Elysium Healthcare (St Mary's) Limited

St Mary's Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The service did not have sufficient numbers of appropriately skilled permanently deployed staff to meet people's needs and keep them fully safe.
- Restrictive practices were used on the acute ward including searching of patients. These restrictions were not individualised and went beyond what we would expect to find on a mental health acute ward.
- Staff were still not keeping appropriate records when people were placed in seclusion so it was still not easy to check whether the safeguards were met. This was despite us raising this before.
- Governance processes needed to improve further to help the service keep people safe, and provide good care, support and treatment.

However:

- People's care and support was provided in an environment which met people's sensory and physical needs. Managers had agreed significant investment to improve the safety, maintenance and furnishings of the hospital.
- People's risks were assessed regularly and managed safely. People were involved in managing their own risks whenever possible.
- People were protected from abuse and poor care.
- People were supported to be independent and had control over their own lives. Their human rights were upheld.
- People now received kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs.
- People had their communication needs met and information was shared in a way that could be understood.
- People's care, treatment and support plans, reflected their sensory, cognitive and functioning needs.
- People received care, support and treatment that met their needs and aspirations. Care focused on people's quality of life and followed best practice.
- The service provided care, support and treatment from trained staff and specialists able to meet people's needs. Managers ensured that staff had relevant training, regular supervision and appraisal.
- People and those important to them, including advocates, were actively involved in planning their care. A multidisciplinary team worked well together to provide the planned care.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005. Managers now had better systems to ensure staff worked within the rules of the Mental Health Act
- Most people made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- People were in hospital to receive active, goal-oriented treatment. Most people had plans in place to support them to return home or move to a community setting. Staff worked well with services that provide aftercare to ensure people received the right care and support in place they went home.
- People felt confident to raise concerns and complaints. People now received appropriate responses to their complaints and leaders kept better records for managing complaints.
- Staff supported people through recognised models of care and treatment for people with a learning disability or autistic people.
- People, and those important to them, worked with leaders to develop and improve the service.

Summary of findings

The service was able to show how they had regard to the principles of 'Right support, Right Care, Right Culture'. This is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people to ensure people receive choices, dignity, independence and good access to local communities that most people take for granted.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for people with acquired brain injury	Requires Improvement 	We have reported and rated all the wards at St Mary's Hospital together within this report. Please see the overall summary for an overview of our findings. The report includes our findings about the wards for people with acquired brain injury together with the wards for people with learning disabilities and autistic people and the mental health health acute ward. This is due to the relatively low number of beds on the wards that did not care for people with acquired brain injury.

Summary of findings

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Summary of this inspection

Background to St Mary's Hospital

St Mary's Hospital is based in Warrington and provides specialist services for people with acquired brain injury, wards for people with learning disabilities and autistic people and a mental health acute ward for adults of working age. It is part of the Elysium Healthcare group, which also has other mental health and learning disability hospitals across England.

St Mary's Hospital is a 67-bed hospital which has five wards:

- Cavendish ward, a 17-bed locked rehabilitation ward for men with an acquired brain injury, serving as a step down from low secure services. It included four flats that had developed into specialist placements for people with complex sensory needs.
- Dalston ward, an 18-bed low secure ward for men with an acquired brain injury.
- Adams Ward, a 12-bed medium secure ward for men with an acquired brain injury including people who are also deaf or hearing impaired.
- Leo ward, a 12-bed assessment, treatment and rehabilitation ward for autistic people. People on the unit have a primary diagnosis of an autism often accompanied by co-morbid conditions and/or a history of regularly showing emotional distress.
- Hopkins ward, a four-bed assessment, treatment and rehabilitation ward for autistic people currently used as two separate, two-bed units providing bespoke hospital placements. Currently it was used for one under 18-year-old and one person transitioning to adult services. Leo and Hopkins wards were next to each other and worked together under the same ward manager and staff group.
- Eve ward, a four-bed mental health acute ward for men which was used to relieve interim bed pressures on the local NHS acute mental health service.

There is a registered manager, accountable officer and nominated individual for this location.

The service is registered to provide the following regulated activities:

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

NHS England and regional specialist commissioners fund the care of people in the medium and low secure wards. The local clinical commissioning group funds people admitted to the non-secure services. St Mary's Hospital accepts referrals from across the United Kingdom and from Ireland.

This is the fourth time we have inspected the St Mary's hospital since it has been managed and overseen by the Elysium Healthcare group. The Elysium Healthcare group took over the running of St Mary's Hospital in August 2018.

- We inspected in March 2019 and we rated four key questions as requires improvement (effective, caring, responsive and well led) and one key question (safe) as inadequate. We issued a warning notice in relation to regulation 12 - safe care and treatment relating to the management of medicines and several requirement notices.
- We returned in July 2019 to check whether the requirements of the warning notice had been met. We found that improvements had been made and the warning notice had been met.
- We returned in December 2019 and checked whether the improvements had been made to the concerns relating to the safe key question. On that inspection, we found that the provider had taken enough action to address the requirement notices relating to safety.

Summary of this inspection

What people who use the service say

We spoke with 17 people. Many people were complimentary about the care they received from hospital staff. Most people told us staff treated them with dignity and respect and were very friendly. Some people told us they were not happy. In summary, this was because they were either detained and did not want to be kept in hospital or they reported there was sometimes a lack of regular staff on the wards which led to leave, and activities being delayed or cancelled.

We used picturebank cards to help communicate and understand the experience of two autistic people – they placed many aspects of their care in hospital in the positive experience column.

We spoke with seven carers. Most of these were very complimentary about the care that their relatives had received. The themes from carers were similar to those from people in that they also commented on the lack of staff and high numbers of agency staff. Many carers felt that the hospital could run more activities especially community based activities and provide more in terms of rehabilitation but accepted that some of these had been halted due to the coronavirus restrictions.

The main service provided by this hospital was specialist services for people with acquired brain injury. The hospital also provides wards for autistic people and people with learning disabilities and a small mental health acute ward for adults of working age. Where our findings on specialist services for people with acquired brain injury – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the main service.

How we carried out this inspection

The team that inspected the service comprised four CQC inspectors, a CQC Mental Health Act reviewer, a CQC inspection manager, one specialist advisor (a nurse) and an expert by experience.

We were also assisted by a sign language interpreter who helped us to communicate with patients who were deaf.

This inspection was unannounced, which means that the provider did not know we were coming before we arrived. The inspection on 5 July was unannounced and took place in the evening (from 7pm to 11 pm).

Before the inspection visit, we reviewed information that we had gathered about the location and requested additional information from the provider.

During the inspection visits, the inspection team:

- visited all the wards
- looked at the quality of the ward environment
- observed how staff were caring for people including observing using our tool called the short observational framework for inspection
- spoke with 17 people
- communicated with two other people using specialist communication equipment (Talking Mats)
- spoke with seven carers
- spoke with managers for each of the wards

Summary of this inspection

- spoke with 31 other staff members from different disciplines including medical staff, nursing, recovery worker, psychology, occupational therapy and social work staff
- interviewed the hospital director
- looked at 29 people' care and treatment records including communication and health passports, positive behavioural support plans and care and treatment review meeting records
- reviewed nine Mental Health Act records and three seclusion records
- looked at 18 medicine charts including looking at the monitoring of people' physical health and checking that people on high dose antipsychotic medication received appropriate monitoring and
- looked at a range of policies, procedures and other records relating to the running of the service.

