Cygnet Hospital Maidstone

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	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.

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

Summary of findings

Overall summary

We rated Cygnet Hospital Maidstone as good because:

- The ward environments were safe and clean. The wards had enough nurses and doctors. They managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed 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.
- On most wards, 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.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led by senior managers and the governance processes ensured that most ward procedures ran smoothly.

However:

- On Bearstead ward, which is a psychiatric intensive care unit, the staff did not always assess and manage risks to patients well. The lack of clear communication between the team, for example during handovers, meant that staff were not clear on the current risks for patients and how these should be mitigated. This meant that incidents were continuing to take place which could have been potentially prevented.
- There were some inappropriate blanket restictions across all three wards including access to some areas of the ward and access to fresh air and outside space. Patients on Bearstead ward did not have access to drinking cups for water. However, the ward staff participated in the provider's restrictive interventions reduction programme and were working to reduce restrictions.
- The staff team on Bearstead needed more support to develop the skills and experience to support the patients who had complex needs. This included the need to improve the therapeutic engagement with patientst.
- The local management of Bearsted ward did not fully support staff to manage patient safety risks. However, the hospital director was aware of the need to provide additional support to this ward and team.

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

Summary of findings

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Good

Cygnet Hospital Maidstone

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards; Long stay or rehabilitation mental health wards for working-age adults;

Summary of this inspection

Background to Cygnet Hospital Maidstone

Cygnet Hospital Maidstone is brand new, purpose built, 65 bed mental health facility for adults. The hospital has four wards:

- Roseacre ward is a 16 bed specialised personality disorder ward for women
- Kingswood ward is a 16 bed high dependency rehabilitation ward for men
- Bearstead ward is a 17 bed (only 15 beds ever used) psychiatric intensive care service for men
- Saltwood ward is a 16 bed forensic low secure ward for men.

Cygnet Hospital Maidstone was registered with the Care Quality Commission (CQC) on the 5 October 2018 to provide assessment or medial treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury. At the time of our inspection, the service had a registered manager and nominated individual, as per CQC's requirements.

This was the first inspection at Cygnet Hospital Maidstone. All wards were inspected under the following core services, each core service was rated and the hospital was given an overall rating:

- Acute wards for adults of working age and PICU services – Bearstead and Roseacre ward
- Long stay/rehabilitation wards for working age adults – Kingswood ward
- Forensic/inpatient secure wards – Saltwood ward

Our inspection team

The team that inspected the service comprised one CQC inspection manager, three CQC inspectors; two CQC pharmacy inspectors and three nurse specialists.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and sought feedback from patients throughout the inspection.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 13 patients on all four wards who were using the service;
- spoke with the registered manager and managers or acting managers for each of the wards;
- spoke with 32 other staff members across the service; including doctors, nurses, occupational therapist, psychologist and social worker;
- reviewed eight staffs supervison files;
- reviewed two complaints and one serious incident;

Summary of this inspection

- attended and observed two hand-over meetings and two multi-disciplinary meetings;
- looked at 20 care and treatment records of patients on all four wards:
- carried out a specific check of the medicine management on all four wards and reviewed 16 precription charts and associated care records; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Bearstead ward:

On Bearstead ward, we spoke with four patients. Feedback was mixed. Some patients described a positive experience of their care and treatment received since their admission to the ward. They spoke well of the staff and the support they received. Other patients described the ward as being chaotic at times which impacted staffs ability to help them. All patients we spoke with told us they were kept up-to-date with changes to their medicines, treatment and discharge plans. However, each spoke of their frustration that access to the ward garden area was kept routinely locked and could only be accessed with staff attendance. They told us this meant when the ward was unsettled they could not access the outside space.

Roseacre ward:

On Roseacre ward, we spoke with two patients. They spoke highly of the staff and the quality of care they received. They said staff were caring and supportive, respectful of their wishes and needs and encouraged them to make decisions as individuals in the therapies and treatments offered to them. Patients told us they felt listened to and involved in the running of the ward. They felt staff enabled them to achieve their goals.

Kingswood ward:

On Kingswood ward, we spoke with three patients. All told us that they felt safe and comfortable on the ward. They felt that their time was well occupied and that there were a good range of activities available. Patients told us that the food served at the hospital was very good and that they had good access to hot/cold drinks and snacks throughout the day.

Saltwood ward:

On Saltwood ward, we spoke with four patients. One patient had been admitted recently to the ward and the others had been patients before the ward moved to the new hospital in December 2018. They told us that the ward was welcoming and staff were approachable and friendly. They said that staff treated them with dignity and respect and that they had formed good relationships.

Patients told us that they could raise any issues about their care and treatment with any of the nurses or doctors. They said they met regularly to review their care and had been offered a copy of their care plan.

The patients we spoke with were positive about the quality and choices of food provided by the hospital. They were less positive about the restrictions on when they could go outside into the ward garden for fresh air. When we spoke to them this was limited to five times per day. Patients also felt that there were insufficient activities for them particularly on Mondays and Fridays and at weekends.

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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:

- On Bearstead ward, which is a psychiatric intensive care unit, the staff did not always assess and manage risks to patients well. The lack of clear communication between the team, for example during handovers, meant that staff were not clear on the current risks for patients and how these should be mitigated. This meant that incidents were continuing to take place which could have been potentially prevented.
- On Kingswood ward. risk assessments and monitoring for identified physical health concerns were not always updated or recorded.
- At the time of the inspection the seclusion suite on Bearstead ward was not safe for use due to significant damage caused previously by a patient the seclusion and did not meet the required standards. However the hospital were arranging for the repairs and alterations to take place and an alternative seclusion room was available.
- On Saltwood ward, patients were not appropriately risk assessed for safe self-administration of their medicines as per their policy. Waste containers were not available to dispose of medicines safely and some staff were not aware of how to report controlled drug incidents.
- There were some inappropriate blanket restrictions across all four wards including access to some areas of the ward and access to fresh air and outside space. However, the ward staff participated in the provider's restrictive interventions reduction programme and were working to reduce restrictions.

However:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff across most wards followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had

Summary of this inspection

training on how to recognise and report abuse and they knew how to apply it. However, only the hospital manager and social worker completed safeguarding alerts rather than ward staff which could potentially cause delays.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The wards had a good track record on safety. 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.
- 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.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- 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 an induction programme for new staff. However, most staff on Bearstead ward had limited or no experience of working with patients in need of psychiatric intensive care and this impacted at times on their management of acutely unwell patients.
- Staff from different disciplines worked together as a team to benefit patients. The ward teams had effective working

Summary of this inspection

relationships with other relevant teams within the organisation and with relevant services outside the organisation. However, the shift-to-shift handover on Bearstead ward was lacking information and structure and was chaotic.

- 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:

- Some care plans were basic and were not always recovery-oriented, or drew on the patients strengths.
- Many of the staff on Bearstead ward lacked the skills or experience to work in a psychiatric intensive care environment which meant they were finding it hard to support the patients.
- On Kingswood ward, a few patients receiving high dose antipsychotic treatment (HDAT) did not have a record to confirm their physical health had been monitored.
- On Kingswood ward, some patients did not have access to primary health services within the local area, such as dentists. The provider was aware of this and making arrangements to meet their needs.

Are services caring?

Good

We rated caring as good because:

- On most wards, 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. However, there was a tense atmosphere on Bearstead ward and we observed a lack of therapeutic engagement between staff and patients. Feedback from patients on Bearstead ward was mixed.
- 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 and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

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- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service 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.
- The food was of a good quality and patients could make hot drinks and snacks at any time. However on Bearstead ward, patients did not have readily available access to cups and these had to be requested from staff.
- 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.
- 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.

However:

- On Saltwood ward, there were gaps in the patients weekly activity planner. Patients and staff said they wanted a better range of activities.

Are services well-led?

Good

We rated well-led as good because:

- Most 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 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 quality improvement activities.

However:

Summary of this inspection

- The local management of Bearsted ward did not fully support staff to manage patient safety risks and was not effective in supporting staff to manage the acuity and fast paced nature of a PICU environment. The hospital manager was aware of this and was providing additional support to enable improvements to take place.

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.

All staff completed mandatory training in the Mental Health Act.

Mental Health Act documentation for detained patients was in place and completed correctly.

Information was displayed on the ward noticeboards regarding the independent mental health advocate and how to contact them.

We reviewed patients records of leave from the ward into the community, granted by the consultant psychiatrist. The parameters of leave were clearly documented. For example, the location of leave, time and duration and the numbers of staff required to support the patient.

Staff supported patients to understand their rights, when detained under the Mental Health Act or as an informal patient.

Patients medicine charts had a photograph attached of the patient together with treatment certificates, which had been authorised by the consultant psychiatrist. Treatment certificates documented the medicines and doses prescribed for the patient.

Staff at the service were fully supported by a Mental Health Act administration team. They provided support and advice when needed and oversaw the renewals of detention under the MHA, consent to treatment and appeals against detention. The MHA team completed regular audits to ensure records and practice was in line with current legislation.

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a provider policy on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were aware of the policy and how to access it.

The MCA enables people to make their own decisions wherever possible and provides guidance and for decision making where people are unable to make decisions themselves. Staff we spoke with demonstrated a good understanding of the MCA. We observed staff seeking informed consent from patients.

No patients were subject to Deprivation of Liberty Safeguards (DoLS) at the time of our inspection.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Long stay or rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

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

Good

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement

Safe and clean environment

- Both Bearstead ward (male PICU) and Roseacre ward (female personality disorder service) were clean and bright with a large communal lounge area, a dining area and serving kitchen. There was a separate room for patients to make phone calls in private, rooms offering quiet space and a computer room. Throughout the wards, the furnishings and fittings were in very good condition. On Roseacre ward, staff had painted rose murals in some of the ward areas to brighten the ward and personalise the environment for the patients.
- Rosecare ward did not have a seclusion suite but did have a de-escalation room.
- There was a seclusion suite and de-escalation room on Bearstead ward. However, at the time of our inspection, the seclusion suite was not fit for purpose and did not meet the required standards.
- The seclusion suite and de-escalation suite on Bearstead ward was poorly designed. For example, there was an imposing supporting pillar in the de-escalation suite. This was directly in the area where patients were seated and posed a potential risk to staff and patient safety should restraint be required. Similarly, there was no clear line of sight in the seclusion suite bathroom.
- The seclusion suite had been designed to allow patients direct access to a secure outside space. However, prior to the inspection, there had been a serious incident which resulted in significant damage. The door to the garden area was permanently blocked off due to damage caused and to prevent future similar incidents.
- At the time of the inspection, staff and senior managers were not clear whether the seclusion suite was able to be used or not, due to the previous incident where damage had occurred. Some staff we spoke with told us it was safe and in use but some staff told us they had been instructed not to use it and in the event of seclusion being required the seclusion suite on Saltwood ward should be used.
- We raised our concerns about the safety of the seclusion suite during the inspection with senior managers. They took immediate action to ensure that risks were mitigated. These included staff briefing on communicating with patients, changes to the longer-term plans to make building improvements such as installing CCTV monitors in the seclusion suite.
- Both wards had a dedicated house-keeping assistant and we saw that they were following a planned cleaning schedule. Cleaning materials were safely stored in a locked cupboard on the wards.
- Both wards had their own secure garden space with astro-turf flooring, picnic tables and table tennis. Part of the garden area was sheltered by a roof so could be used by patients in all weather.

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

Good

- The layout of both wards allowed the nursing staff to have good lines of sight from the nurses' office into the communal ward area's and also in to the bedroom corridor's. The wards also had convex mirrors mounted at corners to ensure that all areas were clearly visible.
- Closed circuit television (CCTV) was in place on both wards in the communal areas. Staff did not continuously monitor the CCTV. This was done on an ad-hoc basis, when needed. There was closed circuit television (CCTV) in the communal areas of both wards. Staff told us CCTV was in place to safeguard patients and staff should an incident happen.
- Ward managers completed ligature assessments which identified any areas on the ward which presented increased risks of patients attaching ligatures to self-harm. Staff could identify the ligature risks on the ward. The last ward audit was completed in March 2019 and carried out every six months.
- Patients on both wards had access to their rooms at any time. The patient bedrooms were en-suite and equipped with a nurse call button. The furniture and facilities were designed to reduce or eliminate the risk of ligature points. The bedroom doors were anti-barricade and had a vision panel which enabled patients to have privacy whilst allowing staff to carry out observations in an unobtrusive way.
- The clinic rooms on both wards were clean and tidy and medicines were stored safely in a secure way. Emergency medicines were contained within a grab bag alongside emergency equipment. Staff checked and recorded the contents daily.
- All staff signed for the ward keys at the hospital reception and carried them safely attached to a belt loop. All staff were issued with personal alarms. Both of the wards had an air lock and intercom system to provide additional security on entry and exit to the wards. Alarms were available for visitors. Nurse call systems were in ward areas and patient bedrooms.
- The hospital had a designated family room. The room was very well furnished and decorated. It was welcoming for both adults and children, with plenty of seating, toys and access to a designated outside space which had additional seating and outside games.

