Nouvita Limited

Baldock Manor

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- Staff on Radley ward undertook long periods of enhanced observations without breaks. This does not adhere to guidelines by the National Institute for Health and Care Excellence. Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety and therapeutic engagement.
- Radley ward had some blanket restrictions in place, including access to fresh air and water without staff assistance.
- Staff on Radley ward described using incorrect restraint techniques.
- Patients on Radley ward reported staff not being interested or helpful, particularly agency staff. We observed staff arguing in front of patients and discussing patients in front of them.
- Patients told us the food was not of a good standard.
- Staff did not provide patients with a copy of their care plan.

However:

- Staffing levels had significantly improved since the last inspection and managers used bank staff wherever possible to fill vacant shifts.
- Staff developed holistic, recovery-oriented 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 these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Baldock Manor

Baldock Manor is an independent hospital provided by Nouvita Limited to deliver acute wards for people over the age of 55 and a psychiatric intensive care unit.

Baldock Manor is registered to provide the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983.

• Treatment of disease, disorder or injury.

The service had a registered manager in post since July 2022.

The service has 4 wards:

- Radley ward is an 8 bed psychiatric intensive care unit for women detained under the Mental Health Act.
- Oakley ward is a 10 bed acute ward for women over the age of 55
- Mulberry ward is a 6 bed acute ward for women over the age of 55
- Burberry ward is a 14 bed acute ward for men over the age of 55

The service was last inspected in November 2019 and was issued requirement notices under regulations 9, 12, 13, 17; warning notices under regulations 9, 12, 13, 15, 17 and 18; and an urgent notice of decision was imposed under regulation 18.

At this inspection we found that the provider had met the requirements issued following the previous inspection.

What people who use the service say

We spoke with 12 patients who had mixed views of the service. Patients on Oakley and Burberry wards were happy with their treatment and spoke positively about staff.

Patients on Radley ward told us that permanent staff were helpful but that agency staff did not take an interest or engage well with them. Patients did not feel there were enough staff due to the number of observations required.

How we carried out this inspection

The team that inspected the service comprised of 2 Care Quality Commission inspectors, a specialist advisor and an expert by experience.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- Visited 3 wards, looked at the quality of the ward environment and observed how staff were caring for patients
- Spoke with 12 patients who were using the service

Summary of this inspection

- Spoke with 1 carer of a patient
- Spoke with the registered manager and 2 ward managers
- Spoke with 18 staff members including a consultant psychiatrist, nurses, healthcare support workers, an occupational therapist, psychologist, mental health act administrator and safeguarding and compliance lead
- Carried out a specific check of the clinic rooms, medication management and emergency equipment on 3 wards
- Reviewed 29 medicine charts
- Reviewed 11 care records
- Looked at a range of policies, procedures and other documents relating to the running of the service including incident data, complaints, safeguarding referrals and ligature audits

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that all staff are aware of correct restraint techniques, including the use of pods and cushions. (Regulation 12(1)).
- The service must ensure that staff follow National Institute for Health and Care Excellence guidelines when undertaking enhanced patient observations. (Regulation 12(1)).
- The service must ensure that staff treat patients with dignity and respect and behave professionally. (Regulation 10(1)).

Action the service SHOULD take to improve:

- The service should ensure there are no blanket restrictions in place on Radley ward to prevent patients accessing cold water without staff assistance, or accessing the garden area at set times.
- The service should ensure that patients are given a copy of their care plan.
- The service should ensure that they gender mix of staff is appropriate for female wards.
- The service should ensure that they consider how therapeutic observations are managed in a small area to balance safety and avoid patients feeling uncomfortable.
- The service should ensure that good quality of food is available.
- The service should ensure that ward facilities allow for all patients to be seated in the lounge and dining areas.
- The service should ensure that continued checks of access to emergency grab bags and defibrillators take place.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Requires Improvement	Good	Good	Requires Improvement
Overall	Requires Improvement	Good	Requires Improvement	Good	Good	Requires Improvement

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

Requires Improvement

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

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas, and removed or reduced any risks they identified.

Staff could not observe patients in all parts of the wards but the risk had been mitigated through the use of mirrors and patient observations.