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

Areas for improvement

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

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with three legal requirements.

- The service must ensure that there are always sufficient numbers of suitably experienced staff deployed to meet the needs of people using the service (Regulation 18 (1) and 2 (a)).
- The service must ensure that the use of blanket restrictions are minimised and any restrictions are individualised decisions based on individualised security and/or clinical considerations (Regulations 13 (1) (4) (b) (c) and (5)).
- The service must ensure that it has robust governance processes to assess, monitor and improve the quality the services provided (Regulations 17 (1) (2) (a) (b) and (e)).

Action the service SHOULD take to improve:

- The service should ensure that staff working on both Adams medium secure ward and Eve mental health acute ward fully understand and implement appropriately the different models of care, approaches, security arrangements and any necessary restrictions of these two very different services.
- The service should ensure that the ward dashboards were used to support improvement in service user's care.
- The service should ensure that the consistency of care plans was improved especially on Cavendish and Eve ward.
- The service should ensure that it fully mitigates and has a clear plan to remove ligature points identified on the environmental risk assessments in the long term.
- The service should ensure it continues with the refurbishment of the hospital and replacement of windows across the hospital.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Services for people with acquired brain injury

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

Are Services for people with acquired brain injury safe?

Requires Improvement

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

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified over the short term. The assessments included details of any amendments that were required to the ward environments and action to mitigate the risks in the interim. This was usually relating to relational security arrangements such as levels of observations. The written risk assessments did not fully identify work over the longer term to mitigate the environmental risks identified such as removal of the risks. The risk score on the written environmental assessment did not reduce once the mitigations in place.

Following a recent serious incident, the provider was working to replace the windows across the hospital and had introduced an interim measure of staff locking the windows open or shut.

Staff could observe people in all parts of the wards. There were good lines of sight through the wards. Where there were blind spots, which hindered staff observing people, there were mirrors at height to help staff have a view of blind spots. There was closed circuit television in communal areas which could be viewed retrospectively for incidents and was also viewed on a random basis to safeguard people. People were informed about the presence of closed-circuit television.

The ward complied with guidance and there was no mixed sex accommodation. All the wards now only admitted males . There were no breaches of mixed sex accommodation guidance within this service.

Although staff knew about any potential ligature anchor points and mitigated the risks to keep people safe, the written environmental risk assessments did not detail how leaders would fully address and remove ligature points on the environmental risk assessments in the long term. Managers had ensured that most significant ligature risks had been removed. Curtain and shower rails were fully collapsible throughout the wards. Toilet, shower and bathroom fittings in

people's bedrooms were anti-ligature. Some fittings such as taps on handwashing sinks in communal areas were not fully anti-ligature. Recent refurbishments to Cavendish flats included door fittings that were not anti-ligature. Staff were mitigating the risks of ligatures on the wards through staffing levels and observations but there were no detailed plans to remove these.

Staff had easy access to alarms and people had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well-furnished and fit for purpose. All ward areas were cleaned to a good standard with comfortable furnishings throughout the hospital. Some décor in the hospital was looking tired due to ongoing wear and tear. Managers had agreed significant investment to improve this.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. Staff in the hospital were following increased infection control to prevent the spread of coronavirus. We observed that staff were regularly cleaning high touch areas, were observing good ventilation through keeping windows open, were using hand gel regularly and routinely and wearing masks appropriately.

Seclusion room

The hospital had one seclusion suite. The seclusion suite was based on a quiet corridor between wards, so it could be utilised by any ward in the hospital. If a person presented with significant behavioural disturbance and could not be conveyed from the ward to the seclusion suite, staff used cleared rooms on the ward while ensuring the required safeguards were still met. There had not been any incidents relating to when people were conveyed to the seclusion room from the wards.

The seclusion room allowed clear observation and two-way communication. The viewing panels in the seclusion room permitted staff to carry out observations.

It had a separate toilet and shower room which could be accessed by people without having to come out of seclusion. The taps in the sink and shower of the seclusion suites were anti-ligature. The side panel window looking into the toilet had been adapted to permit staff to observe people more discretely and maximise people' privacy.

It had a clock outside the seclusion room so people that were secluded could remain oriented to time. It had heating and ventilation which was controlled from a panel outside the seclusion room. It had a tear-proof, seclusion mattress, which afforded comfort especially during longer periods of seclusion.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff monitored ward treatment rooms and refrigerators to ensure that medicines were stored at the correct temperature and were safe to use. Emergency bags were available which included resuscitation equipment and emergency drugs. Staff checked these daily to ensure that all equipment was in date and fit for purpose.

Staff checked, maintained, and cleaned equipment.

Requires Improvement

Services for people with acquired brain injury

Safe staffing

The service did not have enough nursing staff, who knew the people. Staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough permanent staff with the right skills, qualifications and experience for each shift as there were a number of vacancies. However, managers had a strategy to improve this and deployed regular bank and agency staff as an interim measure. The hospital was operating on permanent staff working on 52% of filled shifts and 48% of filled shifts worked by bank, agency and locum staff. Four per cent of shifts still went unfilled.

The service had reducing vacancy rates for registered nurses. There were a number of registered nurse vacancies, but this had improved consistently since Elysium took over the running of the hospital in August 2018. The current vacancy rate was 25% for registered nursing staff (compared with a 40% vacancy rate at November 2019).

At the time of the inspection, the vacancy rate for registered nursing staff per ward at St Mary's Hospital was:

- Adams and Eve ward - six full-time establishment registered nurse vacancies - 40% (down from 50% in November 2019)
- Cavendish ward – one and a half full time establishment registered nurse vacancies – 21% (down from 46% in November 2019)
- Dalston ward - two full-time establishment registered nurse vacancies - 20% (down from 33% in November 2019)
- Leo and Hopkins ward – a half full-time establishment registered nurse vacancies - 7% (down from 33% in November 2019)

The service had increasing vacancy rates for non-registered staff. The vacancy rate for non-registered nursing staff per ward at St Mary's Hospital was 26%:

- Adams ward – nine full-time establishment recovery worker vacancies - 25% (up from 2% in November 2019)
- Cavendish ward - 11 full-time establishment recovery worker vacancies - 36% (up from 9% in November 2019)
- Dalston ward – seven full-time establishment recovery worker vacancies - 23% (up from 7% in November 2019)
- Leo/Hopkins ward – six and a half full-time establishment recovery worker vacancies - 21%. (up from 5% in November 2019)

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers had implemented Elysium's safe staffing procedures which meant that there was an automatic escalation and notification to managers where staffing did not reflect planned numbers so that managers could act to address any shortfall and the team was supported by a senior member of staff. There were also further interviews for both registered and non-registered staff in the pipeline. Recent changes in the tax rules had affected the numbers of staff available for regular agency work. The isolation rules as a result of the coronavirus pandemic had affected the day to deployment of staff.

The provider had a staffing strategy to improve the process of managing staffing, recruit more general and specialist staff and improve retention rates.

Requires Improvement

Services for people with acquired brain injury

The staffing of St Mary's Hospital was highlighted on the risk register. This had continued from when Elysium Healthcare took over and had been included in the risk register from July 2015. This risk remained on the risk register at the time of this inspection in June 2021. With the controls in place to reduce or mitigate the risks, the provider identified that the residual risk score had improved mainly due to rolling adverts for key positions, a recruitment bonus and over recruitment of support worker to cover enhanced observations.

