Elysium Healthcare Limited

Arbury Court

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

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

- Some of the ward environments were not always clean or well maintained. Two of the wards were not clean and some areas of the wards were poorly maintained which presented risks on the ward. The service did not ensure that infection control risks were eliminated from food preparation areas.
- Staff did not always minimise the use of restrictive practices. There were high uses of restraint, on some of the wards. There was also a high use of prone restraint. Prone restraint means that a person is restrained in a face down position. Levels of blanket restrictions were high, and it was not always clear why these restrictions were in place.
- Staff did not always carry out restraints safely.
- Staff did not always manage medicines safely. Medicines cards on some wards were confusing which increased the risk of medication errors. We also found some concerns with Mental Health Act medication paperwork.
- Staff did not always respect patient's privacy and dignity on all wards. We observed conversations about patients between staff in busy bedroom corridors.
- Staff did not always actively involve patients, families and carers in care decisions and communication with families was sometimes poor on some wards.

However:

- Staff had completed a range of mandatory training that was appropriate to the needs of the service.
- There were systems in place for managing the ward environment, ligature risk assessments were up to date and security checks were carried out regularly. The wards had enough nurses and doctors. Staff assessed and managed risk well, patients all had up to date, relevant risk assessments.
- Staff followed good practice with respect to safeguarding. Staff had received appropriate safeguarding training and there were systems in place to support staff make safeguarding referrals when required.
- Staff mostly treated patients with compassion and kindness and understood the individual's needs.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly. Leaders had a good understanding of the service. There were systems in place for monitoring and managing risk and managers collated and used this information effectively. The service had a culture of learning.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	Our rating of this service stayed the same. We rated it as requires improvement because: • Not all ward environments were always clean or well maintained. Some areas on two of the wards were not clean and some areas of the wards were poorly maintained which presented risks on the ward. • Staff did not always minimise the use of restrictive practices. There were high uses of restraint, particularly on Alderley ward. There was also a high use of prone restraint. Prone restraint means that a person is restrained in a face down position. Levels of blanket restrictions were high, and it was not always clear why these restrictions were in place. • Staff did not always carry out restraints safely. • Staff did not always manage medicines safely. Medicines cards on some wards were confusing which increased the risk of medication errors. We also found some concerns with Mental Health Act medication paperwork. • Staff did not always respect patient's privacy and dignity. We observed conversations about patients between staff in busy bedroom corridors. • Staff did not always actively involve patients, families and carers in care decisions and communication with families was sometimes poor. However: • There were systems in place for managing the ward environment, ligature risk assessments were up to date and security checks were carried out regularly. The wards had enough nurses and doctors. Staff assessed and managed risk well, patients all had up to date, relevant risk assessments.

Summary of findings

- Staff followed good practice with respect to safeguarding. Staff had received appropriate safeguarding training and there were systems in place to support staff make safeguarding referrals when required.
- Staff had completed a range of mandatory training that was appropriate to the needs of the service.
- Staff mostly treated patients with compassion and kindness and understood the individual needs.
- The service was well led, and the governance processes mostly ensured that ward procedures ran smoothly. Leaders had a good understanding of the service. There were systems in place for monitoring and managing risk and managers collated and used this information effectively. The service had a culture of learning.

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

Good

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

- The ward environments were safe and clean but in need of a refurbishment. Ligature risk assessments were up to date and security checks were carried out regularly. The ward had enough nurses and doctors. Staff assessed and managed risk well, patients all had up to date, relevant risk assessments.
- Staff followed good practice with respect to safeguarding. Staff had received appropriate safeguarding training and there were systems in place to support staff make safeguarding referrals when required.
- Staff had completed a range of mandatory training that was appropriate to the needs of the service.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly. Leaders had a good understanding of

Summary of findings

the service. There were systems in place for monitoring and managing risk and managers collated and used this information effectively. The service had a culture of learning.

However:

- The service did not ensure that infection control risks were eliminated from food preparation areas. We found a mop and a bucket with filthy water in the ward kitchen.
- The service recorded high levels of restraint.

The acute and psychiatric intensive care unit (PICU) accounts for a small proportion of hospital activity. The main service was the forensic service. Where arrangements were the same, we have reported findings in the main service section.
We rated this service as good because it was, effective, caring, responsive and well led, but safe required improvement.

Summary of findings

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Summary of this inspection

Background to Arbury Court

Arbury Court is an independent hospital, part of Elysium Healthcare Limited and was registered with CQC on 21 October 2016. The service has a registered manager in post.

Arbury Court is registered to provide the following regulated activities:

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

The hospital has 82 beds for women aged over 18 years, with mental health needs. All patients were detained under the Mental Health Act. Five of the six wards provided forensic or secure services, and one ward was a psychiatric intensive care unit.

Forensics inpatients/ secure wards

There were 44 low secure beds across three wards:

• Daresbury ward has 15 beds for female patients who need care and treatment in a longer term low secure setting.

• Hartford ward has 14 beds and was for female patients who required medium or long-term care and treatment in a low secure setting.

• Alderley ward has 15 beds and was the admission ward, for female patients who required a low secure setting.

There were 27 medium secure beds across two wards:

• Delamere ward has 12 beds.

• Oakmere ward has 15 beds

The service was last inspected in May 2022. We rated the service requires improvement overall with ratings of good in caring and responsive and ratings of requires improvement in safe, effective and well-led.

The service was in breach of the following regulations:

Regulation 12 Health and Social Care Act Regulations 2014 Safe care and treatment.

Regulation 15 Health and Social Care Act Regulations 2014 Premises and equipment.

Regulation 17 Health and Social Care Act Regulations 2014 Good governance.

Regulation 18 Health and Social Care Act Regulations 2014 Staffing.

Summary of this inspection

Acute and PICU service

There was 1 PICU ward. There were 10 psychiatric intensive care beds on Primrose ward. Primrose ward had its own consultant psychiatrist, ward manager and nursing team, but was integrated within the rest of the service.