Safe staffing

- Prior to the insection, the provider submitted data regarding their staffing levels. From the 14 September 2018 to the 30 November 2018, the total number of substantive staff on Bearstead ward was 13 In the same time period there had been one substantive staff member leave. The staff vacancy rate was 55%. However, this was being covered with the use of regular agency staff The provider did not report any staff sickness information for this ward.
- From the 14 September 2018 to the 30 November 2018, the total number of substantive staff on Roseacre ward was 21 In the same time period there had been two substantive staff member leave. The staff vacancy rate was 22%. The sickness rate was 1.6%.
- During our inspection, we observed sufficient numbers of staff on both wards. Staff worked 12-hour shifts with six staff on the day shift, two qualified nurses and four health care assistants, and four staff, of which two were qualified nurses, working at nights. Staff and patients on Bearstead ward told us that staffing numbers were sometimes low. This meant they could not always access the locked garden when they wanted as a staff member had to be present in the garden at all times when in use by patients. However, on Roseacre ward, neither staff or patients reported any concerns with staffing numbers or access to activities and leave from the ward.
- We reviewed the shift staffing numbers for the three months prior to the inspection and saw that the minimum staffing numbers were mostly being met on each shift. There was enough staff on duty to safely carry out physical intervention with patients should they be required and staff from other wards were available to support if needed. Training in the prevention and management of violence and aggression was mandatory for staff. Training compliance for the management of violence and agression was 99% across all the staff teams at the hospital.
- There was adequate medical cover day and night. We saw consultants and speciality doctors supported staff on the ward during the day and there was an on-call doctor who was available to attend site when needed.

- Occupational therapy assistants and assistant psychologists were based on the wards to provide additional support throughout the working day, which supported engagement and a reduction in incidents.
- During nights and weekends, a hospital coordinator was responsible for supporting staffing and clinical matters across the site and could support any staffing shortages if required. They were not already included in any of the ward staffing numbers.
- Staff carried out mandatory training in 12 courses in areas including basic and immediate life support, medicines management, safeguarding, equality and diversity and responding to emergencies. The provider had a training compliance target of 95%. The hospital compliance rate for mandatory training was 99%.
- Where there were gaps in training, staff had been given a deadline for when they needed to complete this by. Senior managers monitored training compliance via their weekly meetings. Checks were in place to ensure that agency staff had completed mandatory training prior to them working any shifts on the ward.

Assessing and managing risk to patients and staff

- Staff completed risk assessments for patients on admission to the wards and following a change in risk. Staff used recognised tools to assess the patients' risks. These included the short-term assessment of risk and treatability (START), and the historical clinical risk management 20 (HCR20) which was completed with input from the ward psychologist. Both were appropriate for the patient group being treated on the ward. However, on Bearstead ward, staff did not always assess and manage risks to patients and themselves well.
- We looked at the care records of eight patients across both wards. All records we reviewed contained up-to-date risk assessments in care notes which had been regularly reviewed. On Roseacre ward, the risk assessments were comprehensive, and staff had good working knowledge of the risks of all the patients. However, on Bearstead ward staff could not clearly describe strategies they used to manage patient risk.
- On Bearstead ward, staff did not always manage incidents in a safe way. Prior to our inspection, one patient had managed to cause substantial damage to render the seclusion suite as unfit for use. The damage included, removing metal strips from the door frame and causing irreparable damage to the door. Two patients who were recognised to be at risk of absconding managed to climb the fence and leave the hospital grounds.
- During the inspection, we did not directly observe any incidents or staff responses to escalation and individual risk on Bearstead ward. However, following an incident that occurred overnight during the inspection, staff were not clear what action to take to mitigate the risk of further similar incidents.
- As part of our inspection, we observed a shift-to-shift handover on Bearstead ward. We saw how staff on the night shift shared information with staff coming onto the day shift. The handover appeared chaotic, with people coming and going throughout and interruptions. Information from the previous shift was only discussed, which did not include detailed information from previous days or since the patient's admission. Observation levels and detention status for the patients were not discussed for each patient and when questioned by the inspectors as to what these were, several staff did not know, and others gave conflicting information. Incidents from the previous night were discussed but lacked detail. For example, there had been a safeguarding incident, involving several patients but the information handed over did not detail what action had been taken or what staff would need to do to ensure the patients remained free from harm. Information such as admissions and discharges planned for the day was basic, and any other concerns, such the environment were not discussed. For example, staff were not aware of the concerns raised the previous day about the seclusion room.
- On Bearstead ward, between October 2018 and February 2019 there had been 23 reported incidents of seclusion. There were 39 incidents of rapid tranquilisation. In the same period there was 68 reported incidents of restraint, and 18 incidents of prone restraint.
- On Roseacre ward, between October 2018 and February 2019, there had been no reported incidents of seclusion. There were four incidents of rapid tranquilisation. In the same period there was 13 reported incidents of restraint, and no incidents of prone restraint.

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

Good

- Roseacre ward had low incidents of restraint and staff knew how to alert additional staff for assistance if required. Staff had a good understanding of relational security, which focused on the quality of relationships between staff and patients to improve ward safety. Staff were confident with using de-escalation techniques as a way of managing incidents on the ward.
- Following the inspection, in May 2019, we were made aware that there had been an increase in incidents of assaults between patients on Bearstead ward. These had all been reported appropriately by the provider. This led to an external review by the local authority safeguarding team and supported by other relevant stakeholders.
- There were blanket restrictions across both wards including access to areas of the wards and access to fresh air and outside space. However, the ward staff participated in the provider's restrictive interventions reduction programme, but this required further review.

Safeguarding

- There were appropriate systems embedded to safeguard adults and children at risk. Staff we spoke with were confident with the safeguarding procedures and demonstrated a good understanding of safeguarding issues and they could identify types of abuse. However, only the ward manager or social worker took the lead in reporting all safeguarding concerns to the local authority safeguarding team. Other key staff, such as support workers, were not enabled to report directly themselves. This meant there could be delays in reporting safeguarding concerns when key staff were not on duty.
- Staff we spoke with on Roseacre ward told us they had not experienced many safeguarding concerns. Staff on Bearstead ward told us there were multiple incidents of patient on patient assault/alleged assault which were reported to local safeguarding team.
- Staff told us safeguarding concerns were discussed during shift-to-shift handovers, at multidisciplinary meetings and during daily flash meetings where senior member of the clinical and managerial staff attended.
- Staff received mandatory training in safeguarding adults and children at risk. At the time of the inspection, 100% of staff working at the hospital had completed the training.

Staff access to essential information

- Information needed to deliver care was stored securely and was available in an accessible form to staff when they needed it. Staff used a combination of paper and electronic notes to record care and treatment provided to patients. Paper notes were stored securely in locked offices and included comprehensive assessments, risk assessments and care plans.

Medicines management

- Room and fridge temperatures were monitored, and these were within recommended ranges. Medicines were within their expiry dates. Both wards had appropriately labelled waste containers for the safe disposal of unwanted medicines.
- Staff recorded checks of emergency medicines, including oxygen, daily. Controlled drugs were counted at each shift change and checked against balances recorded in the register.
- On Roseacre ward, two nurses carried out medicines' administration to patients as an extra safety measure. Staff knew how to access the medicines policy and understood how to report medicine incidents. Managers were responsive to investigate serious incidents, implement action plans and share learnings with staff. Staff were aware of issues identified from audits. For example, gaps in administration records. During our inspection, we found that these had improved and there were no missed doses.
- We looked at prescription charts and associated care records for three patients on Roseacre ward and four patients on Bearstead ward. Each patient had their own prescription folder that included their photograph to help staff identify them. Where patients had not consented to being photographed, detailed descriptions of patients were used. Allergies were recorded, and most charts included people's up to date body weight, except where patients had chosen not to

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

Good

be weighed. Staff recorded and rotated sites where patient's injections were administered. This helps to prevent tissue damage and ensure injectable medicines can be properly absorbed.

- Patients detained under the Mental Health Act received medicines in line with the Mental Health Act requirements. Staff carried out physical checks and doctors reviewed people with long term conditions.
- Staff had completed online medicines training and were supported by managers to reflect on medicines incidents and share learnings.

Track record on safety

- In the 12 months prior to the inspection, there had been three serious incidents reported on Bearstead ward and two serious incidents reported on Roseacre ward. Three incidents involved self-harm, one patient going absent without leave and one involving property damage/ threat with a weapon. We saw each of the incidents had been appropriately reported and investigated and the patients were well supported.

Reporting incidents and learning from when things go wrong

- All staff were able to report incidents using a paper-based incident recording system. These reports were then uploaded to the hospital's electronic incident database by hospital admin staff. Types of incidents recorded included physical aggression from patient to patient or patient to staff and property damage.
- The ward manager shared details of any incident with other ward managers and the senior team at the daily morning flash meeting. This meeting allowed ward managers and clinical staff to quickly share information relating to safety, risk and safeguarding daily for the whole hospital and identify any actions that needed to be taken.
- All incidents were investigated. Incidents that met the providers serious incident criteria, where they were rated serious or catastrophic, had a 72-hour report and full root cause analysis completed. Actions from these reports were regularly reviewed during monthly governance meetings to track progress. We reviewed one serious incident and found the reports to be detailed with identified learning and actions.
- Staff received feedback from incidents and investigations, from both professionals internal within the Cygnet group and from external professionals such as the local safeguarding team. Lessons learnt from incidents were discussed in handovers and staff meetings. The clinical services manager sent out a monthly lesson learnt bulletin to all staff via email and printed copies were also kept in the nursing office. All staff we spoke with were able to give examples of lessons learnt from incidents which had taken place on other wards and were also aware of which wards had the highest number of incidents.
- The Duty of Candour regulation explains the need for providers to act in an open and transparent way with people who use services. It sets out specific requirements that providers must adhere to when things go wrong with people receiving care and treatment. The provider had a Duty of Candour policy in place. Staff we spoke with understood the need to be open and transparent when they had made mistakes and to make written apologies when required. At the time of our inspection, we did not see any examples of its use as none of the incidents that had taken place had necessitated a written apology.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- The ward consultant completed a comprehensive pre-admission assessment for newly admitted patients. Areas of assessment included mental health history, medical history, social history and substance misuse.
- Staff assessed the physical and mental health of all patients on admission and throughout their care and treatment. All patients had care plans in place which included short and long-term strategies for how to manage their needs and were completed within 72 hours of the patient being admitted to the ward. Care plans were reviewed every four weeks and discussed during ward rounds. Care plans were personalised and

included the views of the patient, where possible. This was in line with National Institute for Health and Care Excellence (NICE) guidance. However, we did find some of the care plans to be basic. For example, the discharge planning section of the care plan lacked detail as to what the plans for the patient were. On Bearstead ward, care plans did not always record patients' strengths.

Best practice in treatment and care

- All policies and procedures used by staff referenced current guidance such as the Mental Health Act Code of Practice. The management of physical intervention was delivered in line with guidance on short-term management of violence and aggression (2015) issued by the National Institute for Health and Care Excellence. The management of medicines was delivered in line with a range clinical guidelines, including the management of schizophrenia (2009).
- Staff carried out regular audits to ensure medicines were stored and prescribed effectively. Staff monitored patients to check if they were experiencing any side effects from their medicines. Staff monitored the physical health of patients receiving anti-psychotic medicines.
- Staff ensured that patients had access to physical healthcare and supported patients to live healthier lives. Patients received a physical health examination on admission and their physical health was reviewed at least weekly depending on individual circumstances. A general practitioner visited the hospital and each of the wards once a week. Patients were able to access opticians and podiatrists in the community. However, on Roseacre ward we were made aware of a patient who was in pain and needed to visit a dentist. The ward staff had tried to register the patient with local dentists but had not been able to. Staff were continuing to find a solution for the patient.
- Patients had access to psychological and other therapies recommended by the National Institute for Health and Care Excellence (NICE).
- The psychology team conducted psychology assessments with patients to identify a psychology treatment pathway specific to their individual needs. They delivered psychological therapies such as dialectical behaviour therapy and cognitive behaviour therapy. Interventions were based on individual need and assessment and delivered on a one-to-one basis or in a group. The psychology team monitored and measured patient outcomes.
- All staff on Roseacre ward were trained or in the process of being trained in dialectical behaviour therapy (DBT). DBT is a talking therapy specifically designed for patients with a diagnosis of personality disorder. Patients on Roseacre ward were each offered 4 hours of DBT each week, spread over two days.
- On Bearstead ward, the multidisciplinary team held complex case reviews in repsonse to challenging patients with a focus on engaging and reducing use of restraint.
- Occupational therapists also followed best practice guidance. Staff completed assessments and outcomes monitoring with patients using the model of human occupation screening tool. They worked with the patients to develop life and independence skills. Occupational therapists worked with patients on a one-to-one and group basis, dependent on individual need.
- Patients were encouraged to stop smoking and staff offered nicotine replacement therapies to assist them with this. The hospital planned to become smoke-free from 1 May 2019 and staff were working with patients to help them prepare for this.
- Staff used recognised rating scales to assess and record severity and outcomes. Staff used Health of the Nation Outcome Scale (HoNOS) to record and review a patient's progress. Staff also provided examples of using physical health rating scales with patients, including the modified early warning score (MEWS).