Managers reported that four per cent of shifts still went unfilled. From looking at incidents, care records and through speaking to staff and people, we identified a small number of concerns about the quality of care being compromised due to these staffing shortfalls. For example, we asked managers about the impact of staffing and specifically requested the numbers and details of incidents categorised as occurring due to short or critical staffing levels as a primary or secondary factor. The provider told us that there had been five incidents from 1 January 2021 to 5 July 2021. None of the incidents led to direct harm to people using the service but in one case, the ward was unable to facilitate leave for a number of people who require a second or third staff member whilst utilising leave. This led to a person becoming distressed and causing a significant injury to a staff member requiring medical care. In another case, one person's required observation levels were reduced from 3 staff down to two staff for short periods. These unfilled shifts were usually unplanned due to staff lateness or last-minute cancellations and sometime additional staff were found, and the shift was adequately covered part way through the shift.

There were sufficient numbers of trained staff to communicate with deaf people. The hospital brought in interpreters Monday to Friday from 9am until 5 pm to support people with their communication needs. The hospital also had a deaf social worker who worked directly with deaf people.

The NHS standardised contract for specialist mental health services for deaf people stated that all staff should be supported to develop British Sign Language level two as a minimum and it was desirable to be trained to level three, especially expert clinical staff. Managers confirmed that there were 15 staff trained to British Sign Language level one, five staff to British Sign Language level two, and one level three trained staff. There was also one non-registered nursing staff with level six training. Managers at the hospital were supporting staff to develop signing skills and encouraging higher level training. Together with the deployment of signing staff and contracted interpreters, deaf people could communicate effectively with staff about their care and treatment. Both deaf people we interviewed commented that there were enough staff who could communicate using sign language to an appropriate standard.

While managers used bank and agency staff regularly, they requested and tried to use staff familiar with the service. However, this was not always possible due to the high numbers of agency staff required. There was a heavy reliance on agency registered nursing staff largely due to nurse vacancies. Agency recovery worker staff were largely used for observations. Between January and June 2021, 48% of filled shifts were worked by bank, agency and locum staff. It was very rare for shifts not to be filled through utilising regular staff being flexible, bank and agency staff. This meant that people with acquired brain injury did not always receive continuity of care as they did not see the same staff. Managers aimed to ensure people with learning disabilities on Leo and Hopkins ward were protected from short staffing issues by prioritising the deployment of staff; staff were redeployed from other wards to assist with Leo and Hopkins.

The hospital had high staff turnover rate. This was running at 30% at July 2021. Managers recognised and were open about the challenges that staff faced due to the acuity and presentations of some of the people. We spoke with some permanent, experienced staff who were leaving in the near future. Some staff reported they did not always feel fully supported when facing staffing challenges and had not had proper debriefs following incidents. Staff also stated they had additional tasks and responsibilities to carry out including regular surface and deeper cleaning to prevent coronavirus, and organising activities and doing laundry on Eve ward.

Requires Improvement

Services for people with acquired brain injury

Managers made sure all bank and agency staff had an induction and understood the service before starting their shift. Elysium Healthcare had its own bank staff system and provided bank staff with induction and annual refresher training. Regular nursing agency staff were block booked and, where possible, were familiar with the people. External agency staff had a safety briefing at the start of the shift that included detailed information about people, their risks and needs and the ward environment.

The ward managers could adjust staffing levels according to the needs of the people.

Managers supported staff who needed time off for ill health and helped to keep sickness rates low. The sickness levels for the hospital each were as follows:

- April 6.2%
- May 6.7%
- June 6.1%

This meant that sickness rates were slightly higher when compared to an England average of 4.7% sickness rate for NHS mental health and learning disability hospitals according to the most recent annual figures (for the year 2020/1).

People had regular one to one sessions with their named nurse.

People rarely had their escorted leave or activities cancelled, even when the ward was short staffed. Staff prioritised people's leave out of the hospital and the deployment of staff on the shift was discussed each morning. Sometimes leave or activities were rescheduled for the same day when there were not enough staff to escort people.

The service had enough staff on each shift to carry out any physical interventions safely. Most people on the wards required additional observations. There were a significant number of additional recovery workers to provide observations where people required additional observations due to their physical or mental health.

Staff shared key information to keep people safe when handing over their care to others.

Managers were making appropriate checks to make sure staff were of good character. We looked at the personnel and recruitment files for three members of staff. Records showed that appropriate recruitment checks were made including completing disclosure and barring service checks and the verification of identity, qualifications and professional status before staff started working at the hospital.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There were 4.6 whole time equivalent doctors at the hospital including consultant psychiatrists and a consultant neuropsychiatrist . The hospital also contracted with a local GP service that offered extended hours appointments and visits to the hospital. There was a rota for out of hours cover. We did not identify any concerns regarding delays in doctors attending the hospital when needed.

Mandatory training

Requires Improvement

Services for people with acquired brain injury

Most staff had completed and kept up-to-date with their mandatory training. The mandatory training uptake figures showed good compliance rates across all mandatory training courses. The hospital had an overall uptake rate for mandatory training by all staff of 92% as of 1 June 2021.

The mandatory training programme was comprehensive and met the needs of people and staff. The training included equality, diversity and human rights, infection control, medicines management and management of violence and aggression. Staff had access to training on awareness of acquired brain injury, autism and learning disabilities as part of their core training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Each ward had a dashboard so managers could review training uptake figures and ward take action where training was due or overdue for renewal. Regular nursing agency staff who were block booked were able to access elements of Elysium's mandatory training programme.

Assessing and managing risk to people and staff

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

Assessment of risk

Staff completed risk assessments for each person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool. Staff used the short-term assessment of risk and treatability risk assessment tool and historical clinical risk management 20 (widely known as HCR-20) tool. The historical clinical risk management 20 tool is a comprehensive set of professional guidelines for the assessment and management of risk relating to offending history.

Management of risk

Staff knew about any risks to each person and acted to prevent or reduce risks. People had up-to-date risk assessments which identified the risks people posed to themselves or others with risk management plans in place.

Staff had completed a detailed forensic risk assessment for relevant people. Staff reviewed risk assessments for each person on a monthly basis.

Staff identified and responded to any changes in risks to, or posed by, people. Staff completed a detailed positive behavioural support plan and/or a two-page profile to guide staff in how people should be supported and help avoid and manage emotional distress.

People on Leo and Hopkins continued to have positive behavioural support plans which were completed to a high standard.

People on high dose anti-psychotics were supported with physical health observations regularly to check for side effects and for those people at risk of over hydration (polydipsia), their care plan included individualised support around drinks to manage the risks.

Staff could observe people in all areas (of the wards) OR staff followed procedures to minimise risks where they could not easily observe people.

Most staff followed hospital policies and procedures when they needed to search people or their bedrooms to keep them safe from harm. However, on Eve ward searches were overly restrictive and not individualised and went beyond what we would expect to find on a mental health acute ward. Staff on Eve acute ward were routinely searching all people on return from leave, including people who were informal. We also saw that a person was subject to a room search and the record did not clearly indicate that the person's responsible clinician had been asked to determine whether the search should proceed in line with the hospital's written policy. Once we raised this with the hospital, they ensured that this practice was stopped and moved to a more individualised approach. The hospital was also considering using a randomiser search system for Eve ward which was used on the secure wards. This still would go beyond what we would expect on a general acute ward as we expect searches only to take place for specific causes on such wards unless there was good reason. Staff were routinely giving people on Eve ward plastic cutlery and this decision was also not individualised.

