Kneesworth House

Quality Report

Kneesworth House Hospital
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Date of inspection visit: 6-13 & 19 October 2020
Date of publication: 24/12/2020

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?	Requires improvement
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.

Summary of findings

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

Overall summary

Kneesworth House provides inpatient care for people with acute mental health problems, a psychiatric intensive care unit, locked and open rehabilitation services, and medium and low secure forensic services for people with enduring mental health problems.

Following inspections in March and June 2019, the Care Quality Commission placed the hospital in special measures and took enforcement action. Services are placed in special measures when we judge care is inadequate and are inspected again within six months.

When we inspected in March 2019, we found serious issues in the forensic wards and placed the service in special measures. These included safeguarding incidents, environmental breaches, poor quality seclusion practices and paperwork, institutional practices to manage wards over two floors, adequate staffing numbers and the quality and timeliness of risk assessments.

We made a further inspection in June 2019 and placed conditions on the provider's registration in relation to the forensic wards and newly opened psychiatric intensive care unit.We found the quality of the environment was poor, staffing levels were low, risk assessments were missing or of poor quality and incidents were not dealt with safely. On the forensic wards, there were not enough staff to manage the high levels of risk displayed by patients. We required the provider to rectify these issues and monitored that they had done so.

We undertook a comprehensive inspection in January 2020 and removed the conditions placed on the provider in June 2019. However, we found that although the provider had made some significant improvements, some aspects of care remained inadequate. The service overall was re-rated as requires improvement but kept in special measures.

At this inspection, we noted further significant improvements and decided to take the service out of special measures. We will continue to monitor and review their improvement through continued engagement with the service.

We rated Kneesworth House as good because:

- Generally, the ward environments were clean and well maintained. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- The hospital managed the supply of personal protective equipment well during the COVID-19 pandemic and had robust policies in place regarding the wearing of facemasks and other protective equipment where appropriate. Staff received training and used equipment effectively in line with the provider's policy.
- Staff developed holistic, recovery-orientated care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The services were well led, and the governance processes ensured that ward procedures ran smoothly.

Summary of findings

However:

- Seclusion care plans did not always meet the recommendations of the Mental Health Act code of practice. Most plans did not specify what interventions patients needed to maintain their food and fluids intake. Staff did not always update nursing care plans as the patient's presentation and needs changed.
- Emergency equipment on the bungalows was not located where it was signposted or easily accessible. Staff had not clearly labelled two patient-specific medicines in the rehabilitation service, which meant there was a risk patients could receive the wrong medication. On the secure wards, staff had not consistently recorded clozapine prescriptions as an alert on the front record page of the patient's record so staff could identify this easily.
- Staff did not isolate patients newly admitted to the secure wards who had declined a COVID-19 test and were not displaying symptoms. This was in line with the provider's policy but increased the risk of an asymptomatic COVID-19 positive patient transmitting the virus to other patients.
- The rehabilitation service did not provide a structured, recovery-based rehabilitation pathway for some patients. However, most patients had holistic personal goals identified.
- Carers of patients on the secure wards told us the hospital did not always provide regular updates about their relative or gave them information about the service, including how to complain.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Good 	We inspected all three wards in this service and changed our ratings. Our overall rating of the service is Good.
Long stay or rehabilitation mental health wards for working-age adults	Good 	We inspected seven of the eight wards in this service and changed our ratings. Our overall rating of the service is Good.

Summary of findings

Contents

Good

Kneesworth House

Services we looked at

Forensic inpatient or secure wards; Long stay or rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Kneesworth House

Kneesworth House is part of the Priory Group of companies and is situated in Cambridgeshire, close to the Hertfordshire border. It provides inpatient care for people with acute mental health problems, a psychiatric intensive care unit (PICU), locked and open rehabilitation services, and medium and low secure forensic services for people with enduring mental health problems.

The service is registered to provide the following regulated activities:

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

The hospital consists of the following services:

Forensic inpatient/secure wards

- Clopton - 15 bed medium secure service for men with a personality disorder.
- Ermine - 19 bed medium secure service for men with a mental illness.
- Orwell - 18 bed low secure service for men with a mental illness.

Long stay/rehabilitation wards for working age adults

Open settings:

- Bungalow 63 - four bed service for men with a mental illness.
- Bungalow 65 - four bed service for women with a mental illness.
- Bungalow 67 - four bed service for men with a mental illness.
- Bungalow 69 - four bed service for men with a mental illness.
- Swift - four bed service for men with a mental illness/ learning disability.

Locked settings:

- Nightingale ward - 17 bed service for men with a mental illness.
- Wortham ward - 17 bed service for men with a mental illness.
- Fairview - six bed service for women with a mental illness.

Acute wards for adults of working age / Psychiatric Care Units:

- Bourn - 12 bed service for women.
- Wimpole - 12 bed service women.

The hospital had 136 beds. At the time of the inspection there were 112 patients.

Following inspections in January and June 2019, the Care Quality Commission placed the hospital in special measures and took enforcement action.

The Care Quality Commission last completed a comprehensive inspection of this location between 7 January and 22 January 2020. The overall rating for this location was requires improvement, with inadequate in the safe domain, requires improvement for the effective and well-led domains and good for caring and responsive. The provider was retained in special measures, although some improvements had been made. Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified and requirement notices were issued under the following regulations:

- Regulation 12 – Safe care and treatment
- Regulation 13 – Safeguarding service users from abuse and improper treatment
- Regulation 15 – Premises and equipment
- Regulation 17 – Good governance
- Regulation 18 – Staffing

The provider submitted action plans that described how it would make the required improvements and we found that it has addressed the majority of our concerns identified at the previous inspection.

At this inspection we inspected the forensic inpatient/ secure wards and long stay / rehabilitation wards for working age adults. We did not inspect the acute ward and psychiatric intensive care unit. Ratings for this core service have been retained from the previous inspection in January 2020.

Summary of this inspection

Our inspection team

The team that inspected the service comprised an inspection manager, seven inspectors, one assistant inspector and a variety of specialists, including nurses and experts by experience.

Why we carried out this inspection

We inspected this service to see if improvements had been made after the service had been placed in special measures.

How we carried out this inspection

Due to the COVID-19 epidemic, we took a small team to look at two of the hospital's core services. Interviews with the senior management team and with some of the staff teams were carried out remotely during and after the site inspection, between 8 and 19 October 2020. Interviews with carers and some patients were also completed by telephone or teleconference.

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, asked a range of other organisations for information and sought feedback from commissioners.

During the inspection visit, the inspection team:

- visited nine wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients;
- spoke with 18 patients and 11 carers or family members of patients who were using the service;
- spoke with the registered manager, service manager and managers or acting managers for each of the wards;
- spoke with 38 other staff members; including doctors, nurses, occupational therapist, psychologist and social worker;
- received feedback about the service from 10 care co-ordinators or commissioners;
- spoke with an independent advocate (commissioned by the provider);
- attended and observed one multi-disciplinary care planning meeting;
- looked at 19 care and treatment records of patients;
- carried out a specific check of the medication management on nine wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with seven patients on the secure wards and 11 patients on the rehabilitation wards. Most patients we spoke with said they were very satisfied with their care and treatment and told us that staff were generally caring and supportive. However, two patients on the secure wards said a few staff seemed disinterested in patients.

While most patients thought the food was good, two patients said they did not like it and five stated there was not enough choice.

