risk to be accepted and mitigated. We specifically reviewed the audits and risk ratings for patient bedrooms. The service told us that they had four 'safer' and 17 standard bedrooms. We viewed a standard and safer bedroom for comparison. Staff told us that the safer bedrooms had been adapted to a reduced ligature specification. We saw that this was the case because the safer bedroom had an en-suite bathroom with push button shower, toilet and sink. Bedrooms were furnished with floor to ceiling wardrobe and storage with integrated handles. Standard bedrooms were furnished with typical furniture with handles and were not floor to ceiling. Bathrooms had a shower with a hose and sinks with standard taps. No patients had been assessed as needing a safer room.

We saw on the ligature point audit conducted by the service, they had identified one action and this related to the closing arms on doors for safer rooms. The action required to change these to a reduced ligature specification had a target date of 1 July 2017. The service had not completed the work when we revisited on 20 July 2017. The registered manager told us the service was waiting for quotations to complete the work. We noted that observation window adjusters were not on the ligature point audit for the safer bedrooms. We reviewed the provider policy and this specific risk would be assessed as high due to the height of the adjuster.

The service admitted male patients only so was compliant with Department of Health same sex accommodation guidance and guidance contained within the Mental Health Act Code of Practice.

The service had one clinic room used by clinical staff to administer medication and undertake physical health monitoring. The clinic room was clean and organised. There was a range of physical health monitoring equipment such as weighing scales, a blood pressure monitor and a machine for measuring oxygen levels in the blood stream. Equipment was maintained and electrically tested to ensure it was fit for purpose and safe to use.

In a small room joined to the clinic room, there was a patient examination couch, examination lamp and privacy curtain. This meant that patients could be physically examined in an appropriate clinical environment whilst maintaining their privacy and dignity.

There were adequate supplies of medicines and equipment for use in a medical emergency, and a procedure was in place to ensure they were fit for use. However, emergency medicines were not stored in tamper evident containers in accordance with national guidance 'The Safe and Secure Handling of Medicines', published by the Royal Pharmaceutical Society.

Staff checked daily the equipment used in a medical emergency. We reviewed a random sample of documentation for checks undertaken between March 2017 and July 2017. Staff had completed the required checks and paperwork. We saw that a deputy manager had also completed weekly audits of these staff checks and had signed and dated the records to reflect this.

The service did not have a seclusion room. The service had a quiet room; this was furnished with chairs and a sofa. The service had designed it as a safe space for patients to move away from others should they need space to become calm. Staff told us the room was not locked and patients could use it independently or with the support of staff.

The service was welcoming and inviting. All areas of the service were exceptionally clean, well maintained and furnished to a high standard. Domestic staff completed a daily schedule of cleaning, this covered bathrooms, toilets, dining rooms, communal lounges and the laundry. One member of staff we spoke with told us they would work collaboratively with domestic staff to support patients in cleaning their bedrooms.

Staff adhered to infection control principles. Alcohol hand gel was available throughout the unit and hand washing guidance was on display in bathrooms, toilets and clinical areas. An infection control policy was in place to guide staff. 96% of staff had training in the principles of infection control.

The service was inspected for gas safety and rated as safe for use in January 2017. An external contractor on an annual basis completed portable appliance testing and the majority of items had been tested. Maintenance staff told us they completed visual checks of new items as required. We saw documents that supported this; however, of the four visual checks recorded, three were not dated.

A fire detection system inspection and service had been completed in February 2017. The service completed a number of weekly checks of fire equipment including alarms and extinguishers. We reviewed records of these checks and they were incomplete. Fire door release checks were not completed on one occasion in June 2017 when maintenance staff were not at work. We completed visual checks of the fire blanket and fire extinguisher in the main kitchen and both had exceeded the due service date. The fire blanket was due to be serviced in September 2013 and the fire extinguisher in September 2016. The service supplied documents that recorded these items were serviced on 12 July 2017.

All clinical staff carried a radio; this was to summon assistance in the event of an emergency and to aid communication between staff whilst on the unit. Staff we spoke with told they tested each radio every morning to ensure it was working correctly. Patient bedrooms, bathrooms and other communal areas had an alarm system for patients to use. Once activated, a central panel near the main office would indicate to staff where assistance was required. Nursing staff checked this system daily to ensure it was working. We reviewed the documentation for these checks for June 2017 and July 2017, it was complete. We also saw evidence that a deputy manager had completed weekly audits of these documents.

Safe staffing

As of July 2017, a total of 31substantive staff worked at Mill Garth. There were nine whole time equivalent qualified nurses and there were no vacancies. There were 16 whole time equivalent nursing assistants and there were no vacancies. The registered manager told us staffing levels were above the actual number required for the current bed occupancy. The service would adjust these in line with increasing patient numbers. A deputy manager told us they had the autonomy to adjust staffing levels to take account of case mix within the service. They reported no difficulties in the recruitment of qualified nurses or nursing assistants. The service had not used any agency staff. Data provided by the provider prior to the inspection showed that the

service had covered 31 shifts with bank staff. We discussed this with a deputy manager and they confirmed that this was an interim measure in relation to one staff member moving onto a permanent contract within the organisation.