Skilled staff to deliver care

- In addition to qualified nurses and nursing assistants, the ward had a multi-disciplinary team. This included a consultant psychiatrist, a middle grade doctor, an occupational therapist, an occupational therapy assistant. The hospital had a full-time social worker who operated across all the wards and led with patients' social care needs, funding issues for patients' care and safeguarding. A dietician had recently been recruited by the hospital but was not yet in post at the time of the inspection.

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

Good

- All staff received an appropriate local and corporate induction. Induction packages were available for clinical staff, non-clinical staff, bank staff, students and agency staff. Induction provided staff with information on organisational policies and procedures and provided the opportunity to work supernumerary to ward staffing numbers. Staff also completed a ward specific orientation and induction.
- Staff working in areas identified as being high risk of restraint and restrictive interventions were supported to attend RAID training in addition to being trained in the use of the Prevention and Management of Violence and Aggression. However, on Bearstead ward, staff lacked the skills and experience of working in a psychiatric intensive care environment. Staff did not always safely manage incidents of aggressive behaviour from patients or support them well.
- Doctors had completed revalidation where required within the previous 12 months.
- Managers supported staff with supervision, reflective practice sessions and opportunities to update and further develop their skills. Staff received supervision once a month as per the providers policy. Managerial supervision took place alongside clinical supervision. The provider had a clinical supervision target of 90%. Records showed that supervision rates were 100% on both wards. Staff we spoke with confirmed they had regular supervision and felt it was supportive and beneficial for their needs and development. A psychologist from another ward facilitated reflective practice sessions once a month which staff were encouraged to attend.
- Staff had access to monthly team meetings. Managers planned regular team meetings. Staff reported that team meetings followed an agenda, were recorded and all staff were sent a copy of the resulting record. Records showed that staff meetings included discussions about ward audits, governance, incidents, lessons learnt, training and positive comments and complaints.
- The registered manager told us staff would receive an annual appraisal of their work with their manager. However, as the service had only opened in October 2018, and most staff commenced employment in August 2018, they were not yet due an annual appraisal.
- Managers told us they had access to human resources support for dealing with poor staff performance. At the time of our inspection, there were no performance issues with permanent staff on either ward reported.

Multi-disciplinary and inter-agency team work

- The multidisciplinary team at the hospital included psychiatrists, psychologists, mental health nurses, occupational therapists and a social worker. Each contributed to the delivery of care and treatment to patients.
- There were regular face-to-face multidisciplinary meetings, with professionals, patients and families invited to attend or contribute before the meeting. In addition to one-to-one work with the patients, the psychology team supported with reflective practice sessions and de-brief sessions following incidents.
- The hospital had a dedicated social worker who supported patients with their benefits and contact with families. They attended ward rounds and patients care programme approach (CPA) meetings. The ward also had good links with care co-ordinators who were invited to attend ward rounds and CPA meetings.
- The multidisciplinary team meetings were structured, and discussions included background history of the patient, assessment of current presentation, patient, family and/or carers views, risk information, medicine changes, leave from the ward and discharge planning.
- The registered manager told us the hospital worked hard to maintain relationships with professionals outside of the service. This included the visiting GP, commissioners, case managers and local authority safeguarding team.
- The service had an outstanding working relationship with the local police force. Two police officers were designated as key liaison officers for the service. They had their own office space at the service and worked from the service one day every week. The police officers attended debriefs for staff and patients for all incidents that took place that involved the need for police attendance or support. The police also attended and provided feedback at monthly governance meetings and local safeguarding meetings. They were a key

contact point for all staff and patients and regularly attended the wards informally. Staff valued input from the police and continuously looked to make improvements based on their feedback.

Adherence to the MHA and the MHA Code of Practice

- All staff completed mandatory training in the Mental Health Act.
- Mental Health Act documentation for detained patients was in place and completed correctly.
- Information was displayed on the ward noticeboards regarding the independent mental health advocate and how to contact them.
- We reviewed patients records of leave from the ward into the community, granted by the consultant psychiatrist. The parameters of leave were clearly documented. For example, the location of leave, time and duration and the numbers of staff required to support the patient.
- Staff supported patients to understand their rights, when detained under the Mental Health Act or as an informal patient.
- Patients medicine charts had a photograph attached of the patient together with treatment certificates, which had been authorised by the consultant psychiatrist. Treatment certificates documented the medicines and doses prescribed for the patient.
- Staff at the service were fully supported by a Mental Health Act administration team. They provided support and advice when needed and oversaw the renewals of detention under the MHA, consent to treatment and appeals against detention. The MHA team completed regular audits to ensure records and practice was in line with current legislation
- On Bearstead ward, patients remained detained under Section 2 of the Mental Health Act, despite already having been diagnosed with a mental disorder and their treatment plans already agreed. Section 2 is specifically designed for people who require assessment for a mental disorder or new treatment plans.

Good practice in applying the MCA

- There was a provider policy on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were aware of the policy and how to access it.
- The MCA enables people to make their own decisions wherever possible and provides guidance and for decision making where people are unable to make decisions themselves. Staff we spoke with demonstrated a good understanding of the MCA. We observed staff seeking informed consent from patients.
- No patients were subject to Deprivation of Liberty Safeguards (DoLS) at the time of our inspection.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Whilst we observed positive interactions between staff and patients on Bearstead ward, patients we spoke with told us this was not always what they experienced. We saw staff greeted patients in a friendly manner and were respectful during conversations, appearing engaged and responded appropriately. However, we spoke with four patients and feedback was mixed. Some patients described a positive experience of their care and treatment received since their admission to the ward. They spoke well of the staff and the support they received. Other patients described the ward as being chaotic at times which impacted staff's ability to help them. All patients we spoke with told us they were kept up-to-date with changes to their medicines, treatment and discharge plans. However, each spoke of their frustration that access to the ward garden area was kept routinely locked and could only be accessed with staff attendance. They told us this meant when the ward was unsettled they could not access the outside space.
- There was a tense atmosphere on Bearstead ward and we observed a lack of therapeutic engagement between staff and patients. For example, patients told us they were frustrated at the lack of support from staff.

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

Good

- On Roseacre ward, we observed exceptionally good interactions between staff and patients. Staff continuously interacted with patients in a positive, caring and compassionate way and responded promptly to requests for assistance whilst promoting independence. Staff demonstrated creativity to overcoming obstacles to delivering care to patients. Staff appeared highly motivated, interested and engaged in providing a high level of care.
- When staff spoke with us about patients, they discussed them in a respectful manner and demonstrated a good understanding of their individual needs. All patients had a named nurse and an associate nurse, as well as a support worker assigned daily. Patients could request a one-to-one with any member of the staff team. Staff had placed a welcome board at the entrance to the ward, which had photographs and names of all the staff working on that ward.
- Staff on Roseacre ward demonstrated they were very motivated to succeed in delivering care to their patients that was kind and relevant to their needs and always maintained their dignity.
- On Roseacre ward, we spoke with two patients. They spoke highly of the staff and the quality of care they received. They said staff were caring and supportive, respectful of their wishes and needs and encouraged them to make decisions as individuals in the therapies and treatments offered to them. Patients told us they felt listened to and involved in the running of the ward. They felt staff enabled them to achieve their goals.

Involvement in care

- Staff supported patients to be involved in their care. Patients on both wards said they felt involved in their care and treatment and were asked by staff if they would like a copy of their care plans. All the care plans we reviewed included the views of the patient.
- Staff supported patients to have regular access to advocacy. Posters about the advocacy service and how to contact them were on display in the communal area of the wards. All patients we spoke with were aware of the advocacy service and the support they offered.
- Patients were given a welcome guide on admission to the wards which included information about what to expect during their first few days; mealtimes; smoking; phone and internet use; medication times; activities; therapies; visiting times; how to access fresh air; leave; contraband items and details of the different meetings that took place.
- On Roseacre ward, staff were fully committed to working in partnership with patients and their families. They had developed a friends and family guide. This contained basic information such as meal times, details of meetings, discharge planning and access to telephones.
- Bearstead ward held a morning meeting during the weekdays. Patient community meetings took place weekly on both wards and were attended by senior hospital managers, housekeeping staff and the head chef. This enabled patients to give feedback about menu choices. We reviewed copies of community meeting minutes and found that any actions were documented and reviewed in subsequent meetings to ensure they were followed through. There was also a "you said, we did" board displayed on both wards where staff wrote down suggestion's patients had made and how they had addressed them. However, on Bearstead ward, the board was empty.
- Staff involved family members appropriately. All the patients we spoke with told us that their family were involved in their care and most of the care plans we reviewed demonstrated family views and involvement. We saw evidence that home leave had been facilitated and of family members visiting the service. Visits from family members took place off the ward in a dedicated family room. Staff told us that the operational policy included suggested visiting times but that they would be flexible to meet the individual needs of patients and their families. Family members were also invited to attend ward rounds and other key meetings.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

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

Good

- On Bearstead ward, all admitted patients are detained under the Mental Health Act. Referrals came from acute services, prison services or via the criminal justice system. Referrals came through direct to the ward and were triaged and assessed by the ward staff. If a referral was received out of hours, the on-call duty manager was contacted for support. The ward manager told us, all referrals were reviewed swiftly and decisions communicated back to the referrer to ensure patients had timely access to care and treatment. However, we found this was not always the case. During the inspection, an urgent referral had come in overnight. Discussions had been recorded between the ward manager and nurse on shift and a decision made to admit the patient. By the following day, the decision to admit the patient still had not been communicated to the referrer and no admission plans had been put in place.
- At the time of the inspection, there were 12 patients admitted to Bearstead ward, which had 15 beds available beds. Between September 2018 and November 2018, the average bed occupancy was 42%. The average length of stay was 14 days. National guidance states the optimum level of provision of good quality care is 85%.
- Bearstead ward admitted patients from across the country. Since the ward opened, all the patients admitted to the ward were from out of area, often coming from Cumbria and Birmingham.
- The wards focussed on discharge planning. There was a discharge planning section within all patients care plans reviewed. Some were less detailed than others. Patients we spoke with told us about the plans for their discharge which had been discussed at their multidisciplinary meetings. On Bearstead ward, staff told us discharge summaries were sent to the patients' external care team which summarised their treatment, progress and identified needs. Neither ward reported any delayed discharges. Staff we spoke with on Bearstead ward spoke of the difficulties of moving patients back to their local areas.
- On Roseacre ward, referrals were received via the providers central referral line and reviewed and discussed with the wider multidisciplinary team.
- At the time of the inspection, there were four patients admitted to Roseacre ward, which had 16 beds available beds. Bed occupancy and average length of stay information was not given to us by the provider as part of the pre-inspection data requests.
- The providers website included information on bed availability, the care and treatments available on the ward and how to make a referral.

The facilities promote recovery, comfort, dignity and confidentiality

- Both wards were welcoming, with staff names of those on shift clearly displayed, as well as the activities for the day.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom. Any items which were not permitted on the ward, for example cigarettes, were labelled and stored in a locked cupboard. Patients told us they could personalise their bedrooms to make them feel more at home.
- Each ward was spacious with access to open space and rooms. The wards had a quiet room, and large communal room with access to a television and several chairs and sofas, and a dining area where drinks facilities were available. In addition to these rooms was private rooms used for one-to-one sessions and meetings. A laundry room was also available on each ward.
- The hospital had a gym room which had several pieces of gym equipment, which patients could use following a gym induction and with staff supervision. On Bearstead ward, there was a boxing punch bag available for patients to use for exercise and stress relief.
- On the ground floor of the hospital was several meeting rooms used to facilitate CPA meetings and tribunals. There was also a dedicated family room. The room was very well furnished and decorated. It was welcoming for both adults and children, with plenty of seating, toys and access to a designated outside space which had additional seating and outside games.
- The food was of good quality and patients could make hot/cold drinks in the communal area of both wards.

However, on Bearstead ward, whilst hot water and tea/ coffee was readily available for patients to access, they had to request cups from staff which were stored in the locked kitchen. Snacks were available on request.

- Each ward had an ADL kitchen. The occupational therapist supported patients to make their own food as part of aiding their independent living skills.
- Both wards had a weekly activity timetable which included psychological therapies and activities led by the occupational therapy team. Healthcare assistants led activities on weekends. Each patient also had their own individual timetable which could be updated as needed during morning planning meetings. Patients on Roseacre ward told us their time was always occupied. However, some patients on Bearstead ward said there was not enough activity and they often felt bored.
- A range of activities was available seven days a week. The occupational therapist or ward psychologist led activities during the weekdays. On the weekend activities were led by the ward staff. Staff told us on the weekends, patient would utilise their leave from the wards, engage in one-to-one time, relax and socialise or participate in activities such as arts and crafts, board games and watching films.
- The hospital had a shop which patients could volunteer to work in on a rota basis, dependent on assessment. The service was due to open a recovery college in April 2019 and the registered manager had been in contact with a local college to arrange for a mutually beneficial partnership whereby staff would deliver mental health first aid training in return for educational support and equipment to students within the recovery college.

Patients' engagement with the wider community

- Staff had supported patients to access local shops and the town centre. The occupational therapist had completed transport assessments with some patients to promote independence.