The service was last inspected in May 2022. We rated the service requires improvement overall with ratings of good in effective, caring and responsive and ratings of requires improvement in safe and well-led.

Regulation 12 Health and Social Care Act Regulations 2014 Safe care and treatment.

Regulation 17 Health and Social Care Act Regulations 2014 Good governance.

Regulation 18 Health and Social Care Act Regulations 2014 Staffing.

What people who use the service say

We spoke with 27 patients and 7 carers. We also reviewed patient and carer surveys conducted by the hospital.

Most patients shared positive feedback. Patients told us the staff were lovely, that staff were good and very friendly and that they felt safe on the ward and felt staff cared about them.

Carers told us they enjoyed using the café on site for visits.

However, patients on one of the forensics wards were less positive about staff. Some patients told us they did not feel safe on the ward and said that staff were not always responsive. We observed staff, on one ward, talking amongst themselves and not interacting with patients. Some patients told us the night staff were not as good as the day staff and some patients told us that agency staff were not always supportive.

Patients on the PICU ward told us staff understood their needs and that they cared about them. Patients on this ward knew staff well and there was clearly a lot of interaction. For example, we saw a patient completing a daily fitness regime and a member of staff was recording their activity so the patient could monitor their performance.

How we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety.

During our inspection we visited all 5 forensics wards and the PICU ward. This was a focused inspection and we inspected the safe, caring and well-led domains.

During our visit we:

- conducted 6 ward tours.
- spoke with 27 patients.
- spoke with 7 carers.
- spoke with 22 members of staff.

Summary of this inspection

- reviewed 27 care records.
- observed a morning meeting and a multidisciplinary meeting.
- carried out medication checks.
- reviewed a range of policies and documentation.
- carried out observations using the using the Short Observation Framework for Inspection (SOFI) observation tool which is a structured way of observing staff interaction with people using the service.

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

Areas for improvement

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

Action the service MUST take to improve:

Forensics inpatients/ secure wards

- Reg10(1)(2)(a) The service must ensure that staff keep information about patients private and confidential whilst caring for patients.
- Reg 13(4)(b) The service must ensure that all restraint takes place safely and is proportionate to the risks posed.
- Reg 15(1)(a)(e) The service must ensure that the premises are clean and well maintained.

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

- The service must ensure that all restraint takes place safely and is proportionate to the risks posed. (Reg 13(4)(b))

Action the service SHOULD take to improve:

Forensics inpatients/ secure wards

- The service should ensure that all staff work in a person-centred way and treat patients in a caring and responsive manner.
- The service should ensure they mitigate the risks accompanying high levels of new staff who are unfamiliar to the service.
- The service should ensure medication records are clear and unambiguous.
- The service should ensure that staff have clear guidance regarding patient resuscitation information.
- The service should ensure that blanket restrictions are proportionate to the needs of the service and that there is a clear rationale for them.
- The service should ensure communication with family and carers is effective.

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

- The service should ensure that communication with family and carers is effective.
- The service should ensure the ward is redecorated.

Summary of this inspection

- The service should ensure that cleaning equipment is not stored in food preparation areas.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement	Not inspected	Requires Improvement	Not inspected	Good	Requires Improvement
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Not inspected	Good	Not inspected	Good	Good
Overall	Requires Improvement	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement

Requires Improvement

Forensic inpatient or secure wards

Safe	Requires Improvement
Caring	Requires Improvement
Well-led	Good

Is the service safe?

Requires Improvement

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

Safe and clean care environments

Wards were safe, well equipped, well furnished and fit for purpose, but not always clean and 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. Staff had completed up to date environmental risk assessments for each ward and carried out monthly health and safety audits and daily checks of wards. Each ward had a security nurse role who was responsible for the security of the ward, this included monitoring restricted items and carrying out regular safety checks. Staff followed procedures to keep keys safe. Fire risk assessments were in place and up to date.

Staff could observe patients in all parts of the wards. Blind spots were covered by mirrors and staff were present in communal areas to observe patients.

Staff knew about any potential ligature anchor points and mitigated these risks to keep patients safe. The provider had a ligature management policy which was relevant and up to date. The service had up to date ligature risk assessments which included a map highlighting high risk areas, the location of ligature cutters and areas where patients required escorting. Staff had received mandatory security training and had access to ligature cutters. All staff including agency staff received an induction to the ward which included information about ligature risks and how to manage them. Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were well furnished and fit for purpose. However, not all ward areas were clean or well maintained. Although cleaning records were up to date and we saw cleaning taking place, some wards areas were not clean and poorly maintained. On Oakmere ward the area around the water machine was stained and difficult to clean and some of the dining tables were stained. In addition, the serving hatch was badly damaged and there was damage to the kitchen making it difficult to clean. On Alderley ward the lounge floor was not clean in places and some of the walls were stained.

A system was in place for reporting maintenance issues and the maintenance log showed maintenance issues were usually fixed promptly. However, some of the issues we identified were not present on the maintenance log.

Requires Improvement

Forensic inpatient or secure wards

Staff mostly followed infection control policy, including handwashing, however we found blood on the wall in an empty bedroom, this was cleaned when we raised this. Some of the damage to the hatch and the kitchen on Oakmere ward made it difficult to clean and this was an infection control risk. When we raised this the provider purchased a new hatch.

Seclusion room

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

Clinic room and equipment

Clinic rooms, although very small were clean and mostly fully equipped, with resuscitation equipment and emergency drugs that staff checked and maintained regularly. However, not all wards had a defibrillator, which meant that staff had to use a defibrillator from another ward if needed. When we raised this, the provider purchased extra defibrillators to ensure there was one on each ward.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. The service had recruited large numbers of staff which meant there were high numbers of new staff on wards; some of whom were inexperienced. Most shifts were fully staffed, and some shifts had supernumerary staff to support the running of the ward and help new staff settle onto the ward.

The service had low vacancy rates.