Four patients in the rehabilitation service stated that physical health concerns such as toothache or a visit to the opticians had been difficult to address and there were often delays in seeing the doctors. Patients on the secure wards told us that there was a lack of activities during the evenings and weekends, and that they did not always feel involved in setting their care plan goals.

Patients' families and carers in the rehabilitation service expressed some concerns regarding communication from staff not always being timely or informative and patients' belongings going missing. Patients' families and carers on the secure wards told us that they were invited to multi-disciplinary meetings about the patient's care, but did not receive other updates, and had not been given information on how to make a complaint to the service if needed.

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?

Requires improvement 

We rated safe as requires improvement because:

- Seclusion care plans did not always meet the recommendations of the Mental Health Act code of practice on all wards. Most plans did not specify what interventions patients needed to maintain their food and fluids intake. Staff did not always update nursing care plans as the patient's presentation and needs changed.
- Emergency equipment on the bungalows, in the rehabilitation service, was not located where it was signposted or easily accessible.
- Staff did not isolate patients newly admitted to the secure wards who had declined a COVID-19 test and were not displaying symptoms. This was in line with the provider's policy but increased the risk of an asymptomatic COVID-19 positive patient transmitting the virus to other patients.
- Staff had identified that potential ligature risk points on Ermine ward needed to be removed but had not set a target completion date and had not undertaken any work to remove or mitigate against these risks.
- On the secure wards, staff had not consistently recorded clozapine prescriptions as an alert on the front record page of the patient's record so staff could identify this easily.
- Staff had not clearly labelled two patient-specific medicines in the rehabilitation service, which meant there was a risk patients could receive the wrong medication.
- The staff bathroom area on bungalow 67 was dirty, and in the forensic services, some furnishings and décor needed updating.

However:

- Generally, all wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The hospital managed the supply of personal protective equipment well during the COVID-19 pandemic and had robust policies in place regarding the wearing of facemasks and other protective equipment where appropriate. Staff received training and used equipment effectively in line with the provider's policy.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Summary of this inspection

- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- 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 had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Staff regularly reviewed the effects of medications on each patient's physical health. On secure wards, the service used systems and processes to safely prescribe, administer, record and store medicines.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good 

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.

Summary of this inspection

- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The wards included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- The rehabilitation service did not provide a structured, recovery-based rehabilitation pathway for some patients. However, most patients had holistic personal goals identified.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families through multi-disciplinary meetings.

Summary of this inspection

However:

- Patients on the secure wards told us that there was a lack of activities during the evenings and weekends, and that they did not always feel involved in setting their care plan goals.
- Carers of patients on the secure wards told us the hospital did not always provide regular updates about their relative or given them information about the service, including how to complain.

Are services responsive?

Good

We rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients. On secure wards, this included patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom, had access to sufficient bathrooms and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff supported patients with activities outside the service, such as work, education and family relationships where possible during social distancing restrictions.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

However:

- Patient bedrooms were not en-suite and patients had to share toilets, showers and bathroom facilities. The provider showed us plans to address this on the secure wards, with work scheduled for completion in three stages by March 2021, December 2021 and final completion in May 2022.

Summary of this inspection

Are services well-led?

Good

We rated well-led as good because:

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

However:

- Not all staff on the rehabilitation wards could tell us what the provider's vision and values were and fully describe how they were applied to the work of their team.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received training in the Mental Health Act as part of their induction and received yearly updates. Ninety-four per cent of staff on secure wards and 98% of staff on the rehabilitation wards up to date with their training. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and were able to describe the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. This was accessible to staff on the shared drive on the electronic system.

Patients had easy access to information about independent mental health advocacy. There were posters on the wall of all areas we visited with contact telephone numbers.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly on the electronic system, and they were available to all staff that needed access to them.

Staff completed audits regularly to ensure that the Mental Health Act was being applied correctly and learning was shared from those audits.

The service displayed a notice on the rehabilitation wards to tell informal patients that they could leave the ward freely.

Care plans for patients on the rehabilitation wards referred to identified Section 117 aftercare services for patients' subject to section 3 or equivalent part 3 powers authorising admission to hospital for treatment.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act and assessed and recorded capacity clearly for patients who might lack capacity.

Staff received training in the Mental Capacity Act as part of their induction and received yearly updates. Ninety-four per cent of staff on secure wards and 97% of staff on the rehabilitation wards up to date with their training. Staff we spoke with had a good understanding of the Mental Capacity Act, including the five statutory principles.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy, had access to it and were aware of where to get additional advice and support when needed.

Detailed findings from this inspection

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to do so.

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

The service had arrangements to monitor adherence to the Mental Capacity Act.

Staff audited the application of the Mental Capacity Act and learning was shared from those audits.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires improvement	Good	Good	Good	Good	Good
Long stay or rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

The location also has an acute ward and psychiatric intensive care unit, whose previous ratings were also taken into account in deciding the hospital rating.

Good

Forensic inpatient or secure wards

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

Are forensic inpatient or secure wards safe?

Requires improvement

Safe and clean environment

All wards were safe and clean. The wards were generally well furnished and decorated although a little tired. The provider had scheduled refurbishment and redecoration of all the wards, but this had been postponed due to the COVID-19 pandemic halting work. Managers showed us plans and timescales for reconfiguring and refurbishing the wards.

Staff had completed an environmental risk assessment including potential ligature anchor points. Where ligature risk points could not be removed, risks were mitigated through staff observations. Managers had completed a photo guide to high risk areas and displayed this in the staff office for staff to easily note the risk areas and mitigating guidance. However, staff had identified potential ligature risk points on Ermine ward as requiring removal but had not removed or mitigated these risks or set a target completion date for remedial work.

The wards had blind spots where staff could not observe patients at all times. However, the provider had installed mirrors and closed-circuit television to improve observation. Staff carried personal alarms to call for assistance if required, and patients had access to call bells to raise help.

The wards complied with same-sex accommodation guidance as they only admitted male patients.

All wards were visibly clean in all areas and housekeeping visited daily to complete a full clean of all areas. Patients we spoke with told us that the shared toilets got dirty during the day, but they were all clean when checked during the inspection. The provider had increased daily cleaning in response to the COVID-19 pandemic, issued all staff with relevant personal protective equipment and increased hand washing requirements to reduce the risk of contagion.

The hospital had managed the supply of personal protective equipment well during the COVID-19 pandemic and had never run out. The service had robust policies in place regarding the wearing of facemasks and other protective equipment where appropriate. Staff were aware of these requirements and had received training in how to use equipment effectively. Disposal bins were available at the entrance to each ward. All staff we met were wearing facemasks when on the wards and other communal areas.

The provider complied with the national guidance around discharge or transfer of COVID-19 positive patients. However, patients transferring onto the wards who had declined a COVID-19 test and were not displaying symptoms were not nursed in isolation for a quarantine period, in line with Priory's policy. This increased the risk of an asymptomatic COVID-19 positive patient transmitting the virus to other patients.

We viewed the seclusion rooms on all wards, with two seclusion rooms and a de-escalation room on Ermine ward and one seclusion room on both Clopton and Orwell wards. We found that seclusion rooms allowed clear observation and two-way communication. They had access to a toilet, sink and shower and a clock. However, one of the vinyl pillowcases in the seclusion room on Ermine ward was badly worn and in the seclusion room on Clopton

ward there were cobwebs on the ceiling and insects on the ceiling light panel. We raised this with the ward managers who rectified this immediately. Ermine and Clopton ward rooms also contained protruding metal closures and locks which could cause harm to a patient. We also raised this with ward managers during the inspection, who were aware of this and managed the risk appropriately. There were plans to address this in the refurbishments.

