Care Quality Commission

Elysium Healthcare Limited

Wellesley 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	Good	🟢
Are services safe?	**Good**	🟢
Are services effective?	**Good**	🟢
Are services caring?	**Good**	🟢
Are services responsive to people's needs?	**Good**	🟢
Are services well-led?	**Good**	🟢

Summary of findings

Overall summary

Wellesley Hospital, owned by Elysium Healthcare, is a purpose-built hospital in South-West England for men and women with mental health problems and/or learning disability or autism. It provides care for patients aged over 18 years.

The hospital forms part of the South West Provider Collaborative under the new care models. This programme aims to reduce patients' length of stay and reduce the number of out-of-area patient placements.

We undertook this inspection as part of our inspection programme and inspected the following two mental health core services.

Forensic inpatient and secure wards

- The last comprehensive inspection was on the 1st and 2nd of May 2018 where the forensic inpatient and secure wards were rated "Good." Following this inspection our rating for the service stayed the same.
- Many patients who are admitted to a secure service will have been in contact with the criminal justice system. Patients who are admitted to a secure hospital will be subject to detention under the Mental Health Act 1983.
- During this inspection we inspected the following wards: Quantock ward, a medium secure wards for men, Selworthy and Mendip wards, a low secure wards for men, Blackdown ward, a medium secure ward for females and Polden ward, a low secure ward for females.

Wards for people with a learning disability or autism

- Winsford ward opened in April 2021 and has not been inspected previously. During this inspection we have rated the service as "Good."
- Winsford ward provides a service for people with learning disabilities and/or autism who may be informal or detained under the Mental Health Act 1983.
- We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted.
- 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.
- The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.
- Right support: The service gave people care and support in a safe, clean, well equipped, well-furnished and well-maintained environment. The environment met peoples' physical needs while also feeling homely. However, although peoples' sensory needs were considered, the sensory room was not equipped for sensory needs. For example, the room did not have a range of stimuli to help individuals develop and engage their senses such as lights, sounds or sensory soft play resources and aromas.
- Right care: Peoples' care was individualised, planned and delivered in a manner that met their needs. Peoples' care promoted their dignity, privacy and human rights, Staff understood how to protect people from poor care and abuse and worked well with other agencies to do so.
- Right culture: Staff were supporting people with their transition to live successfully in the community. They were respectful to the people they supported. Staff placed people's wishes, needs and rights at the heart of everything they did. Staff understood the importance of family values.

Summary of findings

Our findings

We rated the forensic inpatient and secure wards and the ward for people with learning disability or autism as good because:

- Patients and people across both services had individual and personalised en-suite bedrooms which met their communications and physical needs. Patients and people who used services were protected from abuse and poor care and staff were knowledgeable about the signs of abuse and reporting processes.
- Staff assessed and managed risks well. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour.
- People on the learning disability or autism ward made choices and participated in activities which were part of their planned care and support.
- Staff supported patients and people across both services to achieve their goals through recognised models of care and treatment. Patients and people who use services were involved in all aspects of their care and treatment and support plans. On the learning disability or autism ward easy read copies of their care plans and social stories were developed in a manner that people were able to understand. Posters were in an easy read format to ensure people understood the information on display.
- The services 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 patients and people who use services honest information and suitable support.
- Managers ensured they had staff with the range of skills needed to provide high quality care. They supported staff with supervision and appraisals. Staff were provided with the opportunity to develop and update their skills. Managers provided an induction programme for new staff.
- 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, and discharged these well. The services protected people's human rights and provided good care, support and treatment. Staff helped people with communication, advocacy and cultural and spiritual support.
- Managers made sure that staff could explain patients' rights to them.
- Staff understood the individual needs of patients on the forensic inpatients and secure wards and supported them to understand and manage their care, treatment or condition. People on the learning disability and autism ward had their communication needs met and information was shared in a way that could be understood. All patients and people who use services received kind and compassionate care from staff who protected and respected their privacy and dignity.
- Staff planned and managed discharges well. They liaised well with services that would provide aftercare. Staff did not discharge patients before they were ready and ensured they did not stay longer than they needed to.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results, which were shared with the whole team.
- Leaders had the skills, vision, knowledge and experience to perform their roles and understood the services they managed. Staff felt respected, supported and valued. The service promoted equality and diversity and provided opportunities for development and career progression. Leaders understood the services they managed and had a vision for these services. They were visible and approachable for patients, people and staff.

However:

Summary of findings

- While the forensic inpatient and secure wards and the ward for people with learning disability or autism used systems and processes to prescribe and administer medicines safety, they did not always record, store or destroy medicines appropriately.
- Care records on the forensic inpatients and secure wards and the ward for learning disability or autism did not identify the reasoning for providing PRN (as required) medicines or demonstrate that patients were reviewed after administration of these medicines.
- While the services inspected had enough nursing and medical staff who knew the patients and the people who used services, and had received basic training to keep all safe, they did not have enough therapy staff to maintain daily activities on the forensic inpatient and secure wards.
- Across both services we found staff did not always monitor or record the physical health of patients and people who use services to ensure they responded appropriately to a potential deteriorating condition.

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Forensic inpatient or secure wards	Good	🟢	
Wards for people with learning disabilities or autism	Good	🟢	

Summary of findings

Contents

Summary of this inspection

Background to Wellesley Hospital

The hospital is registered to provide the following regulated activities:

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

What patients and people who use the services said?

Forensic inpatient and secure wards

Patients and people who use services told us that most staff were nice, sympathetic, and attended to their needs. They said staff were helpful and helped to diffuse situations when they arose.

Patients and people who use services said that although staff differed in their ability, they felt they looked after them well.

Patients and people who use services said staff supported them with family visits.

Most patients said they did not find their activities meaningful and were "bored" at weekends with limited events happening.

Wards for learning disabilities or autism

People and relatives told us staff supported people to take part in activities and pursue their interests in their local area. One person said they liked to go out for walks, and another said they liked gardening. We saw staff involving people with activities and tasks. People said they could enjoy activities of their choice daily.

Carers and family members we spoke with said they were "very happy with the care provided" and "felt their relative was safe."

People told us the staff were good and nice. People felt staff listened to them and supported them with what they wanted. One person said it was the "best place they had ever stayed."

How we carried out this inspection

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

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

Summary of this inspection

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

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

During the forensic inpatient or secure wards inspection, the inspection team:

- Checked the safety and cleanliness of the service.
- Observed the interactions between staff and patients.
- Spoke with eight patients and six family members/carer of patients.
- Interviewed the hospital and deputy hospital directors.
- Spoke with 22 staff members including consultant psychiatrists, psychologists, ward managers, registered nurses, health care workers, therapists and a social worker.
- Spoke with an external professional case manager and an independent mental health advocate.
- Observed a morning meeting, a referral meeting, and a community meeting.
- Attended two daily activities with patients.
- Reviewed 25 care and treatment records and nine physical health records.
- Checked 15 prescription charts and reviewed how staff stored and managed medicines.
- Read meeting notes, service dashboard audits and procedures and other documents relating to the service.

During the learning disabilities and/or autism ward inspection, the inspection team:

- Checked the safety and cleanliness of the service.
- Observed the interactions between staff and people.
- Spoke with 11 people and six family members/carer of people.
- Spoke with seven staff members including senior leaders, managers, nursing staff, support workers, speech and language therapist and activity coordinator.
- Observed an external activity outing.
- Observed a morning meeting.
- Attended two daily activities with people.
- Reviewed six care and treatment records including physical health records.
- Checked five prescription charts and how staff stored and managed medicines.
- Read meeting notes, service dashboard audits and procedures and other documents relating to the service.

Areas for improvement

Action the service SHOULD take to improve:

Forensic Inpatient or Secure wards service

- The service should ensure that it has processes for the physical health care management of patients.
- The service should ensure that it has processes for the monitoring and recording of patients' NEWS2 charts.
- The service should ensure there are enough therapy staff to maintain an effective service.
- The service should ensure there are enough housekeeping staff to carry out daily cleaning of wards.
- The service should ensure that there is enough information to support decision making around the use and review of PRN (when required) medicines.

Learning disability and autism service

Summary of this inspection

- The service should ensure that it has processes for the physical health care management of patients.
- The service should ensure that it has processes for the monitoring and recording of peoples' NEWS2 charts.
- The service should ensure that maintenance requests are reviewed and completed in a timely way.
- The service should ensure it has an effective monitoring system to ensure that date expired products were removed in a timely way.
- The service should review their processes for obtaining feedback from family members
- The service should ensure that people have access to a sensory room which meets their needs.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Forensic inpatient or secure wards

Good 🟢

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

Are Forensic inpatient or secure wards safe?

Good 🟢

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

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

Safety of the ward layout
Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff were aware of ligature risks and how to manage these. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. We saw audits and assessments to support this. Staff signed to say they had read the audit and policies.

The layout of wards allowed staff to observe most areas. Risk mitigation plans were in place for areas with a restricted view. This included mirrors and close circuit television (CCTV) placed at strategic points throughout the wards. We observed positioning of staff to monitor patients when on the wards.

All wards were gender specific, and the accommodation complied with the Department of Health guidance on mixed sex accommodation.