The service had reduced rates of bank and agency staff. Managers limited their use of bank and agency staff and requested staff familiar with the service. The average use of agency staff in the month prior to our inspection was 13% and the average use of bank staff was 17.5%. There were higher numbers of bank and agency staff at night.

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

The service had high turnover rates. The annual turnover rate was 33.9% across the forensics service. The service had significantly increased staffing numbers over the last year and taken on high numbers of new staff and told us they had also lost a significant number of staff that were taken on during the Covid pandemic. In addition to new staff there were 34 support workers and 11 registered nurses going through pre-employment checks.

Levels of sickness were mostly low. Sickness levels for the hospital over the last 12 months were 6.9%. Sickness levels varied between wards, for example Oakmere ward had higher sickness levels at 10.7%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Some of the wards had high levels of observations. Managers had increased staffing levels to ensure these needs were met.

Patients and staff told us that escorted leave and activities went ahead as planned and that these were rarely cancelled.

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

Requires Improvement

Forensic inpatient or secure wards

Staff shared key information to keep patients safe when handing over their care to others. Staff attended handovers and shared key information. Ward managers and clinical team leaders also attended a morning meeting Monday to Friday. This was chaired by a senior manager. We observed this meeting taking place and saw that it gave staff the opportunity to discuss risk issues, safeguarding and incidents and escalate any concerns they had.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. The service had a psychiatrist for each ward. There was a rota in place to provide out of hours medical support. Staff told us they could access doctors when required.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Average training compliance was 96%. The mandatory training programme was comprehensive and met the needs of patients and staff. Training included basic life support, breakaway training, epilepsy awareness, infection control, learning disability and autism and security training.

There were two training courses that had low compliance rates. These were food safety level 2 which was compulsory for 9 staff members and was at 67% and therapeutic observation and engagement when was compulsory for 197 staff members and was at 61%. There were plans in place to address this.

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

Assessing and managing risk to patients and staff

Staff mostly assessed and managed risks to patients and themselves well. Staff did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they did not always use restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 19 care records and saw that most patients had detailed, up to date risk assessments. We found 1 risk assessment that was not up to date. Staff updated risk assessments following incidents on the ward.

Staff used a range of recognised risk assessment tools to support the risk assessment process.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. They identified and responded to any changes in risks to, or posed by, patients. Records mainly provided clear guidance on how to manage risk. We found 1 record that gave confusing guidance regarding a do not attempt resuscitation form. The information in this form contradicted other information in the patient's choking care plan. We raised this with the provider who agreed to review the documentation.

Staff followed procedures to minimise risks where they could not easily observe patients. There were mirrors to cover blind spots and staff were present in communal areas and on corridors to observe patients.

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

Use of restrictive interventions

Levels of restrictive interventions were quite high. There were a range of blanket restrictions on wards which applied to all patients. Patients on some of the wards were locked out of their bedrooms for periods of time. For example, patients on Alderley ward were not allowed access to their bedrooms during mealtimes. However, the rationale for this restriction on the restrictive practice register was unclear. Patients on Delamere ward were not allowed to access their bedrooms between 10a.m. and 2p.m. Patients on most wards were not allowed access to the garden unsupervised.

It was not clear whether all staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed. Although most staff engaged well with patients and we saw some staff using distraction techniques, we observed some staff not interacting with patients.

Levels of restraint were high, particularly on Alderley ward which had taken on a cohort of patients who had learning disabilities. This was concerning due to the vulnerability of these patients. 2912 episodes of physical intervention had taken place across the forensics wards in the 6 months prior to our visit with 1377 of these taking place on Alderley ward. There was also a high level of prone restraint taking place with 68 episodes of prone restraint in the 6 months prior to our visit, 39 of these episodes took place on Alderley ward. 47 episodes of prone restraint were used to administer intramuscular medication.

However, the hospital had high levels of acuity on most wards, with many patients who had complex needs and high levels of self-harm. There was clear evidence that managers were monitoring restraint. There was also evidence a plan was in place to reduce levels of restraint and that levels of restraint including levels of prone restraint were reducing. Training was in place for staff and there was a person-centred approach to training. Some of the restraints used were guiding restraints where patients were gently encouraged to leave an area, and these were included in restraint figures.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Restrictive practice was audited on a quarterly basis. Restrictions were reviewed to ensure they were in line with the patient's risk assessment and care plan. Reducing restrictive practice was discussed at team and community meetings and there was information available to patients about the restrictions in place. Each ward had a restrictive practice register.

We reviewed one incident where a patient was restrained in an unsafe manner and the patient received a minor injury during the restraint. The service investigated this incident and found several concerns which included staff using an inappropriate restraint technique, a lack of teamwork and poor communication between staff. Managers took appropriate action in response to the incident and put measures in place to reduce the likelihood of recurrence. However, restraint levels were very high, and the concerns identified from the incident meant we could not be sure that all restraint was taking place safely.

There was an up-to-date policy in place providing guidance for managing violence and aggression and all staff had received relevant training including bank and agency staff.

Staff did not always follow NICE guidance when using rapid tranquilisation. The provider had an up-to-date policy in place with clear guidance for the administration of rapid tranquilisation, however we saw one episode of rapid tranquillisation where observations had not taken place in accordance with the policy.

Requires Improvement

Forensic inpatient or secure wards

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. There was 1 patient in seclusion during our visit. The patient's seclusion records were up to date and seclusion was being monitored by managers. Alderley had 31 episodes of seclusion in the last 6 months which was the highest level of seclusion across the service.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was placed in long-term segregation. Levels of long-term segregation, across forensics wards, was high. There were 7 patients in long term segregation during our visit and there had been 30 episodes of long-term segregation, involving 20 patients in the 6 months prior to our visit. We reviewed the records of 3 patients in long term segregation. Each patient had a detailed long term segregation care plan. Patients in long term segregation were still accessing escorted leave both inside and outside of the hospital grounds and we observed 1 patient who was in long term segregation being supported to engage in a Zumba class.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role and kept up to date with their safeguarding training. Staff received adult and children safeguarding training and there were up to date policies providing safeguarding guidance to staff.