The ward complied with guidance and there was no mixed sex accommodation. Radley, Oakley and Mulberry wards were female only and Burberry ward was male only accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The wards had ligature heat maps in the staff office for permanent and agency staff to easily identify where potential ligature points were.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff carried alarms to call for assistance if required and each ward had a designated staff member to respond to alarms on each shift.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. The service employed housekeeping staff to complete daily cleaning of the service. Staff completed regular audits of cleanliness and action was taken when required.

Staff followed the providers infection control policy, including handwashing.

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

Requires Improvement

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet, shower, a clock and blinds.

Clinic room and equipment

Clinic rooms were fully equipped, however the emergency drugs were stored in grab bags that staff on Radley and Oakley wards could not open due to the seals requiring scissors to open them.

Resuscitation equipment on Radley and Oakley wards was not accessible in a timely manner as the battery was not charged on the Radley ward defibrillator and on Oakley ward a training defibrillator was stored in the cupboard.

We raised these issues with the provider at the time of the inspection and action was taken immediately to remove the emergency bag seals and order new breakable seals, defibrillators were checked and the service held an emergency drill to ensure staff could respond quickly and efficiently.

Staff checked, maintained, and cleaned equipment and completed weekly checks of clinic rooms and equipment.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe.While the service had a 13% vacancy rate for nurses and 6% vacancy rate for healthcare support workers this was a significant improvement from the last inspection in 2019 when vacancy rates were 75% for nurses.

The service used regular bank staff wherever possible to cover vacant shifts to ensure continuity of staff for patients, with an average of 41% of shifts covered by bank staff in the 6 months prior to inspection. However, 21% of shifts were covered by regular agency staff in the last 6 months.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank staff were registered to each ward so worked with the same patients to provide continuity. Agency staff received an induction on the ward and could access in house training sessions.

The service had reducing turnover rates with the percentage reducing from 5% to 3% in the last year.

Managers supported staff who needed time off for ill health.

Levels of sickness were low with 1.8% sickness levels in the last 6 months.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare support workers for each shift. The ward managers met each afternoon to review the staffing levels for the following day and could book additional staff if required. Radley ward booked an additional healthcare support worker above their levels to cover breaks for staff on observations, facilitate leave and respond to incidents.

The ward managers could adjust staffing levels according to the needs of the patients and could book additional staff to cover enhanced observations.

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

Requires Improvement

Staff on Radley ward undertook long periods of enhanced observations without breaks and we saw it was a regular occurrence for staff to undertake 6 to 8 hour periods of enhanced observations. On occasion staff would undertake 12 hours of continual enhanced observations with only a 40-minute break during the day.

This does not adhere to guidelines by the National Institute for Health and Care Excellence. Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety.

Ward managers told us they took into account the gender mix of staff undertaking observations with at least 60% of staff on shift being the same gender as the patient group. However, on the day of inspection there were more male staff than female staff on Radley ward. We reviewed staffing rotas and saw that staffing regularly did not meet the correct gender mix. We also saw occasions where 2 male staff were conducting 2 to 1 observations on a female patient.

Patients had regular 1 to 1 sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely. Each ward had a staff member allocated to respond to incidents and support with physical interventions if required.

Staff shared key information to keep patients safe when handing over their care to others. Staff held handover meetings before each shift to share patient information and risks.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The service employed 2 consultant psychiatrists and an associate specialist doctor to cover the 4 wards with a rota for out of hours cover.

Managers could call locums when they needed additional medical cover.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training with a mandatory training compliance rate of 96%. The lowest compliance rates were for prevention and management of violence and aggression at 87% and basic life support at 89%.

The mandatory training programme was comprehensive and met the needs of patients and staff. The training programme consisted of 20 e-learning modules including autism awareness, infection prevention and control and safeguarding, and 6 face to face sessions including immediate life support and prevention and management of violence and aggression.

Managers monitored mandatory training and alerted staff when they needed to update their training by sending a weekly email of any outstanding training.

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

Requires Improvement

Assessing and managing risk to patients and staff

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

Assessment of patient risk

Staff completed risk assessments for each patient on admission, and reviewed this regularly, including after any incident. We reviewed 11 patient records and saw that staff completed thorough assessments of risk and updated these regularly including after incidents.