Meeting the needs of all people who use the service

- A lift ensured people who could not manage the stairs could access both wards and other areas of the hospital. The corridors and doorways were wide for disability access. The bathroom on both wards was adapted to support people with disabilities and was equipped with a mobile hoist.
- During the inspection, we saw that numerous posters and noticeboards were on the walls informing patients of advocacy, the Mental Health Act, how to complain, safeguarding and activities. However, all information was in English. Staff told us that information could be provided to patients in other languages if needed.
- Staff ensured patients' spiritual needs were met. Patients were able to access the multi-faith room in the hospital. Staff told us they could facilitate church visits for those who wished to attend.
- The hospital had a locally contracted interpreting and signing service. Staff were familiar with and knew how to access these services. We saw that staff were providing regular interpreter services for a patient who required this to participate in planning his care and treatment.
- The hospital offered a choice of food to meet dietary requirements of religious and ethnic groups. Patients we spoke with reported the food quality to be good. However, Halal meal options were limited to ready-made meals. We raised this with the catering staff who confirmed this and said that uptake of the Halal meals was currently low, and they could not be prepared fresh in the kitchen as they could not separate the food items. We noted, no complaints had been made by patients in respect of this.

Listening to and learning from concerns and complaints

- Since the opening of Bearstead ward there had been one formal complaint received. This was a complaint from an external professional regarding staff knowledge of the Mental Health Act and statutory forms. The complaint was partially upheld, and the provider reported the person who raised the concerns was satisfied with the outcome. We were told of changes that had been implemented as a result to better support staff and the checking and receiving of documentation. There had been no complaints received on Roseacre ward.
- The providers complaints process was displayed on the ward noticeboards and in the patient welcome guides. Patients we spoke with told us they knew how to complain. An advocate was also available to support patients in raising any concerns or complaints.

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

Good

- Senior managers told us complaints were discussed in the hospital integrated governance meeting, which enabled staff to learn lessons from complaints from other wards within the hospital. The service also tracked informal complaints and compliments

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Leadership

- We were impressed by the skills and knowledge of the registered manager and the clinical services manager. The registered manager had recently reviewed and implemented changes to the leadership structure. Staff could easily identify the leadership structure through the hospital's reporting structure organogram. The registered manager directly line managed the clinical service manager, the medical director and the admin manager. In turn, these managers line managed other leaders of the service. For example, the clinical services manager line managed the ward managers and the heads of the other clinical disciplines such as psychology and social work. Similarly, the medical director managed the consultant body and the ward doctors.
- The registered manager reported to the regional operational director and the regional quality assurance manager supported the service with ensuring quality was given enough priority.
- The registered manager had developed positive means of engaging with staff. All staff we spoke with reported that the registered manager was approachable and had a visible presence at the hospital. To support improvement and to aid staff morale, the registered manager held monthly staff forums where any staff could raise good ideas or concerns. Staff could also place suggestions into suggestion boxes that were placed throughout the hospital. The registered manager prioritised attending the ward meetings where possible.
- The ward manager on Roseacre ward was clearly passionate and proud to work for the service and was a good role model for the staff. They were experienced and skilled in working with people with personality disorders and had a good understanding on how best to support their staff and be a good manager.
- However, the local leadership of Bearstead ward was not effective in supporting staff to manage the acuity and fast paced nature of a PICU environment. Following the inspection, the provider was working to address this.

Vision and strategy

- The provider had a set of corporate values that were integrity, trust, empower and respect that were understood by the leaders of the service. The provider had a clear vision that was to enable people to progress on their personal journey and to be the preferred provider of outstanding care and the employer of choice in the healthcare sector.
- The registered manager was clear in discussions that staff were committed to providing the best possible care to patents but that as a new service they had been focussed on setting up the practical elements of the service. He reported that they were now focussed on improving the safety and quality of the service. However, we reviewed eight sets of supervision records and found that they did not link the work of staff to the organisational vision or values.

Culture

- The culture on Roseacre ward was exceptional. We observed staff to be inspirational drivers for engaging and enabling patients on the ward. Staff were highly motivated, and this had a noticeable positive impact on patients who were also motivated. Staff were engaging with each other, the service and the organisation and demonstrated they drew on each other's strengths whilst providing a high level of support.
- However, on Bearstead ward, the ward manager did not foster a culture that encouraged staff to make positive changes and improve patient care. Staff we spoke with, were focussed on getting through their shift. There appeared to be little thought how to improve things on the ward or for patients. Staff said the ward manager did not act when issues were raised or listen to suggestions for improvement.
- On Bearstead ward, there was insufficient and appropriate challenge amongst the clinical team. We

observed the nursing team at times, appeared to lack focus or challenge to support the best interests of the patients and their care and treatment. For example, during handover, we observed nursing staff did not challenge or question any of the decisions made, even when conflicting information was presented which could have impacted severely on patient and staff safety.

- To support improvement and aid staff morale, the registered manager held monthly staff forums where any staff could raise good ideas or concerns. Staff could also place suggestions into suggestion boxes that were located throughout the hospital. Staff told us they would not hesitate to seek advice or make suggestions to senior leaders.
- The provider had a clear policy advising staff how to raise concerns. Staff we spoke to were aware of this policy and said they wouldn't hesitate to raise concerns if needed.

Governance

- Leaders ensured that staff received mandatory training and monthly line management supervision and that despite staffing vacancies the wards were covered with appropriately skills and experience.
- The service had a well understood governance structure with clear reporting lines throughout the hospital. The registered manager chaired the monthly hospital wide governance meetings. Ward managers chaired the ward level governance meetings which were also held monthly.
- The service used a performance dashboard to monitor and improve key aspects of care of treatment. The dashboard rag rated key aspects of performance including the amount of therapeutic activity, key documentation, numbers of restraints and seclusions, admissions and discharges and staffing. Ward managers were familiar with the dashboard and said they used the findings to improve the quality of care on their respective wards.
- The service was supported by the regional quality assurance manager who reported to the corporate governance team to ensure consistency and learning across the organisation.
- The service completed regular quality walkarounds which included key aspects such as first impressions, documentation, physical healthcare and safety and security. Leaders who completed these walkarounds gave timely feedback to staff. Ward meetings took place monthly and staff told us these meetings were structured and helpful.
- The service had an annual audit cycle. Staff completed audits on key areas such as medicines management, seclusion and long-term segregation, infection control and mental health act. We saw that audit findings were discussed in a range of groups which led to practice changes where appropriate.
- The heads of department met weekly to discuss key areas of operational safety and quality. We reviewed minutes of these meetings which showed they were well attended, actions were tracked, and changes arose as a result where required. For example, we saw that the on-call rota was discussed, and changes made where needed.

Management of risk, issues and performance

- The learning from complaints, incidents and patient feedback was identified and actions were planned to improve the service. Staff and patients were involved in post incident de-briefs and review processes.
- The provider had a risk register as a means of capturing the collective risks at the service. This meant there were formal mechanisms for the managers, senior managers and board of directors to assess and manage risks.

Information management

- Information needed to deliver care was stored securely and was available in an accessible form to staff when they needed it. Staff used a combination of paper and electronic notes to record care and treatment provided to patients. Paper notes were stored securely in locked offices and included comprehensive assessments, risk assessments and care plans.
- The provider had an audit programme which included the review of documentation, to ensure staff had the information they needed to deliver safe and effective care.
- The provider ensured the confidentiality of patient records through their data protection policy, staff

training and practical measures, such as files stored in locked cupboards, rooms. Information was only shared with other professionals and agencies when appropriate.

Engagement

- The service had prioritised engagement with service users. Each ward had a weekly community meeting where service users could raise any concerns or ideas for improvement. These were then communicated through 'you said, we did' boards which were on each ward. However, we noted that on Bearstead ward the 'you said, we did' board was empty.
- Service leaders invited patients to attend the monthly information governance meetings, so they could contribute to quality monitoring and improvement. The service had also set up a 'people's council' whose aim was to ensure the people's views were represented across the service.
- The service had a newly established carer's group and monthly newsletter. Each ward had an identified carer's lead. The service had invited carers to attend a 'spring tea' which was to take place shortly after our inspection. Similarly, all carers were invited to attend the hospital for an open day prior to its official opening in October 2018.
- Service leaders made efforts to engage with the wider community. The service had held an open day for members of the public prior to its official opening. From this, service leads had been able to recruit volunteers. Service leads had developed working relationships with local members of parliament, local business groups and the local NHS trust. In addition, the service was working to develop a mutually beneficial agreement with a local college whereby the service would provide mental health first aid training in return for educational support for patients at the hospital.

Learning, continuous improvement and innovation

- The service had been focussed on implementing practical care and operational procedures as they had only opened in October 2017. The registered manager described the need to get the basics in place before beginning to focus on innovation and quality improvement. Although there was clear evidence of a commitment from leaders to continually improving there was no overarching approach to quality improvement. Staff had not received training in quality improvement methodology. However, all staff described a culture that was focussed on improvement and said that they could raise new ideas in an open and supported way.
- The service was due to open a recovery college in April 2019.This was to be an innovative approach to ensuring that patients and staff could access a range of mental health related education and personal development.
- The clinical services manager produced a monthly newsletter called 'lessons learnt'. The newsletter detailed learning from incidents, audits, national guidance and complaints. Staff we spoke with were familiar with the newsletter and could describe lessons learnt from this.
- The service held weekly staff continued professional development days. During our inspection, we saw this taking place. Staff would deliver case presentations for discussion or specific staff would give talks on their areas of interest or expertise.

Good

Forensic inpatient or secure wards

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

Are forensic inpatient or secure wards safe?

Good

Safe and clean environment

- The ward was clean and bright with a large communal lounge area, a dining area and serving kitchen. The furnishings and fittings were in very good condition as the ward had only been open to patients for four months.
- The ward had a dedicated house-keeping assistant and we saw that they were following a planned cleaning schedule. Cleaning materials were safely stored in a locked cupboard on the ward.
- There was a large garden space for the sole use of Saltwood patients with astro-turf flooring, picnic tables and table tennis. Part of the garden area was sheltered by a roof so could be used by patients regardless of the weather.
- The layout of the ward allowed the nursing staff to have good lines of sight from the nurses' office into the communal ward area and in to the bedroom corridor. The ward also had convex mirrors mounted at corners to ensure that all areas were clearly visible.
- There was closed circuit television (CCTV) in the communal areas of the ward. Staff used the CCTV to review events following an incident so that lessons were learned from the incident.
- The ward manager had completed a ligature assessment which identified any areas on the ward which presented increased risks of patients attaching ligatures to self-harm. Staff could identify the ligature risks on the ward. The last ward audit was completed in March 2019 and carried out every six months.
- Patients had access to their rooms at any time via a personal fob which unlocked their bedroom door. The patient bedrooms were en-suite and equipped with a nurse call button. The furniture and facilities were designed to reduce or eliminate the risk of ligature points. The bedroom door was anti-barricade and had a vision panel which enabled patients to have privacy whilst allowing staff to carry out observations in an unobtrusive way.
- The ward clinic room was clean and tidy, and medicines were stored in a secure way. Emergency medicines were contained within a grab bag alongside emergency equipment. Staff checked and recorded the contents daily. However, we found that one medicine was a lower strength than was on the checklist in the hospital's policy. Staff had not noticed this during their checks. We raised this with the clinical team leader during our inspection and the error was amended.
- The ward had a seclusion room with toilet facilities, appropriate bedding, and a system for two-way communication, temperature control, appropriate lighting and a clock so patients could keep track of time. At the time of inspection, due to damage the seclusion room was out of action. It had not been used by patients on the Saltwood ward as the ward had not had any incidents of seclusion in the last two years.
- All staff signed for the ward keys at the hospital reception and carried them safely attached to a belt loop. All staff were issued with personal alarms. The

ward had an air lock system, which provided enough security for a low secure environment. Alarms were available for visitors. Nurse call systems were in ward areas and patient bedrooms.

Safe staffing

- Staff worked 12-hour shifts with six staff on the day shift, two qualified nurses and four health care assistants, and four staff, of which two were qualified nurses, working at nights. Staff and patients told us that staffing was stretched when there was a lot of patient activities such as escorted leave from the ward and this needed careful planning to avoid having to cancel activities. Patients told us that occasionally they had their leave cancelled.
- The ward had high levels of nursing staff vacancies with six nurse posts vacant at the time of the inspection visit. There were two health care assistant vacancies. The shifts were covered by locum staff who were contracted to work on the ward. We spoke with locum staff and they confirmed they had received a ward induction and were supervised by the ward managers. They had also completed the Cygnet mandatory training for the low-secure ward. The manager said that recruiting permanent qualified nursing staff for the ward was his top priority.
- The ward manager used a staffing calculator to establish the numbers of staff required dependent on the number of patients on the ward.
- We reviewed the shift staffing numbers for the three weeks prior to the inspection and saw that the minimum staffing numbers were being met on each shift.
- We saw there was always a qualified member of staff on the floor of the ward during our inspection. The patients had regular 1:1 meeting with their keyworkers and we saw good interactions between patients and staff during the inspection visit.
- The ward had low incidents of restraint and staff knew how to alert additional staff for assistance if required. Staff had a good understanding of relational security, which focused on the quality of relationships between staff and patients to improve ward safety. Staff were confident with using de-escalation techniques as a way of managing incidents on the ward.
- The ward had a consultant psychiatrist and a specialist ward doctor. Each patient was supported to attend and contribute to regular meetings with all the multi-disciplinary team at a ward round meeting every two weeks.
- The hospital staff turnover between January to March 2019 ranged between 4-9% per month. The ward reported no staff sickness in the period December 2018 to February 2019.
- There were 12 mandatory training courses offered by the hospital for staff working on the low-secure ward. These included life support and defibrillator training, safeguarding vulnerable adults, and infection control. The hospital compliance rate for mandatory training was 99%.