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

Staff followed clear procedures to keep children visiting the ward safe. Staff ensured that appropriate risk assessments took place prior to children visiting patients and there was space off the ward for these visits.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had made 60 safeguarding referrals over the previous 6 months prior to our inspection. Each ward also had a social worker who could support staff with safeguarding concerns.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were mostly comprehensive, and staff could access them easily. However, we reviewed some observation notes which were unclear and contained some language that was not person centred.

Records were stored securely. Documents were password protected staff used log in accounts to access and update care records.

Medicines management

Staff did not always follow the service's systems and processes to prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

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

Requires Improvement

Forensic inpatient or secure wards

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

Staff did not always complete medicines records accurately. We found some of the medication records on Oakmere were hard to follow, contained scribbling out and dose amendments scribbled over existing doses. This made the some of the medication records confusing. Ward managers carried out weekly audits of medicines records and the pharmacy also carried out a weekly medicines check.

Staff did not store and manage all medicines and prescribing documents safely. For example, one patient on Delamere had two medication cards. When we raised this, the second one was removed. We also found some issues with T2 and T3 treatment certificates, which are required to administer medicine to patients who have been detained under the Mental Health Act for longer than 3 months. For example, staff were unable to locate the T2 form for one patient on Delamere ward.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Some patients were on high doses of medication. However, this was monitored and there was a focus on reducing medication doses where appropriate and possible.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service did not have a good track record on safety.

The service had a high level of serious untoward incidents. This included high levels of self-harm resulting in patients attending hospital. The service had high levels of acuity and monitored and investigated incidents thoroughly. They shared lessons learned to reduce the likelihood of incidents recurring.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The provider had a system in place to monitor the duty of candour process.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents. However, we did not see evidence that patients and their families were involved in these investigations. There were high levels of serious incidents across the service.

Requires Improvement

Forensic inpatient or secure wards

Staff received feedback from investigation of incidents, both internal and external to the service. Information across services in the Northwest was collated, reviewed, and shared with staff. This included information about lessons learned and clear information about changes to procedures.

There was evidence that changes had been made as a result of feedback. For example, a working group was assembled to develop an action plan following an increase in self-harm episodes on Delamere ward. Managers implemented a range of actions from this plan including improving the quality and detail of handovers, ensuring positive behavioural support plans and one page profile information were available for staff undertaking observations, and improving the process for managing high risk items. These actions had reduced the incidents of self-harm on the ward.

Is the service caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff mostly treated patients with compassion and kindness. They did not always respect patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were mainly respectful, and responsive when caring for patients. We observed staff chatting to patients on most wards. However, we observed some staff on one ward who were chatting amongst themselves and during this time patients were not included in the conversation unless they made a direct request. We also observed some elements of institutionalised practice, including patients queueing up for medication and snacks which was not person centred. Staff mostly gave patients help, emotional support and advice when they needed it.

Staff were not always discreet. We observed staff talking to each other about other patients care in the bedroom corridor on Oakmere ward. This was a busy corridor, and they could be overheard by other patients.

Staff were unable to always keep patient information confidential. Rooms were not soundproof and confidential conversations between staff and patients could be heard in the corridors.

Staff supported patients to understand and manage their own care and treatment or condition. Patients told us they understood what medication they received and were given options about their medication. Staff directed patients to other services and supported them to access those services if they needed help.

Patients mostly said staff treated them well and behaved kindly. For example, patients told us staff were supportive, looked after them and that the ward was lovely. However, some patients on Oakmere ward were less positive and told us they did not always feel safe on the ward. They told us this was partly due to the level of incidents on the ward and partly because they felt staff did not always respond to them or give them support. Patients told us that agency staff were less responsive than permanent staff.

Requires Improvement

Forensic inpatient or secure wards

Staff understood and respected the individual needs of each patient. Information about patients' individual needs was accessible to staff. All patients had an up-to-date care plan and patients who required them had positive behaviour support plans and sensory assessments in place. Patients also had one-page profiles to help staff understand their needs at a glance.

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

Involvement in care

Staff did not always involve patients in care planning and risk assessment. Staff actively sought patients' feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

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

Staff did not always involve patients or give them access to their care planning and risk assessments. Most patients we spoke to told us they did not have access to a care plan. Some patients told us they had asked for a copy but had not received one. Care plans did not always include patients views and tended to be written from a professional perspective.

Staff mostly made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, some patients had easy read care plans.

Staff involved patients in decisions about the service, when appropriate. For example, patients were involved in the recruitment of staff.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff held regular patient meetings, and these were attended by the hospital manager. There were processes in place for escalating patient feedback to senior managers in the organisation.

Staff made sure patients could access advocacy services. Patients told us they had access to advocacy services and that they found this helpful.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always support, inform and involve families or carers. The friends, families and carers survey showed that although most carers had a point of contact, a significant proportion of carers felt they did not receive information about their loved ones and did not feel involved in their care.

We spoke with 5 carers and received a range of feedback. Some carers were positive about the service and said that staff were caring and supportive of their loved one. Other carers had concerns about their loved one's care. Most carers told us that communication with the service could be improved. They said it was difficult to get through to the service and that staff did not return their calls. This meant that carers were sometimes anxious about their loved one's welfare.

Requires Improvement

Forensic inpatient or secure wards

Staff helped families to give feedback on the service. The service provided friends, families and carers experience survey. Staff gave carers information on how to find the carer's assessment.

Is the service well-led?

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

There was a clear staffing structure in place to support the wards. The hospital had a group of charge nurses who reported to the ward managers. There was a ward manager for each ward and ward managers reported to 2 clinical nurse managers who each oversaw 3 wards.