We observed staff proactively engaging with patients in communal areas. The nurse in charge allocated a security nurse on a daily basis to take responsibility for completing environmental and security checks. There were sufficient staff available and accessible for patients to have one-to-one time with their named nurse and additional time was available with nursing assistants. Patients that we spoke with reported no concerns with accessing one-to-one time.

All staff and patients we spoke with told us that they had not experienced cancelled activities or section 17 leave. We reviewed how the service would capture this information. Patients' electronic care and treatment record included a planned individualised timetable of activities. Staff would record if the activity went ahead as planned, patient declined to participate or the service did not deliver. Staff could generate reports in the electronic care record to inform staff and patients of activity time and engagement levels.

A consultant psychiatrist was in post at the service and provided medical cover for five days each week, although for one of these days they were located at another of the provider's hospitals nearby. An on-call duty rota provided medical cover when the consultant psychiatrist was not on site. Doctors from other sites managed by the provider, provided medical cover during the day and night. The consultant psychiatrist told us the medical resource would increase once the bed occupancy rate increased.

Prior to inspection the service submitted data about the range of mandatory training staff could access. There were 20 different courses including Mental Health Act Code of practice, conflict resolution and safeguarding. The service reported a compliance rate for all staff between 84% and 100%. The registered manager monitored attendance at mandatory training by staff through the electronic learning system, the average attendance was 96%.

Assessing and managing risk to patients and staff

The service did not have a seclusion facility and had not recorded any episodes of seclusion. Staff told us they would encourage patients to use the quiet room and would support them to do this if required. The quiet room remained unlocked at all times. Staff we spoke with during the inspection told us they would record in the electronic care record if a patient had used the quiet room.

There were no recorded incidents of the use of restraint or rapid tranquilisation since the unit opened in December 2016. The service had a policy in place to provide guidance to staff on the prevention and management of disturbed and violent behaviour. This had been issued in August 2016 and due for review in August 2019. The policy provided guidance to staff on the use of physical interventions, including the use of prone restraint. Prone restraint is holding a person chest down and staff placing patients prone onto any surface. Prone restraint carries a high risk of asphyxiation to patients and services have reported a number of deaths. Staff received prevention and management of violence and aggression training and 84% of staff had completed this. The policy also included information on rapid tranquilisation, incorporating the National Institute for Health and Care Excellence guidance. Staff received conflict resolution training as part of the mandatory training programme. At the time of our inspection, 100% of staff had received this training.

The service had a policy to provide guidance for staff on clinical risk assessment and management. A multidisciplinary approach to risk assessment was in place at the service. A multidisciplinary team assessed a patients' suitability for the service prior to admission and all admissions were planned. Staff gathered some risk information during this assessment but the deputy manager told us that this information could be limited. The consultant psychiatrist and a nurse completed the initial patient assessment on the day of admission. The consultant psychiatrist and nurse developed an initial care plan that included risk based information. We reviewed the service care pathway; this informed us that the initial care plan remained live for up to eight weeks and incorporated weekly reviews by nursing staff or the multidisciplinary team. A risk care plan was required to be in place following this.

As part of our inspection activity, we reviewed all five patient care and treatment records. We found inconsistencies in the recording of patient risk levels via risk assessment. The provider did not require the service to use a recognised risk assessment tool. We saw that staff used a variety of risk assessment tools and formulations. Only two

of the five patients we reviewed had the appropriate risk documentation as required by the provider, these were up to date and had been reviewed. Three patients had the initial health of the nation outcome scale documented in the care record. The focus of this tool is to measure outcomes of interventions and not risk.

The deputy manager told us staff at the service completed the short-term assessment of risk and treatability. The expectation was this commenced within the first three months of a patients admission to the service. Three patients should have had this risk assessment, however only one patient had this recorded five months after admission. We reviewed the clinical governance meeting minutes for 28 April 2017 and the senior management team identified that staff training was required to use this risk assessment tool. Staff completed training in May 2017. However, all five records contained detailed risk management plans. This meant that the recording of risk was unclear because the information that informed the content of risk management plans was not easily identifiable.

Senior staff told us the service was moving towards using a specialist risk assessment tool, the historical clinical risk management – 20. The consultant psychiatrist lead on this work but this did not form part of the care record for patients currently at the service.

We observed staff discussing risk during a staff meeting. A new admission to the service was expected and staff discussed practical aspects of their initial management. This related to potential risk to female staff. Staff had specific concern for the housekeeper in relation to their roaming role around the unit. The team discussed in detail how to manage this effectively and shared this with housekeeping in preparation for the planned admission.

There were no blanket restrictions in place at the service at the time of our inspection. A blanket restriction is a rule that a provider puts into place for all patients regardless of their risk level or detention status. Where restrictions were in place, we saw that these were individually care planned and reviewed by a named nurse and were appropriate for the service. We saw one example of this in relation to the use of a breathalyser. A multidisciplinary review with the patient agreed the need to undertake this action to provide continued support to the patient in their recovery. The service had a number of restricted items not allowed on the unit. This information was clearly documented in the patient information booklet and available to families and carers.