Clinic rooms on all wards had significantly improved since the previous inspection. Clinic rooms were fully equipped, and equipment was clean and checked regularly. Emergency drugs were available to the relevant registered staff, and staff checked and audited stock medicines weekly. Staff monitored room and fridge temperature daily and all medications were labelled and in date.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The provider had calculated the number of staff required and reviewed this when needed, for example, deploying additional healthcare support workers when there were a number of patients requiring one to one observations.

Managers reviewed staffing levels each morning at the daily managers meetings and ward managers could deploy bank and agency staff to cover staff absence. The provider used long term contracted agency staff so that they were familiar with the wards and patient group.

A registered nurse was present on the wards at all times, with two nurses on each shift on Clopton and Orwell wards and three nurses on Ermine ward.

The wards had sufficient medical cover with a consultant psychiatrist in post on wards, and access to medical cover through the duty doctor overnight. Doctors providing out-of-hours medical cover lived on-site.

Staff had received and were up to date with most appropriate mandatory training. The provider set 19 training sessions as mandatory training and 86% of staff were up to date with all training sessions. Completion of basic life support training was low on Clopton and Ermine wards. However, the provider explained that this was due to managers having to cancel face-to-face training sessions due to the COVID-19 pandemic. Managers had mitigated the risk to some extent by providing additional Emergency First Aid at work e-learning for staff. This had been completed by 90% of staff.

Assessing and managing risk to patients and staff

Staff completed a risk assessment of every patient on admission and updated these regularly including after any incident. We reviewed 11 care records and saw that staff used recognised risk assessment tools to assess all patients on admission. Staff updated these regularly and following any incident.

Staff identified changing risk levels and amended observation levels and interaction with patients in response. Staff followed provider policy on the use of observation and searching, and staff discussed levels of observation with the multidisciplinary team.

There were no blanket restrictions on the wards and access to the internet was individually risk assessed.

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 and had completed Safewards training to reduce conflict and aid de-escalation.

Clopton ward recorded 13 incidents of restraint in the year prior to inspection and three incidents of seclusion in the last six months. Orwell ward recorded three incidents of restraint in the year prior to inspection with two incidents of seclusion and three incidents requiring rapid tranquilisation. Ermine ward reported 78 incidents of restraint in the year prior to inspection with 14 incidents of seclusion and four requiring rapid tranquilisation. The ward manager on Ermine ward had worked with the restrictive interventions lead to reduce the number of incidents leading to restraint and seclusion. They implemented a weekly community meeting where patients and staff would agree the risks on the ward and how to deal with them, which had reduced the number of incidents of violence and aggression over the four months prior to inspection.

We reviewed 11 seclusion records and found that although staff had completed care plans in all cases and these had improved since the last inspection, they did not always meet the recommendations of the Mental Health Act Code of Practice. Most plans contained interventions for staff to maintain food and fluids but rarely specified how to do this

safely or gave specific directions for the individual at that time. Staff had not updated care plans as the patient's presentation and needs changed. We noted the nursing reviews for three patients showed the patient was calm and settled for a period of time, but the nursing staff and in one case the duty doctor waited for the next medical or multidisciplinary team review before discussing whether to end seclusion. On one occasion, this was for an additional one hour and fifty minutes.

The provider had introduced a 'seclusion noticeboard' outside each seclusion room giving patients clear information about their rights and how staff would keep them safe during their seclusion. We saw that staff gave patients extra blankets and clothing if patients requested this and adjusted the temperature of the room as needed. Staff offered toiletries and clothing changes to patients who were in seclusion for prolonged periods or overnight.

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. All staff on Orwell ward and 83% of staff on Clopton and Ermine wards had completed safeguarding adults and safeguarding children training.

Staff we spoke with knew how to identify when someone was at risk of harm, how to raise a safeguarding referral and could give examples of when they had done this.

Staff were aware of the provider's policy on equality and how to prevent harassment or discrimination of any patient with protected characteristics.

Staff access to essential information

The provider used an electronic patient records system that was available to all staff, including guest logins for agency staff so that all staff had easy access to patient clinical information. The provider had updated the electronic patient record system since our last inspection and the system was quicker and easier to use. Information governance systems included confidentiality of patient records and all access was password protected. There were sufficient computers for staff to update records easily and quickly.

Staff recorded seclusion, external transfers and discharges on paper records, which were accessible to staff.

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 physical health.

We reviewed seven medication records and saw that staff prescribed and administered medication safely and used the National Early Warning Score 2 to monitor the effects of medication on patients' health.

The provider had significantly improved their monitoring and care planning of patients prescribed clozapine since the previous inspection and all records had a clozapine care plan. However, only two of the seven records had clozapine prescription listed as an alert on the front record page for easy identification for staff.

The provider contracted a pharmacy to complete weekly audits of medicines management including prescriptions. Managers and medical staff had access to a dashboard that provided up to date information on prescriptions and medicines administration.

Track record on safety

Ermine ward had recorded three serious incidents in the past six months and Clopton and Orwell wards had not recorded any serious incidents.

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.

The provider used an electronic incident reporting system and had a policy on incident reporting and investigation. Staff we spoke with knew what incidents to report and how to report them.

Good

Forensic inpatient or secure wards

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, were personalised, holistic and recovery-oriented.

We reviewed 11 care records and saw that staff completed a comprehensive assessment of physical and mental health on admission to the wards.

Staff developed recovery focussed, personalised care plans with patients and reviewed these regularly at multidisciplinary meetings.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.

We reviewed 11 care records and saw that staff delivered interventions in line with National Institute for Health and Care Excellence guidelines. These included psychology-led emotional management sessions, mindfulness sessions, dialectical behavioural therapy informed interventions and life skills such as cooking.

The provider employed physical health nurses across the service to monitor and treat any physical health concerns, with access to local GPs if required.

Staff used recognised rating scales including Health of the Nation outcome scales to assess and monitor outcomes for patients.

There were limited activities provided for patients during evenings and weekends.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided a three-week induction programme for new staff that included mandatory training, shadowing and mentoring.

The teams included a consultant psychiatrist, psychologist, occupational therapist, nurses and support workers. Physical health nurses also attended the ward when required.

Staff were experienced and had the relevant qualifications and training. Managers provided an induction course to newly employed staff.

Managers provided staff with supervision in line with provider policy with 90% of staff on Ermine and Orwell wards and 94% of staff on Clopton ward up to date with supervision. Staff also participated in weekly reflective practice group sessions led by the psychologist. Managers conducted an annual appraisal of each member of staff's work performance and 96% of staff had received an appraisal in the last year. Managers ensured that staff had access to regular team meetings. We saw that managers dealt with poor staff performance effectively.

Managers ensured that staff received the necessary training for their role and staff had completed training in safewards. Staff on Clopton ward had received personality disorder and dialectical behavioural therapy training.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held weekly multidisciplinary meetings and handover meetings at the start of each shift where they discussed relevant information about patients. Staff worked closely with other teams within the service and external organisations such as local authorities and commissioners of healthcare services.

Good

Forensic inpatient or secure wards

Are forensic inpatient or secure wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We spoke with seven patients across the three wards who told us that staff were generally caring and supportive. However, some patients told us that a few members of staff seemed disinterested in them.

Staff had a good understanding of patients' needs and supported them to understand and manage their treatment. Staff supported patients to access additional services when required, including physical health services.