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

Maintenance, cleanliness and infection control
While there was a shortage of cleaning staff, we found that cleaning records were up to date and demonstrated regular cleaning. Ward areas were visibly clean, well maintained, well-furnished and fit for purpose.

The service had two housekeepers with four vacancies. Nursing staff said they helped with cleaning duties throughout the day where possible, but this was often left to the night staff.

Staff followed the provider's infection control policy, including handwashing. Additional infection control procedures had been introduced and audited in order to manage the spread of Covid-19.

Forensic inpatient or secure wards

Good 🟢

Seclusion room

The seclusion rooms met the required standard as described in the Mental Health Act Code of Practice.

Seclusion rooms allowed clear observation and two-way communication. Seclusion room had toilet facilities, externally controlled heating and lighting and a clock visible to the patient.

Clinic room and equipment

Staff checked and monitored clinic rooms. Clinic rooms were fully equipped, well-maintained and clean.

There were appropriate records to demonstrate that staff were monitoring emergency drugs, resuscitation equipment and fridge temperatures.

The service had processes in place for the disposal of used needles. We saw the sharp bins (a container for sharp items such as needles) were not overfilled and had been dated appropriately to facilitate disposal.

Safe staffing

While the service had enough nursing and medical staff there continued to be therapy staff shortages which could impact the service. Staff received basic training to keep patients safe from avoidable harm.

Nursing staff

Managers told us staffing could, at times, be a challenge due to vacancies and the increased acuity of patients that were being admitted. Senior staff attended a daily morning meeting to review staffing levels to ensure the wards were safely staffed.

Managers calculated and adjusted staffing levels according to the needs of the patient and could flex staff accordingly. Staff told us they often worked across wards to support staff shortages. Ward managers said that on occasions they had to be part of the numbers due to staffing shortages which meant they could not always oversee the day to day running of the wards.

Regular locum, agency and bank staff were used to maintain consistency and continuity. Managers ensured all bank and agency staff received a full induction and understood the service. However, staff told us that although temporary staff were regular, there continued to be concerns regarding their forensic experience and the consistency of care they delivered.

The service was facing challenges with recruiting occupational therapists (OTs) and had sourced two locum OTs.

Managers told us they participated in the service's recruitment programme and were actively recruiting to increase staffing levels.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Staff confirmed they were able to rearrange escorted leave. This was confirmed by the patients we spoke with.

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

Medical staff

The service had enough daytime and night-time medical cover available to go to the ward quickly in an emergency.

Forensic inpatient or secure wards

Managers could access locum staff when they needed additional medical cover. Medical staff told us all locum staff had a full induction and understood the service before starting their shift.

The consultants confirmed they did not have junior doctors but were supported by local GPs who attended the wards regularly. GPs saw patients on their request if there were any concerns identified with their physical health.

Medical staff received regular appraisal and supervision and were able to liaise with the medical director when required. All said their caseload was manageable and this was discussed at regular medical meetings.

Medical staff accessed training via the provider network as well as nationally.

There was no weekend consultant psychiatrist cover, but they were available if required out of hours or at weekends in an emergency. Staff said doctors always responded quickly to an emergency.

Mandatory training

Staff completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Training figures showed that 95% of staff had completed mandatory training which was above the provider's target of 90%.

Agency and bank staff also attended the provider's mandatory training requirements.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw details of up-and-coming training on display across the wards.

Assessing and managing risk to patients and staff

While staff reviewed and managed risks to patients, they did not always achieve the right balance when monitoring the person's deterioration. They achieved the right balance when providing the least restrictive environment possible to support patients' recovery.

Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each person on admission/arrival, using two recognised tools, the short-term assessment of risk and treatability and the Historical Clinical Risk management 20 (HCR20).

Risk assessments were reviewed regularly and updated following any incidents and fed into the persons' care plans. These were reviewed and reported monthly via the service's quality account. We saw the service achieved 100% for the review of risk assessments between March and May 2022.

Staff completed risk assessments for patients thought to be at risk of self-harm or suicide.

Forensic inpatient or secure wards

Management of patient risk

Staff identified and responded to changing risks to or posed by patients. Staff managed risks to patients using several approaches, including increased levels of observations. Most patients we spoke with said they felt unsafe on the wards and lacked confidence in staff's ability to manage risk. They felt this was due to having agency staff and not enough staff who knew them. However, we found no recorded incidents that led to patients feeling unsafe on the wards.

Staff did not always monitor the physical health of patients using the National Early Warning Scores (NEWS2). This is a tool that aids the detection and response to clinical deterioration in adult patients. We saw inconsistency in the recording of NEWS2. Staff we spoke with were unaware whether they should be completing the form as a paper record or electronically. This meant there was a risk of staff not recognising deteriorating patients.

We reviewed both paper and electronic NEWS2 charts across two wards and found gaps in seven of the nine charts based on the provider's recommended observation levels and the person's presentation. The clinical paper notes for six of the nine NEWS2 charts did not have corresponding electronic entries to evidence that measurements of vital signs had been escalated or repeated. Issues identified were also found in the April and May 2022 audit reports for Quantock and Blackdown wards. The results showed the wards achieving between 32% and 87% for the completion of charts. The report identified the improvement actions recommended. It was also noted that this concern had been identified in the provider clinical assessment review for August 2021. We spoke with the senior leadership team who confirmed they were aware of the concerns and were continuing to work closely with the team to improve.

Based on the NEWS2 charts reviewed and the information seen it was difficult to ascertain whether the appropriate responses had been made or if there was a risk that staff may not always recognise a deteriorating person correctly. Following the inspection, the service provided us with their continuous action plan. This included weekly audits and additional NEWS2 training to manage the concerns.

Staff were able to observe patients in most areas and staff followed local procedures to minimise risks. Staff had relational security training. Relational security is the knowledge and understanding staff have of a person and of the environment, and how this information is linked into appropriate responses and care. Staff knew about environmental risks for each person and acted to prevent or reduce these.

The service had a policy for searching patients. Details were included in the persons' welcome pack. Staff gave patients and carers information about restricted items. Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe.

The service had completed personalised emergency evacuation plans (PEEPs) for patients with mobility concerns. A PEEP is a plan for a person who may need assistance. Staff had completed evacuation chair training to support patients in an emergency. Evacuation chairs are specially designed seats for transporting patients from a building, usually via stairways.

Staff had easy access to personal alarms and patients had easy access to nurse call systems.

Use of restrictive interventions

Staff made attempts to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the person or others safe. The service was introducing safety pods onto the wards to facilitate safe restraint and administration of intramuscular medicines. A safety pod is a specially designed bean bag that allows physical restraint to be carried out in a safer way.

Forensic inpatient or secure wards

The service had introduced a quality improvement project to review its restrictive practices. This was in its infancy and was being piloted over two wards. The aim was to look at ways' seclusion was being managed by using positive behaviour plans to anticipate and reduce escalation. The project aimed to reduce violence and aggression incidents by 25% per month.

Staff had received training in the Management of Violence and Aggression (MVA).

Blanket restrictions were minimal and suitable for the environment. They included locked wards and the suitable management of contraband items in a forensic setting. Staff reviewed blanket restrictions regularly to ensure they complied with the persons' individual needs.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We reviewed the quality of physical health monitoring following rapid tranquilisation and found no issues or concerns.

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

Staff received training on how to recognise and report abuse, appropriate for their role. Training data showed the service was ensuring between 90% and 100% of staff had completed training Staff were aware of who to contact for support.

Staff knew how to recognise adults at risk of or suffering harm and made safeguarding referrals if they had any concerns. Staff worked with other agencies to protect patients. Patients were given a "Keeping Safe from Abuse" booklet which gave advice on how to protect themselves.

Staff understood their responsibilities to ensure patients were protected from bullying and harassment and/or racial abuse. Patients told us they could raise any concerns at either the weekly community meetings or confidentially in a one-to-one meeting.

The hospital had a safeguarding lead who provided support and guidance to staff. They helped staff to become more involved in the safeguarding process and were in the process of setting up a 24 hour on-call safeguarding line to support both staff and patients.

The senior management team reviewed all safeguarding concerns and ensured concerns were submitted and discussed with the local authority during regular engagement meetings.

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

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

Staff access to essential information
While staff had easy access to clinical information, we found inconsistencies in the management of clinical records with staff being confused between paper and electronic records.

Forensic inpatient or secure wards

Staff had access to essential information. The provider used an electronic system for the recording of essential information on a person's care and treatment. We reviewed 15 sets of care records and found patient's notes contained comprehensive information.

Records were stored securely.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

While the service used systems and processes to prescribe and administer medicines safely, they did not always record, store or destroy medicines in a timely manner. Staff did not always review the effects of medications on each person's mental and physical health.

Staff completed medicine management training and had achieved 92% for level 1 (general support/assisting with medicines) and 98% for level 2 (safe handling of medicines). However, we found staff did not always manage medicines safely. We found the processes on Mendip, Quantock and Blackdown wards for monitoring expiry dates on products was not effective. For example, we found out of date sterile products and needles within the clinic room. Staff told us the out-of-date needles belonged to visiting GPs. However, there was no process or procedure to identify who was accountable for this stock.