At the time of our inspection, all patients were detained under the Mental Health Act. The service displayed information telling informal patients of their right to leave the service and how they might go about leaving. The registered manager told us staff had received additional training in relation to informal admissions to the service.

The provider had a search policy in place for patients and their belongings. Staff did not routinely search patients entering or exiting the service for the purpose of section 17 leave. We saw evidence of documented searches of patient bedrooms in care records. The deputy manager told us this had been in response to a missing restricted item, a lighter. Staff documented patients had consented to the search.

An observation and engagement policy was in place. The policy provided guidance to staff on the therapeutic nature of observations, defined four levels of observation and the process for changing observation levels to maintain patient safety. Staff we spoke with told us how accurate observation was fundamental to maintaining safety for patients and staff. During the inspection, we consistently observed staff undertaking observational checks and discussing observational levels. Staff accurately recorded this and any subsequent changes in care records. Staff carried out observational checks in a respectful and dignified manner, clearly demonstrating the least restrictive approach to patient care and embraced the recovery focus of treatment. All patients told us they felt safe.

The Care Quality Commission had not received any notifications or safeguarding concerns for this service. The provider had a safeguarding adult policy and this provided guidance for staff on types of abuse, dealing with incidents of abuse and how to report them. Staff received safeguarding adult training as part of the mandatory training programme, 84% of staff had completed the training. Staff we spoke with knew who the safeguarding lead was for the service and felt confident to discuss any concern they had. We saw a useful visual display of the safeguarding process in the nursing office. Staff could also access a series of small quick glance guides relating to their responsibilities for safeguarding adults.

Medicines were supplied by a community pharmacy contractor under a service level agreement; pharmacy staff visited weekly to ensure there were adequate stocks of medicines to meet patients' needs. We found medicines were stored securely with access restricted to authorised staff, including controlled drugs and medicines requiring refrigeration. Staff monitored medicines fridge temperatures daily in accordance with national guidance.

A protocol was in place to ensure the safety of children visiting the service and this formed part of the patient information booklet. The service provided a room away from the main ward area for children and families that wished to visit. One carer told us that they had visited with children and felt welcomed and able to use child friendly activities.

Track record on safety

During the period 1 December 2016 to 7 July 2017, there were no reported serious incidents.

Reporting incidents and learning from when things go wrong

All staff we spoke with during the inspection confirmed they were able to use the electronic incident reporting system and were aware of their responsibilities to report incidents. We reviewed records for 21 recorded incidents within the service. Of these, 17 incidents were classed as 'no harm' and four as 'low' harm. Incidents reported included verbal aggression, alleged assault, inappropriate behaviour, broken equipment and minor injury to patients. Of the 21 incidents recorded, one patient accounted for 11 recorded incidents. We identified one incident that would have benefitted from clearer recording within the clinical record of the patient. The registered manager told us the incident had been recorded by staff but the details of the incident were brief.

The senior management team reviewed all incidents on a daily basis at the morning business meeting. The hospital director, consultant psychiatrist, deputy manager and lead occupational therapist attended. During this inspection, we attended and observed one of these meetings. The meeting had a structured format and provided the opportunity to review incidents from the previous day. The senior management team identified what actions were required in relation to each incident and who would undertake these. This approach ensured a timely and consistent approach to managing incidents locally within the service.

All staff we spoke with told us they received feedback following incidents, this was by email or at the twice-weekly staff meetings. In the morning business meeting that we observed, discussion was held regarding an incident with an e-cigarette. In the staff meeting that day, we observed the outcome of the incident being fed back to staff. Staff discussed the issue in relation to risk, restrictive practice and the possible impact on other patients. This meant all staff within the service had an awareness of recent incidents reported and the outcome of action taken. Incidents were a standard agenda item for the monthly clinical governance meeting; this ensured the service retained a focus on sharing information and learning from incidents.

We reviewed arrangements the provider had for the management of serious incidents with a senior lead for quality. We found there were clear and co-ordinated systems in place that enabled the provider to have oversight of incidents reported at each local service. The electronic reporting system provided data about serious incidents to the quality improvement team. A review of these incidents by the quality improvement team would trigger a team incident review at local service level or escalated for investigation by an appropriate individual external to the service. The quality improvement team received feedback regarding the learning from these two processes. For those incidents investigated externally to the service, learning would be cascaded through regional meetings and then back into the local service. Learning from serious incidents was shared across the organisation through these processes.

The provider had developed a Duty of Candour policy. This provided guidance to staff on the principles of being open, transparent and accountable when things went wrong. Staff received relevant training for Duty of Candour during their induction to the service. Staff had adequate understanding of the Duty of Candour.

The service had had no serious incidents that required a statutory notification to the Care Quality Commission. The senior management team told us staff would be supported following a serious incident. We were assured a de-brief would take place, this was in line with the providers policy

Long stay/rehabilitation mental health wards for working age adults

Good

for incident management, reporting and investigation. Senior managers also told us that they had an open door policy, whereby staff could approach them directly for support. All staff we spoke with during the inspection confirmed this.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed the care records for all five patients using the service. All records reviewed included recovery focussed care plans. Goals for treatment were clear and focussed on the discharge of the patient from the service. Patients confirmed they had copies of their care plans. Patients were able to describe their long-term goals.