Staff could raise concerns about disrespectful, discriminatory or abusive behaviour and language towards patients and we saw that the hospital had investigated these concerns when reported.

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.

We reviewed 11 care records and saw that patients' views were included in their care plans and were offered a copy of the care plan. However, most of the patients we spoke with told us they did not always feel involved in deciding their care plan goals. Patients participated in multidisciplinary reviews unless they declined to attend.

Staff did not provide patients with an information pack on admission to the wards. However, we saw that staff were in the process of developing a pack.

Staff held weekly community meetings where patients could give feedback and raise any concerns about the wards. We saw that issues raised in community meetings were put right as quickly as possible.

The service contracted two independent advocacy services for patients to speak to about their treatment or rights under the Mental Health Act.

We spoke with six family members who told us that they were invited to care planning meetings but that they did not receive any updates about patient care unless they called to ask. Carers told us they had not been given information about the service, including how to complain and none of the carers we spoke with knew how to make a formal complaint.

Are forensic inpatient or secure wards responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

The service had clear criteria for accepting patients on to the wards and did not accept anyone whose physical health needs could not be met by the provider or anyone with reduced mobility due to the layout and lack of wheelchair access on the wards.

Staff planned patients' discharge from the wards and had effective liaison with care co-ordinators. Staff supported patients during transfers between services. There had been no delayed discharges since the last inspection.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom and although these were not en-suite there were enough shared toilets, bath and shower rooms for the number of patients. There were quiet areas for privacy on each ward.

Patients had access to their own mobile telephones where the risk had been assessed as low, and both wards had a telephone in a quiet, private room. Wards had quiet rooms available for patients to use at any time.

Patients had access to outside space, with open access to gardens throughout the day.

The food was of a good quality and patients could make hot drinks and snacks at any time. Patients had a variety of choices for meals including healthy options and fruit was available as a snack for patients to help themselves.

Good

Forensic inpatient or secure wards

Patients' engagement with the wider community

Staff supported patients to maintain contact with families and friends either through telephone and internet contact or visiting the wards.

During the initial lockdown period where families were unable to visit the wards, the provider had ensured they helped patients to maintain family contact where appropriate.

Meeting the needs of all people who use the service

The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. However, the wards were not able to accept anyone with reduced mobility or wheelchair users due to ward layouts, which meant patients had to use stairs to access their bedrooms or reception as there were no lifts. The provider made this clear in their referral criteria.

The provider displayed information about services, including advocacy, clearly on noticeboards on all the wards.

The service had access to translators and signers for any patients whose first language was not English. They worked with individual patients to provide accessible information where needed.

Patients had a choice of food to meet their requirements including vegetarian, vegan and halal options available. Staff provided access to spiritual support with visiting Christian and Muslim religious leaders, and access to spiritual support for other faiths was available when required.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service. In the past year Clopton ward had received 32 complaints with six complaints upheld and four partially upheld, Ermine ward had received 17 complaints with three upheld and one partially upheld, Orwell ward had received four complaints with one upheld and one partially upheld.

Staff provided information on how to make a complaint displayed on notice boards on the wards. Patients we spoke with knew how to make a complaint, however carers we spoke with were unsure of how to make a formal complaint.

Are forensic inpatient or secure wards well-led?

Good

Leadership

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

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider values were displayed on the wards and on the provider's internet pages. Staff understood how to apply the values to their day to day work.

Culture

Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution and were aware of the provider's confidential whistleblowing hotline.

Staff we spoke with were aware of how to raise any concerns and felt confident that any concerns raised would be dealt with appropriately.

The provider offered career progression opportunities for all staff and nursing staff also had the opportunity to access leadership training to progress in their careers.

There were processes to support staff and promote their positive wellbeing. The provider recognised staff success within the service, for example, through their 'star awards' and 'wall of praise' programmes. The provider had a 'ward of the month' recognition scheme that staff felt helped recognise their achievements.

Good

Forensic inpatient or secure wards

Governance

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

Managers and staff had addressed the issues identified in previous reports in relation to medicines and clinic rooms. Clinic rooms on all wards had significantly improved and equipment was clean and checked regularly. Emergency drugs were available, and staff checked and audited stock medicines weekly.

Managers and staff had ensured that seclusion practices and paperwork had improved significantly since the last inspection. However, seclusion care plans did not always give sufficient information to staff about how to support patients effectively.

The provider had a clear framework of what was discussed at governance meetings and how this was fed back to staff. Staff participated in local clinical audits and acted on the results when needed.

Management of risk, issues and performance

The service had an overall site risk register and staff could escalate concerns to the risk register via the ward managers.

Wards had introduced individual 'top 5 risks' documents for each ward that was agreed and discussed by staff and patients in community meetings to address risks on the ward.

Information management

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

Ward managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. All managers we spoke with used the organisation's electronic monitoring system to benchmark themselves against other wards and wider services within the organisation. Managers monitored mandatory training and alerted staff when they needed to update their training.

Staff had access to the equipment and technology needed to do their work, and there were sufficient numbers of computers available on the wards for staff to update patient records in a timely manner. Managers had addressed the IT issues identified at the last inspection. The service used an electronic system that was easy for all staff to use, including agency staff, and access to the system was smooth and quick on all wards.

Staff made notifications to external bodies as needed.

Engagement

Patients and carers had opportunities to give feedback on the service, either informally at multidisciplinary reviews or through patient satisfaction questionnaires. Prior to the COVID-19 pandemic, carers could also attend a carers forum and an annual open day. Wards had patient representatives who attended a monthly patient council meeting to provide feedback to senior managers from the service.

Learning, continuous improvement and innovation

The service had individual ward improvement plans in place to identify areas for improvement.

The provider had set up a 'seclusion task force group' who met fortnightly to review and audit seclusion practices. We saw that seclusion records had improved since the last inspection. The provider had introduced a 'seclusion noticeboard' outside each seclusion room giving patients clear information about their rights and how staff would keep them safe during their seclusion. They had also created a flow chart for staff to ensure they complied with the Mental Health Act Code of Practice.

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Requires improvement

Safe and clean environment

Ward areas were safe, clean, well furnished, well maintained and generally fit for purpose. The wards were well equipped and refurbishment work was in progress, although this was not complete due to the COVID-19 pandemic halting works. There had been considerable improvements since our last inspection, and other areas were still in the process of being refurbished, such as the bathroom floor on Wortham ward. Staff commented that they were still in the process of compiling a 'snagging' list of work that required completing or redoing. However, there were cobwebs and dirt in the staff toilet area on bungalow 67 and the laundry room was very cluttered.

Staff completed regular risk assessments of the care environment and managers did a monthly 'walkabout' to review this. Staff had completed ligature risk assessments for all the wards and bungalows within the last 12 months. Where staff identified risks, they managed these through individual risk assessments, engagement with patients and observations.

The ward layouts did not always allow staff to observe all parts of the ward and there was limited space on the bungalow corridors. The service mitigated this by using mirrors. There were no potential ligature anchor points where staff had not mitigated the risks adequately. The provider had recently installed closed circuit television cameras in Fairview and had plans to introduce them in Wortham and Nightingale wards as part of the refurbishment programme.

The provider had decommissioned the seclusion room on Nightingale ward in 2018 and staff used this as a de-escalation area. Staff had not secluded patients in this room since the last inspection. We noted that the mechanism on the viewing panel of the toilet door protruded and could be a risk to anyone attempting to self-harm through head banging. We raised this issue during the last inspection. Staff confirmed there had been no incidents of self- harm relating to this.