Staff used a recognised risk assessment tool, the Short-Term Assessment of Risk and Treatability tool.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. All staff had access to patient records including risk assessments on a handheld electronic device, and risks were discussed in the handover meeting prior to each shift.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff updated risk assessments and amended observation levels daily or following any incident.

Staff followed procedures to minimise risks where they could not easily observe patients by the use of observations.

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

Use of restrictive interventions

The provider had a reducing restrictive practice policy and held monthly meetings to discuss ideas of least restrictive practice. We saw examples of how these had helped to reduce restrictive practice such as removing a blanket rule of only 1 patient from Radley ward accessing the garden at a time and removing a blanket restriction limiting takeaway orders. However, there were still some overly restrictive practices in place including limiting access to toilet paper for patients with a risk of ingesting items, so patients needed to approach staff to request toilet paper or flannels to use when wanting to use the toilet.

Radley ward was on the first floor and staff had to escort patients down stairs to the garden area, so the service had set garden access times for patients to have access to fresh air. Patients could not make their own hot or cold drinks and snacks on Radley ward and were dependent on staff.

Patient observations at times seemed overcrowded, we observed a patient pamper session on Radley ward with 3 patients taking part and 8 staff members observing them at arm's length as part of their enhanced observations. Patients told us and staff they felt overcrowded and left the session as a result.

The service reported 819 incidents of restraint in the last year although the majority of these were wrist holds to redirect patients, with 493 of these restraints resulting in rapid tranquilisation. None of the restraints were prone restraints where patients were restrained face down on the floor.

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

Requires Improvement

Whilst 87% of staff were up to date with prevention and management of violence and aggression training, staff we spoke with on Radley ward described using incorrect restraint techniques and the use of beanbags when de-escalating patients using pods. Safety pods are large bags that help staff restrain patients safely. Some staff also reported concerns that staff moved to restraint too early in the de-escalation process.

Managers reviewed closed circuit television recordings following incidents involving restraint and there had been minimal occurrences of incorrect uses of restraint.

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

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Levels of seclusion were low with 1 episode of seclusion in the last 3 years and this was terminated as soon as possible.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role with 92% of staff having completed safeguarding adults training and 100% of staff having completed safeguarding children training. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff followed clear procedures to keep children visiting the ward safe. The service had family visiting rooms so that children did not enter the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding lead and staff we spoke with were aware of who the lead was and how to contact them if they had any concerns. The service had made 13 safeguarding referrals in the 3 months prior to inspection.

Managers took part in serious case reviews and made changes based on the outcomes. The safeguarding lead met regularly with the local authority safeguarding lead to review referrals and outcomes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality electronic clinical records.

Patient notes were comprehensive and all staff could access them easily. The service used an electronic records system and staff had a handheld electronic device that they used to update patient records including observation notes in real time. Bank and agency staff could also log in to the system.

Records were stored securely.

Medicines management

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

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

Requires Improvement

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 29 medicines records and observed medicine administration on Radley ward, and found that staff prescribed and administered all medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff held a weekly review with all patients to review their medicines and patients told us that they were involved in discussions about their medicines.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 29 medicines records which were all accurate and staff audited medicines administration records, disposal of medicines and medicines transfer records.

Staff stored and managed all medicines and prescribing documents safely. The fridge lock on Oakley ward was broken so any staff could access medicines in the fridge, this had been reported as needing to be replaced in April 2023 but this had still not been fixed. This was raised as an urgent request during the inspection. All other medicines and prescriptions were stored safely.

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

Staff learned from safety alerts and incidents to improve practice. Staff signed to say they had read safety alerts.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed 29 medicines records and found that patients' medicines were all prescribed within guidelines.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Staff completed regular physical health checks and could complete electrocardiogram tests and blood tests to monitor effects of medicines on patients.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. The service used an electronic incident reporting system that all staff knew how to use.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported 504 incidents in the 3 months prior to inspection with the majority of these occurring on Radley ward. Most incidents were attempted or actual self harm, physical and verbal aggression.

Managers reviewed all incidents from the previous day in the morning meeting and completed an incident analysis dashboard each month to review any trends and themes.