All care records were comprehensive, holistic and current. All care plans were person-centred and recorded a patients' preferred name. Staff captured the patient voice by recording direct quotes and if a patient had declined to contribute to the care plan or review. The records reflected how effectively and consistently the service reviewed and managed patient risk. All patients had a risk management plan addressing the level of observation and engagement they required. We saw evidence of regular reviews and responsive reviews of risk management plans in relation to patient safety incidents. We saw evidence in two records where staff had reviewed and increased patients' observation levels in response to their changing need. In one example, staff had completed this on two consecutive days in response to a patients changing need.

We found inconsistencies in recording the initial assessment of patients. Only two of the five patients we reviewed had an initial assessment and care plan as required by the provider. Staff had updated and reviewed the care plans. This meant that the recording of initial need was unclear for all patients.

Staff completed a physical health examination with patients upon admission to the service. Baseline observations were recorded and a blood sample taken. All five patients had a care plan to meet their physical health needs and ongoing monitoring of physical health was evident. Patients with long-term health conditions such as asthma, epilepsy or diabetes, had condition specific care plans.

The service had a secure system to store and record patient information. The service was undergoing a change of computer system and as a contingency; the service held printed copies of patients care plans and section 17 leave proposals. These were located in the secure nursing office.

Best practice in treatment and care

The consultant psychiatrist told us when prescribing medication, National Institute for Clinical and Healthcare Excellence guidance was followed, (CG76, Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, 2009), along with recommendations from the Royal college of Psychiatrists and The Maudsley Prescribing Guidelines (2015).

We examined five prescription charts and all prescribed medication was within British National Formulary limits. Prescriptions for medicines to be given as or when required contained sufficient information to enable staff to administer them safely. We spoke with the consultant psychiatrist who told us they carried out side effect monitoring for patients prescribed antipsychotic medicines, however staff did not use a recognised tool to rate the severity of problems associated with medicines used to treat mental illness. In addition, we found some physical health monitoring and blood test results for patients prescribed antipsychotic medicines had not been recorded in their clinical notes. The consultant psychiatrist told us a monitoring schedule was being implemented and we saw examples of monitoring templates that could be used to collect this information. Although these were not in use at the time of our inspection.

The consultant psychiatrist told us they were the service lead for physical healthcare and had previous specialist training in this area. All patients had a comprehensive physical health examination and assessment upon admission to the unit. The physical assessment tool included long-term health conditions such as asthma, diabetes and epilepsy. All patients were registered with a local GP and the service shared this information with them.

Long stay/rehabilitation mental health wards for working age adults

Good

Staff we spoke with told us patients were encouraged to attend their local GP surgery to address physical health care needs. This approach reflected the recovery focus the service promoted.

We reviewed five care records and all five patients had an up to date care plan in place for physical health monitoring. Care plans were in place for those patients diagnosed with complex conditions such as diabetes and epilepsy. Care plans for long term physical health conditions included National Institute for Clinical and Healthcare Excellence guidelines. We saw evidence staff had referred patients to specialist services, including audiology and sleep clinic.

Interventions and treatments recognised by the National Institute for Clinical and Healthcare Excellence were promoted alongside medication regimes. A cognitive behavioural approach underpinned care plans for recovery and positive behavioural support plans. A positive behavioural support plancontains a range of strategies, which not only focus on the challengingbehaviour (s) but also include ways to ensure the patient has access to things that are important to them. Of the five care records we reviewed, three patients had clear and detailed positive behavioural support plans. The service did not have a psychologist at the time of our inspection and no specific psychological therapy was undertaken. However, the registered manager confirmed the service had successfully recruited a psychologist to commence in August 2017.

Occupational therapy was provided in line with the Model of Human Occupation. Patients could access a range of activities including, walking group, cooking, budgeting, craft and health and fitness.

We spoke with clinical staff, including allied health professionals and found that knowledge of best practice was good. Staff stated National Institute for Clinical and Healthcare Excellence guidelines were followed and were able to discuss these. A deputy manager told us the service had developed a resource file of current guidance and we observed this was located in the main nursing office. Care plans in all five patient care records referenced the appropriate National Institute for Clinical and Healthcare Excellence guidelines.

The service used a range of outcome measures and rating scales, nursing staff and the occupational therapist completed these. The occupational therapist used The Model of Human Occupation tool to assess patient functioning in cognitive and motor skills. Nursing staff used the Health of The Nation Outcome Scale to measure the health and social functioning of patients. Staff had commenced this assessment for three patients. Two patients did not have this assessment as they were relatively new to the service and continued to be appropriately assessed using the initial care plan.

The regional head for quality improvement told us the provider had an annual audit cycle addressing nine different areas, including the Mental Health Act, clinical supervision and Mental Capacity Act. The service had successfully completed the National audit for schizophrenia and an environmental audit of ligature points. The provider's quality improvement team monitored audit compliance and actions centrally. The consultant psychiatrist told us the service was implementing a small number of local audits. We saw an example of a clinical room audit recently undertaken; however, this had not been formally documented at the time of our inspection. A deputy manager had undertaken regular audits of documentation for security and environmental checks. Senior staff told us clinical staff involvement in audits will be developed as the service grows.