All wards were single sex and complied with guidance on eliminating mixed-sex accommodation.

There were communal spaces, activity rooms, a lounge, dining area and kitchens on each ward. The bungalows had less space but still had communal kitchens, dining and lounge space. There were quiet rooms available for patients who needed space away from other patients.

Staff on every ward had easy access to alarms to summon staff in an emergency. Patients had access to nurse call alarms.

Cleaning records were up to date and demonstrated that staff cleaned the ward areas regularly. However, the fabric seating in the bungalows was difficult to clean for infection prevention and control. We saw on the schedule that staff could shampoo this to clean it but did not see this had taken place on any of the cleaning records we reviewed. We requested evidence of regular specialist cleaning of the fabric soft furnishings, but this was not provided, and we were not assured this took place.

Long stay or rehabilitation mental health wards for working age adults

Good

The hospital had managed the supply of personal protective equipment well during the COVID-19 pandemic and had never run out. The service had robust policies in place regarding the wearing of facemasks and other protective equipment where appropriate. Staff were aware of these requirements and had received training in how to use equipment effectively. Disposal bins were available at the entrance to each ward. All staff we met were wearing facemasks when on the wards and other communal areas.

Staff adhered to infection control principles, including handwashing. We requested audits from the provider who provided evidence for a one-week period, which showed 100% compliance. There were signs demonstrating effective handwashing in all areas and alcohol gel was available.

The provider complied with the national guidance around discharge or transfer of COVID-19 positive patients. Staff arranged for patients to be tested and isolated, pending confirmation of the test results.

Clinic rooms on Nightingale ward, Wortham ward and Fairview were fully equipped, stocked and regularly checked. The bungalows did not have any clinic rooms although the provider stated that they had planned a clinic room as part of the current refurbishment. Staff cleaned and maintained equipment well. Staff had easy access to green bags which contained all items needed to monitor patients' physical health. We checked eight pieces of equipment including blood pressure machines and glucometers and all were calibrated and in date. Staff monitored clinic room and fridge temperatures daily with only the occasional missing date.

Resuscitation equipment on Nightingale ward, Wortham ward and Fairview, including a defibrillator, was accessible and kept in red emergency bags with a separate bag for emergency drugs. Staff completed weekly checks of all equipment and daily checks of the red bags.

However, the red emergency bag on the bungalows was not located where stated and was not easily accessible to staff. We had raised this at a previous inspection, and the provider had addressed this; however, due to building works, staff had moved the bag but not updated the signage. At the time of our inspection, the red bag and emergency drugs bag were stored in bungalow 65 in a locked cupboard with items piled around them and on top of it making it difficult to retrieve in an emergency. Four of the seven staff we asked did not know where the bag was. We escalated our concerns to the nurse in charge who moved the bag back to the correct location with immediate effect. Senior managers also performed an emergency drill which recorded that staff from the neighbouring ward arrived on scene with a red emergency bag in one minute and 22 seconds. This provided assurance that staff could manage appropriately in an emergency.

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. The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The service had calculated the number and grade of nurses and healthcare assistants required for each of the wards. The number of nurses and healthcare assistants mostly matched the number planned on all shifts. Ward managers adjusted staffing levels daily to take account of case mix.

Managers used regular agency and bank nursing staff whenever possible to maintain safe staffing levels when needed. They deployed extra staff for patients on enhanced observations and to accompany patients on escorted leave. All staff, including agency staff, received a full induction and were familiar with the wards. Managers also had access to 'floating staff' who they could allocate to a ward when needed.

At the time of our inspection there were 10 registered nurse vacancies across the service which were covered by regular agency staff.

The service allocated a named nurse for each patient and staffing levels allowed patients to have regular one-to-one time with them. Staff documented these sessions and escalated any concerns raised to the appropriate person.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. Staff always arranged for patients to take their leave later or on a different day.

There were enough staff to carry out physical interventions, for example, observations, restraint and seclusion, safely and staff received training to do so.

Long stay or rehabilitation mental health wards for working age adults

Good

There was adequate medical cover during the day with each ward having access to one or more consultant staff during normal working hours. Out of normal working hours (evenings and weekends), an 'on-call' doctor, based on site, was available to attend the wards quickly in an emergency.

Staff had received and were up to date with most appropriate mandatory training. The provider set 19 training sessions as mandatory training overall mandatory training compliance for the rehabilitation and recovery service ranged between 75% on Wortham ward and 80% on Nightingale ward. Although this did not meet the organisation's target of 85% compliance, this was mainly due to ceasing face to face training for basic and intermediate life support and restrictive interventions and breakaway training, due to COVID-19 restrictions. Ward managers said it took time for the organisation's electronic system to update and were confident staff had completed the courses they could access.

All staff, including new starters, completed emergency first aid at work as a refresher or standalone e-module. The service designed restrictive interventions training with virtual classroom sessions and recommenced this in September with an action plan to complete by the end of October.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Patient records we reviewed during the inspection showed staff completed a risk assessment of every patient on admission and updated it regularly, including after any incident, using a locally developed risk assessment tool. We observed staff assessing patients prior to unescorted leave in the grounds and following procedures to search patients when they returned from leave. Staff followed the provider's policies and procedures for searching patients or their bedrooms and only did so as the result of individual risk assessments.

Staff observed patients appropriately, to ensure they were safe, including to minimise risk from potential ligature points, and kept detailed records.

Staff were aware of and dealt with specific risk issues, such as falls or pressure ulcers.

Staff restricted patients' access to the downstairs areas on Nightingale ward between 6am and 8am to enable housekeeping staff to thoroughly clean. Patients had access to a small lounge and drinking water and could make hot drinks under supervision in the upstairs kitchen. Staff confirmed most patients were still sleeping at this time. Staff had not recorded this on Nightingale ward's blanket restriction audit form.

Staff had addressed the blanket restriction on Wortham ward and patients now had unrestricted access to the enclosed outside space.

Staff adhered to best practice in implementing a smoke-free policy. The provider restricted smoking and vaping to outside spaces only and staff offered patients advice on smoking cessation and nicotine replacement therapy.

Informal patients could leave at will and we saw signs explaining this at ward entrances.

Staff used seclusion appropriately and mostly followed best practice. Episodes of seclusion had decreased since our last inspection. Between 1 April 2020 and 30 September 2020 there were two episodes of seclusion. These occurred on Fairview and Nightingale ward where there were no seclusion rooms. Staff secluded a patient on Fairview in their bedroom for 15 minutes and secluded a Nightingale ward patient on Icknield ward (currently unused) before their transfer to a psychiatric intensive care unit. Seclusion paperwork was in place, however, the care plan for the seclusion on Icknield ward did not contain all the information recommended in the Mental Health Act Code of Practice.

The wards in this service participated in the provider's restrictive interventions reduction programme. Staff used restraint only after de-escalation had failed and used correct techniques. Staff described using verbal de-escalation and quiet spaces to help diffuse behaviour

that challenged. Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

There were 76 episodes of restraint during the period October 2019 to September 2020. Of these, 56 occurred in one of the bungalows which had been adapted for a single patient. There were no prone restraints. Data supplied by the service showed there were between six and 12 episodes per month between January 2020 and June 2020. July and August showed one restraint per month. There were three episodes of restraint lasting 60 minutes or more with one episode lasting 95 minutes. Staff improved access to the community for this patient, leading to a reduction in restrictive interventions.

There were 12 episodes of restraint recorded on Nightingale ward with many of them relating to a specific patient prior to their transfer to a psychiatric intensive care unit.