Assessing and managing risk to patients and staff

- Since the ward opened at the Maidstone hospital in December 2018 there had been no reported incidents of seclusion, or of rapid tranquilisation. In the same period there was one reported incident of restraint, and no incidents of prone restraint.
- We looked at the care records of six patients on the ward. All records we reviewed contained up-to-date risk assessments in care notes which had been regularly reviewed. The risk assessments were comprehensive, and staff had good working knowledge of the risks of all the patients.
- Staff used recognised tools to assess the patients' risks. These included the short-term assessment of risk and treatability (START), and the historical clinical risk management 20 (HCR20) which was completed with input from the ward psychologist. Both were appropriate for the patient group being treated on the ward.
- The ward had a process in place for reducing restrictive practices. The manager completed a blanket rules self-assessment tool every six months. This was next due for review in April 2019. However, we did find many blanket rules on the ward concerning access to the secure garden area and other rooms such as the quiet lounge which was kept locked. We did not see that patients had individual risk assessments in place relating to accessing areas of the ward. We raised this with the hospital director during the inspection and rules were relaxed for patients' access to the Saltwood garden while inspectors were at the hospital.

- We saw evidence that staff observations of patients were reviewed and set at levels to reflect the patient risk. All patients were reviewed once per hour as the standard frequency.

Safeguarding

- Training data showed that 100% of staff had completed safeguarding adults training. Staff we spoke with were confident with using the safeguarding procedures and how to report concerns. The ward had a named nurse lead for safeguarding. The hospital social worker supported staff and offered training and advice with safeguarding concerns.

Staff access to essential information

- Information needed to deliver care was stored securely and was available in an accessible form to staff when they needed it. Staff used a combination of paper and electronic notes to record care and treatment provided to patients. Paper notes were stored securely in locked offices and included comprehensive assessments, risk assessments and care plans.

Medicines management

- Medicines were stored safely and securely in a clinic room. Storage temperatures, including fridges, were recorded daily. An audit from February 2019 identified that fridge temperatures had gone above the recommended range. Staff had taken appropriate action and during our inspection we found that medicines were stored at safe temperatures.
- Staff carried out balance checks of controlled drugs at each shift handover. While there had not been any discrepancies, staff were not aware of the hospital's policy on how to report any controlled drug incidents.
- Staff checked expiry dates of medicines and disposed of unwanted medicines according to waste regulations. However, the waste container was overflowing, and staff said they were waiting for a new container to be delivered.
- Staff had completed online medicines training and were supported by managers to reflect on medicines incidents and share learning.
- Emergency medicines were contained within a grab bag alongside emergency equipment. Staff checked and recorded the contents daily. However, we found that one medicine was a lower strength than was on the checklist in the hospital's policy. Staff had not noticed this during their checks. We raised this with the clinical team leader during our inspection and the error was amended.
- We observed medicines being administered to three patients. The nurse had good rapport with patients and awareness of the support each patient required. Medicines were administered safely through a hatch from the clinic room and patients stood in a purpose-built area that enabled privacy. The nurse checked each medicine against the prescription chart and signed for them after they were given. The nurse was able to describe the process for reporting any medicines administration errors. Lessons from errors and incidents were discussed at handover, in meetings and were shared with staff through a newsletter.
- We looked at prescription charts and associated care records for four patients. Photos were used to identify patients correctly. Allergies and body weights were recorded. There were no missed doses. Staff recorded and rotated sites where patient's injections were administered. This helps to prevent tissue damage and ensure injectable medicines can be properly absorbed.
- Doctors reviewed patients living with long term conditions and staff carried out physical monitoring. For example, patients living with diabetes. Patients detained under the Mental Health Act received medicines in line with legal requirements.
- The service had a process in place for patients to self-administer their medicines. Medicines were supplied in monitored dosage systems; these were stored securely until required for self-administration. We were told that patients' suitability for self-administration was discussed by the multi-disciplinary team. However, there were no risk assessments in care records which was not in line with the hospital's own policy.

Track record on safety

- In the period December 2018- 20 March 2019 there had been two serious incidents reported on Saltwood ward. One incident involved a patient making threats to another. We saw that this had been recorded and reported to the Police and to the appropriate

safeguarding team. A second incident was a medical one and we saw that the patient was appropriately cared for and an investigation in to the potential cause of the incident had taken place.

- The Duty of Candour regulation explains the need for providers to act in an open and transparent way with people who use services. It sets out specific requirements that providers must adhere to when things go wrong with people receiving care and treatment. The provider had a Duty of Candour policy in place. Staff we spoke with understood the need to be open and transparent when they had made mistakes and to make written apologies when required. At the time of our inspection, we did not see any examples of its use as none of the incidents that had taken place had necessitated a written apology.

Reporting incidents and learning from when things go wrong

- The ward used a paper incident reporting book to log all incidents. These reports were then uploaded to the hospital's electronic incident database by hospital admin staff. Types of incidents which had been recently recorded were damage to ward property by a patient, discovery of contraband items, lost items and disinhibited behaviour on the ward.
- Staff we spoke with were confident about how the incident reporting system worked and confirmed that they received the outcome of investigations. Lessons learned from investigating incidents were circulated to all staff via email.
- The ward manager shared details of any incident with other ward managers and the senior team at the daily flash meeting at 10am. This meeting allowed ward managers and clinical staff to quickly share information relating to safety, risk and safeguarding daily for the whole hospital.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- The ward consultant completed a comprehensive pre-admission assessment for newly admitted patients. Areas of assessment included mental health history, medical history, social history and substance misuse.
- We looked at six patient's care records and found that clinical notes had been kept up to date and contained detailed information including comprehensive assessments and care plans.
- We reviewed the care plans of six patients and found that they were holistic, and recovery focused and based upon assessed needs. Whilst the plans were broad in scope occasionally we found that they were short and brief in detail.
- Where patients had specific physical health issues, such as diabetes, their care needs were detailed within the care plan. We saw that patient's views on their plans had been sought and recorded. Most plans had been signed by the patient.
- Records demonstrated that staff had updated care plans during a patient's admission. This included following multi-disciplinary reviews, one to one named nurse sessions or when staff and patients identified a new care need.
- The ward doctors carried out comprehensive reviews of each patient and this included both mental and physical health including the management of long-term conditions, as well as the side-effects of medications such as clozapine. There was evidence that patient risks and care plans were amended and updated regularly because of ward reviews.

Best practice in treatment and care

- The hospital offered psychological therapies recommended in National Institute for Health and Care Excellence guidance. Each ward had a psychologist and an assistant psychologist employed as part of its multi-disciplinary team. Interventions included cognitive behavioural therapy, dialectical behavioural therapy, trauma work and relapse prevention. Cognitive behavioural therapy and dialectical behavioural therapy are designed to help people change patterns of behaviour that are not helpful, such as self-harm, suicidal thinking and substance abuse.

- Patients were offered weekly 1:1 time with psychology staff to work through a structured programme called foundation block. Topics included treatment needs and readiness, relationships, substances and communication and coping styles.
- The Saltwood patients had access to a smoking cessation counsellor who also ran a group support programme to help patients dealing with addictions.
- We looked at prescription charts and associated care records for four patients. Photos were used to identify patients correctly. Allergies and body weights were recorded. There were no missed doses. Staff recorded and rotated sites where patient's injections were administered. This helps to prevent tissue damage and ensure injectable medicines can be properly absorbed.
- Doctors reviewed patients living with long term conditions and staff carried out physical monitoring. For example, patients living with diabetes. Patients detained under the Mental Health Act received medicines in line with legal requirements.
- All patients had access to a GP who attended the hospital once a week and visited the ward.
- Staff used recognised rating scales to assess and record severity and outcomes. Staff used Health of the Nation Outcome Scale (HoNOS) to record and review a patient's progress. Staff also provided examples of using physical health rating scales with patients, including the modified early warning score (MEWS).
- Staff of all grades participated in clinical audit. Staff completed a range of audits, including clinic rooms, physical healthcare, ligatures, clinical notes, patient monies, observations and infection control.

Skilled staff to deliver care

- In addition to qualified nurses and nursing assistants, the ward had a multi-disciplinary team. This included a consultant psychiatrist, a middle grade doctor, an occupational therapist, an occupational therapy assistant. The hospital had a full-time social worker who led with patients' social care needs, funding issues for patients' care and safeguarding.
- The hospital provided all staff with an induction. Induction packages were available for clinical staff, non-clinical staff, bank staff, students and agency staff. Induction provided staff with information on organisational policies and procedures and provided the opportunity to work supernumerary to ward staffing numbers. Staff also completed a ward specific orientation and induction.
- The hospital provided staff with supervision. Supervision is a meeting to discuss case management, to reflect on and learn from practice, personal support and professional development. We saw records that staff were receiving regular monthly supervision and the ward compliance for monthly staff supervision was 98%.
- Managers planned regular team meetings. Staff reported that team meetings followed an agenda, were recorded and all staff were sent a copy of the resulting record. Records showed that staff meetings included discussions about incidents, lessons learnt, training and positive comments.
- Staff received an annual appraisal of their work with their manager. The compliance rate for the completion of staff appraisals on the ward was 90%.

Multi-disciplinary and inter-agency team work

- Staff held regular and effective multi-disciplinary meetings. Each ward held a weekly multidisciplinary meeting. Staff discussed all patients on the ward and met with individual patients in the multidisciplinary meeting once every two weeks.
- Effective handover meetings between ward staff took place at changes of shift during the day. Staff recorded patient information on an electronic record to handover information to all staff commencing a shift. This information included Mental Health Act status, observation levels, identified risk, medication administered, mental health presentations and significant history from the previous seven days. Staff discussed each patient, highlighting individual needs and appointments. Staff stored and accessed completed handover sheets on computers. Following handover, the nurse in charge commencing duty by completing an initial observation of all patients. We observed one ward handover meeting and saw staff listened and contributed to discussions about patients.
- Senior and multidisciplinary team staff attended daily morning multi-disciplinary handover meeting. Staff discussed staffing levels, incidents, patient risk levels, patient observation levels, and patient community leave.

Good

Forensic inpatient or secure wards

- Staff worked with clinical commissioning groups and community mental health teams to plan for discharges. Staff invited care co-ordinators and commissioning leads to care programme approach and Section 117 discharge planning meetings. Staff reported slow communication from the Ministry of Justice that resulted in delays to accessing leave for some patients. Staff regularly contacted the Ministry of Justice for updates.

Adherence to the MHA and the MHA Code of Practice

- All staff completed mandatory training in the Mental Health Act.
- Mental Health Act documentation for detained patients was in place and completed correctly.
- Information was displayed on the ward noticeboards regarding the independent mental health advocate and how to contact them.
- We reviewed patients records of leave from the ward into the community, granted by the consultant psychiatrist. The parameters of leave were clearly documented. For example, the location of leave, time and duration and the numbers of staff required to support the patient.
- Staff supported patients to understand their rights, when detained under the Mental Health Act or as an informal patient.
- Patients medicine charts had a photograph attached of the patient together with treatment certificates, which had been authorised by the consultant psychiatrist. Treatment certificates documented the medicines and doses prescribed for the patient.
- Staff at the service were fully supported by a Mental Health Act administration team. They provided support and advice when needed and oversaw the renewals of detention under the MHA, consent to treatment and appeals against detention. The MHA team completed regular audits to ensure records and practice was in line with current legislation.

Good practice in applying the MCA

- There was a provider policy on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were aware of the policy and how to access it.
- The MCA enables people to make their own decisions wherever possible and provides guidance and for decision making where people are unable to make decisions themselves. Staff we spoke with demonstrated a good understanding of the MCA. We observed staff seeking informed consent from patients.
- No patients were subject to Deprivation of Liberty Safeguards (DoLS) at the time of our inspection.

Are forensic inpatient or secure wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- On the ward we saw examples of positive staff interactions providing patients with help and support, all delivered with kindness and respect. Staff met patients' needs in a timely manner, offered practical support with tasks, facilitated ward activities and encouraged patient participation.
- We spoke with four patients who told us that staff were generally kind and caring and responded when they needed support or assistance. They told us that staff were polite and that they usually had time to meet one-to-one with patients.
- Staff were respectful in knocking before entering bedrooms or looking through observation windows, and the staff took care at night not to wake sleeping patients
- Staff knew the patients and had a good understanding of their needs.