The provider required senior managers of services to undertake quality walk rounds; this was to provide real time and ongoing assurance of clinical practice. The provider identified five domains for review; these were documentation, physical health, service user, staff and environment. The registered manager had completed the documentation review and had made plans to complete the remainder of the domains on a weekly basis. Staff and patients would receive feedback as required to drive quality improvement.

Skilled staff to deliver care

The service had access to a comprehensive multidisciplinary team. This included a consultant psychiatrist, occupational therapist, nurses, support workers and administrators. The service also had access to a pharmacist. Staff could also access additional specialist knowledge and support through the providers other hospital sites.

Staff were experienced and qualified in their various roles. We reviewed five staff personnel files and these were

adequate. The registered manager told us the service held separately information relating to disclosure and barring checks. We reviewed this information and all staff checks were complete.

All staff had undertaken an intensive two week induction programme at another of the providers' hospital sites. The induction programme covered mandatory topics including safeguarding adults, infection prevention and control, basic life support and information governance. All staff we spoke with confirmed they had completed the induction programme. Following the successful completion of the induction programme, some staff worked in different hospital sites until Mill Garth officially opened in December 2016.

At the time of our inspection, the service had been operational for almost eight months. We spoke with the registered manager and a deputy manager regarding supervision and appraisal. Five staff were eligible for annual appraisal, three were completed and two had confirmed dates for completion. A deputy manager told us all staff would receive annual appraisal as required. Supervision was available to all staff. A deputy manager told us they used a supervision tree to support the process whereby senior staff supervised nurses and nurses supervised support workers. The registered manager told us supervision rates were 100%. Staff confirmed they received regular supervision. In addition, the senior management team operated an open door policy, where staff could access ad hoc supervision when required. Staff we spoke with told us this was a positive mechanism for support and responsive to their needs. Specialist colleagues at the providers' main hospital site provided supervision for occupational therapy and psychiatry.

The service supported nurses in their revalidation. The registered manager told us all nurses were current and up to date. Nurses could access the e-learning system to gain additional support for this requirement of their registration and the service would provide dedicated time to complete this.

Specialist training was available and staff told us the service was supportive in their development. Staff could access training through the providers' e-learning platform and staff could attend face-to-face training. Two members of staff had recently completed training so they could take blood samples from patients. The registered manager told us of plans to deliver recovery focussed training sessions to staff. The service was also working with the local university to access mentorship training for nurses with the view to providing clinical practice placements for student nurses.

Multi-disciplinary and inter-agency team work

There were two daily clinical handovers within the team, these occurred when the shift changed. Staff told us these were effective for discussing information regarding patients' needs, risk and levels of observation. In addition, each morning a daily business meeting occurred. Senior staff from each discipline met to discuss the previous 24 hours service delivery. Discussion focussed on nursing feedback, incidents, section 17 leave and safeguarding. Staff recorded if any action was required and who was responsible for completing this. Staff recorded minutes for each meeting.

The service had regular and effective multidisciplinary meetings. Patients and carers were very complimentary about how they felt involved in these meetings. They told us they were encouraged to contribute to discussions, given time to reflect on information and received feedback regarding outcomes from meetings. The service had strong relationships with care co-ordinators in the community. We saw evidence of written communication between the service and care co-ordinators in relation to updates, capacity assessments and planning future meetings. The responses from care co-ordinators reflected a positive and inclusive relationship with the service.

The service established good working relationship with the local GP surgery and all patients had registered with them. We saw effective communication with patients' GP in relation to treatment and physical health monitoring.

Adherence to the MHA and the MHA Code of Practice

The service employed a Mental Health Act administrator and they provided guidance on the application of the Mental Health Act to staff. The Mental Health Act administrator had responsibility for ensuring that all Mental Health Act documentation was accurate and complete. The provider had a specific policy for supporting staff in checking mental Health Act documentation. We spoke with the Mental Health Act administrator during the inspection and they told us they also had the responsibility for organising Mental Health tribunals and managers meetings for patients detained under the Mental Health Act. Staff we spoke with confirmed they knew who the Mental Health Act

administrator was and how they could access support if it was required. The service could access legal advice on the implementation of the Mental Health Act and its Code of Practice from a central team at provider level.

We reviewed Mental Health Act documentation for all five patients; detention paperwork was completed accurately and up to date. The service had an organised system for storing detention paperwork, consent to treatment forms, approved mental health professional reports and second opinion approved doctor reports. This systematic approach ensured the Mental Health Act administrator had oversight for patients' ongoing detention. The Mental Health Act administrator told us no audit schedule had been formalised to ensure the correct application of the Mental Health Act. However, there was evidence that nursing staff were checking consent to treatment forms alongside prescription charts. Nurses had recorded this in the daily checks and a deputy manager had undertaken weekly audits of these. A quality improvement lead told us the Mental Health Act audit was part of the providers annual audit cycle.