The organisation had implemented the 'safewards' model on all the wards. The 'safewards' model helps reduce conflict and containment by implementing ten interventions agreed with the patients, which include soft words, positive words, mutual expectations, reassurance and calm down methods. The wards had posters displayed about the model.

The wards had a 'top 5 risks' which was reviewed at the weekly community meetings.

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 completed training in safeguarding for adults and children, knew how to identify adults and children at risk of, or suffering, significant harm and make a safeguarding alert, and did so when appropriate. Safeguarding training figures showed 97% of staff were up to date with their training. There were posters of how to contact the safeguarding lead on each ward along with contact details for the local authority.

Staff were able to give examples of when they had recognised and raised a safeguarding alert and how to escalate to the safeguarding lead, including working in partnership with other agencies. Staff we spoke with could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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. Care records were in electronic form and accessed using staff specific passwords. Agency staff also had temporary access to these systems.

All information needed to deliver patient care was available to all relevant staff when they needed it. This included when patients moved between teams within the organisation. Seclusion records, external transfers and discharges used paper records.

Staff monitored patient's physical health daily in paper format using National Early Warning Score 2. Staff kept these records with paper prescriptions and detention/ consent forms in the clinic room.

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 physical health which was an improvement since the last inspection.

Staff mostly followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance. However, on Nightingale ward, staff had identified two patients' inhalers with only their initials, which were similar, and not their full names. This could have led to patients being given the wrong inhaler. We escalated this to the ward manager who took action to resolve this.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance, especially when doctors prescribed a high dose of antipsychotic medicines. Staff dated all medicines charts appropriately which had improved since the previous inspection.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff stored medicines in locked cabinets or fridges and monitored the temperatures to ensure they had stored them appropriately. We reviewed 10 medicines across all the wards and saw they were all within expiry date. The medicine cabinets on Nightingale ward were overstocked and staff confirmed the pharmacy provider was undertaking a review in order to reduce stocks. Staff stored and managed controlled drugs appropriately.

The service had an appropriate method to cascade alerts for medicines and medical devices.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

Track record on safety

The service had a good track record on safety and had no never events on any wards.

The service reviewed incidents appropriately, including an emergency hospital admission for life saving surgery, an expected patient death and assaults on staff.

Reporting incidents and learning from when things go wrong

The service generally 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.

All staff we spoke with knew what incidents to report and how to report them on the electronic reporting system. Staff gave examples of the type of incidents they would report, such as patient incidents resulting in harm. Managers debriefed and supported staff after serious incidents. Staff confirmed they received feedback and felt supported, following investigation of incidents, both internal and external to the service. Managers shared learning from incidents during daily handover meetings and e-mail bulletins and staff we spoke with were aware incidents had occurred both on their own wards and throughout the hospital.

We reviewed a selection of incidents reported on the organisations electronic reporting system during the period April to August 2020. Staff graded the incidents according to the level of harm appropriately and described actions taken at the time. There was a strong theme of racially driven abuse reported towards some staff and other patients by a small minority of patients and managers encouraged staff to report this to the police.

Managers 'signed off' the incidents and recorded lessons learned however we noted there was often no learning identified when there were repeated incidents of the same type with the same patients. There was evidence of changes made as a result of feedback with the installation of close circuit television in the upstairs corridor of Fairview.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation, apologised and gave patients honest information and suitable support if and when things went wrong.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans and reviewed them regularly through multidisciplinary discussion and updated them as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

We reviewed eight care records and saw staff completed comprehensive mental health assessments of the patients in a timely manner at, or soon after, admission. Care plans reflected the needs identified during the assessment. Staff updated all the care plans we reviewed regularly with the inclusion of the patient.

Staff assessed patients' physical health needs in a timely manner after admission and regularly assessed to identify if their condition was deteriorating. Staff also offered patients access to well man and well women health monitoring. This was an improvement since our last inspection.

Long stay or rehabilitation mental health wards for working age adults

Good

Best practice in treatment and care

Staff provided a range of treatment and care for patients, based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation.

Staff had developed a new pathway on Nightingale ward. This defined four stages from admission to discharge encompassing the interventions a patient might encounter on their journey to recovery. This provided a clear visual representation of the recovery path for patients and staff. Interventions were those recommended by, and delivered in line with, guidance from the National Institute for Health and Care Excellence. These included medication and psychological therapies, training and work opportunities to help patients develop daily living skills such as shopping, budgeting, cooking and laundry.

The service did not provide a structured, recovery-based rehabilitation pathway for some patients, particularly those subject to ministry of justice restrictions. However, most patients had holistic personal goals identified.

Staff provided patients a rolling three-month programme of activities which took the impact of social distancing into account and monitored their attendance. However, this was not directly linked to their recovery plan and staff had not evaluated it. Five staff members said it was often difficult to motivate patients to participate in activities which could help their recovery.

Staff supported patients with their physical health and encouraged them to live healthier lives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff ensured patients had good access to physical healthcare, including access to specialists when needed. Staff recorded this in patient notes.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Staff monitored patients' weight and fluid intake where appropriate and had access to a dietitian for further support and advice when needed, for example, for diabetic patients and where patients had specific nutritional needs, including percutaneous endoscopic gastrostomy feeding.

Staff supported patients to live healthier lives, for example, through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, screening for cancer, and dealing with issues relating to substance misuse.

Staff used recognised rating scales to assess and record severity and outcomes (for example, Health of the Nation Outcome Scales).

Staff used technology to support patients effectively (for example, for prompt access to blood test results and online access to self-help tools).

Staff participated in clinical audit, benchmarking and quality improvement initiatives. We saw staff had set a spreadsheet to assist them to monitor patients' physical health, particularly those with long term conditions.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. This included doctors, registered nurses, clinical psychologists, occupational therapists, activity co-ordinators, pharmacists, speech and language therapists, dieticians and social workers. In addition, GPs visited weekly, a dentist every two weeks and a chiropodist every six weeks. Managers made sure staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

There was also a physical health nursing team on-site from Monday to Friday, consisting of two registered nurses and a healthcare worker. The service had introduced a red, amber, green monitoring system to ensure long term physical health reviews took place and physical health staff attended weekly GP clinics. Staff incorporated physical health reviews into the patients Care Programme Approach reviews every six months and were introducing a system to keep all physical health documentation together so staff could audit them effectively. Staff we spoke with said access to physical health care for patients had improved since our last inspection and the wards had a named physical health nurse allocated to them for continuity.

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

Long stay or rehabilitation mental health wards for working age adults

Good

Managers provided new staff with appropriate induction and staff who were new to the service said it gave them a good introduction to the service. Managers ensured staff received the necessary specialist training for their roles.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Staff we spoke with confirmed they received this and found it useful for their learning and development. The percentage of staff that received regular supervision across the rehabilitation and recovery wards was 96% overall with some wards achieving 100%.

Managers ensured staff had access to regular team meetings. Ward managers shared the meeting minutes for staff to read for those unable to attend the meetings. We reviewed a selection of meeting minutes and saw they were comprehensive and contained pertinent information relating to changes and communication within the wards. However, the meetings did not follow a set agenda or record what action the provider had taken in relation to concerns from previous meetings.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. The service held six-weekly training meetings attended by a wide range of staff, which provided opportunities for group supervision. We reviewed the minutes of a selection meetings which covered a variety of topics.

The percentage of staff that had had received an appraisal in the last 12 months was 95%.