There was inconsistency in the recording of expiry dates for inhalers. We found the date recorded by the service was longer than that recommended by the manufacturer. This was brought to the attention of the service director who confirmed they would review all inhalers to ensure they were suitable for use.

Staff had a process for reviewing crash bags regularly. The service had a supply of a hormone medicine which helps to raise blood glucose levels in an emergency. While staff followed the shelf life when the medicines were stored in a refrigerator, they did not record/date the medicine when stored outside of the refrigerator in crash bags. Guidelines state the medicine has a storage life of 18 months once removed from the refrigerator and that the expiry date is not to be exceeded. This meant that there was a risk of medicines being out of date and not effective. The hospital director arranged for all medicines to be checked and removed and replaced when this was raised during the inspection. New forms were implemented to manage future recordings of medicines.

The wards ensured a person's behaviour was not controlled by excessive and inappropriate use of medicines. We looked at 15 medicine charts and 10 care records. Although staff were able to explain the decisions to administer medicines, none of the care records included information to support the decisions/rationale for the administration of PRN (when required) medicines. None of the 10 care records seen identified the patient being reviewed after administration of PRN medicines.

Staff did not always review the effects of medicines on each person's mental and physical health according to the National Institute for Health and Care Excellence (NICE) guidance. Staff monitored patients starting on medicines to stabilise/control their mood or those needing an antipsychotic medicine.

Staff had received training in the management of antipsychotic medicines. High dose antipsychotic treatment guidance provided staff with information to follow when medicines exceeded the upper limit stated in the British National Formulary (BNF) guidelines. The high dosage antipsychotic therapy audit for March and June 2022 identified no issues.

Forensic inpatient or secure wards

Good 🟢

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

Staff learned from safety alerts and incidents to improve practice.

The service used an external pharmacy service which provided oversight of medicine management. This included an audit of medicine management and monitoring of certain medicines, such as antipsychotic medicines or mood stabilisers. Staff could access out of hour on-call medicines advice.

Track record on safety
The service had a good track record on safety.

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

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Staff knew what incidents to report and how to report them.

The service reviewed all incidents. Incident reports identified key themes such as violence and aggression and self-harm. Incident records showed a good understanding of what had happened and what actions were taken as a result.

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

Staff reported serious incidents clearly and in line with the provider's policy.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff understood the duty of candour and gave patients and families a full explanation when things went wrong. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Are Forensic inpatient or secure wards effective?

Good 🟢

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

Forensic inpatient or secure wards

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each person either on admission or soon after. Care plans addressed individual patients' communication needs and tailored staff's approach when engaging with them.

While quality data showed that 100% of patients had their physical health assessed within 48 hours of admission we found that staff did not always monitor the physical health of patients when using the National Early Warning Scores (NEWS2). We saw inconsistency in the recording of NEWS2 which meant there was a risk of staff not recognising deteriorating patients.

Staff developed a comprehensive care plan for each person that met their mental and physical health needs. These were reviewed regularly through multidisciplinary discussion and updated as needed. Most patients told us they had been involved in the creation of their care plans, which was reflected in the records seen.

Staff regularly reviewed and updated care plans when patients' needs changed.

The psychology team were working with staff to provide positive psychology interventions. This is a set of strategies focused on increasing happiness, wellbeing and positive emotions by giving positive feedback. This continued to be a work in progress and the team were working with staff to promote this approach.

The service had close circuit television (CCTV) in ward communal areas. The primary reason for use of CCTV was the protection of patients, staff and visitors. All areas where CCTV were used displayed prominent notices and all cameras, while discrete, were visible.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for patients in the service. The service had a clinical audit programme which included areas such as; health and safety, complaints and reducing restrictive practise.

Staff delivered care in line with best practice and national guidance. Staff followed the National Institute of Health and Care Excellence (NICE) guidelines. The service was part of the Qualified Network for Forensic Mental Health Service (QNFMHS) The QNFMHS is a quality improvement network for low and medium secure forensic mental health services in the UK.

The service used Health of the Nation Outcome Scales (HoNOS) to measure the behaviour, impairment, symptoms and social functioning of patients with severe mental illness.

The service had access to a team of psychologists. Psychology sessions enabled patients to be supported with for example, their offending behaviour, managing emotions and their rehabilitation needs.

Forensic inpatient or secure wards

Staff made sure patients had access to physical health care, including specialists as required. A local general practitioner (GP) visited the hospital once a week to provide physical healthcare support for patients.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. However, most patients told us they thought the food quality was poor and could be improved. Staff confirmed they were able to cater for a patient's individual requirements.

Staff told us they helped patients live healthier lives by supporting them to take part in activity programmes. However, most patients we spoke with felt the range of activities were not beneficial to them and said they were bored at weekends due to the lack of events.

Staff gave advice on areas such as smoking cessation. The hospital was aiming to achieve a smoke free environment in line with Department of Health, Public Health England, and NHS expectations. Patients were allocated four specific times daily when they could have a cigarette. Most patients told us they would use up their escorted leave or access into the community to have additional cigarettes.

Patients had opportunities to develop their activities of daily living skills and could build on their work experience and education. For example, patients had volunteer opportunities in the hospital shop and supported the trainer in the gym.

Staff used technology to support patients. Patients had access to electronic tablets to call friends and families.

Skilled staff to deliver care

While the ward teams included or had access to a full range of specialists required, they did not have enough occupational therapists to meet the needs of patients. 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 all staff.

Managers ensured staff, including bank or agency staff, had the right skills, qualifications, and experience to meet the needs of the patients in their care. Managers made sure staff received any specialist training for their role. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, we saw arrangements for venous thromboembolism (a blood clot) training to support staff's knowledge and understanding.

While the service had access to a full range of specialists to meet the needs of the patients on the wards they did not have enough therapy staff to meet the daily activities of patients. Ward staff included registered nurses, healthcare workers, medical staff, and psychologists. Staff told us they could make made referrals to other specialists when needed.

Managers gave each new member of staff a full induction to the service before they started work. This was spread over three weeks and covered aspects of mental health awareness including conflict resolution and breakaway techniques. Locum, bank and agency staff were provided with an overview of the ward and what to do in the event of an emergency.

Managers supported staff through regular, constructive appraisals and supervision of their work. The most up to date records showed the service achieving 97% compliance.

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

Forensic inpatient or secure wards

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

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

Staff held weekly multidisciplinary team (MDT) meetings to discuss patients and improve their care. Patients were included and represented by advocates where necessary. Four of the six family members/carers we spoke with said they had been involved in decisions about the care and treatment their relative received.

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Staff could access other specialists as needed which included speech and language therapists.

Consultants, social workers, ward managers and psychologists attended ward rounds alongside the patient.

Patient's care pathways were led by the MDT and focused on all aspects of the person's physical and mental health. Treatment and progress were monitored through the Care Programme Approach (CPA) where the value and importance of input from patients and families, where appropriate, was recognised. The quality account for May 2022 showed the service achieving 100% in its review of CPA documentation.

Ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early in the patient's admission to plan discharge.

Staff shared information about patients at handover meetings. They referred to the psychological and emotional needs of patients as well as any changes in their care.

The hospital had developed an effective working relationship with the local GP practice.

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

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

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for support. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

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

Patients had access to information about independent mental health advocacy (IMHA) and patients who lacked capacity were automatically referred to the service. To maintain patient contact during the pandemic the advocates provided both face to face and remote support. We spoke with an IMHA who confirmed they attended the wards regularly.

Forensic inpatient or secure wards

Good 🟢

There were appropriate checks in place to ensure consent to treatment was obtained, and second opinion appointed doctors were requested when needed.

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 person's notes each time. Section 132 of the Mental Health Act requires the manager of a hospital to inform a detained patient of their legal position and rights. Staff explained to each patient their rights in a way that they could understand, repeated as necessary and recorded it clearly in the patient's records.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff told us that this could on occasions be a challenge, but all patients spoken with confirmed they had received their leave.

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

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

Good practice in applying the Mental Capacity Act

Staff supported patients 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 patients who might have impaired mental capacity.

Staff received, and were consistently up to date, with training in the Mental Capacity Act (MCA). Staff we spoke with had a good knowledge of the MCA.

There was a clear policy on MCA and Deprivation of Liberty Safeguards (DoLS), and staff knew how to get advice where necessary. Staff gave patients support to make specific decisions for themselves before deciding a person did not have the capacity to do so. There were no patients subject to a DoLS authorisation at the time of the inspection. Staff were aware of when a DoLS may be applicable and whom to contact for advice. We noted that mental capacity assessments and best interest decisions where applicable had been completed and recorded appropriately.

Managers monitored how staff applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Are Forensic inpatient or secure wards caring?

Good 🟢

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

Kindness, privacy, dignity, respect, compassion and support

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

Forensic inpatient or secure wards

Good ●

Staff were discreet, respectful, and responsive when caring for patients. They understood and respected the individual needs of each person.

Staff gave patients help, emotional support and advice when they needed it. Staff used effective de-escalation skills to manage conflict well while maintaining privacy and dignity.

They supported patients to understand and manage their own care treatment or condition and directed them to other services if they needed help.