Involvement in care

- The hospital had an admission process that informed and oriented patients. Staff provided patients with a ward booklet and completed an induction checklist with patients.
- All patients we spoke with felt involved in decisions about their care and confirmed that staff shared copies of care plans with them. Records in paper notes demonstrated that patients were offered copies of their care plans. We saw that care plans had a recovery focus and identified patients' strengths and independence.

Good

Forensic inpatient or secure wards

- All patients had a multidisciplinary care review meeting with the care team from the ward, including their doctor, every two weeks. During our inspection we saw that patients were encouraged and assisted by staff in preparing the issues and questions that they wanted to raise at the meeting.
- Staff ensured that patients could access advocacy. We saw advocacy posters displayed in ward areas and patients were aware of advocacy services.
- Patients could make daily decisions about what activities they preferred to do at morning meetings Patient views were encouraged at the weekly ward community meeting regarding how the ward was run and any concerns.
- Patients could make choices about their meals from a menu which was available on the ward. The hospital chef offered meals which were balanced in the quantities of protein, fat and carbohydrates and patients told us that the meal choices were good. However, at the time of inspection halal meals were only available as ready-made meal options for patients requiring this.

Are forensic inpatient or secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- Beds on the low secure wards were commissioned by NHS England specialist commissioners and patients came from the local Kent area. At the time of inspection there was one patient placed from out of area.
- The hospital's website included information on bed availability, the care and treatments available on the ward and how to make a referral.
- At the time of inspection bed occupancy was at 100% with 16 male patients on the ward. Since moving to the new hospital in December 2018 the ward occupancy had been 15-16 patients.
- The hospital manager confirmed that four of these patients were classed by the hospital as delayed discharges. This equated to 25% of the available beds. One patient was discharged to the hospital rehabilitation ward shortly after the inspection visit. The reasons for the delays ranged from difficulty with agreeing funding panel approval for the purchase of move-on placements, and the lack of availability of specialist learning disability and substance misuse beds.
- There was an internal recovery pathway in place between the low-secure ward and the hospital's rehabilitation ward. Staff told us that this pathway could become delayed for patients due to the complexity of arranging funding which needed to transfer from NHS England to local clinical commissioning groups.
- The average length of stay on Saltwood ward was 28 months. There were patients whose length of stay was as high as five years and this affected the overall average. We asked for further details about patients with extended lengths of stay and the provider demonstrated that they were actively working on rehabilitation plans with the patients who had complex needs, and the MDT was working to identify funding for future placements.
- There was evidence in patient records of section 117 aftercare meetings and identification of aftercare services to be provided for relevant patients. However, the level of discharge planning was not consistent in all care plans we reviewed.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward provided a full range of rooms and equipment to support treatment and care. There was a clinic room, quiet lounge, computer room, training kitchen, large communal lounge and dining area. The hospital also provided patients with a gym.
- At the time of inspection, the computer room, quiet lounge and access to the garden area were locked and patient access was controlled by staff. Staff we spoke with were unclear why this was the case and suggested that it was how access was managed before the ward moved to the new hospital. We raised these blanket restrictions with hospital managers at the time of inspection.
- There was a secure garden with seating and a sheltered area. Staff had clear lines of sight into the garden enclosure. Access to the garden was locked and patients were able to go outside at five set times per day. We

raised this with staff who told us that the access was restricted to ensure that patients would attend daily activities. Staff had not completed individual risk assessments for patients regarding access to the garden and we raised this blanket restriction with hospital managers. Hospital managers reviewed the ward rules concerning access and unlocked the door to the garden area.

- Patients had access to activities, including at weekends. Each ward had a dedicated occupational therapist and occupational therapy assistant. We saw that there were few activities available for patients on Mondays and Fridays. Ward staff told us that this was due to a part-time occupational assistant vacancy. Staff told us that they would like to provide more activities for patients such as using the local swimming pool and a community gym. Patients confirmed that they found the general activities programme was basic and would like more variety. The hospital recovery college was planned to commence in April 2019.
- All patients had a single bedroom with ensuite shower and toilet. Following a risk assessment, staff provided key fobs to bedrooms and encouraged patients to personalise their rooms.
- Each patient had a wardrobe and a large locked storage cupboard in their bedroom. Within wardrobes, patients had access to their own safe for storage of valuables. All patients and carers reported that possessions were safe on the ward.
- The ward provided mobile phones for patients. Mobile phones were basic models, and none had cameras. Staff asked patients to sign agreements with guidance on safe phone use and respecting the confidentiality of others. Patients had access to their own phones when on leave from the hospital.
- There was a private telephone room on the ward where patients could take confidential calls. The calls were free as the phone service used the hospital internet connection.
- The hospital provided a visitor's room located near the main reception. Visiting times for the ward were set as Monday to Friday 4.30-7pm, weekends 11am-7pm.
- The hospital had its own kitchen that prepared meals on site daily. The meals were taken up to the ward and serves to patients from the ward kitchen. Patients could make meal choices from a weekly menu with 24 hours' notice. Patients commented that the quality of the food was good.
- Patients had access to hot and cold drinks from a small kitchenette in the communal area of the ward.

Patients' engagement with the wider community

- Staff had supported patients to access local shops and the town centre. The occupational therapist had completed transport assessments with some patients to promote independence.

Meeting the needs of all people who use the service

- The hospital had adjusted for people requiring disabled access. There was a lift to the ward area. The bathroom in the ward was adapted for people with disabilities and was equipped with a mobile hoist.
- The ward had a range of information available to patients. The subjects included advocacy, the Mental Health Act, how to complain, safeguarding and activities. All information was in English, but staff told us how they could get information translated into other languages.
- The hospital had a locally contracted interpreting and signing service. Staff were familiar with and knew how to access these services. We saw that staff were providing regular interpreter services for a patient who required this to participate in planning his care and treatment.
- The hospital offered a choice of food to meet dietary requirements of religious and ethnic groups. However, Halal meal options were limited to ready-made meals.
- The hospital supported patients' spiritual needs. There was a room onsite that patients could use for prayer.

Listening to and learning from concerns and complaints

- Between December 2018 and February 2019, the ward had not received any formal complaints. The service also tracked informal complaints and compliments.
- Staff knew how to respond to complaints or concerns raised with them. Firstly, staff tried to address and resolve complaints locally. If this failed, staff assisted patients to make written complaints or to speak with the ward manager.
- Senior staff met to discuss complaints and the outcomes of investigations at ward governance

meetings. Meeting records identified actions resulting from complaints, lessons learned, and actions taken to share best practice. Ward staff reported they received feedback on the outcome of the investigation of complaints through handovers, supervision or during team meetings.

- Patients we spoke with knew how to make a complaint and felt confident to do so. Patients believed they could speak to staff about complaints and would be listened to. We saw posters and information on how to make a complaint displayed in communal areas around the hospital.

Are forensic inpatient or secure wards well-led?

Good

Leadership

- Managers and clinical leaders of the multi-disciplinary team were visible and accessible to staff and patients on the ward. Staff reported they were approachable, and they listened, supported, inspired and thanked staff for their work.
- The ward had clearly designated roles including a ward manager and three clinical team leaders. The registered manager had recently reviewed and implemented changes to the leadership structure. Staff could easily identify the leadership structure through the hospital's reporting structure organogram.
- The registered manager reported to the regional operational director and the regional quality assurance manager supported the service with ensuring quality was given enough priority.
- We observed that the ward manager's office was in a side corridor off the main ward. We observed the ward manager did not have full awareness of ward activity and contact with the patients.
- Staff we spoke with told us that they were still becoming accustomed to working in a new ward environment and they said that not all ward procedures had been reviewed since the move to the hospital in December 2018. We saw this in the application of blanket restrictions on the ward.

Vision and strategy

- The provider had values to care, respect, empower, trust and have integrity. These were available to view on the hospital's website. Staff we spoke with and agreed with the hospital's values. The provider had a clear vision that was to enable people to progress on their personal journey and to be the preferred provider of outstanding care and the employer of choice in the healthcare sector.

Culture

- To support improvement and to aid staff morale, the registered manager held monthly staff forums where any staff could raise good ideas or concerns. Staff could also place suggestions into suggestion boxes that were located throughout the hospital. Staff told us they would not hesitate to seek advice or make suggestions to senior leaders.
- The provider had a clear policy advising staff how to raise concerns. Staff we spoke to were aware of this policy and said they wouldn't hesitate to raise concerns if needed.

Governance

- Leaders ensured that staff received mandatory training and monthly line management supervision. Despite staffing vacancies, the ward was covered with appropriately skilled and experienced staff.
- We reviewed eight sets of supervision notes and found that there were effective processes in place to record staff training and appraisal, and to record when staff had received supervision. However, the supervision process did not link the work of staff with the organisation's values.
- The ward had a well understood governance structure with clear reporting lines throughout the hospital. The registered manager chaired the monthly hospital wide governance meetings. Ward managers chaired the ward level governance meetings which were also held monthly.
- Managers used a performance dashboard to monitor and improve key aspects of care of treatment on the ward. The dashboard rag rated key aspects of performance including the amount of therapeutic activity, key documentation, numbers of restraints and

seclusions, admissions and discharges and staffing. Ward managers were familiar with the dashboard and said they used the findings to improve the quality of care on their respective wards.

- The work of ward staff was supported by the regional quality assurance manager who reported to the corporate governance team to ensure consistency and learning across the organisation.
- The ward managers and clinical leaders completed regular quality walkarounds which included key aspects such as first impressions, documentation, physical healthcare and safety and security. Leaders who completed these walkarounds gave timely feedback to staff. Ward meetings took place monthly and staff told us that these meetings were structured and helpful.
- There was an annual audit cycle. Staff completed audits on key areas such as medicines management, seclusion and long-term segregation, infection control and mental health act. We saw that audit findings were discussed in a range of groups which led to practice changes where appropriate.

Management of risk, issues and performance

- The learning from complaints, incidents and patient feedback was identified and actions were planned to improve the service. Staff and patients were involved in post incident de-briefs and review processes.
- The provider had a risk register as a means of capturing the collective risks at the service. This meant there were formal mechanisms for the managers, senior managers and board of directors to assess and manage risks.

Information management

- Information needed to deliver care was stored securely and was available in an accessible form to staff when they needed it. Staff used a combination of paper and electronic notes to record care and treatment provided to patients. Paper notes were stored securely in locked offices and included comprehensive assessments, risk assessments and care plans.
- The provider had an audit programme which included the review of documentation, to ensure staff had the information they needed to deliver safe and effective care.
- The provider ensured the confidentiality of patient records through their data protection policy, staff training and practical measures, such as files stored in locked cupboards, rooms. Information was only shared with other professionals and agencies when appropriate.

Engagement

- The ward prioritised engagement with service users. There was a weekly community meeting where service users could raise any concerns or ideas for improvement. These were then communicated through 'you said, we did' boards which we observed on the ward.
- The service had a newly established carer's group and monthly newsletter. The ward had an identified carer's lead. Ward staff had invited carers to attend a 'spring tea' which was to take place shortly after our inspection. Similarly, all carers were invited to attend the hospital for an open day prior to its official opening in October 2018.

Learning, continuous improvement and innovation

- The service had been focussed on implementing practical care and operational procedures as they had only opened in October 2018. The registered manager described the need to get the basics in place before beginning to focus on innovation and quality improvement. Although there was clear evidence of a commitment from leaders to continually improving there was no overarching approach to quality improvement.
- Patients on the ward would have access to a recovery college from April 2019. This was to be an innovative approach to ensuring that patients and staff could access a range of mental health related education and personal development.
- The clinical services manager shared a monthly newsletter called 'lessons learnt' with all ward staff. The newsletter detailed learning from incidents, audits, national guidance and complaints. Staff we spoke with were familiar with the newsletter and could describe lessons learnt from this.

Good

Forensic inpatient or secure wards

- Ward staff took part in weekly professional development days. During our inspection, we saw this taking place. Staff would deliver case presentations for discussion or specific staff would give talks on their areas of interest or expertise.

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

- The ward environment was bright, clean and welcoming. The décor was well maintained, and the furniture was comfortable.
- The ward layout enabled staff to observe all areas of the ward. There was always a member of staff in the communal area of the ward. A ligature assessment was carried out prior to the ward opening in October 2018 and this was updated in February 2019. Where risks had been identified there were plans in place to mitigate these, for example by carrying out individual risk assessments for each patient and staff conducting regular checks of high-risk areas. Closed circuit television (CCTV) was also in place in all communal areas of the ward.
- The ward was safe and secure. A member of staff was allocated to carry out security checks on each shift which included checking for any environmental risks and ensuring that all cutlery was accounted for at the end of mealtimes. The security lead reviewed the reports from each shift weekly to ensure that any identified actions had been completed.
- All bedrooms and bathrooms were fitted with a call button to enable patients to request assistance. Patients told us that staff were responsive when called. Staff carried personal alarms and a member of staff on each shift was allocated to respond when assistance was requested on other wards. Staff also used radios to communicate with staff in other areas of the hospital.
- Staff adhered to infection control principles, including handwashing. There was an identified infection control lead on the ward who carried out quarterly audits to assess infection control processes on the ward. Staff and visitors could access hand cleaning gel at the entrance to the ward.
- Emergency resuscitation equipment was available. The physical health lead was responsible for checking that the security tags on this equipment were intact daily and doing a full check of the equipment every week, which included checking it was all in date. Ligature cutters were available in the nursing office and in a linen cupboard located halfway down the bedroom corridor. Staff we spoke with knew where the emergency equipment was located. All staff had completed training in basic life support including how to use a defibrillator and qualified nursing staff had completed training in immediate life support. Managers carried out regular resuscitation simulations where the alarm was raised, and staff were called to deal with a life-like emergency. Managers gave feedback to staff involved in the simulations and action plans were generated.
- There were no seclusion facilities on the ward. Staff told us they would use the seclusion room on Saltwood or Bearstead wards if needed, however they had not needed to seclude a patient since the ward opened in October 2018. Staff we spoke with were aware that the seclusion room on Saltwood ward was closed and that the seclusion room on Bearstead ward had recently re-opened following an incident.