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

Requires Improvement

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw examples of where the service had written to patients to explain when something went wrong and actions taken to prevent reoccurrence.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers reviewed the previous days incidents at the morning meeting and set action plans for any action required. Incident investigation reports were shared with the Care Quality Commission on a weekly basis following the previous inspection.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed in the morning meeting and managers fed back to staff following this.

There was evidence that changes had been made as a result of feedback. Examples of these included staff awareness of patient access to jewellery after a patient swallowed an earring, and a staff reminder about radio management after a radio went missing.

Is the service effective?

Good

Our rating of effective improved. We rated it as 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 were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 11 care records and saw that staff had completed a comprehensive assessment with each patient shortly after admission.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The 11 care records we reviewed all had a physical health assessment completed on admission and reviewed regularly.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed 11 care records and found that they all had a personalised, comprehensive care plan that included physical and mental health needs. These included individual needs such as nutrition, dental and falls prevention plans.

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

Requires Improvement

Staff regularly reviewed and updated care plans when patients' needs changed. Staff reviewed care plans at the weekly ward round and updated them as necessary.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported 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 provided a range of care and treatment suitable for the patients in the service. Therapies provided included mindfulness, psychoeducation and cognitive behavioural therapy.

Staff delivered care in line with best practice and national guidance. Staff on Radley ward provided a trauma informed approach with patients.

Staff identified patients' physical health needs and recorded them in their care plans. We reviewed 11 care records and saw that staff had recorded patient physical health needs including nutritional needs, diabetes care and dental care.

Staff made sure patients had access to physical health care, including specialists as required. The service employed a practice nurse to provide physical health care and train staff in managing physical healthcare including wound care. The service registered patients with the local GP surgery and could access visiting dental, podiatry, speech and language therapists and optician services.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Staff monitored patients' food and fluid intake and where there were concerns about nutritional needs these were care planned including providing supplements and regular blood tests.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The practice nurse delivered sessions on smoking cessation and wellbeing groups for patients.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used Health of the Nation Outcome Scores to assess patient outcomes.

Staff used technology to support patients. Staff provided mobility aids and profiling beds for patients with reduced mobility.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service had a monthly audit schedule that included clinic room and medicines, care records, infection prevention and control, and environmental and security audits. Managers completed a monthly walkaround to audit the service and set an action plan for any improvements.

Managers used results from audits to make improvements. Managers audited care records and saw that staff were not recording therapeutic conversations during observations so this was raised with staff and monitored.

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

Requires Improvement

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 the 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.

The service had access to a full range of specialists to meet the needs of the patients on the ward. The service employed consultant psychiatrists, an associate specialist doctor, psychology and occupational therapy staff as well as nurses and healthcare support workers. Patients could also access physical health staff including a podiatrist, speech and language therapist, optician and a dentist.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Agency staff could attend any in house training as well as completing their mandatory training with their agency.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work with 88% of staff having an up-to-date annual appraisal.

Managers supported staff through regular, constructive clinical supervision of their work and 86% of staff were up to date with clinical supervision. Staff also attended regular reflective practice sessions.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Managers held monthly team meetings following clinical governance meetings so that information could be cascaded to staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Healthcare support workers had been given training in observations and physical health.

Managers made sure staff received any specialist training for their role. Staff received specialist training in personality disorders and substance misuse in the past year.

We saw examples where managers had professional discussions with staff about behaviour including sleeping on shift.

Multi-disciplinary and interagency teamwork

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 regular multidisciplinary meetings to discuss patients and improve their care. Weekly ward rounds were attended by the consultant, named nurse, patient and families were invited if the patient agreed.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. All staff attended a handover meeting before each shift to share up to date information about risk and incidents.

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

Requires Improvement

Ward teams had effective working relationships with external teams and organisations. Staff worked closely with the local safeguarding lead and had good relationships with the local GP surgery and other health providers.

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

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 and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles with 98% of staff up to date with their training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The service employed a Mental Health Act administrator to audit Mental Health Act paperwork and advise on the Code of Practice. The Mental Health Act administrator had trained nurses in scrutinising patients' section papers when admitted to the wards.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The service contracted an independent advocate who visited the service weekly.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. The Mental Health Act administrator kept a spreadsheet of when patients were due to have their rights read and updated staff weekly.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. The Mental Health Act administrator completed checks to ensure section 17 leave processes were followed correctly including the use of risk assessments prior to leave and patient feedback following leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We reviewed 29 medicine records and found they all had T2 or T3 paperwork included.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Oakley and Burberry wards had some informal patients and posters reminding them they could leave the ward at any time.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act administrator completed a monthly audit of 5 patients' paperwork and fed back the findings to staff.