Staff followed policy to keep patients' information confidential.

Patients told us that staff were kind and involved their relatives in their care.

Patients were encouraged to participate in roles across the hospital.

Staff understood the individual needs of patients, including their personal, cultural, social, and religious needs. This was evident through conversations with staff and observing interactions.

Involvement in care

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

Involvement of patients

The service had a patient engagement lead who introduced patients to the ward. They provided them with an information pack and a bag of toiletries on accessing the service.

Most patients were encouraged to be involved in the development of their care plans and had copies of their care plans given to them if they wanted. This was reflected in the care records seen.

Patients were encouraged to take an active role where possible in the day to day working of the hospital through participating in key meetings and voluntary opportunities. For example, some patients had taken up employment within the hospital.

The Service User Council, peer support and social inclusion activities prepared patients with their ongoing recovery, rehabilitation, and discharge to a community placement.

Staff involved patients in decisions about the service, when appropriate. Patients were given the opportunity to attend weekly community meetings to provide feedback on the service. We attended a meeting and found good participation and consideration of each patient's requests and concerns.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff communicated with patients in a way they could understand, especially where patients had communication needs. We saw the patient satisfaction survey and associated action plan which showed that most patients had been given the required information and were well supported by staff.

Staff made sure patients could access advocacy services.

Forensic inpatient or secure wards

Good ●

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Four of the six carers/relatives we spoke with said they had been given information or been involved in decisions about their relative.

The service had a carer lead who sent out an information pack to relatives. They liaised with families and carers by establishing ongoing needs and providing information. They followed up with families and carers monthly to ensure there weren't any issues or concerns. All carers and families we spoke with said staff were considerate of their specific needs when organising for example, family visits.

The service had access to an external provider collaborative case manager who regularly visited patients and met with families three or four times a month. They confirmed they often received direct contact from families and had open discussions to address any ongoing or new concerns.

Staff told us they helped families to give feedback on the service. However, only two of the six relatives/carers we spoke with said they have been given the opportunity of providing feedback on the service.

Staff supported patients to maintain contact with those who mattered to them. For example, during the COVID-19 pandemic staff across the hospital had actively facilitated regular video conferencing calls for patients whose relatives were unable to visit.

Are Forensic inpatient or secure wards responsive?

Good ●

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

Access and discharge

Staff planned and managed patients' discharge well. They worked well with services providing aftercare and managed patients' moves to another service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Senior leaders and managers staff monitored patient's waiting time. We attended a bed management meeting which reviewed the number of patients waiting for admission. The co-ordinating team aimed to admit patients as soon as possible to avoid delay in the management of their wellbeing. The bed management meeting identified that seven patients were waiting for admission but there were plans to admit them within the next few days.

Managers regularly reviewed patient's stay at the hospital to ensure they did not stay longer than they needed to. Length of stay refers to the average number of days that patients spend in hospital. The hospital director told us that patients stayed on average between 18 and 24 months with some staying over 36 months. The main reason for any extended length of stay was due to the complex needs of the person and the unavailability of beds or suitable placements in the community.

Forensic inpatient or secure wards

Good ●

There was a clear pathway for patients across the service, for example, patients were provided with a range of interventions to enable them to use the step-down service. The step-down service supported patients who have been treated within a secure setting to progress and move out of a hospital environment. This was observed during the inspection, with one person moving internally from a medium secure ward to a low secure ward.

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the person.

Discharge and transfers of care

The service was part of the South-West Provider Collaborative under the new care models which aimed to decrease the person's length of stay and reduce the number of out-of-area placements. The South-West collaborative team referred patients into the service to ensure they placed patients near their families.

The hospital was working in collaboration with the local acute hospital and the ambulance service to provide a smooth transfer of care between sites to ensure clear communication and expectations, were maintained.

Patients did not have to stay in hospital when they were well enough to leave. The service aimed to reduce the length of stay where possible. The service, alongside external agencies had been successful in discharging 69 patients over the last two years.

Staff started discharge paperwork on admission, and discharge planning was clearly documented in patients' records. Staff planned patients' discharge and worked with the person, their care managers, and coordinators to make sure this went well.

Social workers liaised closely with community and housing teams to help ensure patients could be discharged in a timely way.

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

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' 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.

Each person had a private en-suite bedroom, which they could personalise. Patients had access to lounge and dining room areas. The service provided a range of vocational facilities which included access to the library and education centre. There was an equipped gym with sessions delivered by qualified physical health instructors. Patients told us they were happy on the wards and felt it was appropriate and met their needs.

There was access to outside space. Where this was restricted, there was clear risk-based documentation to demonstrate the reason why.

The hospital provided facilities suitable for disabled patients, including lift access to the upstairs wards and wide corridors for the safe navigation of wheelchairs.

Forensic inpatient or secure wards

Patients could access kitchen facilities to build their cooking skills with support from staff.

Although patients had restrictions in place depending on their individual risks, patients were supported to make telephone calls and access the internet where this was appropriate for them.

The service had allocated family rooms where patients could meet with visitors in private.

Personal searches were conducted in the most dignified way possible.

The service had an outside space that patients could access.

Patients had a secure place to store personal possessions.

The service had a range of equipment which patients could access to support their treatment and care.

The service offered a variety of food which included a vegetarian or vegan option. Staff told us they could cater for each person's individual needs and supported patients with different mealtimes during religious festivals. However, most patients we spoke with said their food was "poor" and "could be improved." Patients told us they would like more variety and meals were very repetitive.

Patients' engagement with the wider community

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

Staff supported patients and ensured they had opportunities for education and work.

Staff helped patients to stay in contact with families and carers. Families and carers told us they could visit the wards to see their relatives.

Wards displayed information for patients which included a list of useful contacts in the local community that patients could approach for support.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Access to interpreters was sourced locally as and when required.

The advocacy service confirmed they signposted patients where appropriate to the Citizens Advice Bureau.

Meeting the needs of patients who use the service

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

The service could support and adjust for disabled patients and those with communication or specific needs.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

Forensic inpatient or secure wards

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

Patients could access a multi-faith room. Staff told us a chaplain visited the hospital weekly. Staff said they were able to support patients who adhered to various faiths.

Patients could access areas such as the gymnasium, the library, and a shop. Patients told us they enjoyed listening to music and watching sport in the television room.

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. However, carers and relatives did not know how to make a complaint.

The service used compliments to learn, celebrate success and improve the quality of care. The service had a weekly informal drop-in session to discuss complaints.

A range of information was available to patients. Notice boards displayed information on local services, advocacy, patient's rights and how to complain. However, none of the six carers/relatives we spoke with knew how to make a complaint.

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

Clear records of all complaints were kept, including actions taken to resolve the complaint and any learning or changes made because of the complaint. Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Patients received feedback from managers after the investigation into their complaint.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw evidence of feedback given to staff during team meetings.

Are Forensic inpatient or secure wards well-led?

Good ●

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

Leadership

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

Ward managers told us that on occasions when the wards were unable to fill shifts, they were part of the staffing numbers. However, managers said this did not happen often due to good oversight of staffing levels during daily meetings. Staff said they were well supported by their ward managers. Staff felt comfortable and confident in approaching the managers if they had any concerns.

Forensic inpatient or secure wards

Managers confirmed they received support from the hospital director and deputy director when required. All ward managers confirmed they received continuous support to enable them to do their role.

Staff were aware of the provider's leadership team and felt they were flexible and approachable.

Staff encouraged patients to give feedback on the service and reported back to them. The senior management team told us that they involved patients in the delivery of the service which included for example, interviews.

Vision and strategy

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

The provider's vision and values for the service were evident and displayed throughout the hospital. Staff we spoke with understood the vision of the organisation and explained where to obtain additional information if required.

Staff demonstrated the hospital's values during their interaction with patients. They felt they were improving the wellbeing and life skills of patients in the service.

Staff told us they were given the opportunity to contribute to discussions about their service so they could put forward tor continuous development.

The physical health team had created objectives for 2022, which included improving health outcomes and the development of nutritional training which included dysphagia training.

Culture

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

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff said that morale across the service had improved although most felt that their increasing and heavy workload were the common factor. All staff showed passion and commitment to providing high quality care.

Staff found working on the wards very challenging and felt the mentoring of ad hoc agency staff was a contributory factor. However, all staff we spoke with said they felt respected and that managers recognised and rewarded their hard work. Staff said they enjoyed supporting patients to get better.

Staff understood the whistleblowing process for raising concerns. They felt comfortable approaching their manager or clinical lead if applicable.

Staff told us the provider responded efficiently during the coronavirus pandemic and showed their support and understanding of staff experiences.

Staff reported that the service promoted equality and diversity in its day-to-day working and staff received the appropriate training. The service embraced cultural differences and valued the knowledge and understanding a diverse workforce brought to the service. The service had celebrated Black History Month and Africa Day.

Forensic inpatient or secure wards

Good 🟢

Staff praised the development opportunities available particularly for nurses and health care workers. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

Staff told us they enjoyed coming to work. Staff survey results also showed that staff felt positive about working for the provider.

Governance

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

The service liaised with an external provider collaborative case manager. They attended quarterly meetings focused on quality, to ensure lessons such as thematic reviews of incidents were embedded across the service.