The service had a multidisciplinary approach to managing and monitoring section 17 leave. A patients' primary nurse planned all section 17 leave in advance and made a written proposal to the multidisciplinary team. All patients had a care plan specifically relating to section 17 leave and this detailed the conditions and contingencies of that period of leave. Staff considered the therapeutic value and risks associated with section 17 leave and we saw detailed evidence of this in all care records. Staff we spoke with told us section 17 leave forms were electronic. Staff told us patients' were given a copy of their approved section 17 leave and this detailed the conditions of section 17 leave. Patients individual care records contained historical section 17 leave forms. Staff reviewed how well leave had gone for patients when they returned to the service and we found evidence in all care records.

At the time of our inspection, 100% of staff had received training on the Mental Health Act and the 2015 Mental Health Act Code of Practice. Staff we spoke with had a good understanding of the Mental Health Act and the Code of Practice guiding principles. Staff told us they would access support from the wider clinical team, as they were confident in the depth of knowledge and understanding available. A paper copy of the Code of Practice was available in the nursing office and staff told us information was available on the intranet.

We reviewed consent to treatment documentation for all five patients and found medicines were prescribed in accordance with the provisions of the Mental Health Act. Two patients had received treatment under section 62 of the Mental Health Act. We examined the documentation specifically for these two patients and the service did not allow sufficient time to apply for a second opinion approved doctor. The service had an administrative system in place to identify in advance when this was needed but time remained insufficient.

All patients had their rights under the Mental Health Act explained to them on admission to the service. All five care and treatment records contained this information and recorded when this had been repeated.

Patients were able to access independent mental health advocacy and patients told us they were familiar with how to access this service.

Good practice in applying the Mental Capacity Act

At the time of our inspection, all staff had received training in the Mental Capacity Act. The provider had a policy to guide staff. The registered manager was the service lead for the Mental Capacity Act and provided support to staff. Staff we spoke with demonstrated a good understanding of the Mental Capacity Act, its five statutory principles and the definition of restraint.

At the time of our inspection, all patients admitted to the service were detained under the Mental Health Act. There had been no Deprivation of Liberty Safeguards referrals made by the service. The provider had a policy to guide and assist staff to apply the Deprivation of Liberty Safeguards.

Staff had completed capacity assessments when required, these were time and decision specific. We saw evidence of two capacity assessments of patients. Staff assisted patients to maximise their understanding and make decisions for themselves. Staff considered all available sources of information, including care co-ordinators and did not make decisions in isolation relating to capacity. Staff recorded the outcome of assessment clearly and in detail in the patients care record.

Long stay/rehabilitation mental health wards for working age adults

Good

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

We observed positive interactions between staff and patients throughout our inspection. Genuine warmth, understanding and mutual respect were evident. We observed staff directly supporting patients in a calm, caring and reassuring manner. Staff demonstrated respect for patients by discreetly carrying out observational checks.

Staff understanding of individual patient need was thorough and consistent within the service. This was reflected in the detailed plans of care we reviewed in patient records.

All the patients we spoke with were complimentary about the service and how they were cared for. Patients told us they felt safe and supported by staff.

The involvement of people in the care they receive

Patients were provided with a patient information booklet during their admission to the service, This provided detailed information about the service, staff team and care and treatment available We reviewed the guide and found detailed information provided on how the service would meet religious and cultural needs, safeguarding, advocacy, complaints and other sources of information for patients. Staff that we spoke with told us that new patients were orientated to the unit by a member of staff.

We reviewed five care and treatment records. We saw evidence that patients were actively involved in planning their care. Care plans were personalised by referring to patients by their preferred name and included direct patient quotes. All patients we spoke with told us they had copies of their care plans in their bedrooms. Patients were aware of their long-term goals and plans for discharge.

Independent advocacy services were available for patients. The service clearly displayed in communal areas information about how to access the service. The advocates name and contact details were displayed. Patients we spoke with told us the advocate visited weekly and they were confident to contact the service outside of these planned visits.

The service valued the involvement of families and carers and saw them as an important part of patients' recovery. The service held individual monthly meetings to enable families and carers to meet with the clinical team with the permission of patients. A senior clinician told us this was a successful way to support patients alongside families and carers. Carers told us staff invited them to attend clinical meetings and felt involved.

Patient community meetings occurred every two weeks and patients were encouraged to attend. During the inspection, we reviewed minutes of previous meetings and saw the most recent minutes on display. The community meeting provided the opportunity for patients to raise any concerns, suggest new ideas and provide feedback. Patients told us about a positive example of their involvement in service change; this was a review and production of a new menu for patients. We also observed a wall display in the main lounge, this featured 'You said and we did' actions, this provided immediate feedback to patients on issues they had raised. Senior staff discussed patient involvement at the monthly clinical governance meetings.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

At the time of our inspection, the service had low bed occupancy at 32%. The registered manager told us that the service had projected to have 12 patients but the current bed occupancy was five. However, the service received a planned admission of a sixth patient on the second day of our inspection. The registered manager told us that all patients were referrals from the local community and there were no patients from out of area placements. The service was accessible to other regional clinical commission

groups. The registered manager clearly appreciated that the service was in its infancy and was aware of the need to establish its profile within the rehabilitation and recovery sector.