Managers dealt with poor staff performance promptly and effectively.

At the time of our inspection there were no volunteers working due to the COVID-19 pandemic restrictions.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff in services providing care following a patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular and effective six weekly multidisciplinary meetings and recorded this in the patient's notes. These meetings included all relevant staff, including from external organisations, such as the patient's care co-ordinator. We observed a routine weekly care review meeting for two patients attended by the consultant psychiatrist, trainee psychologist and occupational therapist. Staff worked collaboratively to plan patients' care and treatment.

Staff shared information about patients at effective handover meetings within the team for example, shift to shift. We reviewed a selection of handover notes and saw that staff shared pertinent information relating to risk and actions.

The ward teams had effective working relationships with other relevant teams within and outside the organisation (for example, local authority social services and GPs).

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

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.

Staff attitudes and behaviours when interacting with patients showed they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.

We observed staff providing care and saw they interacted with patients in a thoughtful, kind way and showed an understanding of the individual needs of the patients.

Staff supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate and, if required, supported them to access those services.

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

Long stay or rehabilitation mental health wards for working age adults

Good

Staff maintained the confidentiality of information about patients.

Seven of the eleven patients we spoke with said they were grateful for the care staff provided and said staff treated them well and behaved appropriately towards them. Three of the five carers were positive about the care received by their relative. The negative responses related to specific incidents/complaints. Two patients felt staff did not always attended to their physical health needs in a timely manner.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.

Involvement in care

Staff involved patients in care planning, risk assessment and helped them participate in multidisciplinary team reviews. Staff recorded this in the patient's care notes. Patients we spoke with confirmed this, although one patient felt staff did not understand their needs around eating plans. Staff offered patients a copy of their care plan and recorded whether patients accepted or declined.

Staff used the admission process to inform and orientate patients to the ward and to the service.

Staff communicated with patients, so they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. However, one patient felt staff did not understand their needs around eating plans. We saw evidence staff had completed specialist training when caring for patients with Autistic Spectrum Disorder and the processes and care pathways they had put in place to enable communication to support patients.

The organisation sought feedback from patients on how to improve their care and environment during the weekly community meetings. This provided patients with the opportunity to request changes to activities and make suggestions for ward improvements and community outings. Staff recorded and acted on these requests in community meeting record books and on 'You said, we did' boards on each ward.

Staff enabled families and carers to give feedback on the service they received through surveys or direct contact. Staff provided carers with information about how to access a carer's assessment.

However, not all families and carers felt informed and involved in their loved ones' care. Staff said it was often difficult when patients specifically requested staff not to provide information to their families. This was especially difficult when patients and families were unable to meet during COVID-19 pandemic restrictions. This then meant they were unable to keep families and carers involved appropriately and provide them with support when needed.

Patients had access to advocacy services, and we saw posters with contact details on all the ward areas we visited.

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

Good

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Despite this, some patients were required to remain inpatients for a number of years. Discharge was usually only delayed due to the lack of suitable accommodation or facilities or for other clinical reasons.

There was no specified length of stay in the rehabilitation and recovery service. The average length of stay on the rehabilitation wards was; Fairview 472 days, Nightingale ward 363 days, Wortham ward 782 days, bungalow 65 was 64 days, bungalow 67 was 274 days, bungalow 69 was 311 days and Swift House 1058 days. This lies within the expected range for this service, given the mix of patients in the service.

There was always a bed available when patients returned from leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. When

patients were moved or discharged, this happened at an appropriate time of day. Staff confirmed a bed was always available in the onsite psychiatric intensive care unit if a patient required more intensive care.

Staff planned for patients' discharge, including good liaison with care managers and co-ordinators. Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. We spoke with one patient who had been involved in their discharge arrangements and was excited to show us the supported living accommodation they were moving to.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the wards mostly supported patients' treatment, privacy and dignity. Each patient had their own bedroom and although these were not en-suite there were enough shared toilets, bath and shower rooms for the number of patients. There were quiet areas for privacy on each ward.

Patients could personalise bedrooms. Two patients invited us to look in their bedrooms which contained posters, personalised bedlinen and plants.

Patients had somewhere secure to store their possessions as they had keys to their rooms and there were lockers on the wards. This was an improvement since our last inspection.

Staff and patients had access to the full range of rooms and equipment to support treatment and care, although some of the clinic room spaces were small, with cupboards situated above the examining couches which could limit the ability to perform a full physical examination.

There were quiet areas on the wards and a room where patients could meet visitors. Due to restriction relating to COVID-19, visiting occurred in the activity centre. Wards were quieter and calmer than at the last inspection.

Patients could generally make a phone call in private using their own mobile phone or on the wards where there were private cubicles. There were no cubicles on the bungalows.

Patients had access to outside space on all the wards and this was an improvement since our last inspection when there was a restriction on Wortham ward.

The food was of good quality and was cooked on site. Menus contained several choices, including healthy and vegetarian options, which kitchen staff repeated on a four-week rolling basis. Although there were limited choices on the menus to support a vegan diet, staff worked with patients who were vegan to provide individual options. Patients could make hot drinks and snacks at any time. When appropriate, staff supported patients to self-cater.

Staff supported patients who were self-catering to budget, shop for and cook their own food. Patients could make hot drinks and snacks at any time.

Patients had access to computers and could access the internet subject to risk assessment.

The organisation provided a range of activities available five days a week, both on and off the wards however there was limited activities at the weekends. Each ward had dedicated occupational therapy staff. During the COVID-19 pandemic restrictions, the service encouraged physical activity with a range of activities such as walking, foot golf and 'keepy uppy' and held quizzes and competitions with prizes to help motivate patients.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships where possible during social distancing restrictions.

When appropriate, staff ensured patients had access to education and work opportunities. The organisation supported education and staff we spoke with told us about patients who were participating in learning opportunities.

Prior to the COVID-19 pandemic social distancing measures, staff supported patients to access the local community, including local public services such as the gym and the library and arranged trips to local towns. During the restrictions staff had to curtail many community activities, which limited patients' opportunities to work and mix with patients on other wards. Staff attempted to mitigate this by arranging for some patients to participate in the paid vocational 'sparkle and shine' programme to help keep the wards clean and prevent the spread of COVID-19 and on one ward the provider paid a patient a small sum for doing the gardening.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff supported patients in gaining life skills such as cooking and laundry and were setting up an on-site grocery shop for patients.

Staff supported patients to maintain contact with their families and carers and encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. Although not all wards were easily accessible for those with limited mobility, the provider made this clear in their referral criteria. Nightingale ward and Fairview had ramps to access the buildings but did not have any ground floor bedrooms and there were no lifts on any of the wards. However, the service could accommodate patients with poor mobility on Wortham ward, where there were some downstairs bedrooms and on the bungalows. The service made adjustments for disabled patients – for example, by meeting patients' specific communication needs.

Information was not routinely displayed in other languages, but staff could arrange for a translation and had access to interpreter services for those whose first language was not English or who used sign language.

Staff ensured patients could obtain information on treatments, local services, patients' rights, how to complain and so on. The information provided was in a form accessible to the patient group.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups and could speak to the kitchen staff about other meal options when needed.

Staff ensured patients had access to appropriate spiritual support. There was access to a dedicated pastoral care team who represented Christian and Muslim faiths. Staff arranged for patients to attend religious venues in the community if required.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, family members and carers knew how to complain or raise concerns. Those we spoke with knew how to complain to the provider and we saw posters on the wards explaining the complaints procedure. When patients complained or raised concerns, they received feedback; most agreed that staff had been responsive and had resolved their concern.