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

Requires Improvement

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the providers policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act with 100% of staff up to date with their training. Staff we spoke with had a good understanding of the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards and could contact the Mental Health Act administrator or consultant for advice.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We reviewed 11 care records and saw that staff had completed capacity assessments where required.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw examples of best interest decisions recorded in patient records.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were not always discreet, respectful, and responsive when caring for patients. We observed several staff on Radley ward completing observations with long periods of not interacting with the patients being observed. We observed staff arguing between each other in front of patients and on occasion speaking about patients in front of them.

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

Requires Improvement

Patients on Radley ward with a risk of ingesting items did not have access to toilet paper and had to ask staff to provide toilet paper or flannels to clean themselves when using the toilet. This did not protect patients' dignity and respect.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us that they understood their treatment and were involved in discussions during ward round.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said most staff treated them well and behaved kindly. We spoke with 12 patients who told us mixed reports of staff treatment. Patient on Oakley and Burberry ward told us that staff were kind and helpful, patients on Radley generally felt that permanent staff treated them well but that agency staff did not care about their welfare or take any interest in them.

Staff understood and respected the individual needs of each patient. Patients mainly felt that permanent staff understood and respected their needs but that agency staff on Radley ward did not.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. The service had a freedom to speak up guardian in post for staff to raise any concerns with if they needed to.

Staff followed policy to keep patient information confidential.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff gave patients a tour of the ward on admission and introduced their named keyworker. Staff also gave patients a welcome pack and a Mental Health Act information pack for their stay.

Staff involved patients but did not give them access to their care planning and risk assessments. We reviewed 11 care records and saw that they all included patient voice and views, however there was no indication that care plans were shared with patients. We spoke with 12 patients and none of them had a copy of their care plan.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). We saw evidence in 11 care records that staff explained patients care and treatment.

Staff involved patients in decisions about the service, when appropriate. The service held monthly service user forums where patients could feedback and be involved in decisions about the service. Patients also attended clinical governance meetings.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff held weekly community meetings had set agendas for patients to give feedback about food, health and safety, leave and activities.

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

Requires Improvement

Staff made sure patients could access advocacy services. The service had an independent advocate who visited weekly, and this was advertised on the wards. The advocate chaired the patient forum to encourage feedback from patients.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff invited families and carers to attend ward rounds with the patients consent, and could offer virtual attendance by video conference to anyone unable to attend in person.

Staff helped families to give feedback on the service. The service held monthly carers forum meetings for carers to give feedback and learn more about the service.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff managed beds well. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay for Radley ward was 43 days, 61 days for Oakley ward and 71 days for Burberry.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Radley ward had the highest number of delayed discharges but staff worked proactively with commissioners to move patients as quickly as possible.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff started discharge plans from patients admission.

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

Requires Improvement

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Patients could make cold drinks and snacks at any time on Oakley and Burberry wards.

Each patient had their own bedroom, which they could personalise. Bedrooms were en-suite with a shower and the wards had disabled access bathrooms with accessible baths.

Patients had a secure place to store personal possessions. Patient bedrooms were lockable to enable safe storage of possessions.

The dining areas and lounge areas on both Radley and Oakley ward did not have sufficient chairs for all patients to be seated at the same time.

The service had quiet areas and a room where patients could meet with visitors in private. The wards all had separate lounges for patients to use and the multi faith and family rooms were used for visits.

Patients could make phone calls in private. Patients had access to their mobile phones subject to individual risk assessment and could use the ward phone if required.

The service had an outside space that patients could access easily. Burberry ward had a garden that was open for patients to access whenever they wanted. Oakley ward and Radley ward had courtyard areas that did not have sufficient seating for patients to all use at the same time. Radley ward outside area was only available for patients with staff escort as it was downstairs from the first floor ward. The service had a garden area within the grounds that patients could use to sit outside.

Patients on Oakley and Burberry wards had access to cold drinks and snacks, and could make hot drinks dependent on individual risk assessment.