Long stay or rehabilitation mental health wards for working age adults

Good

Safe staffing

- At the time of our inspection six patients were being cared for on the ward. The ward operated a two-shift system with two qualified nurses and two healthcare assistants working the day shift, and one qualified nurse and two healthcare assistants working the night shift. The hospital used a staffing matrix which showed that the number of staff working day shifts would increase once there were 12 patients on the ward. When the ward reached maximum capacity of 16 there would be two qualified nurses and three healthcare assistants working the day shift; staffing for the night shift would remain the same. Managers told us that staffing levels could be increased if needed, for example if patients required an enhanced level of observation.
- The hospital was still recruiting to fill all staff vacancies. On Kingswood ward there was a 40% vacancy rate for qualified nurses and a 16% vacancy rate for healthcare assistants. Where possible bank and agency staff were being used to fill any gaps while recruitment was taking place. Despite this, there were 65 unfilled shifts between October 2018 and the time of our inspection. However, patients told us that they always felt safe on the ward. They also said that activities were rarely cancelled due to staff shortages. Staff told us that they would always try to re-arrange activities rather than cancelling them, for example when there was not enough staff to facilitate a planned group outing this was re-arranged for another day, and staff organised a football game to take place instead which required fewer staff members to facilitate. Weekly recruitment days were taking place to try and recruit staff to fill the vacancies. Sickness rate was less than one percent.
- We reviewed training records which showed that over 90% of staff had completed all their mandatory training. Where there were gaps staff members had been given a deadline for when they needed to complete this by. Senior managers monitored training compliance via their weekly meetings. Checks were in place to ensure that agency staff had completed mandatory training prior to them working any shifts on the ward.

Assessing and managing risk to patients and staff

- Staff managed risks to patients well. Staff used the Short-term Assessment of Risk and Treatability tool (START) to assess risk. Information about risk was obtained from each patients' previous placement and from the patient on admission. Risk assessments were reviewed at regular intervals and updated following incidents. Each patient had a red, amber or green risk rating and this was discussed in every handover meeting. All six patients being cared for on the ward had risk assessment and management plans in place. However, in the records of one patient we found that risks relating to their physical health had management plans in place and were mentioned in progress and handover notes but had not been included on the START risk assessment. Staff told us that they were working to improve the quality of the START risk assessments and that the ward psychologist was taking a lead on this.
- There were some blanket restrictions in place on the ward, for example the kitchen was kept locked and patients could only use this under staff supervision regardless of their individual level of risk. Blanket restrictions were reviewed by staff and patients every six months. The blanket restrictions we observed in use were proportionate to the patient risks on the ward at the time of our inspection. There was a list of items which were banned on the ward, such as drugs, weapons and alcohol.
- The provider had a search policy in place and regular audits took place to check that staff adhered to this. Searches were only carried out if staff had reason to suspect that a patient was bringing contraband items onto the ward. We reviewed three room search forms and found that these clearly documented the rationale for the search and the views of the patient.
- All staff had been trained in the prevention and management of violence and aggression and staff told us they felt confident in de-escalation. There had been one instance of restraint on the ward since it opened. Prone restraint had never been used.
- Informal patients were able to leave the ward as they wished. Staff worked with informal patients to create a mutually tailored agreement which stated the time they would return to the ward.

Safeguarding

- Staff we spoke with knew how to recognise abuse and what actions they should take to ensure that patients

Long stay or rehabilitation mental health wards for working age adults

Good

were protected. There were two safeguarding leads within the hospital who staff could approach for advice on safeguarding matters. All staff had completed mandatory safeguarding training.

Staff access to essential information

- Information needed to deliver care was stored securely and was available in an accessible form to staff when they needed it. Staff used a combination of paper and electronic notes to record care and treatment provided to patients. Paper notes were stored securely in locked offices and included comprehensive assessments, risk assessments and care plans.

Medicines management

- Medicines were stored safely and securely in a clinic room. Storage temperatures, including fridges, were recorded and these were within recommended ranges. Staff checked expiry dates of medicines and disposed of unwanted medicines according to waste regulations. Staff carried out balance checks of controlled drugs twice a day and records were completed in line with legal requirements.
- Staff had completed online medicines training and were supported by managers to reflect on medicines incidents and share learning.
- We looked at prescription charts and associated care records for five patients. Prescription charts were legible, and allergies were recorded. However, bodyweights were not written on charts, although details were found in care records. We found that staff had not completed physical health monitoring records for one patient receiving high dose antipsychotic treatment (HDAT). However, nursing staff were able to explain the observations carried out and how patients are educated about any side effects to report to staff.
- Patients completed self-assessments recording their symptoms and side effects from their treatment. These were discussed at multi-disciplinary team meetings. Care plans stated if patients required extra support to take their medicines. For example, if they needed to be observed closely following medicines administration due to non-compliance.
- The hospital offered nicotine replacement therapy (NRT) to patients who smoked. NRT was prescribed appropriately on charts and patients were supported.
- Patients detained under the Mental Health Act received medicines in line with the Mental Health Act requirements.
- The provider had a clear process in place to support patients to self-manage their medication. This was a three-stage process. Patients first had to attend for their medicines at the right time without prompting; they then had supervised consumption and finally moved on to having their own access to medicines. One patient was being supported to do this.

Track record on safety

- There had been one serious incident since the ward opened in October 2018. This involved medication being given to the wrong patient. An investigation into the incident was underway at the time of the inspection. There was evidence that staff had learnt from this and that procedures had been updated to prevent further incidents occurring.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise incidents and recorded these appropriately in an incident log book. Incident reports were countersigned by the ward manager and uploaded onto the electronic system within 72 hours. Staff involved in incidents were asked to write a reflective statement.
- Lessons learnt from incidents were discussed in handovers and staff meetings. The clinical services manager sent out a monthly lesson learnt bulletin to all staff via email and printed copies were also kept in the nursing office. All staff we spoke with were able to give examples of lessons learnt from incidents which had taken place on other wards and were also aware of which wards had the highest number of incidents.

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

Long stay or rehabilitation mental health wards for working age adults

Good

- Staff assessed the physical and mental health of all patients on admission. All six patients had care plans in place which included short and long-term strategies for how to manage their needs. Care plans were reviewed every four weeks. All care plans were personalised and included the views of the patient. This was in line with National Institute for Health and Care Excellence (NICE) guidance. However, we found that care plans did not always include the relevant interests of the patients which were mentioned in their progress notes. For example, a patient was being supported to maintain a hobby in the community, but this was not included in their care plan.
- We also found that recovery care plans did not always capture patient's strengths and weaknesses; half of the care plans we reviewed were very basic.

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. This included access to psychological therapies and recovery focused interventions including support with everyday living skills. The occupational therapist worked with patients to prepare their own breakfast and cook meals several days each week.
- Staff ensured that patients had access to physical healthcare and supported patients to live healthier lives. Patients received a physical health examination on admission and their physical health was reviewed at least weekly depending on individual circumstances. A general practitioner visited the ward once a week. Patients were able to access dentists, opticians and podiatrists in the community. However, while we found evidence of patients being supported to attend optician appointments, we also found in one care record that a patient had needed to see a dentist, and this had not been facilitated. Staff told us that this was because the local dentists were not accepting new patients and they advised them to try again later, but this had not been followed up. There was a physical health lead on the ward and the hospital was also in the process of recruiting a registered general nurse to cover all wards.
- All staff participated in clinical audits. Staff completed a range of audits, including clinic rooms, physical healthcare, ligatures, clinical notes, patient monies, observations and infection control. These were regularly reviewed and updated at governance meetings and actions identified to ensure improvements were made.
- Staff used recognised rating scales to assess and record severity and outcomes. The Health of the Nation Outcome Scale (HoNos) was carried out on admission, two weeks following admission and then at every care programme approach meeting following this. The Global Assessment of Functioning scale was also completed every four weeks.

Skilled staff to deliver care

- The ward team included a range of specialists required to meet the needs of patients. A full-time psychologist worked on the ward and an assistant psychologist was due to commence employment the week following the inspection. An occupational therapist and an occupational therapy assistant worked on the ward Monday to Friday. A consultant psychiatrist worked on the ward three days a week and there was a full-time ward doctor. A dietician had recently been recruited by the hospital but was not yet in post at the time of the inspection. Speech and language therapists were accessed via the visiting general practitioner.
- Managers supported staff with supervision, reflective practice sessions and opportunities to update and further develop their skills. Staff received supervision once a month. Records showed that supervision rates were 97%. A psychologist from another ward facilitated reflective practice sessions once a month which staff were encouraged to attend. Staff told us they felt supported to further develop their skills, for example it had been arranged for healthcare assistants to complete training in phlebotomy and electrocardiograms.

Multi-disciplinary and inter-agency team work

- There was a team of social workers working across the hospital to support the wards. They attended ward rounds and care programme approach (CPA) meetings. The ward also had good links with care co-ordinators who were invited to attend ward rounds and CPA meetings.
- The hospital had developed good links with local police who worked from the hospital site one day a week. The

Long stay or rehabilitation mental health wards for working age adults

Good

hospital was still working to develop relationships with some organisations in the local community, for example, with a local leisure centre to enable patients to go swimming.

Adherence to the MHA and the MHA Code of Practice

- All staff completed mandatory training in the Mental Health Act.
- Mental Health Act documentation for detained patients was in place and completed correctly.
- Information was displayed on the ward noticeboards regarding the independent mental health advocate and how to contact them.
- We reviewed patients records of leave from the ward into the community, granted by the consultant psychiatrist. The parameters of leave were clearly documented. For example, the location of leave, time and duration and the numbers of staff required to support the patient.
- Staff supported patients to understand their rights, when detained under the Mental Health Act or as an informal patient.
- Patients medicine charts had a photograph attached of the patient together with treatment certificates, which had been authorised by the consultant psychiatrist. Treatment certificates documented the medicines and doses prescribed for the patient.
- Staff at the service were fully supported by a Mental Health Act administration team. They provided support and advice when needed and oversaw the renewals of detention under the MHA, consent to treatment and appeals against detention. The MHA team completed regular audits to ensure records and practice was in line with current legislation

Good practice in applying the MCA

- There was a provider policy on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were aware of the policy and how to access it.
- The MCA enables people to make their own decisions wherever possible and provides guidance and for decision making where people are unable to make decisions themselves. Staff we spoke with demonstrated a good understanding of the MCA. We observed staff seeking informed consent from patients.
- No patients were subject to Deprivation of Liberty Safeguards (DoLS) at the time of our inspection.

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

Good

Kindness, privacy, dignity, respect, compassion and support

- All the patients we spoke with said that staff were kind, compassionate and respectful. Patients told us that staff always knocked prior to entering bedrooms and they felt as though their privacy was maintained.
- We observed staff interacting with patients in a positive manner throughout the inspection. Staff always greeted patients in passing. We observed staff playing pool and completing jigsaws with patients in the communal area. Patients told us that staff often engaged in activities they enjoyed, such as dancing competitions or tai-chi.
- We observed a handover session and found that staff had good knowledge about all the patients and their individual preferences. Staff used positive words when speaking about patients and seemed genuinely pleased to see patients achieving their goals.

Involvement in care

- All the patients we spoke with felt involved in their care planning and had been offered a copy of their care plan. All care plans we reviewed included the views of the patient.
- Staff ensured that patients had access to independent advocates. Posters about the advocacy service and how to contact them were on display in the communal area of the ward. All patients we spoke with were aware of the advocacy service and the support they offered.
- Patients were given a handbook on admission to the ward which included information about what to expect

Long stay or rehabilitation mental health wards for working age adults

Good

during their first few days; mealtimes; smoking; phone and internet use; medication times; activities; therapies; visiting times; how to access fresh air; leave; contraband items and details of the different meetings that took place. Patients were also given a welcome box which contained a notepad, sweets, biscuits, toiletries and an e-cigarette for those who smoked.