Staff understood the policy on complaints and knew how to handle them. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to handle complaints appropriately.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. Managers shared feedback from complaints with staff and used learning to improve the service.

Between 1 October 2019 and 30 September 2020 there were 20 complaints relating to the rehabilitation and recovery service. Of those, 12 came from patients (mostly one patient) on Fairview. Overall, two complaints were upheld and one recorded as not applicable. The rest were either withdrawn or not upheld. There were no specific themes, and none were referred to the ombudsman.

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

Good

Leadership

The leaders had the skills, knowledge and experience to perform their roles. There had been some changes in the service since our last inspection with two out of the three ward managers new in post. The leaders we spoke with were knowledgeable about the type of patients they cared for, how they saw the service evolving and how to support their patient group. They had a good understanding of the

services they managed and could explain clearly how the teams were working to provide high quality care. Patients and staff knew who they were and could approach them with any concerns.

The leaders were visible in the service and approachable for patients and staff.

Leadership development opportunities were available, including opportunities for staff below team manager level and we saw this in the training data we reviewed.

Staff said managers at all levels had an open-door policy and that they could always speak to them and we observed this in practice during our inspection. Managers were approachable and the senior management team were visible and accessible.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders.

Not all staff could tell us what the provider's vision and values were and how they applied to the work of their team, although they knew where to find them on the organisation's website and on the posters displayed throughout the service. Staff were able to explain how they were working to deliver high quality care within the budgets available.

Staff we spoke with had not been involved in developing the strategy for their service but did contribute to its implementation.

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.

Managers promoted a positive culture and the teams worked well together. Staff felt positive and proud about working for the provider and their team and an agency staff we spoke with told us that as a result of working at the service, they were in the process of changing careers to retrain.

There were processes to support staff and promote their positive wellbeing. The provider recognised staff success within the service, for example, through their 'star awards' and 'wall of praise' programmes.

The service had recently introduced a 'ward of the month' award with a £50 prize for the winning ward. The organisation was in the process of acquiring a trophy and there was a board displaying the ward of the month in the main office building of the hospital.

Staff told us they felt respected, supported and valued. They felt the service promoted equality and diversity in its day to day work and in providing opportunities for career progression and we saw this in the development of a ward manager and their deputy.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process. Managers dealt with poor staff performance when needed.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

The service's staff sickness and absence rates were in line with the provider's target.

Governance

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

Overall, governance systems were effective. There were procedures to ensure wards were safe and clean, there were enough staff on each shift who were trained and supervised, patients were assessed appropriately, physical health was monitored, discharges were planned, information was provided in accessible ways, and incidents were reported, investigated and learnt from. This was an improvement since our last inspection.

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what was discussed at ward, team or directorate level to ensure that essential information, such as safeguarding information, and learning from incidents and complaints, was shared and

discussed. There was evidence in the team and governance meeting minutes that there was a clear pathway to ensure staff disseminated information from ward to directorate level and from directorate to ward level.

We reviewed a selection of governance meeting minutes and saw staff followed a standard agenda.

Team meeting minutes were more detailed which enabled team members who were unable to attend to access the information.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

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

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.

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level.

Ward managers had access to the hospital risk register at directorate level but could not make changes or add risks. Senior managers added and updated risks at governance meetings and ensured there was oversight of the risks.

Staff at ward level could escalate concerns when required and each ward had a 'top 5 risks/concerns and actions taken by the staff and patient community to address plan' which staff and patients reviewed at the weekly community meetings. Staff concerns matched those on the risk register.

We reviewed the site risk register and saw that staff had graded risks and rated them red, amber or green. Each risk was dated, had ownership and mitigating actions to reduce risk. There was evidence of updating of risk as changes occurred.

Where cost improvements were taking place, they did not compromise patient care.

The service had plans for emergencies, for example, adverse weather and specifically for dealing with patients who were admitted during the COVID-19 pandemic and there was guidance available for staff.

Where cost improvements were taking place, they did not compromise patient care.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. The information systems were integrated and secure. Staff commented that the electronic patient record system had been updated since our last inspection and that the system was quicker and easier to use.

Information governance systems included confidentiality of patient records.

Ward managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. All managers we spoke with used the organisation's electronic monitoring system to benchmark themselves against other wards and wider services within the organisation. Managers monitored mandatory training and alerted staff when they needed to update their training.

The provider did not have one governance dashboard for managers to have an overview of performance, but managers could easily access the information through different systems or via an administrator.

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. Managers had access to timely and accurate information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

Long stay or rehabilitation mental health wards for working age adults

Good

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used, for example, through the intranet, bulletins and newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. We reviewed some of the feedback provided. Most patients we spoke with said they were grateful for the care staff provided. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service. Managers received minutes of ward community meetings and used the information to make improvements. For example, sending out a new menu sample out for patient trial and making changes after feedback. Patients and staff met with members of the provider's senior leadership team and governors to give feedback.

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Learning, continuous improvement and innovation

Staff had opportunities to participate in research and participated in audits relevant to the service and learned from them.

There was good information sharing and discussion on the wards. Staff used quality improvement methods and knew how to apply them, for example staff reviewed feedback and complaints and made changes to improve patients' experiences.

The organisation had its own internal forums for sharing practice with other rehabilitation and recovery services on other sites through the 'Rehabilitation and Recovery services Network'. There were plans in place for the service to be accredited by the Royal College of Psychiatrists for the 'Accreditation for Inpatient Mental Health Services' (AIMS) but we were not provided with any timeline for this. AIMS is a professionally recognised scheme with a set of standards for rigorous and supportive quality assurance and accreditation process for mental health services.

Staff were committed to improving services and had a good understanding of quality improvement methods.

Outstanding practice and areas for improvement

Outstanding practice

The provider had introduced a 'seclusion noticeboard' outside each seclusion room giving patients clear information about their rights and how staff would keep them safe during their seclusion. They reviewed seclusions with patients in order to improve their experience and made adjustments to the noticeboard in response to patient feedback.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that infection prevention and control measures are in place when admitting new patients to the wards [Regulation 12 (2) (a) (b)].
- The provider must ensure that all emergency equipment is properly stored, and easily accessible and that all staff know where to locate it [Regulation 12 (2) (e) and Regulation 15 (1) (a) (e) (f) (2)].
- The provider must ensure that care plans for patients in seclusion fully document all the patients' needs and that there are clear plans for patients exiting seclusion in line with the Mental Health Act Code of Practice [Regulation 17 (2) (c)].

Action the provider SHOULD take to improve

- The provider should ensure that ligature risk points are removed or mitigated against in a timely manner [Regulation 12 (2) (a) (b)].
- The provider should ensure infection prevention and control audits are completed in line with guidance [Regulation 12 (2) (e)].
- The provider should ensure best practice in relation to the safe storage and administration of medication, in line with guidance [Regulation 12 (2) (g)].
- The provider should ensure that when patients are prescribed clozapine, this is listed as an alert on the front page of the patient's record for easy identification by staff [Regulation 17 (2) (c)].
- The provider should ensure that there are sufficient activities for patients in the evenings and at weekends [Regulation 9 (1) (a) (b) (c) (3) (b)].
- The provider should ensure carers receive information about the service, including how to complain, and regular updates about patient care where appropriate [Regulation 9 (3) (g)].

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

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

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 17 HSCA (RA) Regulations 2014 Good governance