Staff carried out random and specific searches on people on the secure wards and worked within a policy on searching. Many people were on 1:1 observation levels which meant that staff were always with them.

Use of restrictive interventions

Levels of restrictive interventions had increased, since our last inspection in December 2019. Most of these were recorded as staff putting very minimal hands on to guide people to, or from, places. Restraint episodes included episodes where staff put hands on to support personal care to people and to prevent injury for people showed emotional distress as a persistent feature of their condition.

However, the service was ensuring that incidents of restraint were thoroughly reviewed and had investigated patterns to try and prevent restraint. For example, the hospital was looking to introduce different types of activities after recently noticing a peak in incidents in the late afternoon.

Over the 3 months prior to the inspection, incidences of restraint were as follows:

• April 2021 – 228 episodes; 142 of which were noted as staff putting hands on as 'friendly come alongs'. There were 686 recorded episodes of early intervention which were methods staff used to prevent restraint from happening.

• May 2021 – 224 episodes; 165 of which were noted as staff putting hands on as 'friendly come alongs'. There were 585 recorded episodes of early intervention which were methods staff used to prevent restraint from happening.

• June 2021 – 178 episodes; 128 of which were noted as staff putting hands on as 'friendly come alongs'. There were 531 recorded episodes of early intervention which were methods staff used to prevent restraint from happening.

There was a mean (average) of 210 incidents per month in this period compared to 103 incidents in the period between September to November 2019.

Requires Improvement

Services for people with acquired brain injury

There was only four episodes of prone (face-down) restraint in the period of January 2021 to June 2021. This included a controlled descent to the floor into prone position and unexpected unintentional descent to the floor into prone.

The increase in restraint was not solely due to one individual factor. Staff reported it was due to a small number of current people and their presentation, the restrictions on community activities due to the pandemic and greater awareness of reporting following training. Some staff also reported that the high use of agency staff had led to an increase in restraint too, as unfamiliar staff were working with people with complex needs.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Managers could access a computer-based dashboard for each ward which was used to monitor and analyse information about the use of restrictive interventions such as restraint and seclusion pulled from the electronic incident record system.

Most people across the hospital were allowed their own mobile phone. Exceptions to this was where people had been risk assessed on clinical or security grounds. However, we saw that one written care plan for one person had not been updated to reflect a recent decision to re-allow him his mobile phone.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep the person or others safe. The hospital employed a positive behavioural support practitioner who had many years' experience employed by a charity working with autistic people. They supported staff with functional assessments and positive behavioural support plans.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. There had been 16 episodes of rapid tranquilisation in the period between 1 April 2021 and 30 June 2021. We sampled episodes of rapid tranquilisation which showed that appropriate physical health checks had been made after an episode in line with national guidance.

When a person was placed in seclusion, staff did not always keep clear records to show that they followed best practice guidelines. Seclusion was not used frequently, and where it was used it was often used for short periods of less than four hours. On the inspection, we reviewed four individual record of seclusion. There were still a small number of gaps in the separate seclusion records. For example, the rationale for seclusion being required, the time the doctor was informed and attended, or the multidisciplinary review was not always recorded on the records we saw. However, the corresponding written daily record usually provided a record and the assurance that the safeguards were met. In one case, the doctor did not attend within the prescribed one hour of seclusion starting but had not recorded a reason for the delay. This was despite us raising seclusion recording on December 2019 inspection as a should-do action. Following the inspection, managers streamlined the recording requirements relating to seclusion to avoid duplication and the potential for staff failing to record key information. They had also introduced an audit checklist to ensure the revised expectations were adhered to.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a person was put in long-term segregation. Long term segregation was not used frequently and there were two episodes of long-term segregation at the time of the inspection. We saw that that an independent review had been carried out in each case.

Safeguarding

Requires Improvement

Services for people with acquired brain injury

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

Staff received training on how to recognise and report abuse, appropriate for their role. All staff were required to undertake training in safeguarding adults and safeguarding children. The level of training was dependent on the staff member's responsibilities and contact with people.

Staff kept up to date with their safeguarding training. Across the hospital, 94% of staff were up to date with their safeguarding adults and children training.

Staff could give clear examples of how to protect people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with had a good understanding of safeguarding procedures and what to do when faced with a safeguarding concern.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Managers in the hospital had notified us of safeguarding incidents and had taken appropriate action to safeguard vulnerable people. There were some safeguarding incidents still being investigated at the time of the inspection.

Staff followed clear procedures to keep children visiting the ward safe. There was a well-equipped family visiting room off the ward areas so people could receive supervised visits from children without them going on the wards. The hospital's social workers assessed the appropriateness of children visiting people.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had developed links with local authority staff for guidance on whether a referral was necessary when the staff in the hospital were in doubt. Staff acted promptly to raise safeguarding incidents and speak out. Each incident was considered and investigated by a senior member of clinical staff. Where safeguarding incidents concerned allegations against staff, we saw that managers took action including considering wider root cause analysis, organisational and systemic factors as part of their local investigations.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

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

People's notes were comprehensive and all staff could access them easily. The hospital used an electronic care notes system. Records were completed electronically by staff or documents were scanned in. The hospital had a standardised filing system within their electronic database so documents could be easily located.

Records were stored securely on password protected computers and applications.

Medicines management

Requires Improvement

Services for people with acquired brain injury

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each person's mental and physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autistic people or both).

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. As at June 2021, 88% of relevant staff had completed medicines level one training and 93% of relevant staff had completed higher level medicines level two training. We saw that following audits from the pharmacist, staff had taken action to address any areas identified to ensure safe prescribing, administering, recording and storing medicines

Staff reviewed people' medicines regularly and provided specific advice to people and carers about their medicines. We reviewed medicines charts and associated records in detail and found staff kept accurate records of the treatment people received.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff ensured medicines including controlled drugs were securely stored. Staff checked emergency medicines regularly to ensure they were available if needed. Clinic and fridge temperatures were monitored to make sure that medicines were stored at correct temperatures.

Staff followed current national practice to check people had the correct medicines. Medicines were prescribed in accordance with the provisions of the Mental Health Act. Staff ensured that legal certificates authorising treatment for mental disorder for detained people were kept with the medicine chart (as required by the Mental Health Act Code of Practice). This meant that staff administering medicines could check that they had the appropriate paperwork and legal authority to give medication to detained people at the time the medicine was given.

The service had systems to ensure staff knew about safety alerts and incidents, so people received their medicines safely. Staff displayed safety alerts in clinic rooms. Managers ensured that medical alerts were routinely discussed as a standard agenda item in monthly governance meetings and disseminated to staff as required, such as medicine batch recalls.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). Doctors reviewed people' medication regularly and, where possible, people were not on anti-psychotic medication or doctors had significantly reduced the dose while at St Mary's Hospital. This was in line with national guidance on the stopping over medication of people with a learning disability or autistic people.

Staff reviewed the effects of each person's medication on their physical health according to NICE guidance. A physical health assessment was completed when people were admitted. Staff kept records of investigations and physical observations in people' medical notes. Staff had completed monitoring in accordance with national guidance and the hospital policy. For example, people on Clozapine and Lithium received regular blood testing in line with the requirements for each of these medicines.