- Patient community meetings took place weekly and were attended by senior hospital managers, housekeeping staff and the head chef. This enabled patients to give feedback about menu choices. We reviewed copies of community meeting minutes and found that any actions were documented and reviewed in subsequent meetings to ensure they were followed through. There was also a "you said, we did" board displayed on the ward where staff wrote down suggestion's patients had made and how they had addressed them.
- Staff involved family members appropriately. All the patients we spoke with told us that their family were involved in their care and all the care plans we reviewed demonstrated family views and involvement. We saw evidence that home leave had been facilitated and of family members visiting the ward. Staff told us that the operational policy included suggested visiting times but that they would be flexible to meet the individual needs of patients and their families. Family members were also invited to attend ward rounds.
- Patients were invited to sit on recruitment panels for new members of staff. They were able to write their own questions and were kept informed as to whether interviewees had been successful.

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

- Since opening in October 2018 six patients had been admitted to the ward. No patients had yet been discharged. Staff told us that the expected length of stay would be 12-18 months and they began planning for discharge when patients were admitted to the ward. Patients we spoke with were aware of their estimated discharge date and the steps they needed to take to get there.
- Staff had a clear understanding of the recovery-oriented focus of the ward and how the needs of the client group differed to those on an acute inpatient ward.

The facilities promote recovery, comfort, dignity and confidentiality

- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and had a key for their room, so they could keep their personal belongings safe. Any items which were not permitted on the ward, for example cigarettes, were labelled and stored in a locked cupboard. Patients told us they could personalise their bedrooms to make them feel more at home.
- There was a quiet room, which patients could access for privacy. Each patient had their own set of log in details for the ward computer room which they could access freely. There was a multi-faith room and a gym on the lower ground floor of the hospital which patients could access with staff supervision following an induction.
- Patients had access to outside space. There was a terrace off the communal lounge which was kept open during the day and locked at midnight. Staff told us that if patients requested fresh air during the night the terrace would be opened. There was a sign displayed on the ward stating that 'fresh air' breaks were available for 30 minutes three times a day. We questioned this with staff who told us that this referred to grounds leave. Staff told us they would update the sign to avoid any confusion as patients could always access fresh air throughout the day.
- The food was of a good quality and patients could make hot/cold drinks and snacks in the communal area at any time. Patients told us that the portion sizes were enough and that there was good variety. One patient told us this had "improved dramatically" since the new head chef had been in post. When clinically appropriate, staff supported patients to self-cater using the occupational

therapy kitchen. The occupational therapist assisted patients to make their own breakfast three days a week and took patients out to the supermarket and helped them to cook dinner once a week.

- The hospital had a shop which patients could volunteer to work in on a rota basis. We found that staff had facilitated some patients to access groups and hobbies in the local community, but that other patients had expressed interest in activities which had not been facilitated. For example, in the records of two patients it stated they had expressed an interest in gardening, but this need was not captured in their care plans and it was unclear how staff planned to address this. Some patients had also expressed an interest in going to college which had not yet been facilitated. However, the service was due to open a recovery college in April 2019 and the registered manager had been in contact with a local college to arrange for a mutually beneficial partnership whereby staff would deliver mental health first aid training in return for educational support and equipment to students within the recovery college.
- The ward had a weekly activity timetable which included psychological therapies and activities led by the occupational therapy team. Healthcare assistants led activities on weekends. Each patient also had their own individual timetable which could be updated as needed during morning planning meetings. Patients told us that they appreciated the structured days on the ward and that their time was always occupied. They said that staff listened to their individual requests for activities, for example some of the patients were very interested in music so staff had arranged karaoke nights and purchased a guitar.

Patients' engagement with the wider community

- Staff had supported patients to access local shops and the town centre. The occupational therapist had completed transport assessments with some patients to promote independence. Staff also facilitated group leisure outings once a month, for example to the cinema, bowling or to play mini golf.

Meeting the needs of all people who use the service

- The ward and terrace area were accessible to patients with mobility difficulties via a lift. There were also disabled rooms available.
- Staff ensured that patients' spiritual needs were met. Patients were able to access the multi-faith room in the hospital and staff also facilitated church visits for those who wished to attend.
- Staff told us that information could be provided to patients in other languages if needed and that an interpreter service was available, however these had not yet been needed.

Listening to and learning from concerns and complaints

- The ward had not received any complaints since opening in October 2018. Patients told us that they knew how to make a complaint but that they had not had reason to.
- Managers told us that complaints were discussed in the hospital integrated governance meeting, which enabled staff to learn lessons from complaints from other wards within the hospital.

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

Good

Leadership

- We were impressed by the skills and knowledge of the registered manager and the clinical services manager. The registered manager had recently reviewed and implemented changes to the leadership structure. Staff could easily identify the leadership structure through the hospital's reporting structure organogram. The registered manager directly line managed the clinical services manager, the medical director and the admin manager. In turn, these managers line managed other leaders of the service. For example, the clinical services manager line managed the ward managers and the heads of the other clinical disciplines such as psychology and social work. Similarly, the medical director managed the consultant body and the ward doctors.

Long stay or rehabilitation mental health wards for working age adults

Good

- The registered manager reported to the regional operational director and the regional quality assurance manager supported the service with ensuring quality was given enough priority.
- The ward manager told us that they felt recognised and extremely well supported by senior leaders within the organisation. They also felt that there was a strong network of peer support from other ward managers within the hospital. They reported good access to leadership training and said that they were given opportunities to further develop in areas they were interested in, for example being given the opportunity to develop and deliver training.
- The registered manager had developed positive means of engaging with staff. All staff we spoke with reported that the registered manager was approachable and had a visible presence at the hospital including attending community meetings on the wards. Staff told us that the registered manager and clinical services manager had attended induction with new starters prior to the hospital opening and that this was approached from an "everyone is equal" standpoint. During the inspection we observed the registered manager on the ward greeting staff and patients by name.

Vision and strategy

- The provider had a set of corporate values which were integrity, trust, empower, respect and care that were understood by the leaders of the service. These were displayed in the nursing office. The provider had a clear vision that was to enable people to progress on their personal journey and to be the preferred provider of outstanding care and the employer of choice in the healthcare sector. All staff we spoke with were aware of these values. However, when we reviewed supervision records we found that they did not link the work of staff to the organisational vision or values.
- The registered manager was clear in discussions that staff were committed to providing the best possible care to patients but that as a new service they had been focussed on setting up the practical elements of the service. He reported that they were now focused on improving the safety and quality of the service.

Culture

- To support improvement and to aid staff morale, the registered manager held monthly staff forums where any staff could raise good ideas or concerns. Staff could also place suggestions into suggestion boxes that were located throughout the hospital. Staff told us they would not hesitate to seek advice or make suggestions to senior leaders.
- The provider had a clear policy advising staff how to raise concerns. Staff we spoke to were aware of this policy and said they wouldn't hesitate to raise concerns if needed.
- Staff on Kingswood ward were attending a development day shortly after the inspection.

Governance

- Leaders ensured that staff received mandatory training and monthly line management supervision and that despite staffing vacancies the wards were covered by staff with appropriate skills and experience.
- The service had a well understood governance structure with clear reporting lines throughout the hospital. The registered manager chaired the monthly hospital wide governance meetings. Ward managers chaired the ward level governance meetings which were also held monthly.
- The service used a performance dashboard to monitor and improve key aspects of care and treatment. The dashboard rag rated key aspects of performance including the amount of therapeutic activity, key documentation, numbers of restraints and seclusions, admissions and discharges and staffing. Ward managers were familiar with the dashboard and said they used the findings to improve the quality of care on their respective wards.
- The service was supported by the regional quality assurance manager who reported to the corporate governance team to ensure consistency and learning across the organisation.
- The service also completed regular quality walkarounds which included key aspects such as first impressions, documentation, physical healthcare and safety and security. Leaders who completed these walkarounds gave timely feedback to staff.

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Good

- The service had an annual audit cycle. Staff completed audits on key areas such as medicines management, infection control and the Mental Health Act. We saw that audit findings were discussed in a range of groups which led to practice changes where appropriate.
- The heads of department met weekly to discuss key areas of operational safety and quality. We reviewed minutes of these meetings which showed they were well attended, actions were tracked, and changes arose as a result where required. For example, we saw that the on-call rota was discussed, and changes made where needed.

Management of risk, issues and performance

- The learning from complaints, incidents and patient feedback was identified and actions were planned to improve the service. Staff and patients were involved in post incident de-briefs and review processes.
- The provider had a risk register as a means of capturing the collective risks at the service. This meant there were formal mechanisms for the managers, senior managers and board of directors to assess and manage risks.

Information management

- Information needed to deliver care was stored securely and was available in an accessible form to staff when they needed it. Staff used a combination of paper and electronic notes to record care and treatment provided to patients. Paper notes were stored securely in locked offices and included comprehensive assessments, risk assessments and care plans.
- The provider had an audit programme which included the review of documentation, to ensure staff had the information they needed to deliver safe and effective care.
- The provider ensured the confidentiality of patient records through their data protection policy, staff training and practical measures, such as files stored in locked cupboards, rooms. Information was only shared with other professionals and agencies when appropriate.

Engagement

- The service had prioritised engagement with patients. Each ward had a weekly community meeting where patients could raise any concerns or ideas for improvement. These were then communicated through a “you said, we did” board.
- Service leaders invited patients to attend the monthly information governance meetings, so they could contribute to quality monitoring and improvement. The service had also set up a ‘people’s council’ whose aim was to ensure the people’s views were represented across the service.
- The service had a newly established carer’s group and monthly newsletter. Each ward had an identified carer’s lead. The service had invited carers to attend a ‘spring tea’ which was to take place shortly after our inspection. Similarly, all carers were invited to attend the hospital for an open day prior to its official opening in October 2018.
- Service leaders made efforts to engage with the wider community. The service had held an open day for members of the public prior to its official opening. From this, service leads had been able to recruit volunteers. Service leads had developed working relationships with local members of parliament, local business groups and the local NHS trust.

Learning, continuous improvement and innovation

- The service had been focused on implementing practical care and operational procedures as they had only opened in October 2018. The registered manager described the need to get the basics in place before beginning to focus on innovation and quality improvement. Although there was clear evidence of a commitment from leaders to continually improving there was no overarching approach to quality improvement. Staff had not received training in quality improvement methodology. However, all staff described a culture that was focused on improvement and said that they could raise new ideas in an open and supported way.

The service was due to open a recovery college in April 2019.This was to be an innovative approach to ensuring that patients and staff could access a range of mental health related education and personal development.

Long stay or rehabilitation mental health wards for working age adults

Good

- The clinical services manager produced a monthly newsletter called 'lessons learnt'. The newsletter detailed learning from incidents, audits, national guidance and complaints. Staff we spoke with were familiar with the newsletter and could describe lessons learnt from this.
- The service held weekly staff continued professional development days. During our inspection, we saw this taking place. Staff would deliver case presentations for discussion or specific staff would give talks on their areas of interest or expertise.
- The ward did not participate in the Accreditation for Inpatient Mental Health Services – Rehab programme managed by the Royal College of Psychiatrists, however managers told us they intended to sign up soon.

Outstanding practice and areas for improvement

Outstanding practice

- The service had an outstanding working relationship with the local police force. Two police officers were designated as key liaison officers for the service. They had their own office space at the service and worked from the service one day every week. The police officers attended debriefs for staff and patients for all incidents that took place that involved the need for police attendance or support. The police also attended and provided feedback at monthly governance meetings and local safeguarding meetings. They were a key contact point for all staff and patients and regularly attended the wards informally. Staff valued input from the police and continuously looked to make improvements based on their feedback.
- The culture on Roseacre ward was exceptional. We observed staff to be inspirational drivers for engaging and enabling patients on the ward. Staff were highly motivated, and this had a noticeable positive impact on patients who were also motivated. Staff were engaging with each other, the service and the organisation and demonstrated they drew on each other's strengths whilst providing a high level of support.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that when incidents take place, appropriate action is always taken to remedy the situation and prevent future reoccurrence.

Action the provider SHOULD take to improve

- The provider should ensure that all staff are enabled and supported to make appropriate safeguarding referrals to the relevant agencies (All wards).
- The provider should ensure that there is a clear rationale recorded for any blanket restrictions across the wards that reflect the environment and the patient risks, and that staff understand why these are in place (All wards).
- The provider should ensure they further develop staff skills to support them in working in a psychiatric intensive care environment (Bearstead ward).
- The provider should ensure they review the actions taken in respect of the seclusion suite on Bearstead ward.
- The provider should ensure that all identified patient risks are included on their risk assessment (Kingswood ward).
- The provider should ensure that care plans are holistic and include all relevant information about patients' strengths and interests (Kingswood ward).
- The provider should ensure that all physical health monitoring for patients receiving high dose antipsychotic treatment (HDAT) is recorded (Kingswood ward).
- The provider should ensure all patients have access to primary health services within the local area (Kingswood ward).
- The service should ensure patients are appropriately risk assessed for safe self-administration of their medicines as per their policy. Waste containers are available to dispose of medicines safely and all staff are aware of how to report controlled drug incidents (Saltwood ward).
- The provider should ensure that there is a programme of activities for patients that is varied and regular and provided consistently across the week (Saltwood ward).
- The provider should ensure the manager and leadership team on Bearstead ward receive the support to develop the skills so they can manage the ward with confidence

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments were not always completed and did not identify and mitigate all risks. Appropriate action was not always taken in response to incidents to remedy the situation and prevent future reoccurrence. This was a breach of regulation 12 (1) (2) (a) (b)