The service did not offer a variety of good quality food. We spoke with 12 patients and none of the patients spoke highly of the food overall although 2 patients told us they liked the puddings. Patient complaints about food were highlighted in the community meeting minutes.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, and family relationships.

Staff made sure patients had regular access to activities outside the hospital including visiting a local farm, and private hire of a cinema screen for patients to attend. Staff also took patients on escorted visits to the local town for shopping and café visits.

Staff helped patients to stay in contact with families and carers. Staff included social contact with families and carers in care plans.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

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

Requires Improvement

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The wards were accessible to patients with reduced mobility and had a lift to access the first floor and ramp out to garden areas. Each ward had an accessible bathroom and could provide profiling beds where required.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Staff displayed information about treatment and service on the wards, including how to complain and this was also in patient welcome booklets provided on admission.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients and could offer vegetarian, halal, and a variety of cuisines including Caribbean. However, whilst patients told us they appreciated the variety of food available they told us the quality was not good.

Patients had access to spiritual, religious and cultural support. Whilst the service did not have visiting spiritual leaders, patients could use the multi-faith room for private worship and religious texts were available.

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, relatives and carers knew how to complain or raise concerns. We spoke with 12 patients who knew how to make a complaint.

The service clearly displayed information about how to raise a concern in patient areas and this was also included in patient admission booklets.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw examples of feedback letters including duty of candour where complaints were upheld.

Managers investigated complaints and identified themes. The service received 20 formal complaints in the last year, these mainly related to complaints about staff or treatment in the service.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. The service received 121 compliments in the year prior to inspection.

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

Requires Improvement

Is the service well-led?

Good

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

Leadership

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

Local leaders at ward had good knowledge and understanding of the service they managed and were visible on the ward for staff and patients. Staff told us that managers at all levels were supportive and approachable.

Vision and strategy

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

The provider values were kindness, openness, competence, honesty and professionalism. Staff were aware of the values and how they applied to their day-to-day work.

Culture

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

Overall, staff told us they felt supported and valued however there had been a culture of cliques between staff on Radley ward which had caused low morale and job satisfaction. Managers had taken steps to address this.

Healthcare support workers told us that they had been told the service would fund their National Vocational Qualification but this had not happened. However, staff gaining their nursing qualification were offered preceptorship.

Staff felt they could raise any concerns with managers and felt supported by them.

Governance

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

Governance processes had significantly improved since the last inspection. The service had introduced a dashboard that managers used to keep oversight of training, supervision and staffing levels.

Managers met daily to review the 24-hour site report that included incidents and patient risk, and set action plans for any issues requiring follow up. The service completed monthly dashboards that provided an overview of incidents, restraints and seclusions. This enabled managers to review trends and themes and identify any areas for improvement.

Managers shared weekly reports of incidents and safeguarding referrals with the Care Quality Commission.

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

Requires Improvement

Managers completed regular audits and shared action plans and learning from these with staff.

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.

Staff had access to the information needed through the use of handheld electronic devices which they could read and update patient records.

The service had a site wide risk register that was reviewed and updated regularly.

The service had joined the restraint reduction network in 2021 and introduced reducing restrictive practice policy with monthly meetings held. However, the service did not always follow least restrictive practice with some patients facing restrictions on items in possession despite the risk being mitigated by high levels of staff observation. The service did not always balance patient safety with positive risk taking.

Information management

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

The service used a dashboard system to collect data from the ward, and this was not burdensome on staff. Managers collated key performance indicators to monitor the ward that included incidents, safeguarding and restraint.

Engagement

Managers engaged actively other local health and social care providers.

Staff worked closely with commissioners and integrated care boards to ensure patients were moved appropriately when needed and to reduce the number and length of any delayed discharges.

Patients' care co-ordinators were invited to attend review meetings.

Learning, continuous improvement and innovation

The service had a service improvement plan in place that was reviewed and updated regularly.

Radley ward was in the process of accreditation with the Quality Network for psychiatric intensive care units.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • Staff did not always treat patients with dignity and respect on Radley ward, or behave professionally.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did ensure that staff followed National Institute for Health and Care Excellence guidelines when undertaking enhanced patient observations. • Staff were not all aware of correct restraint techniques, including the use of pods and cushions.