Clinical ward managers were overseen by the deputy director and director of the hospital. Staff told us that clinical ward managers were visible on the wards, but they did not regularly see other managers. Senior managers told us there were plans to increase their presence on the wards. The hospital manager held a staff consultative forum to provide opportunities for staff to share feedback and ideas.

Leaders had a good understanding of the services they managed, knew patients and understood challenges to the service. Managers told us they had the opportunity to complete leadership courses.

Vision and strategy

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

Staff knew about the organisation's values. Staff spoke about KITE which stood for kindness, integrity, teamwork and excellence. Staff also told us there were some consultative events, where the providers vision and values were discussed.

Managers had recently reviewed the clinical governance model for the service. This had included restructuring the multidisciplinary team and improving the flow of information between the senior managers and ward level.

The service had a ward planning and development team meeting where staff reviewed the development of the service including the ward's philosophy, statement of purpose, the implementation of new initiative and the service's model of care.

Culture

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

Staff were mostly positive about working at Arbury Court and told us they felt respected and valued by their managers. The last staff survey showed that 70.8% of staff said there was a positive culture in the organisation and 70.2% said staff successes were celebrated.

Some staff raised concerns about how the service responded to racial discrimination from patients. Managers were aware of these concerns and had put some measures in place to address these concerns.

Managers understood the potential of closed cultures within services and had strategies in place to monitor this and to promote an open culture. This included staff development and performance monitoring, promoting a consistent person-centred approach and listening to the patient's voice.

The provider arranged staff wellbeing events including relaxation treatments, star awards and staff raffles.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The hospital had a robust governance structure in place. There were a range of staff meetings which provided an effective pathway for information to be shared. Team meetings and monthly patient community meetings fed into a monthly operational governance and clinical governance meeting attended by senior staff and ward managers. These fed into a regional governance meeting, attended by a range of staff including senior occupational therapists, psychology and social work staff. There was also a corporate clinical governance meeting which enabled information to be shared across the whole organisation, and for organisational information to be disseminated back to staff.

Senior managers including the safeguarding coordinator lead, the occupational therapist lead, psychologist, consultant and practice nurse attended a daily senior management team meeting. Key risk issues and concerns were reviewed during this meeting. This meant that senior staff at the hospital had an overview of activities and concerns on the wards and understanding of the needs of individual patients. Staffing was reviewed each day after handover to address any concerns with the skills mix on the wards.

There was a range of governance policies in place to which provided guidance to staff. These were reviewed regularly, in date and relevant to the service.

Audits were mainly completed by staff in governance roles. These staff accessed and reviewed a range of information which included restrictive practice, medication, and clinical record quality compliance. This information was then fed back to ward managers to action.

Managers were aware of the concerns we raised about medicines records and had taken action to address these concerns, this included developing a focus group to address these issues with medical staff.

The service had systems in place to address maintenance issues. Damage to the environment occurred frequently because of the acuity of the patient group and there was evidence that damage was generally repaired in a timely manner, however, some maintenance issues had not been identified by staff.

Levels of restrictive interventions were high. However, managers were aware of this and restrictive interventions were monitored and reviewed. There was a reducing restrictive interventions group and plans were in place to reduce levels of restrictive interventions and to review wards on a quarterly basis.

Staff were provided with a range of training relevant to their roles including training for people who had learning disabilities. The service also had a continuous professional development programme which included sessions on dysphagia, observation and engagement and healthcare competencies.

Requires Improvement

Forensic inpatient or secure wards

The provider had a whistleblowing process and a freedom to speak up guardian which staff were aware of.

Management of risk, issues and performance

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

The hospital had a risk register that identified key risks to the service. This included mitigating measures to be taken for each risk. Not all managers were aware of the risk register, however managers told us they could escalate ward risks. Key issues on the risk register included the recruitment and integration of nursing staff with a focus on the quality of staff, staff burnout and resilience.

The service had taken on high levels of new staff. Managers were aware of the challenges and potential risks that accompanied this, and this was reviewed regularly to identify and manage concerns.

Managers monitored incidents during clinical governance meetings and identified themes and trends which helped them to understand and reduce risk.

Information management

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

The service had key performance indicators and managers gathered and submitted data on these. These included monitoring supervision and appraisal compliance and team meetings taking place. Managers collected a range of information including complaints, incidents and staffing. These were analysed and trends reviewed during governance meetings.

Staff made notifications to external bodies when required including CQC statutory notifications.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The service had a high number of patients attending the local hospital due to self-harm incidents. The service was actively working with the hospital to ensure this was managed in the best way and that patients were cared for effectively.

The service engaged with staff by conducting staff surveys and by holding a staff consultative group once a month. Managers engaged with patients through regular community meetings and by holding a patient's council once a month. There were systems in place to escalate the patient's voice to senior staff within the organisation.

Learning, continuous improvement and innovation

The service had a culture of learning and improving and staff told us the service was open to new ideas and different ways of doing things.

The provider produced learning round up documents, which contained learning from incidents across other services in the area.

Requires Improvement

Forensic inpatient or secure wards

The service was also involved in research projects. These included a piece of research exploring the use of how risk assessments of violence were completed and research into restorative justice.

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

Good

Safe	Requires Improvement
Caring	Good
Well-led	Good

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 safe, clean well equipped, well furnished, and fit for purpose. However, the wards décor was ready for a refurbishment.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. During the inspection we reviewed both environmental and ligature risk assessments. These were well written. Staff we spoke with knew about any potential ligature anchor points and mitigated the risks to keep patients safe. For example, all staff conducting observations were able to tell us what and why they were conducting observations.

Staff could observe patients in all parts of the wards. Where there were blind spots there were mirrors to aid staff's vision.

The ward complied with same sex accommodation guidance as the ward was female only. All patients had en-suite bathrooms.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. A map demonstrating ligature points and the location of the ligature cutters, which were stored in secure cupboards in different locations making it easier for staff to access them quickly, was displayed in the ward office. Ligature risks were mitigated by the use of observation and individual risk assessments.