Track record on safety

The service had a good track record on safety.

Requires Improvement

Services for people with acquired brain injury

Reporting incidents and learning from when things go wrong

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

We looked at the incidents that had occurred recently at this hospital. All independent hospitals were required to submit notifications of significant incidents to us. Between 1 January 2021 and 30 June 2021, the hospital had notified us of 41 relevant notifiable events including safeguarding incidents. These included one death and three police incidents which included assistance to convey people back from going absent without leave from escorting staff. Most incidents were people who used the service verbally abusing or hitting other people who used the service. Of the total number of non-notifiable incidents reported, the most common type of incident was 'no harm' incidents which made up 66% of incidents reported.

Following any death where there had been an inquest, local coroners may issue a report with the intention of learning lessons from the cause of death and preventing deaths. There had been no reports to prevent future deaths issued by the coroner in the 12 months up to the inspection for St Mary's Hospital. There was one person's death from 2016 which was still to be considered by the local coroner and one death from March 2021 that was still subject to an internal investigation.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff reported serious incidents clearly and in line with hospital policy. The hospital had a standard system of incident monitoring. Staff we spoke with understood the types of incidents to report.

The service had no never events on any wards. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. In mental health services, the relevant never event within hospital settings was actual or attempted suicide of a person due to the failure to install functional collapsible shower or curtain rails and falling from an unrestricted window.

Staff understood the duty of candour. They were open and transparent, and gave people and families a full explanation if and when things went wrong. Managers and staff were aware of their responsibilities in relation to duty of candour which required staff to be open and offer an apology when an incident occurred resulting in serious harm. Managers were meeting their responsibilities following a recent serious incident.

Although mangers aimed to support and debrief staff after any serious incident, staff said debriefs did not always happen. Some staff we spoke with said that they usually received a brief welfare call following incidents but did not always get the opportunity to have a fuller debrief where they could talk about the incident, how it made them feel and lessons for future working. Senior managers, doctors and ward managers attended a daily morning handover meeting where incidents were reviewed, and actions planned. Once a week, the handover reviewed actions overall to ensure a broad view of issues across the hospital and incidents were maintained.

Managers investigated incidents thoroughly. People and their families were involved in these investigations. Managers had very detailed safety incident data for each ward through a computerised dashboard. This included information for

Requires Improvement

Services for people with acquired brain injury

incidents on each ward including numbers, types and categories of incidents, analysis of the days and times when most incidents occurred, the types of injuries sustained and interventions used, where appropriate. We saw that from this, staff had worked out that there were more incidents on Leo and Hopkins ward in the late afternoon and were looking to change the activities programme to assist with the reduction in incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to people's care. Managers discussed learning from incidents at the hospital's monthly hospital governance meeting. From this, lessons learned which occurred within St Mary's Hospital and from across Elysium were shared with the staff team. This included a staff newsletter. Following a recent incident, we saw that staff were routinely locking windows open or shut to reduce the risks of people ligaturing.

There was evidence that changes had been made as a result of feedback. (provide information about improvements in safety specific to this service) Staff and operational managers could tell us about local lessons learnt. For example, following a recent serious untoward incident staff knew that windows had to be locked in the open or closed position.

Managers shared learning with their staff about never events that happened elsewhere.

Managers and staff were aware of the Learning from Deaths Mortality Review (LeDeR) Programme. Managers and staff supported the review process and changes made from any learning shared. For example, staff were checking appropriate people with learning disabilities and autistic people to make sure they were going to the toilet regularly as one common theme arising from recent deaths nationally was the dangers of severe constipation.

Are Services for people with acquired brain injury effective?

Good

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

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of people who would benefit. They worked with people and with families and carers to develop individual care and support plans, and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

Staff completed a comprehensive mental health assessment of most people either on admission or soon after. While we found initial assessments on most people's files, we found that one newly admitted person did not have an initial or 72-hour care plan to guide his care and treatment even though nine days had elapsed since his admission to the hospital. The assessment prior to admission included a likely care and treatment plan but this had not been reviewed. This was rectified by the time of our out of hours inspection.

People had their physical health assessed soon after admission and regularly reviewed during their time on the ward. People had health passports which were updated. All people had regular physical health checks. People were encouraged to attend their GP for routine health checks and annual physical health checks. Staff ensured that people received appropriate physical and dental health care including attending primary and secondary medical care appointments. The provider had a registered general nurse to focus on physical health checking and promotion to further ensure people' physical health needs were met.

Requires Improvement

Services for people with acquired brain injury

Staff developed a comprehensive care plan for most people that met their mental and physical health needs. People had one-page profiles so that staff and people could quickly understand people' likes, strengths and needs. Staff completed detailed care plans for most people's individual needs leading to a separate care plan for each need. On most wards this provided a good level of detail included which would enable new staff to provide person-centred care and support. On Cavendish ward and Eve ward, we saw some needs which had been identified in other parts of the record which were not fully reflected or reviewed in people's care plans. From their own audits, the hospital were aware of the need to improve consistency in care planning.

Staff regularly reviewed and updated most care plans and positive behaviour support plans when people' needs changed. On Cavendish ward, we saw that written plans of care had not always been fully reviewed following a change in the person's needs or presentation.

Care plans were personalised, holistic and strengths based. Most care plans were detailed and helped to meaningfully maximise recovery from mental health and physical health problems, functional ability, self-care and, where possible, person's own goals. Staff also provided practical assistance to people to aid their independence. For example, people were supported with help with budgeting and assistance with activities of daily living, such as shopping, cooking and cleaning. However, the care plans on Eve ward were limited in detail on some records.

Positive behaviour support plans were present and supported by a comprehensive assessment. Staff on Leo and Hopkins worked with people and carers to produce detailed positive behaviour support plans.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported people with their physical health and encouraged them to live healthier lives.

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

Staff provided a range of care and treatment suitable for the people in the service. People with acquired brain injury received care and treatment using neuro-rehabilitation approaches which included providing acquired brain injury awareness to people, psychological therapies, structured programmes and structured days, and work on behaviour approaches.

Staff delivered care in line with best practice and national guidance (from relevant bodies e.g. NICE).People had access to psychological therapies through the dedicated clinical psychology service available within the hospital. Clinical psychologists worked with people on an individual basis and in groups, providing evidence-based formulation and interventions.

People with a learning disability or autistic people had a care and treatment review, in accordance with NHS England's commitment to transforming services for people with a learning disability and autistic people. The written records showed that the reviewing care and treatment review teams were positive about people' progress in the records we looked at.

Requires Improvement

Services for people with acquired brain injury

Staff understood people positive behavioural support plans and provided the identified care and support. Staff continued to complete positive behavioural support plans to a high standard on Leo and Hopkins ward.

Staff identified peoples' physical health needs and recorded them in their care plans. Some people on the acquired brain injury wards had Huntingdon's disease which was a chronic and progressive neurological disorder which led to cognitive deficits and physical impairment. People had detailed plans to manage their condition and people regularly saw neurologists to help monitor their condition.

Staff made sure people had access to physical health care, including specialists as required.

Staff met people' dietary needs and assessed those needing specialist care for nutrition and hydration. People who were at risk of aspiration (choking) had specific soft diets or thickened fluids.