Managers could access information from a variety of sources that allowed them to understand their team's performance against identified key performance indicators. This information was shared at team meetings to let staff know how well they were doing.

Staff were clear about their roles and responsibilities, and they understood the management structure within the service.

The senior leadership team and the manager's ensured information was fed between the board and the wards, and that information was shared to the staff team.

The service systematically monitored standards of care to continually improve outcomes for patients. All wards carried out a programme of audits to monitor areas such as care and treatment records, specialist training, staffing levels and staff supervision and appraisals.

The leadership, culture and governance at ward level were effective in the delivery of high-quality, person-centred care.

The service held a range of meetings including weekly managers meetings which shared issues and concerns, identified actions and monitored progress. All wards held community meetings with patients, handover meetings, ward rounds and multidisciplinary meetings. Meeting agendas were standardised across the service and covered learning from incidents, complaints, and safeguarding cases.

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.

Identified risks were escalated through the hospital governance structure and identified on the risk register. Risk management across the service was comprehensive, well embedded and recognised as the responsibility of all staff. The main risks identified to the service were; recruitment, violence and aggression and physical health concerns.

The security manager supported staff to manage security concerns. Staff had completed their search and security training. Managers attended security meetings to review and manage any identified risks. Security concerns were discussed at clinical governance meetings to ensure the hospital had oversight of all identified risk.

Forensic inpatient or secure wards

Good ●

Staff attended regular team meetings which was reflected in the minutes seen. There was a clear agenda which included; patient concerns, compliance with training, regulatory issues, and the local risk register.

The service had contingency plans for emergencies which wards reviewed as part of the risk registers. Wards carried out regular health and safety monitoring.

Ward teams knew the patients well and were able to defuse situations effectively before they escalated. The multidisciplinary team meetings discussed any incidents, changes to patients' care or new insights into their presentation.

Information management

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

The service used several tools and audits to collect and analyse data on the service. The performance reports provided information on areas such as mandatory training, staffing, complaints, safeguarding and care planning. Managers received feedback on their key performance indicators from which they created action plans if applicable.

The electronic system supported staff to report incidents and manage their own performance.

There was enough equipment and information technology available for staff to do their work.

The service made notifications to external bodies as required.

Staff had access to the electronic and paper documents they needed.

Engagement

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

Staff participated in feedback surveys and the service provided us with the action plan for 2022. Areas for improvement included; improving communication and encouraging staff to report harassment, bullying or abuse from patients or relatives.

The service worked closely with external stakeholders such as commissioners and NHS England.

Staff had access to the provider's intranet system which provided them with up-to-date information on items such as policy updates.

Patients and carers could access information about the service through the provider's website.

Patients told us that they were able to provide feedback at either the weekly community meetings or directly with staff. Relatives and carers, we spoke with said they had not been given the opportunity to provide feedback on the service.

Forensic inpatient or secure wards

Good 🟢

Learning, continuous improvement and innovation

The managers worked together as a team to make improvements in the running of the service. Staff were encouraged to develop their skills in this area and contribute to the quality improvement programme.

Leaders were responsive to concerns raised and performance issues and sought to learn from them to improve services.

Staff said they were given the time and opportunity to learn.

Wards for people with learning disabilities or autism

Good 🟢

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

Are Wards for people with learning disabilities or autism safe?

Good 🟢

We had not previously rated this service. We rated it as good:

Safe and clean care environments

People's care and support was provided in a safe, clean, and well-maintained environment.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. The number of staff assigned to work with people depended on the individual's needs. There were enough staff to do this, and all staff were aware of people's risks and their observation levels.

Staff had easy access to alarms and there were processes to prevent personal alarms being removed from the building, for example alarms would sound if staff members tried to take an alarm through the main airlock.

The service had close circuit television (CCTV) in ward communal areas. The primary reason for use of CCTV was the protection of people, staff and visitors. All areas where CCTV were used displayed prominent notices and all cameras, while discrete, were visible. Staff reduced the risks of blind spots in bedrooms by using concave mirrors.

Individual risks to the person were assessed and action plans were developed and reviewed to reduced or remove any environmental risks identified.

People were protected from potential ligature risks or anchor points in the service (anything that can be used to tie a cord, rope or other material for the purpose of hanging). Staff knew about any potential ligature or anchor point and mitigated the risks to keep people safe. Ligature cutters were available in an emergency and all staff knew where to find them. However, at the time of the inspection there were two electrical cables in unlocked cupboards, in a locked room. People on the ward only had access to this room when a staff member was present. The manager locked the cupboards during our visit.

Maintenance, cleanliness and infection control

Wards for people with learning disabilities or autism

The ward was clean at the time of our inspection. Cleaning records were kept up to date and showed all areas were regularly cleaned.

People were protected from the spread of infection. Staff followed infection control procedures, including hand washing, and we saw appropriate use of PPE. There were adequate supplies of hand sanitising gels. Staff wore masks correctly, had temperature checks at the start of each shift and regular tests for COVID-19.

We saw records of maintenance requests that had not been completed. For example, a complaint raised during a community meeting in February 2022 identified that the doors accessing the garden were broken, although people could still access the garden. We saw community meeting minutes for June 2022 where these concerns were still being raised. During our inspection the garden door was still broken.

Seclusion room

The seclusion room met the required standard as described in the Mental Health Act Code of Practice. It allowed clear observation and two-way communication. There were toilet facilities, externally controlled heating and lighting and a clock visible to the person. However, we observed dirty windows in the seclusion room and the lights were very bright and could not be dimmed. At the time of our inspection the seclusion room was being used for a person on long term segregation.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment.

Safe Staffing

Nursing staff

The service had enough nursing and medical staff. Staff knew the people they cared for well and received basic training to keep people safe from avoidable harm.

The manager told us that staffing numbers had improved but could still be a challenge due to increased acuity of people coming into the service. Senior staff attended a daily morning meeting to review staffing levels to ensure the ward was deemed safe.

Managers calculated and adjusted staffing levels according to the needs of the people and could flex staff accordingly.

Locum, agency and bank staff were used to maintain consistency and continuity. The manager ensured all bank and agency staff received a full induction and understood the service. This was confirmed by agency staff we spoke with.

The service was facing challenges with qualified occupational therapists (OTs) and had sourced two locum OTs that were due to start their role by the end of June 2022.

People rarely had their escorted leave or activities rearranged, even when the service was short staffed. This was confirmed by the people we spoke with.

Wards for people with learning disabilities or autism

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

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go there quickly in an emergency.

Managers could access locum staff when they needed additional medical cover. Locum staff had a full induction and understood the service before starting their shift.

Consultants confirmed they were supported by local GPs who attended the ward regularly. Consultants, social workers, ward manager and psychologists attended ward rounds alongside the people.

Medical staff confirmed they received regular appraisal and supervision and were able to liaise with the medical director when required. All said their caseload was manageable and this was discussed at regular medical meetings.

Medical staff told us they accessed training via the provider network as well as nationally.

There was no weekend consultant cover, but they were available if required out of hours or at weekends in an emergency. Staff said doctors always responded quickly to an emergency.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of people and staff.

Training figures showed that 95% of staff had completed mandatory training which was above the provider's recommended target of 90%.

Managers told us that agency and bank staff also attended the provider's mandatory training requirements. This was confirmed by agency staff we spoke with.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw details of available training on display.

Staff told us about their induction which included specific training for people with a learning disability and autistic people. Staff induction was over eight days and comprehensive.

Staff told us training was mostly online. Staff shadowed more experienced staff on induction to gain insight into the people they were supporting.

Assessing and managing risk to peoples and staff

Assessment of people's risk

Wards for people with learning disabilities or autism

Good ●

Risk assessments were individual, person centred and reviewed regularly. Staff knew the risks to people and the actions needed to reduce or remove the risk. Individual risk assessments were completed for activities such as external trips, choking and for physical health.

Management of people risk

Staff anticipated and managed risk. They had a high degree of understanding of people's needs. Staff knew about risks to each person and acted to prevent or reduce risks.

Staff had a good understanding of people's needs. Staff identified and responded to any changes in risks to, or posed by, people using the service.

The multidisciplinary team (MDT) discussed people's risks daily in the morning meeting and updated assessments where needed. Staff we spoke with understood people's care plans and their positive behaviour support plans and knew how to support each person to reduce their risks.

There were people whose behaviours at times placed them and others at risk of harm. Positive behaviour support (PBS) plans were developed with the person and followed best practice in anticipating, de-escalating and managing challenging behaviour. Also included in the PBS plan was "My best day," "Things I need to learn," and "Important things you need to know about supporting me".

Hospital passports were developed to help staff with understanding the person's needs in the event of an admission to hospital. However, at the time of the inspection we were told not all people had a copy of their updated hospital passports, but staff were working towards this.

Relatives told us staff organised the medical care and accompanied their family member on appointments.

Relatives said that staff recognised their family member's triggers of behaviours and used the appropriate strategies to reduce the levels of distress, anxiety and frustration. Reactive strategies included clear descriptors of the triggers of peoples' behaviours. De-escalation strategies were built around people's preferred activities. As a result, restraint and seclusion were reducing.