Staff had easy access to alarms and patients had easy access to nurse call systems. All bedrooms were fitted with alarms. Staff carried personal alarms on them. Patients told us staff responded to call bells immediately.

Maintenance, cleanliness and infection control

Ward areas were clean, well furnished and fit for purpose. However, the décor was ready for refurbishment. We were told this was scheduled to take place within the hospital maintenance programme.

Staff made sure cleaning records were up-to-date and the premises were clean. The ward was visibly clean, and records indicated that cleaning was completed daily. We spoke with the cleaning staff who could clearly outline the weekly schedule and how they recorded their work.

Staff did not always follow infection control policy, including handwashing. We found a mop and bucket with filthy water left in the kitchen used to serve patients meals prepared in another kitchen outside the ward. The mop and bucket did not belong to the cleaning staff as they used an individual cleaning trolley containing all their equipment which we checked. The mop and bucket had been left in the kitchen by a member of ward staff and was immediately removed when this was pointed out to the ward manager.

Seclusion room

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. The viewing panel in the seclusion room door permitted staff to carry out observations. The taps in the sink of the seclusion suites were anti-ligature. Strong seclusion type mattresses, which afforded comfort especially during longer periods of seclusion, were used in each seclusion room.

Seclusion rooms were not used for any other purpose and were ready to be used.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The ward had its own clinic room, there was an additional room just for physical observations.

Medication cupboards were not over-stocked, and medication was in date. Emergency drugs were available and within date. Oxygen and resuscitation equipment, including defibrillators, were all maintained and recently checked.

Staff checked, maintained, and cleaned equipment. All maintenance and cleaning checks were up to date.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. The service had low vacancy rates. There had been a recruitment campaign and Primrose ward now had virtually a full team. There were nine out of ten nurse vacancies filled, and they had 25 health care workers in place with 20 budgeted posts. The service was running extra health care posts to accommodate the induction of new staff who were mostly inexperienced in working in this environment.

The service had low and reducing rates of bank and agency staff. Primrose ward was the only ward for this core service within a much larger hospital. The provider could not supply figures for this ward only. However, staff told us they were permanent staff and patients told us that staffing had improved.

Managers limited their use of bank and agency staff and requested staff familiar with the service. We spoke with one nurse who was covering from another ward; they had an extensive knowledge of the ward and patients.

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

The service had reducing turnover rates. Since August 2022, 12 health care assistants and one nurse had left the service. In the same period, they had recruited 17 health care assistants and four nurses.

Managers supported staff who needed time off for ill health.

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

Good

Levels of sickness were low and reducing. Since June 2022, the monthly average sickness rate had been 6.1%. The last three months prior to inspection averaged at 3.63%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients, such as increased levels of observations. Managers had increased staffing levels to ensure these needs were met.

Patients had regular one to one session with their named nurse. We saw patients who confirmed they spoke to their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients and staff told us that escorted leave and activities went ahead as planned and that these were rarely cancelled. We saw a number of patients accessing leave.

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

Staff shared key information to keep patients safe when handing over their care to others. Staff attended huddles at the start of each shift to ensure they were aware of the current key information in relation to each patient. Staff were well briefed with a daily briefing note and a risk register for each patient. Staff completing patient observations were given a document which outlined the risk each patient presented and how they could recognise triggers and action to take that supported the patient.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. **The ward had a named psychiatrist and nighttime cover was provided from the hospitals out of hours rota, who could respond within 30 minutes. Staff understood how to contact the on-call duty cover.**

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Average training compliance was 93%, the hospitals target was 90%. The mandatory training programme was comprehensive and met the needs of patients and staff. Training included basic life support, breakaway training, epilepsy awareness, infection control and security training. Staff had completed Oliver McGowan training for autism.

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

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, there was a large number of restraints.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. At the last inspection we found that staff had not always completed risk assessments for each patient on admission / arrival. On this inspection we examined eight patients care records and saw that all patients had detailed up to date risk assessments.

On the last inspection risk assessments had not always been updated following incidents. On this inspection we cross referenced incidents with risk assessments and found that they had been updated as required after incidents.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. All staff we spoke with could identify what risks each patient presented.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff also received a risk briefing at the start of each shift and there was also a morning huddle where risk was reviewed. We saw evidence of levels of observation being changed to reflect the current needs of each patient.

Staff could observe patients in all areas of the wards, staff followed procedures to minimise risks, including individually risk assessed patient observations.

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

Use of restrictive interventions

Levels of restrictive interventions were high. There had been 325 restraints over the last six months. Supine restraint was used on seven occasions and prone restraint on five occasions. Intramuscular medicine was administered to patients whilst in prone or supine restraint on each occasion. Restraints were high on this ward due to the acuity of the patients.

Prone restraint is the restraint of a person in a chest down position. NICE guideline NG10: Violence and aggression also recommends avoiding prone restraint, and only using it for the shortest possible time if needed due to the risks associated.

Supine Restraint is a restraint that places the patient in a face-up position on the patient's back on the floor or other surface, and physical pressure is applied to the student's body to keep the patient on their back.

There were five restraints where the prone position was used on Primrose ward; this is concerning as any incidents of prone restraint can impact on a patient’s breathing.

Staff participated in the provider’s restrictive interventions reduction programme, which met best practice standards. Restrictive practice was audited on a quarterly basis. Restrictions were reviewed to ensure they were in line with the patient’s risk assessment and care plan. Reducing restrictive practice was discussed at team and community meetings and there was information available to patients about the restrictions in place.

The ward had its own restrictive practice register. There was free access to outdoor spaces, and patients were not locked out of spaces, except the kitchen, where staff supervised patients while accessing drinks or food.

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. Out of the 325 incidents there were 93 recorded as “Friendly come along” incidents which were the lowest intervention and accounted for 29% incidents. Staff described using verbal de-escalation and distraction skills to avoid incidents escalating. All staff were trained to use de-escalation skills and staff acknowledged that restraint was only used as a last resort.