Staff helped people live healthier lives by supporting them to take part in programmes or giving advice. The hospital had 'fakeaway' nights where people had healthier versions of popular takeaway meals.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Leaders ensured that staff carried out a range of audits including records checks, observation checks, infection control measures, ligature and medicines audits.

Managers used results from audits to make improvements. The hospital was looking to improve the detail in written dysphagia (swallowing difficulties) plans following recent audits highlighting minor shortfalls.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of people on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of the people on the ward. People were supported by a staff team that included a registered manager, registered mental health nurses, learning disability trained nurses, and experienced recovery support workers ward managers, and responsible clinicians. The ward teams were also supported by specialist doctors, occupational therapists and occupational therapy assistants, clinical psychologists and social work staff.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank and agency staff.

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

Managers supported staff through regular, constructive appraisals of their work. The appraisal rate was 98% of staff had received an annual appraisal as of June 2021.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. There were systems in place to ensure doctors working at St Mary's Hospital had been appraised and revalidated.

Requires Improvement

Services for people with acquired brain injury

Managers supported staff through regular, constructive clinical supervision of their work. The supervision rate was 85% of staff had received the expected levels of supervision as of June 2021.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff received training in relevant subjects in addition to their mandatory training such as specialist training on autism, acquired brain injury awareness, Huntingdon's disease awareness, and mental health tribunal training for nurses.

Managers recognised poor performance, could identify the reasons and dealt with these. We saw managers had addressed concerns with staff members

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. The ward team(s) had effective working relationships with staff from services that would provide aftercare following the person's discharge and engaged with them early on in the person's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss people and improve their care. Records showed that various professionals involved in peoples' care regularly attended and contributed to key meetings discussing people' care.

Staff made sure they shared clear information about people and any changes in their care, including during handover meetings. Staff worked longer shifts to promote continuity of care. There were two handovers each day when shift changes occurred. At the handover, people' current clinical presentation and anticipated needs were discussed.

Ward teams had effective working relationships with other teams in the organisation. Ward staff reported that the multi-disciplinary team worked well together with effective communication. Staff we spoke to told us that all professionals worked to ensure people were at the centre of their discussions.

Ward teams had effective working relationships with external teams and organisations. We saw that staff worked with other services such as the GP service, physiotherapy and other professionals. Staff were now recording the input of these professionals in people' care records.

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

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

Most staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At June 2021, 88% of the workforce had received training in the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The hospital had a Mental Health Act administrator who was based in the hospital. Staff told us that they were accessible and provided advice and support to staff.

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

administrator now had a more robust system to ensure that the hospital's legal responsibilities were met. There was now an electronic care records system which was properly effective. This made sure staff did not miss important dates relating to meeting their Mental Health Act responsibilities.

People had easy access to information about independent mental health advocacy and people who lacked capacity were automatically referred to the service. People had access to an independent mental health advocacy service as a representative from the local advocacy visited regularly. One of the independent mental health advocates was from the deaf community and was fluent in British Sign Language.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Detained people were informed of their rights frequently through their detention. This included staff using information in easy read formats. Staff now kept better records relating to people' rights which were systematically filed for easy access on the people' electronic records. Staff were now revisiting people' rights at particular intervals such as when a patient's detention was renewed, or their legal status changed.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Clinicians clearly recorded Section 17 leave decisions with clear conditions, a risk assessment prior to leave and the outcome of leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Staff were now ensuring that legal authorisations around consent to treatment (T2 and T3 forms) were routinely attached to medicines charts to aid nurses to check them prior to administering medication for mental disorder.

Staff stored copies of people' detention papers and associated records correctly and staff could access them when needed. Staff had ready access to these important documents in the patient's electronic care records. This included detention paperwork, patient rights' records, annual reports to the Ministry of Justice for restricted people, tribunal decisions and consent to treatment records.

Informal people knew that they could leave the ward freely and the service displayed posters to tell them this. On Eve ward, staff displayed posters for informal people around their right to leave and the right to refuse treatment. On the other wards all the people were detained under the Mental Health Act.

Care plans included information about after-care services available for those people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Managers had access to an electronic dashboard which included how the hospital was meeting their responsibilities under the Mental Health Act. They reported through hospital governance meeting.

Requires Improvement

Services for people with acquired brain injury

Good practice in applying the Mental Capacity Act

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

Most staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. As of June 2021, 86% of the workforce had received training in the Mental Capacity Act.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. Staff recorded what supportive aids were used to aid people' understanding. Staff also recorded when advocates or interpreters were brought in to assist people to understand and communicate decisions about care and treatment.

Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision. Staff were ensuring that capacity assessments were decision and time specific.

When staff assessed people as not having capacity, they made decisions in the best interest of people and considered the person's wishes, feelings, culture and history. People who were deemed to lack capacity over ongoing treatment decisions for physical health had corresponding best interest considerations for continuing treatment in the absence of fully informed consent. We saw examples of good best interest decisions made in line with the principles of the Mental Capacity Act relating to specific decisions such as decisions to receive the coronavirus vaccine.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. One person was in the hospital by an order from the High Court and staff were clear on the conditions attached to the order.

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

Staff knew how to apply the Mental Capacity Act to people 16 to 18 and where to get information and support on this. There was one young person and records showed that staff had an understanding of the rules relating to 16 to 18-year olds.

Are Services for people with acquired brain injury caring?

Good

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

Requires Improvement

Services for people with acquired brain injury

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for people. During our observations, staff were now respectful and responsive when caring for people. We observed most interactions between people and staff as good quality, dignified and respectful care. The rest of the observations were neutral. We did not observe any negative interactions.

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

Staff supported people to understand and manage their own care treatment or condition. Staff spoke to and about people in a way that was consistent with a culture of positive behaviour support.

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

People said staff treated them well and behaved kindly. We spoke with 17 people. Many people were complimentary about the care they received from hospital staff. Most people told us staff treated them with dignity and respect and were very friendly. Some people told us they were not happy. In summary, this was because they were either detained and did not want to be kept in hospital or they reported there was sometimes a lack of regular staff on the wards which led to leave, and activities being delayed or cancelled.

We used picturebank cards to help communicate and understand the experience of two autistic people – they placed many aspects of their care in hospital in the positive experience column.

We spoke with seven carers. Most of these were very complimentary about the care that their relatives had received. The themes from carers were similar to those from people in that they also commented on the lack of staff and high numbers of agency staff. Many carers felt that the hospital could run more activities especially community-based activities and provide more in terms of rehabilitation but accepted that some of these had been halted due to the coronavirus restrictions.

Staff understood and respected the individual needs of each person. Staff spoke about people in a way that respectful. Staff had a good understanding of individual people' needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people. Staff were clear they would raise concerns and felt these would be treated seriously.

Staff followed policy to keep person information confidential. The hospital's computer system was secure, and staff locked their screens when they weren't using them.

Involvement in care

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

Requires Improvement

Services for people with acquired brain injury

Involvement of people

Staff introduced people to the ward and the services as part of their admission. Staff completed detailed admission checklists when a new person came onto the ward.

Staff involved people and gave them access to their care planning and risk assessments. Staff usually recorded that people were involved in their own care and treatment if they could engage in these decisions. Staff usually recorded that people had been given or offered a copy of their care plans. Where people could not communicate or engage in their care and treatment, staff recorded that this was provided in their best interests.