Staff received and kept up to date with training on NEWS2 and 95% of staff had completed this training. However, staff did not always monitor the physical health of people using the National Early Warning Scores (NEWS2). This is a tool that aids the detection and response to clinical deterioration in adult people. We reviewed NEWS2 audit reports and results demonstrated completion of NEWS2 charts of between 58% and 89% with improvement actions recommended. It was also noted that this concern had been identified in the provider clinical assessment review for August 2021.

Following the inspection, the service provided us with an action plan which included weekly audits and additional NEWS2 training to manage concerns identified.

Use of restrictive interventions

Restrictive practices were used as a last resort, for the shortest time possible and in situations where people were a risk to themselves or others.

Wards for people with learning disabilities or autism

Good ●

Staff had confidence in their relationships with people who used the service to reduce restrictive practices. The service monitored and reported the use of restrictive practices. 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 number of restraints used was ten in April 2022, five in May 2022 and none in June 2022. During this period there was one incident of rapid tranquilisation. There were no prone restraints recorded. Staff told us they used verbal de-escalation to help people to reduce their distress.

For the period of April to June 2022, there were two episodes of seclusion lasting between four and 24 hours and five episodes of seclusion lasting over 24 hours. During this episode there were two people on enhanced observations to reduce the risk to themselves and others. Seclusion was reviewed twice per day by the multidisciplinary team with two hourly nursing reviews completed when decisions about continuing or ending seclusion were needed. At the time of our inspection the seclusion room was being used for a person on long term segregation (LTS). The Mental Health Act (MHA) Code of Practice defines LTS as "a situation where, in order to reduce a sustained risk of harm posed by the patient" they "should not be allowed to mix freely with others."

People's records included an individual plan on how staff were to support them to reduce restrictive practice. People made decisions as to the restrictions they wanted to keep themselves safe, for example, limited access to their belongings that they may harm themselves with.

We reviewed care plans and personal behavioural support plans for people in long term seclusion, which confirmed people had been involved and had a copy of their care plan. For example, we saw graded reintegration documented alongside external reviews of long-term seclusion.

All incidents of restraints or de-escalation were reviewed in the daily morning MDT meeting. At this meeting, risks were discussed, and risk assessments updated including an updated body map and a debrief scheduled for the person and all involved. Restraints were also discussed at team meetings, ward and clinical governance meetings and reducing restrictive practice meetings. Discussions included lessons learnt.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation.

Safeguarding

People were safeguarded from abuse. 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 kept up to date with their safeguarding training. The provider had trained all staff in safeguarding adults and children at Level 2 and 93% of staff in safeguarding adults and children at Level 3. The provider's target was 90%.

Staff were aware of their responsibilities towards ensuring people were safeguarded from abuse including how to recognise the signs of abuse, raising safeguarding referrals and who to inform if they had concerns. People on the ward told us they felt safe.

Staff access to essential information

Wards for people with learning disabilities or autism

People's care records were a mixture of paper-based and electronic. All staff including bank and agency workers had access to people's records on the computer and those on paper. Staff said they had the current information about each person and any changes were notified to staff at the morning meeting and again during the evening handover. The manager told us they had also recently introduced email updates to staff to improve handover information. Records were stored securely.

Medicines management

While the service used systems and processes to prescribe and administer medicines safely, they did not always record, store or destroy expired medicines. However, staff regularly reviewed the effects of medications on each person's mental and physical health.

The service had systems and processes to prescribe and administer medicines safely. However, the service did not have an effective monitoring system to ensure that date expired products were removed in a timely way. The system for monitoring expiry dates of sterile products was not effective. We found out of date sterile products within the clinic room.

Ninety-two per cent of staff had completed medicine management training at level 1 (general support/assisting with medicines) and 98% had completed level 2 (safe handling of medicines).

Staff were able to explain how decisions to administer were made. However, the support plans did not include information to support decision-making. Records made after administration of "when required" medicines did not always contain detail around the decision-making process or the outcome of administration.

The service followed good practice guidance such as the reduction of restrictive practice and STOMP (stopping over-medication of people with a learning disability, autism or both). This meant that staff understood peoples' positive behavioural support plans and provided the identified care and support.

The STOMP audit for May 2021 to April 2022 reviewed 11 people's records. The audit demonstrated all people had clearly documented multidisciplinary care plans and prescribing records. For example, if a person had been prescribed over the British National Formulary maximum limits at point of admission staff would introduce a medicine reduction plan during their stay. All persons had received a capacity assessment for treatment and in all cases the person's views about drug treatment had been recorded.

Doctors reviewed each person's medicines and gave clear direction to staff about the medicines each person was prescribed. Information about medicines was provided in accessible formats to each person.

Staff followed national practice to check people had the correct medicines when they were admitted, or they moved between services. On admission there was a system in place to carry out reconciliation of medicines in line with national best practice.

Staff learned from safety alerts and incidents to improve practice.

Staff reviewed the effects of each people's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance.

Track record on safety

Wards for people with learning disabilities or autism

Good 🟢

The service kept people and staff safe. There were three serious incidents at ward level in the last 12 months that involved people using the service. Lessons learned and recommendations were discussed and shared in clinical governance meetings and team meetings.

Reporting incidents and learning from when things go wrong

The service managed safety incidents well.

Managers maintained peoples' safety and investigated incidents and shared lessons learned with the whole team and the wider service. Staff told us they received lessons learned information in handovers and we saw this information was given to staff via email and discussed in the morning meeting.

The service apologised to people, and those important to them, when things went wrong. Staff gave honest information and suitable support and applied duty of candour where appropriate. Managers were able to give examples of events that required this level of transparency. Relatives said they were informed about important events such as incidents and accidents.

Electronic reporting systems were audited to ensure debriefs with the person and staff involved happened following incidents and accidents.

Are Wards for people with learning disabilities or autism effective?

Good 🟢

We had not previously rated this service. We rated it as good because:

Assessment of needs and planning of care

Assessment of people's needs started at admission. Care and support plans were holistic and reflected people's needs and aspirations. People, those important to them and staff developed individualised care and support plans. Staff took the time to understand people's behaviours. However, one person's care plan we reviewed demonstrated they had not received a full physical health assessment from the GP since admission.

Staff completed a comprehensive mental health assessment of each person either on admission or soon after. People's records showed an assessment of all their needs and plans were detailed as to how staff were to support the person to meet these.

Best practice in treatment and care

Staff provided care and treatment for people in the service, reflecting the CQC guidance 'Right support, Right Care, Right Culture' and the service delivered care in line with best practice and national guidance.

The service worked to reflect the 'Right Support, Right Care, Right Culture' guidance set by the CQC. The ward manager was aware of the guidance, and said the service had an open-door policy to challenge practice.

Wards for people with learning disabilities or autism

Good 🟢

People benefitted from a range of treatment and care delivered by staff based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills. People were supported with their physical health and encouraged to live healthier lives. Staff identified peoples' physical health needs and recorded them in their care plans.

Staff understood peoples' positive behavioural support plans and provided the identified care and support. All staff had access to these, and they were up to date.

People were meaningfully occupied. People could go out in the minibus for group activities like having a picnic in the nearby woodlands. People did activities on the ward which they enjoyed such as pool, gaming, cooking, arts, crafts, and jigsaws. We saw some of the artwork and jigsaws on the walls of a person's bedroom.

The activity programme was discussed during daily community meetings. People had supervised access to the computer room and were able to use the computer for 30-minute sessions.

Staff used technology to support people to stay connected with their families when they were unable to see them face-to-face. People had their own phones to stay connected with their friends and relatives.

While people's sensory needs were considered, the sensory room was not equipped for sensory needs. For example, the room did not have a range of stimuli to help individuals develop and engage their senses such as lights, sounds or sensory soft play resources and aromas. The manager told us staff had visited other hospitals to review their sensory room to make improvements. We were told the ward had secured a large budget to purchase sensory equipment and improve the lighting on the ward, to include dimmable lighting.

Skilled staff to deliver care

People received care, support and treatment from staff and specialists who received relevant training, including around mental health needs, supporting autistic people, human rights and reducing restrictive interventions.

Managers provided an induction programme for any new or temporary staff including agency staff where used. 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 identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

People's needs were met by skilled staff and they had access to the full range of specialists required to meet their needs. The manager made sure they had staff with the range of skills needed to provide high quality care.

Ward staff included registered nurses, healthcare workers, medical staff, occupational therapists, and psychologists. Staff told us they could make made referrals to other specialists when needed.

Relatives said staff were skilled and understood the needs of their family members and how to manage situations.

Managers supported staff through appraisals, individual supervision, team meetings and with opportunities to update and further develop their skills. Staff had regular supervision with their line manager. The senior management team had a weekly meeting with staff to discuss professional development and training needs.

Multidisciplinary and interagency teamwork

Wards for people with learning disabilities or autism

Good ●

People were supported by staff from a range of disciplines who worked together to ensure care was delivered and outcomes achieved in line with care and discharge plans.

The service had access to a full range of specialists to meet people's needs. Staff held weekly MDT meetings to discuss people and improve their care. People were included and represented by advocates where necessary

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. Staff could access other specialists as needed which included speech and language therapists.