The service responded promptly to requests for assessment and had the capacity to provide a multidisciplinary team assessment within four days. The multidisciplinary team determined a patients' suitability for the unit and all admissions were purposeful. At the time of our inspection, there had been no discharges from the service.

We reviewed the care plans for all five patients in relation to section 117 aftercare. Section 117 is aftercare is the provision of free aftercare for people who have been in hospital subject to certain sections of the Mental Health Act. We found evidence in all five care records that discharge planning commenced early in a patients admission to the service and reviewed regularly.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a full range of facilities and equipment to support treatment and care. These included two fully equipped kitchens for patients to use to develop their skills for daily living and meal preparation. Other rooms available included TV lounges, quiet rooms, activity rooms and an equipped gym. The service had a large secure garden with seating. Patients could access this freely throughout the day. Staff locked the door at night to maintain security but patients could still access the garden at night when they requested to do so. The service had a large café, this room had comfortable seating, a large projection screen and games console. Patients currently used the room for movie nights and some visits with family or professionals. The registered manager told us the plan was to use this room as a resource to develop real life working opportunities for patients.

The service provided a separate room for visits that involved children and patients could also receive visits in the café area. Both rooms were located away from the main care area.

Patients could make private telephone calls from a payphone located in a dedicated room. The service had made available a portable telephone so calls could be made to patients on the ward and improved communication and access to patients external to the service. Most patients had their own mobile phones, and were able to use them to make phone calls in private.

The service provided a catering facility. Patients we spoke with described it as the 'best bit' of the service. We saw there was a menu in the dining room where patients could choose meals, which met a variety of dietary requirements. Patients told us they were able to discuss menu choice and had successfully changed the menu options through discussion at the community meeting. The service encouraged staff and patients to take meals together. We observed positive engagement between staff and patients at meal times. Patients could independently make hot and cold drinks in a beverage bay.

Patients were able to personalise their bedrooms, and had safe places in their room to store their possessions. All patients had keys to their bedrooms. Patients told us that they felt their possessions were safe.

The service had a dedicated occupational therapy team; this included an activity co-ordinator. The service offered each patient a range of group and individual activities between Monday and Friday. The service displayed an activity timetable in the communal lounge. At the time of the inspection, activities were predominantly on an individual basis. Staff told us additional group activities would be available once patient numbers had increased. Group activities available included art and crafts, walking, breakfast club and gardening. Individual activities were specific to patient need and these included accessing public transport and using the community gym. Nursing and support workers provided patients with activities at the weekends.

The provider collected data measuring patient engagement and recorded this within the care record. A detailed report of patient activity was complemented by a timetable that used different coloured emoji faces to indicate patient engagement with activities, including section 17 leave. This visual aid provided a useful quick glance of patient engagement. The recording of this information is central for delivering care and treatment that supports recovery and discharge.

Meeting the needs of all people who use the service

The service base was a two-storey building and access was level throughout. All patient areas were on the ground floor

and staff offices on the first floor. Patient bedrooms were spacious and had en suite bathrooms. Doorways into patient bedrooms were antibarricade, meaning doors could easily open both ways in the event of an emergency. The service had one accessible bathroom that included a bath with hoist, wet room with shower chair and a toilet with raised seat. We noted the hoist had not been serviced since December 2013. The registered manager took immediate steps to make sure patients did not use the bathroom.

During the inspection, we saw information on display for patients, including information about how to complain, how to contact the Care Quality Commission and the independent mental health advocacy service.

The service had a spiritual room for patients. The registered manager told us information was obtained through the providers' religious leader to develop the room appropriately. The service had made contact with the Iman from the community mosque to seek advice in supporting patients. Staff told us patients would be encouraged to use section 17 leave to meet their spiritual needs.

Listening to and learning from concerns and complaints

The service had not received any formal complaints since opening in December 2016. The service received two informal complaints from patients and one from carers. We discussed this with the registered manager and these had been resolved locally.

The provider had a policy that guided staff on their responsibilities in dealing with complaints and manging them effectively. Patients told us they were confident in raising concerns about the service and would speak to a member of staff. Staff told us they would encourage patients to raise a concern before it became a complaint. Staff achieved this through the community meetings and 'you say, we did' initiative. Staff told us patients had requested a fixed time for multi-disciplinary reviews. This promoted patient involvement in the review and maximised their engagement with other activities.

We did observe that no information was available to patients on how to make a formal complaint about the service, as required by the provider. The registered manager addressed this immediately. A poster was displayed providing information to patients on who to contact with a complaint about the service. The service provided information on how to contact the Care Quality Commission and the independent mental health advocacy service.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

Vision and values

The Priory group of companies had developed a provider wide statement of purpose. This was 'To make a real and lasting difference for everyone we support.' Staff from across the UK had chosen a number of behaviours to aspire to, including:

- Putting people first: We put the needs of our service users above all else.
- Being a family: We support our employees, our service users and their families when they need us most.
- Acting with integrity: We are honest, transparent and decent. We treat each other with respect.
- Being positive: We see the best in our service users and each other and we strive to get things done. We never give up and we learn from our mistakes.
- Striving for excellence: For over 140 years, we have been trusted by our service users with their care. We take this trust seriously and constantly strive to improve the services we provide.