Staff made sure people understood their care and treatment (and found ways to communicate with people who had communication difficulties). Staff had developed information in simpler language and pictorial formats about their care for people with learning difficulties or cognitive impairment.

Staff involved people in decisions about the service, when appropriate. People could give feedback on the service and their treatment and staff supported them to do this. The hospital had a regular forum run by people who used the service with people represented from each ward. This group ensured people had a voice in not just their own care but how the hospital was run. The senior managers welcomed the input of people in having a say in the service. Issues raised by the forum had been fully addressed. The minutes were written in easy read format. The minutes now clearly recorded what action was needed or what action had been taken to show that issues had been fully addressed.

Staff supported people to make decisions on their care. Staff made sure people could access advocacy services. The advocacy service actively supported people to speak up at wards rounds and care programme approach meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Records showed that carers were routinely invited and attended meetings in the hospital to discuss people' care and progress. Most carers told us they were involved and informed in their loved ones care.

Staff helped families to give feedback on the service. The hospital had recently restarted the carer's forum. This provided an opportunity for carers to have a say in the running of the hospital. Managers planned to have monthly meetings going forward.

Are Services for people with acquired brain injury responsive?

Good

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

Access and discharge

Requires Improvement

Services for people with acquired brain injury

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, people did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Bed management

Managers made sure bed occupancy did not go above 85%. The hospital offered medium secure, low secure and locked rehabilitation services for people with acquired brain injury and hospital care for autistic people and people with learning disability. In addition, the hospital provided acute mental health care which was accessed by the local mental health NHS trust to help relieve bed pressures locally. Referrals for people requiring forensic specialist neuro-rehabilitation care for people with acquired brain injury were received from specialist commissioners at NHS England. The bed occupancy levels for non-secure service beds was 73% in June 2021.

Managers regularly reviewed length of stay for people to ensure they did not stay longer than they needed to. Managers had a detailed report which showed the length of stay for people. This showed that the average length of stay varying depending on the ward. The average length of stay on 1.2 months on Eve (mental health acute) ward, 36 months on both Adams (medium secure) ward and Cavendish (rehabilitation) ward and 49 months on Dalston ward. There had been 31 discharges between July 2020 and July 2021. This included 21 discharges from the acute ward and 10 from the rest of the hospital.

The hospital provided a national service and accepted referrals from a national catchment area for these services. However, most people were from the North West as commissioners were guided to find people a hospital bed as close to home as possible.

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

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

People were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the person. For example, people moved between wards to progress to discharge such as moving down from conditions of medium secure care to low secure care.

Staff did not move or discharge people at night or very early in the morning.

Discharge and transfers of care

The service had no / low number delayed discharges in the past year.

Managers monitored the number of delayed discharges. For autistic people, most care and treatment reviews reported staff were making good progress with working with people towards being discharged.

The only reasons for delaying discharge from the service were clinical. Managers reported good links with care co-ordinators and case managers from specialist commissioners to ensure people are appropriately placed in the correct level of security.

Requires Improvement

Services for people with acquired brain injury

Staff carefully planned people' discharge and worked with care managers and coordinators to make sure this went well. Staff were reliant on local services and commissioners to find placements for people to move to community placements and conditions of lower security. However, in some cases, staff recording within the care programme approach documentation were not clear or explicit about progress towards discharge, including any successes and barriers to progress and how far local services and commissioners were engaged to support people transfer and discharge.

Staff supported people when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people' treatment, privacy and dignity. Each person 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 good quality and people could make hot drinks and snacks at any time.

Each person had their own bedroom, which they could personalise. For example, one autistic person had decorated their bedroom with posters and flags from the country where they were from.

People had a secure place to store personal possessions. Following an appropriate individualised assessment, people could have fob to their bedrooms to open or lock their own bedrooms. Bedrooms contained a secure place to keep valuables and each person was allocated a secure locker on the ward.

Staff used a full range of rooms and equipment to support treatment and care. Each ward had central lounge areas with other rooms available. The other rooms differed for each ward but included a games room with a television and games console, pool table, and comfortable seating. Some wards had a sensory room.

People had supervised access to occupational therapy kitchens on each ward where people' daily living skills could be assessed. People could also access shared spaces off the ward including an art and craft workshop, a woodwork workshop, shop and gym.

The service had quiet areas and a room where people could meet with visitors in private. People were not usually restricted and could access their bedrooms throughout the day to spend some quiet time. There were also smaller communal lounges on each ward. People could also see family members in a family visiting room in reception.

People could make phone calls in private. People were allowed their own mobile phone. The only exceptions were when staff had risk assessed this for individual people on clinical or security grounds. People also had access to a portable phone.

The service had an outside space that people could access easily. Each ward also had secure courtyards which people accessed with staff support.

People could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. Most people told us that the food was generally good and did not raise any concerns about the quality of the food.

People' engagement with the wider community

Requires Improvement

Services for people with acquired brain injury

Staff supported people with activities outside the service, such as work, education and family relationships.

Staff made sure people had access to opportunities for education and work, and supported people. Managers continued to offer a permitted earnings scheme to people. People were interviewed and assessed for various roles, which included assisting in the people' shop and cleaning the outdoor courtyard areas. People were paid money for completing identified tasks. People were offered a structured programme of activities planned by the therapy team. There were individual activities also planned for each person that included community leave, college courses, and other activities based on people' interests. Some of these were just starting up again following the social distancing requirements during the pandemic.

Staff helped people to stay in contact with families and carers. People had access to an outside visiting pod so they could still meet with their relatives during the coronavirus pandemic when there were restrictions on hospital visitors. Most carers we spoke with felt welcomed when

they visited and were kept informed of significant events.

Staff encouraged people to develop and maintain relationships both in the service and the wider community. Staff supported people with a variety of social, cultural and leisure activities. People had individualised plans for care and treatment and the hospital monitored uptake of 25 hours of meaningful activity a week. These included staff supporting people to attend community facilities and groups to assist with their well-being.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospital had disabled parking, ramped access at the front, level access on both floors throughout the building and there was a lift to the first floor to enable people who use a wheelchair easy access. Wards had a bathroom with some aids and adaptations to assist people with physical care needs. Adams ward had adaptions for deaf people including staff using flashing bedroom lights to inform people they were entering their bedroom and a flashing fire alarm light.

Staff made sure people could access information on treatment, local service, their rights and how to complain. There were notice boards available on the wards on many topics, including local services, patient rights, advocacy, safeguarding, and complaints.

The service had information leaflets available in languages spoken by the people and local community. Staff presented information in easy read formats to assist autistic people and people with acquired brain injury to understand information. Where appropriate, staff displayed posters with visual pictures including pictorial sign language to aid understanding among deaf people.

Managers made sure staff and people could get help from interpreters or signers when needed. People who were deaf were supported by hospital staff who could sign to a basic level (level one or two). The provider brought in sign language interpreters for 5 days a week. Both deaf people we interviewed commented that there were enough staff who could communicate using sign language to an appropriate standard.

Requires Improvement

Services for people with acquired brain injury

The service provided a variety of food to meet the dietary and cultural needs of individual people. (refer to PLACE data if available, and on-site findings) Catering staff cooked food for people on-site which helped to ensure flexibility around people' choice. People made daily choices regarding their food choice including a meat and vegetarian option available. Staff supported people with cultural dietary needs. For example, one person told us that they were happy with the kosher food and snacks provided by the hospital.