People's care pathway was led by the MDT. This focused on all aspects of the person's physical and mental health. Treatment and progress were monitored through the Care Programme Approach (CPA) where the value and importance of input from people and families, where appropriate, was recognised. The quality account for May 2022 showed the service achieving 100% in its review of CPA documentation.

The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. Staff engaged with them early in the person's admission to plan discharge.

Staff shared information about people at handover meetings. They referred to the psychological and emotional needs of people as well as any changes in their care.

The hospital had developed an effective working relationship with the local GP practice.

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

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.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. Ninety-five per cent of staff had completed this training. Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

People had easy access to information in accessible formats about independent mental health advocacy (IMHA) and people who lacked capacity were automatically referred to the service. This included information in easy read for sections of the Mental Health Act that related directly to the people at the Hospital.

IMHAs attended the wards regularly. To maintain people's contact during the pandemic the advocates provided both face to face and remote working.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand. The speech and language therapist had developed information accessible to individuals and staff used these to explain to people their rights.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Before each person went on section 17 leave staff completed a risk assessment with them to ensure their safety during their leave.

Wards for people with learning disabilities or autism

People's mental health status was documented in their care files and relatives we spoke with knew the conditions of their family member's section under the Mental Health Act 1983.

People were reminded of their section 132 rights and recorded clearly in their care notes each time. Staff used the person's preferred method of communication which ensured they understood their legal position and rights under the MHA. For example, social stories and easy read formats.

Good practice in applying the Mental Capacity Act

People were supported to make decisions about their care. Staff understood the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards.

Staff provided information about decisions that a person needed to make in a format that was accessible to them. Staff made reasonable adjustments to maximise the opportunity for individuals to make decisions. Staff made sure the person was making the decision at a time they were alert and, in a place, where they were comfortable.

Records showed that staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision. When staff assessed people as not having capacity, they made decisions in the person's best interests and staff recorded these.

Staff received and were up to date with training in the Mental Capacity Act (MCA). Staff we spoke with had a good knowledge of the MCA.

There was a clear policy on MCA and Deprivation of Liberty Safeguards (DoLS), and staff knew how to get advice where necessary. Staff gave people support to make specific decisions for themselves before deciding a person did not have the capacity to do so. There were no people subject to a DoLS at the time of the inspection. Staff were aware of when a DoLS may be applicable and whom to contact for advice. We noted that mental capacity assessments and best interest decisions where applicable had been completed and recorded appropriately.

Managers monitored how staff applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Are Wards for people with learning disabilities or autism caring?

Good 🟢

We had not previously rated this service. We rated it as good because:

Kindness, privacy, dignity, respect, compassion and support

People received kind and compassionate care. We observed that staff were discreet, respectful, and responsive when caring for people.

Staff protected people's privacy and dignity and understood people's needs. Staff took time to listen to and speak with people in a kind and compassionate way. Staff supported people to understand and manage their care, treatment or condition.

Wards for people with learning disabilities or autism

All people we spoke with told us they felt safe and cared for. One person said it was the best place they had ever been. All people we spoke with told us they felt completely supported by the management and their team. They told us the staff were approachable and always there when they needed them.

People were given easy to read information on mutual expectations and boundary settings. People were expected to talk respectfully and listen to others.

People were enabled to make choices for themselves, and staff ensured they had the information they needed. Information was provided in individual easy read, symbols, and picture formats to help the person to understand.

Staff gave people help, emotional support and advice when they needed it. We observed staff speaking with people using a calm tone of voice and helping them to relieve their distress.

People had been involved in creating their 'mood board' and how they might be feeling at various times and what support they would want from staff. Staff directed people to other services and supported them to access those services if they needed help.

All people spoke highly of staff and the care they received. People said staff were always available to talk with and supported them when needed.

Staff understood and respected the individual needs of each person. All staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people who used the service and would not hesitate in doing so.

We observed staff withdrawing themselves from situations which potentially placed them and others at risk of harm. Staff explained the reasons for their action and described their approach once the person was more receptive to their engagement.

We saw people respond to staff when they engaged. The staff we spoke with gave us examples of people's responses to their kind and compassionate approach. They said some people responded well to kindness and being involved in their care.

All staff told us they loved their job. Staff spoke with passion about their role and spoke with empathy when discussing people. They had a detailed understanding of the person which showed they knew the person they were supporting.

Involvement in care

People, and those important to them, took part in making decisions and planning of their care.

Care plans included easy read information to enable the person to be involved in their care. Care plans focused on people's strengths. Staff worked with people to focus on their goals and hopes for their future. People were empowered to feedback on their care and support.

There were regular meetings with the people who used the service. We saw people had made suggestions about the redecoration of the building, improvements to communal areas and staff had listened to these and made the changes people wanted where they could. Minutes of meetings were in easy read and picture format and showed that people were involved in their care.

Wards for people with learning disabilities or autism

People said their views were listened to and valued.

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

People's individual feedback and experiences of their care was gathered in a way the person was able to understand. For example, an easy read debrief was developed to support a person to give feedback about incidents. Relatives told us they did get feedback but felt it could be improved.

Involvement of families and carers

Staff supported people to maintain links with those that are important to them. However, families did not always feel informed and involved.

Staff supported people with family visits, when appropriate. Staff knew how difficult this could be for the person and supported them throughout. Staff maintained contact and shared information with those involved in supporting people, as appropriate.

However, relatives told us they felt the visiting times were not long enough for the distance they had to travel to visit people on the ward.

The service had a carer lead who sent out an information pack to relatives. They liaised with families and carers by establishing ongoing needs and information. They followed up with families and carers monthly to ensure there weren't any issues or concerns.

The service had access to an external provider collaborative case manager who regularly visited people and met with families three or four times a month. They confirmed they often received worries directly and had open discussions to address any ongoing or new concerns.

However, some family members felt disconnected from the ward. Two relatives/carers we spoke with said they had not been given the opportunity of providing feedback on the service.

Staff supported people to maintain contact with those who mattered to them. For example, during the COVID-19 pandemic staff across the hospital had actively facilitated regular video conferencing calls for people whose relatives were unable to visit.

Are Wards for people with learning disabilities or autism responsive?

Good ●

We had not previously rated this service. We rated it as good because:

Access and discharge

Wards for people with learning disabilities or autism

Staff planned and managed peoples' discharge well. They worked well with services providing aftercare and managed peoples' moves to another service. As a result, people did not have to stay in hospital when they were well enough to leave.

People had discharge plans with clear timeframes in place to support them to return home or move to a community setting. Staff liaised well with services that provide aftercare, so people received the right care and support when they went home.

Bed management

There were two bed vacancies at the service. Meetings with commissioners and the hospital's leadership team were held to discuss potential admissions and the most appropriate pathways for the person into hospital. Decisions about admissions to the hospital were made at MDT meetings. Managers told us they felt able to challenge inappropriate admissions and gave examples of how assessments aided decisions.

Managers regularly reviewed people's stay at the hospital to ensure they did not stay longer than they needed to. The hospital director told us that the main reason for any extended length of stay was due to the complex needs of the person and the unavailability of beds or suitable placements in the community.

Discharge and transfers of care

The service was part of the South-West Provider Collaborative under the new care models which aimed to decrease the person's length of stay and reduce the number of out-of-area placements. The South-West collaborative team referred people into the service to ensure they placed people near their families.

The hospital was working in collaboration with the local hospital and the ambulance service to provide a smooth transfer of care between sites and ensure clear communication and expectations were maintained.

People did not have to stay in hospital when they were well enough to leave. The service aimed to reduce the length of stay where possible.

Staff carefully planned peoples' discharge and worked with care managers and coordinators to make sure this went well. People's records included a discharge plan that the person was involved in. People discussed with staff where they would like to move to and why and plans were in a format that was accessible to the individual.

Facilities that promote comfort, dignity and privacy

People's privacy and dignity was respected by staff. Each person had their own bedroom with an en-suite shower room. People could personalise their room and keep their personal belongings safe. People had access to quiet areas for privacy. The service's design, layout and furnishings supported people's good care and support.

The environment was 'low arousal' and uncluttered. People had access to a sensory room and quiet space. People had individual en-suite bedrooms. Minimal furnishing helped with the low arousal environment. Some people had keys to their bedrooms and others were supported to access their room.

Wards for people with learning disabilities or autism

Bedrooms were individually furnished and fit for purpose. We saw personalisation of individual bedrooms, which included posters, jigsaws and plants. At the time of the inspection two bedrooms were empty and one was being used as a storeroom.

People had a secure place to store personal possessions. People told us that they could store their possessions in a different room if they thought having their clothing for example in their bedroom could put them at risk of harming themself.

The service had listened to the people on the ward and created a ward specific computer room. Previously people used the library for the computer. There were other dedicated activity areas.

The ward was separated by two seven-bedroom corridors with a large central community space. This area had seating and a full-size pool table. Leading from the communal space were a number of activity specific areas, including a phonebooth, multidisciplinary room, quiet room, activities room, kitchen and laundry. There were large dining areas attached to each bedroom corridor. The dining rooms had hot and cold drinking facilities and individual people lockers to keep personal items.