Staff we spoke with during the inspection had some awareness of the providers' vision and values. The registered manager told us the service expectation was for these to embed as the staff team grew and the service developed. During this inspection, it was evident from our observations that this had begun. We felt the genuine sense of achievement staff had in developing a cohesive team and this reflected across all the professional groups within the service. In addition, we saw evidence from external professionals that congratulated the service on the marked difference made to a patient and delivering care that almost had a 'family feel approach.'

Long stay/rehabilitation mental health wards for working age adults

Good

There were established links between the registered manager and other senior staff within the service line for rehabilitation and recovery. These included the regional operational director and regional quality improvement lead.

Good governance

The service had established governance systems in place that supported the service to run safely.

Staff compliance with mandatory training was at 96%. The registered manager used the electronic learning system to regularly monitor this and maintain oversight of the safety of the service.

All staff who were eligible for an annual appraisal had received one or awaiting to complete their planned appraisal. Supervision for all staff was consistent, including profession specific supervision for occupational therapy and psychiatry. The service had an effective system in place to manage and monitor supervision.

We did not have any concerns about staffing levels; staff with suitable experience and qualifications covered all shifts. The service had taken a proactive approach to the recruitment of staff, addressing the short and long-term requirements of the service. The use of bank staff was minimal and the service did not use agency staff.

The provider had an annual audit cycle and the service successfully completed two audits for ligature points and schizophrenia. The provider initiative of quality walk rounds gave the registered manager additional assurance regarding the quality and safety of care provided.

Staff reported incidents and received feedback following investigations. The service had not reported any serious incidents but we saw evidence at provider level that a robust governance system was in place to respond and learn from such incidents. The service provided an effective mechanism for patients to raise concerns and provide feedback to staff.

The service met the requirements for the Mental Health Act and Mental Capacity Act. Documentation was complete and reviewed by a competent staff member. Safeguarding processes were clear and strengthened by a service lead for safeguarding.

The registered manager told us that the service was not currently working towards any key performance indicators due to the merger of providers and the short time the service has been operational. Key performance indicators would be implemented following a recent review and adjustment of bed occupancy and staffing. However, the service had commenced recording data that would enable the registered manager to monitor the performance of the service, such as incidents reported, safeguarding, staff training and appraisals. The providers' quality improvement team were also supporting the service in its development.

There were regular local, regional and national clinical governance meetings attended by the registered manager and senior management team. Agenda items on the clinical governance agenda included governance, operational performance, quality and assurance. We reviewed the minutes for six meetings between January 2017 and June 2017. The senior management team recorded and reviewed actions for completeness during these meetings.

The registered manager reported that they had sufficient authority to run the service. Admin support was good and provided support to the registered manager and wider clinical team.

The service had a risk register and any recorded risk was included in the provider risk register. The service had no items on their risk register at the time of inspection. We reviewed the providers risk register and this included current risks such as serious incidents and high staff vacancies. All risks received a risk rating and a detailed action statement to reduce the severity or impact on the service. The service had a clear process for escalating local service risks through regional business reviews up to divisional and corporate meetings. This mechanism was also used to cascade information down to local services to share information and learning from across the provider organisation.

Although, there were some areas found during the inspection that could be improved within the governance system, such as accurate recording of service dates for fire equipment and bath hoist and consistent assessment of patients, including risk.

Leadership, morale and staff engagement

We observed that staff had a strong and purposeful approach to their work. Staff told us that morale was very positive; the senior management team echoed this. Staff

reported a cohesive working relationship with the multidisciplinary team. Teamwork underpinned this and was a positive support for joint decision making. We saw extensive mutual support within the service and this made a positive difference to staff. Staff spoke highly about the team and the senior management team. Lines of communication were open and honest within the service and staff felt listened to.

A whistleblowing policy was in place and provided guidance for staff on reporting concerns without fear of victimisation. Staff told us they were confident in speaking to their immediate manager to raise concerns. There had been no reported bullying or harassment issues.

Staff told us that the service gave them opportunities for training and development, ranging from competency based skills to formal qualifications. Staff told us their ideas for service development and improvement were encouraged through regular supervision and team meetings.

Commitment to quality improvement and innovation

The registered manager told us the service has identified and set three quality objectives for the service to work towards. These are improving patient access to information, physical healthcare and implementation of the 'Safewards' initiative. The service is working in collaboration with the providers' quality improvement team.

The service was not involved in any quality improvement networks. However, this has been discussed this at a recent clinical governance meeting. The registered manager told us that the service hoped to work towards accreditation for inpatient mental health rehabilitation services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure they carry out a risk assessment for the provision of medicines for use in a medical emergency.
- The provider should review the process for ensuring physical health monitoring is carried out and recorded in accordance with national guidance for patients prescribed antipsychotic medicines.
- The provider should ensure all assessment of risk for patients and the environment are completed fully and accurately; and action is taken to mitigate risk.
- The provider should ensure sufficient time is allowed when requesting a second opinion approved doctor.