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

Good

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff were aware of least restrictive practice and applied blanket restrictions on patients' freedom only when this was justified. There were some items that were not allowed on the ward, but many items were individually risk assessed.

Staff followed NICE guidance when using rapid tranquilisation. From August 2022 to August 2023, there had been 17 incidents of rapid tranquilisation, on 13 patients. We found that physical health checks were being completed after each incident.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. There was one patient in seclusion during our visit. The patient's seclusion records were up to date and seclusion was being monitored by managers. Primrose ward was trialling the introduction of a seclusion/long term segregation booklet to record all the information about the patient in one record, this included daily physical health checks. Primrose had 29 episodes of seclusion in the last six months.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There were six patients who had been placed in long term segregation in the six months prior to our visit. The longest period was 49 days with the shortest being six days. We reviewed the records of these incidents of long-term segregation. Each patient had a detailed long term segregation care plan. Patients in long term segregation were still accessing escorted leave both inside and outside of the hospital grounds.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role and kept up-to-date with their safeguarding training. Staff received adult and children safeguarding training and there were up to date policies providing safeguarding guidance to staff.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff discussed any incidents in the previous 24-hours at daily safety huddles to ensure all safeguarding concerns were captured and reported. From February 2023 staff had made 12 safeguarding referrals.

Staff followed clear procedures to keep children visiting the ward safe. A specific visiting room was available to book for visits with children which was separate from the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they felt confident to raise and report concerns and could give us examples of where they had done so. There was a dedicated social worker for Primrose ward and staff could name them and give examples of when they had sought advice.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. Observation notes were handwritten but accurately described a patient's activity in the last hour.

When patients transferred to a new team, there were no delays in staff accessing their records. All staff could access the provider's computer systems and all records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. There were systems in place for staff to get medicines prescribed including in an emergency and out of hours and emergency stock was available. Staff stored and managed all medicines and prescribing documents safely. Pharmacy staff attended the ward at regular intervals to ensure stock was managed appropriately and available when needed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacists attended the wards when required and met with patients to discuss and provide information around medicines. This included leaflets in easy read formats and different languages.

Staff completed medicines records accurately and kept them up-to-date. We reviewed eight patient's prescription charts and found all entries to be accurate and up to date.

Staff stored and managed all medicines and prescribing documents safely. All medicines, including controlled medicines were stored appropriately. An external pharmacy visited the ward regularly to conduct a medicine audit. A weekly internal audit was also conducted by staff.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The provider's medicine management policy followed national practice.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Some patients were on high doses of medication. However, this was monitored and there was a focus on reducing medication doses where appropriate and possible.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. We found that for patients prescribed medicines that required ongoing monitoring, this was carried out.

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.

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

Good

Staff knew what incidents to report and how to report them. Incidents and concerns for safety were raised in the daily morning huddle to ensure incidents were reported appropriately.

Staff raised concerns and reported incidents and near misses in line with provider policy. The service reported three serious incidents between July 2022 to August 2023. These were three that required acute hospital admissions. One for bruising caused by self-harm, another for being prescribed the wrong medication and the third because of a patient's deteriorating physical health. We saw that all three incidents had been investigated and learning sent to staff.

The service had no never events on Primrose ward.

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. The provider had a system in place to monitor the duty of candour process.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Patients told us they were given feedback when they complained and that they were aware how issues they had raised were resolved.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they discussed incidents not only in team meetings but also as soon as practicable after incidents.

There was evidence that changes had been made as a result of feedback. For example, a new flow chart provided staff with an aide memoire to ensure that hospital transfers to the local hospital were carried out quickly and with all the relevant documentation and medication as agreed in the shared protocol.

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

We spoke with eight patients and two carers.

Staff were discreet, respectful, and responsive when caring for patients. We spoke with patients across the service, all of whom were positive about the politeness and respectfulness of staff. They spoke positively about staff who they worked with. Staff were described as supportive, kind, respectful and caring.

We spoke with the activity co-ordinator who was well liked by the patients. They could describe a whole range of activities, including that they came in on Christmas Day dressed as Father Christmas.

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

Good

Staff gave patients help, emotional support and advice when they needed it. Patients reported that staff were available to them if they requested support. Staff endeavoured to help patients with any practical or emotional needs.

Staff supported patients to understand and manage their own care, treatment or condition. Patients were often on Primrose ward for short periods of assessment before transfer to other wards, and they were often displaying high levels of acuity. However, we observed members of the multidisciplinary team explain all decisions and how they hoped that would help the patient towards recovery. The patients we spoke with could clearly explain their treatment plan and what might happen next.

Staff directed patients to other services and supported them to access those services if they needed help. Patients told us they had no difficulty getting support both on and off the ward.

Patients said staff treated them well and behaved kindly. We saw staff speaking with patients, interacting in a caring, interested manner and patients appreciated this.

Staff understood and respected the individual needs of each patient. We saw in handovers that staff knew the patients well. Staff were able to tell us about patients and their histories how they recognised if patients were having a difficult time and how they would interact with those patients to support them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff told us they knew how to complain, but felt they had no need to do so. Some had raised minor concerns and were happy that managers had taken them seriously and dealt with the issues raised.

Staff followed policy to keep patient information confidential. All patient details were securely stored in the electronic recording system, and any paper notes were held in the nursing station.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Primrose ward had an admission pack that they gave to patients. They also had staff information boards with information and pictures of staff.

Staff involved patients and gave them access to their care planning and risk assessments. Care records showed that patients were always offered copies of care plans, and risk assessments showed evidence of patient involvement.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, there was provision for patients who did not speak English as their first language to receive translated information, including relating to their rights under the Mental Health Act.

Staff involved patients in decisions about the service, when appropriate. Community meetings were held on the ward, we saw minutes from meetings on the notice board. These showed consideration of patients' thoughts and outlined attempts to include patients on improving the service.