There was a meeting room for staff handovers and multidisciplinary team meetings. People could also access this room for their reviews and meetings. People could make phone calls in private. There was a telephone for people to use although they said they did not use this as they used their own mobile phones.

The service had an outside space that people could access when they wanted to. Due to the risk of people absconding staff always supported people in the garden. We were told maintenance had been scheduled to make the roof anti-climb following an incident where a person managed to climb onto the roof.

The service had allocated family rooms where people could meet with visitors in private.

The service offered a variety of food which included a vegetarian option. Staff told us they could cater for each person's individual needs and supported people with their mealtimes. Most people we spoke with said their food was okay.

Peoples' engagement with the wider community

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

Staff helped people to stay in contact with families and carers. Families and carers visited the service and also used technology to have virtual meetings with family.

Staff helped people to stay in contact with families and carers. Families and carers told us that while they could visit the wards to see their relatives, they were frustrated with the lack of weekend visiting and shorter visits particularly if they had travelled a long distance for a visit.

The ward displayed information including a list of useful contacts in the local community that people could approach for support.

Wards for people with learning disabilities or autism

Good 🟢

Staff encouraged people to develop and maintain relationships both in the service and the wider community. We were told of an example where staff had created links with a person's home county as their heritage was very important to them. Staff engaged with contacts in the county and arranged visits for the person to build on links for when they were discharged back to the community.

Access to interpreters was sourced locally as and when required.

Meeting the needs of all people who use the service

The service met the needs of all people using the service, including those with needs related to equality characteristics. Staff helped people with advocacy, cultural and spiritual support. People's communication needs were always met. People had access to information about their rights in appropriate formats.

Staff supported people with communication needs. The speech and language therapist assessed people's communication needs and staff followed individual communication plans. They provided information in a variety of formats including pictures, easy read and symbols. This made sure people could access information on treatment, local service, their rights and how to complain.

Speech and language therapists created mood cards to help people express their emotions were used for all people. Easy read posters were on display in the communal area on activities, advocates and symbols.

Staff asked people during their assessment what support they wanted to meet their spiritual needs.

Individual therapeutic activities timetables were developed, and easy read copies of the timetable were on display on the wards. Staff were knowledgeable about people's preferred activities.

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

Staff knew how to access interpreters or signers when needed.

People could access other areas in the hospital such as the gymnasium, the library, and a shop. People told us they enjoyed listening to music and watching films together.

Listening to and learning from concerns and complaints

People, and those important to them, could raise concerns and complaints easily and staff supported them to do so. The service treated all concerns and complaints seriously, investigated them and learned lessons from the results. They shared the learning with the whole team and the wider service.

People and their relatives knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in formats that were accessible to individuals. There was a notice board that told people using pictures and easy read information about how to make a suggestion, compliment or make a complaint.

Staff knew how to acknowledge complaints. There was a 'You said, We did' board that showed action taken following feedback about the service. Managers shared feedback from complaints with staff and learning was used to improve the service.

Wards for people with learning disabilities or autism

The service used compliments to learn, celebrate success and improve the quality of care.

Relatives said they felt they could approach managers with complaints.

Are Wards for people with learning disabilities or autism well-led?

Good ●

We had not previously rated this service. We rated it as good because:

Leadership

Leaders had the skills, knowledge and experience to perform their roles and understood the services they managed. They had a vision for the service and for each person who used the service. They were visible in the service and approachable for people and staff.

Local leadership was provided by a ward and deputy managers. They were aware of the challenges facing the service.

All staff told us that their manager was supportive and provided direct care as appropriate. They said the ward manager and senior management team were visible on the ward.

The manager told us they received support from all layers of the senior leadership team when required. They received continuous support to enable them to do their role.

Staff were aware of the provider's leadership team and felt they were flexible and approachable.

Staff encouraged people to give feedback on the service and responded and reported back to them. The senior management team told us that they involved people in the delivery of the service which included for example, interviews of new staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how to apply them in the work of their team.

All staff we spoke with were aware of Elysium's vision and values. They knew how to apply the values of kindness, integrity, teamwork and excellence in their day-to-day work and demonstrated this throughout our inspection.

The vision and values for the service were on display throughout the hospital. Staff understood the vision of the organisation and explained where to obtain additional information if required.

Staff told us they were given the opportunity to contribute to discussions about their service so they could put forward their views for continuous development.

We saw minutes from business meetings developing an ethos and mission statement for the service.

Wards for people with learning disabilities or autism

Good 🟢

Culture

Staff felt respected, supported and valued. The provider promoted equality and diversity in its work. They felt able to raise concerns without fear of retribution.

Staff said morale was good. They said there was a good culture where staff felt able to share their views without fear of reprisals. They felt supported and valued.

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff said that morale across the service had improved although most felt that their workload was the common factor. All staff showed passion and commitment to providing high quality people care.

Staff understood the whistleblowing process for raising concerns and said they felt comfortable in approaching their manager or clinical lead if applicable.

Staff were aware of the role of the Freedom to Speak Up Guardian and knew how to contact them. Staff said they were able to raise concerns to the manager or senior management team and would be listened to if they did.

Staff told us the service promoted equality and diversity in its day-to-day working and they had received the appropriate training. The service embraced cultural differences and valued the knowledge and understanding a diverse workforce brought to the service. The service had celebrated Black History Month and Africa Day.

Staff praised the development opportunities available particularly for nurses and health care workers. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

Staff told us they enjoyed coming to work. Staff survey results also showed that staff felt positive about working for the provider.

Governance

Our findings from the other key questions showed that governance processes helped to keep people safe, protect their human rights and provide good quality care and support.

The service liaised with an external provider collaborative case manager. They attended quarterly meetings focused on quality to ensure lessons were embedded across the service.

The senior leadership team and managers ensured that information was fed between the board and the wards and that information was shared to the staff team.

The service monitored standards of care to continually improve outcomes for people. The ward had a programme of audits to monitor areas such as care and treatment records, specialist training, staffing levels and staff supervision and appraisals.

The leadership, culture and governance at ward level were effective in the delivery of high quality, person centred care.

Wards for people with learning disabilities or autism

The service held a range of meetings including weekly managers meetings which shared issues and concerns, identified actions and monitored progress. All wards had a framework of community meetings with people, handover meetings, ward rounds and multidisciplinary meetings.

Management of risk, issues and performance

Staff had the information they needed to provide safe and effective care. They used information to make informed decisions on treatment options. Where required, information was also reported externally.

The manager was aware of risks to the service and the people using it and had acted to reduce these risks.

Identified risks were escalated through the hospital governance structure and identified on the risk register. Risk management across the service was comprehensive and recognised as the responsibility of all staff. The main risks identified to the service were; recruitment, ligature risks, violence and aggression.

The security manager supported staff to manage security concerns. Staff had completed their search and security training. Managers attended security meetings to review and manage any identified risks. Security concerns were discussed at clinical governance meetings to ensure the hospital had oversight of all identified risk.

Information management

Staff collected analysed data about outcomes and performance.

All staff had access to the information they needed to deliver safe and effective care. There was enough equipment and information technology available for staff to do their work. Staff had access to the electronic and paper documents they needed.

Performance reports provided information on areas such as mandatory training, staffing, complaints, safeguarding and care planning. Managers received feedback on their key performance indicators from which they created action plans if applicable.

The electronic system supported staff to report incidents and manage their own performance.

Engagement

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

People had care and treatment reviews and the manager and staff participated in these, so the teams had the information needed about the person for their review.

Staff participated in feedback surveys and the service provided us with the action plan for 2022. Areas for improvement included; improving communication and encouraging staff to report harassment, bullying or abuse from peoples or relatives.

Wards for people with learning disabilities or autism

The service worked closely with external stakeholders such as commissioners.

Staff had access to the provider's intranet which provided them with up to date information on items such as policy updates.

Peoples and carers could access information about the service through the provider's website. The information available gave a brief description of the hospital and the contact details.

People told us that they were able to provide feedback at either the weekly community meetings or directly with staff. We reviewed feedback information, which included details of the resolution and the person's agreement to the feedback being closed.

However, relatives and carers, we spoke with told us they were frustrated that they had not been given the opportunity to provide formal feedback on the service.

Learning, continuous improvement and innovation

People, and those important to them, worked with managers and staff to develop and improve the service. The provider sought feedback from people and those important to them and used the feedback to develop the service.

The managers worked together as a team to make improvements in the running of the service. Staff were encouraged to develop their skills in this area and contribute to the quality improvement programme. Staff said they were given the time and opportunity to learn.

Leaders were responsive to concerns raised and performance issues and sought to learn from them to improve services.

The service continued to develop their service improvement plan. We were told of plans to apply to the Royal College of Psychiatry Learning Disabilities Services QNLD (Quality Network Learning Disabilities) in the near future. We reviewed business meeting minutes outlining the model of care under discussion to measure where the service was, what it needed to improve and how to progress these improvements to meet best practice guidelines. We were told it would be a good opportunity for staff to be involved in sharing good practice and development.

All staff spoke with passion and determination to improve their service and felt confident they were able to improve the lives of people on their ward.

Requirement notices

Action we have told the provider to take

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