People had access to spiritual, religious and cultural support. People had access to a multi faith room. Staff considered how people' cultural and religious requirements could be supported through care planning.

Listening to and learning from concerns and complaints

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

People, relatives and carers knew how to complain or raise concerns. Staff informed people of their right to complain as part of a discussion about their rights as detained people.

The service clearly displayed information about how to raise a concern. Staff displayed information on complaints and the Care Quality Commission's role in complaints were displayed on the wards. Posters were displayed on the ward containing information about the independent mental health advocacy service.

Staff understood the policy on complaints and knew how to handle them. The hospital had received 13 complaints between December 2020 and June 2021. Many of these were resolved locally or partially upheld of these were upheld. None of the complaints were referred to the Health Service Ombudsman, who looks further at unresolved complaints from people receiving NHS funded care.

Managers had improved how they investigated complaints and identified themes. It was now clear that managers carried out a proper investigation had occurred into the complaints made. The responses now addressed the issues raised by the complainants.

Staff protected people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and people received feedback from managers after the investigation into their complaint. Managers responded to people' complaints formally and the responses now addressed each aspect of any complaint to enable people to understand the outcome and how the hospital would improve to prevent a reoccurrence.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers reported on complaints and themes through hospital governance.

The service used compliments to learn, celebrate success and improve the quality of care. The hospital had received 18 compliments between December 2020 and June 2021. This included a range of compliments from people, family members and visiting professionals.

Are Services for people with acquired brain injury well-led?

Requires Improvement

Services for people with acquired brain injury

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for people and staff. The hospital manager was an experienced nurse with many years of clinical experience including within secure services within Elysium Healthcare. They had continued to make changes such as improving the environment and staffing establishment. There was a clinical lead and senior nurse working across the hospital. The wards were managed by experienced nurses who led the wards and ensured the complex needs of the people were met. The exception was Eve ward which was managed as part of the duties of the ward manager of Adams ward.

Most staff commented that they felt well supported by the senior leadership team and by the ward managers.

Senior managers were well cited on issues within the hospital and were working to address these. The hospital had hospital and ward dashboards which assisted managers to understand what each ward did well, and the actions required by ward staff to ensure good quality care to people.

Senior managers held a 'patient forum' where people who used the service and staff met to discuss issues raised by people across the wards.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. The hospital follows the Elysium Healthcare values which were:

- Kindness
- Integrity
- Teamwork
- Excellence

The vision and values were displayed throughout the hospital and managers were working to ensure they were evidenced by staff in their appraisals. Staff we spoke with understood the values of the company.

Culture

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

There was information displayed in the hospital about how staff could raise concerns about people's care. Staff told us that they knew how to raise any issues through this process or anonymously.

Requires Improvement

Services for people with acquired brain injury

We also expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted.

In relation to Leo and Hopkins wards, the service was able to show how they had regard to the principles of 'Right support, Right Care, Right Culture'. 'Right support, Right Care, Right Culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people to ensure people receive choices, dignity, independence and good access to local communities that most people take for granted.

- The values, attitudes and behaviours of leaders and staff ensured that people using the service lead inclusive and empowered lives.
- The needs of people formed the basis of the culture at the service. Staff understood their role to make sure that people were always put first and provided care that was person centred.
- The leadership of the service were working to improve the learning culture. Staff could suggest improvements and question poor practice. There was a culture that respected the views of people, those important to them, staff and leaders.
- Although staffing pressures existed, Leo and Hopkins wards were prioritised to make sure that people with learning disabilities and autistic people received safe care that met their needs.

Governance

Our findings from the other key questions demonstrated that governance processes had improved but were still not fully effectively and needed to improve further to keep people safe and provide good quality care and support.

We found new shortfalls in relation to staffing levels and restrictive practices on the acute ward. These have resulted in regulatory breaches. In relation to restrictive practices, the hospital's governance systems were not fully effective to identify and ensure restrictive practices were kept to a minimum. The monthly operational and clinical governance meetings had highlighted the need to have better oversight of ward's restrictive practices. However, at the June 2021 meeting this could not be done effectively because only one ward had submitted the required information.

There was not appropriate clinical separation of duties between staff on Adams and Eve ward. This led to staff having to manage the restrictions of two very different services – a medium secure unit for people with acquired brain injury and an acute ward for people with sever and enduring mental illness.

We also highlighted a variability of approach across the hospital in other matters which led us to the judgement that governance processes had improved but were still not fully effectively and needed to improve further. These included:

- Staff reporting that they were not fully supported with staff debriefs following incidents.
- The ward dashboards were not always used to fully improve people's care. For example, we found that one new person did not have an initial or 72-hour care plan to guide his care and treatment in the first few days of his admission to the hospital. This was rectified after the inspection but could have been picked up earlier through proper and regular review of the ward dashboard which highlighted shortfalls.
- The quality of care plans was sometimes variable especially on Cavendish and Eve ward.
- There was a lack of detail in relation to proper and full mitigation to fully address ligature points on the environmental risk assessments and some environmental changes had not been captured on the environmental risk assessments.

Requires Improvement

Services for people with acquired brain injury

Managers had not always put improved measures for all the matters raised on previous inspections. For example, we continued to find shortfalls in seclusion recording despite us raising this on the December 2020 inspection. There were some improvements noted as we found that the provider had met requirement notices relating to Mental Health Act adherence, privacy and dignity and complaints handling.

Management of risk, issues and performance

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

Managers kept a risk register which identified risks to people or staff which were managed locally by managers and staff within the hospital. The current risks identified were:

- The COVID-19 pandemic and associated staffing challenge
- Qualified nurse vacancy rates and high use of agency staff.
- Providing care and treatment to forensic people and people with significant levels of need and disturbed behaviour

The risk register had details of how these risks could be mitigated and we saw that managers were making efforts to improve in these areas.

The concerns we saw on the inspection broadly matched those on the risk register.

The service had clear plans for dealing with emergencies and staff understood these. Wards had emergency equipment which were easily accessible and checked regularly. The hospital had a business continuity plan which included identifying and mitigating the risks in relation to disruption of services including flooding, fire and other key risks.

Managers made sure that cost improvements did not compromise care. Elysium Healthcare were making further significant improvements including substantial environmental improvements.

Information management

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

Managers monitored a range of performance indicators through the electronic record system which populated computerised dashboards which provided information for incidents on each ward including observations levels, seclusion and long-term segregation use, incidents, leave episodes, care planning and risk assessments, and other key performance and safety data for each ward. These also included people's activities uptake levels, Mental Health Act adherence and commissioner led metrics.

Managers had started to meet regularly with the local clinical commissioning group who acted as host commissioner and oversaw the quality and safety of the service.

Requires Improvement

Services for people with acquired brain injury

The hospital took part in accreditation schemes and learned from this. Health providers can participate in several accreditation schemes where the services are reviewed, and a decision is made whether to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice. The hospital's low and medium secure wards had been awarded an accreditation by the Royal College of Psychiatrists' quality network for forensic mental health services in September 2018.

At the time of inspection, managers were completing actions from an action plan to address some minor shortfalls identified at their most recent review from the quality network for forensic service accreditation review. The other wards at the hospital did not take part in relevant accreditation schemes.