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

Good

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff held regular patient meetings, and these were attended by the hospital manager. There were processes in place for escalating patient feedback to senior managers in the organisation.

Staff made sure patients could access advocacy services. Patients told us they had access to advocacy services and that they found this helpful.

Involvement of families and carers

Staff informed and involved families and carers appropriately. However, some carers felt they could be informed more quickly when incidents had occurred.

Staff supported, informed and involved families or carers. Patients told us their loved ones were able to visit. Carers were able to attend ward rounds and meetings when patients wanted them to attend, including some carers whose attendance was worked around other commitments.

We saw family visiting patients and they spoke positively about the support their loved ones had received.

However, there was no friends or family survey data for Primrose ward only. The carers we spoke with were positive but were not convinced that they were kept up to date as quickly as they could be.

Is the service well-led?

Good

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

While this service only comprised of one ward, the leadership, vision, culture, management of risk, learning and continuous improvement came from the wider hospital senior management team. So, the managers of Primrose ward attended the same meetings as all the other ward managers at the hospital.

There was a clear staffing structure in place to support the ward. There was a charge nurse who reported to the ward manager. The ward manager reported to a clinical nurse manager.

Clinical ward managers were overseen by the deputy director and director of the hospital. Staff told us that the clinical ward manager was visible on the ward, but they did not regularly see other managers. Senior managers told us there were plans to increase their presence on the wards. The hospital manager held a staff consultative forum to provide opportunities for staff to share feedback and ideas.

Leaders had a good understanding of the services they managed, knew patients and understood challenges to the service. Managers told us they had the opportunity to complete leadership courses.

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

Good

Vision and strategy

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

Staff knew about the organisation's values. Staff spoke about KITE which stood for kindness, integrity, teamwork and excellence. Staff also told us there were some consultative events, where the providers vision and values were discussed.

Culture

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

All staff we spoke with said they felt supported and valued at the service, with both management and staff saying they felt the staff team had been under pressure from staff shortages but with the recruitment of new staff the team were happy and beginning to develop. Staff told us the role could be stressful, but that they were managed and supported by colleagues and senior staff.

There were no reports of bullying or harassment at the service, and all staff we spoke to knew how to use the whistleblowing process. All staff told us that they felt they could raise concerns to management about the service without fear of retribution.

The ward manager we spoke to about the risk of closed cultures told us that staff took turns to work nights, so staff worked with different staff to prevent staff from always working with the same people.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

At the last inspection we found systems and processes were not fully effective in identifying gaps in the risk assessment provision. However, on this inspection we found auditing processes had ensured all patients had a risk assessment in place.

The hospital had a robust governance structure in place. There were a range of staff meetings which provided an effective pathway for information to be shared. Team meetings and monthly patient community meetings fed into a monthly operational governance and clinical governance meeting attended by senior staff and ward managers. These fed into a regional governance meeting, attended by a range of staff including senior occupational therapists, psychology and social work staff. There was also a corporate clinical governance meeting which enabled information to be shared across the whole organisation, and for organisational information to be disseminated back to staff.

Senior managers including the safeguarding coordinator lead, the occupational therapist lead, psychologist, consultant and practice nurse attended a daily senior management team meeting. Key risk issues and concerns were reviewed during this meeting. This meant that senior staff at the hospital had an overview of activities and concerns on the wards and understanding of the needs of individual patients. Staffing was reviewed each day after handover to address any concerns with the skills mix on the wards.

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

Good

There was a range of governance policies in place which provided guidance to staff. These were reviewed regularly, in date and relevant to the service.

Audits were mainly completed by staff in governance roles. These staff accessed and reviewed a range of information which included restrictive practice, medication, and clinical record quality compliance. This information was then fed back to ward managers to action.

Staff were provided with a range of training relevant to their roles including training for people who had learning disabilities. The service also had a continuous professional development programme which included sessions on dysphagia, observation and engagement and healthcare competencies.

The provider had a whistleblowing process and a freedom to speak up guardian which staff were aware of.

Management of risk, issues and performance

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

The hospital had a risk register that identified key risks to the service. This included mitigating measures to be taken for each risk. Key issues on the risk register included the recruitment and integration of nursing staff with a focus on the quality of staff, staff burnout and resilience.

The service had taken on high levels of new staff. Managers were aware of the challenges and potential risks that accompanied this, and this was reviewed regularly to identify and manage concerns.

Managers monitored incidents during clinical governance meetings and identified themes and trends which helped them to understand and reduce risk.

Managers recognised the issues the service faced. They had oversight of governance issues via electronic record keeping, for example, clinical notes, multidisciplinary team and service user meetings, learning and development, physical health, safe staffing and risk. They used the dashboards routinely to monitor performance targets.

Information management

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

The service had key performance indicators and managers gathered and submitted data on these. These included monitoring supervision and appraisal compliance and team meetings taking place. Managers collected a range of information including complaints, incidents and staffing. These were analysed and trends reviewed during governance meetings.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

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

Good

The service had a high number of patients attending the local hospital due to self-harm incidents. The service was actively working with the hospital to ensure this was managed in the best way and that patients were cared for effectively.

Information was shared with staff, patients and carers about the work of the provider via the intranet, bulletins, newsletters, carers meetings etc. Staff had regular meetings and information was shared via monthly lessons learnt bulletins that included learning from other services.

Patients and carers gave feedback on the service via surveys, community meetings and carer events. Families said that they were always invited to meetings about their relatives' care and that they could approach the ward managers or social worker with any queries.

Learning, continuous improvement and innovation

The service had a culture of learning and improving, and staff told us the service was open to new ideas and different ways of doing things.

The provider produced learning round up documents, which contained learning from incidents across other services in the area.

The service was also involved in research projects. These included a piece of research exploring the use of how risk assessments of violence were completed and research into restorative justice.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not ensure that all restraint took place safely and was proportionate to the risks posed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The service did not ensure that premises were clean and well maintained.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The service did not always ensure that patient's privacy and dignity were respected by staff.