Pathfinder Group Healthcare Limited

Pathfinder Ashness House

Inspection report

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Tel:

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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?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced, comprehensive inspection of Pathfinder Ashness House. We have rated the service for the first time. After a focused inspection in September 2022 identified serious concerns, we went back to check the provider had made improvements.

The hospital had made progress in addressing the concerns identified at the last inspection. This included clearly documenting when staff restrained patients. Staff ensured they clearly documented patients' physical health observations after they administered rapid tranquilisation. Staff adequately monitored the administration of rapid tranquilisation through robust audits.

At this inspection we rated safe, caring, responsive and well-led as good and effective as requires improvement.

We rated this location as good because:

- The service had addressed the concerns raised at the last inspection in September 2022. The service had made improvements to how they managed and safely restrained patients. Staff had made improvements to how they carried out observations and engagement with patients. Staff had improved how they documented patients' physical health observations after they administered rapid tranquilisation.
- The service had enough nursing and medical staff, who knew the patients and received essential training to keep people safe from avoidable harm. Although the unit had a high number of vacancies, the service had enough staff on each shift to support patients safely. The service provided staff with emergency scenario training to help staff prepare for a medical emergency.
- Staff managed medicines safely and regularly reviewed the effects of medications on each patient's mental and physical health.
- The ward environment was safe and clean. The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients undergoing rehabilitation. The service had a full-time responsible clinician. Managers ensured that staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who had a role in providing aftercare.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff felt respected, supported and valued. They said the provider gave them opportunities for development and career progression. They could raise any concerns without fear.

However:

- Staff did not always discharge their roles and responsibilities under the Mental Health Act 1983 in a timely way. Patients detained under the Mental Health Act did not always have their rights explained to them in a way they could understand. An audit of the Mental Health Act patient files did not effectively monitor how the Mental Health Act was implemented at the hospital.

Summary of findings

- Staff had not displayed written information to inform patients of what items were prohibited. Not all staff knew about what restrictive practices there were on the ward.
- Staff used some generic statements in patients care and treatment records. Patient goals were not always specific, measureable and achievable.
- Staff did not always help patients to live healthier lives. The hospital site was not smoke-free as patients could still smoke in the garden area. This was not in line with best practice.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Good	

Summary of findings

Contents

Summary of this inspection

Background to Pathfinder Ashness House

We undertook this unannounced, comprehensive inspection of Pathfinder Ashness House to follow up on changes made as a result from our focused inspection in September 2022 and to rate the service for the first time.

At our inspection in September 2022, we found instances of unreported physical restraint, incidents of restraint that were not clearly recorded and staff administering rapid tranquilisation and not carrying out the required post administration physical health monitoring. We served a section 29 Warning notice which required the provider to make improvements by November 2022.

Pathfinder Ashness House is in Harrow, North West London. The service is provided by Pathfinder Group Healthcare Limited and registered to provide the following regulated activities:

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

The service provides long stay/rehabilitation services to male adults of working age with complex mental health issues. The service has 26 beds. Seven of the 26 beds are high dependency, supporting people that need extra support. In addition, the service has two flats for patients getting ready for discharge. On the days of our inspection, there were 10 patients receiving care at the hospital – with 3 of these patients admitted to the high dependency unit.

Nine patients were detained under the Mental Health Act (1983).

The service registered with the CQC in March 2022. We have not previously rated this service.

At the time of the inspection, there was a registered manager in place.

What people who use the service say

We spoke with 5 patients on the ward. Patients said staff treated them well and behaved kindly towards them. Patients said staff were willing to listen and that they felt respected. Another patient had requested a battery-operated lawn mower and staff facilitated this to support with gardening.

Whilst patients reported that they knew about their care plans, three patients reported that they had not been given a copy.

Three patients did not know what their discharge plan was.

Two patients said staff discussed quitting smoking with them. One patient said they were not supported with their physical health needs.

Summary of this inspection

How we carried out this inspection

The team that inspected this service consisted of 3 CQC inspectors, a CQC pharmacist specialist, and a specialist advisor who had experience working within rehabilitation services.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

During the inspection visit, the inspection team:

- visited the service, observing the environment and how staff were caring for patients
- spoke with 5 patients who were using the service
- spoke with 14 members of staff including the registered manager, consultant psychologist, nurses, healthcare assistants, occupational therapy assistant, psychology assistant and the consultant psychiatrist
- reviewed 6 patient care and treatment records.
- checked how medicines were managed and stored, including reviewing prescription charts
- reviewed information and documents relating to the operation and management of the service

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

Areas for improvement

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

Action the service MUST take to improve:

- The provider must ensure that staff provide clear information to detained patients in line with their policy and the Mental Health Act code of practice. For patients with communication needs, the provider must explore appropriate ways to support them to understand their rights whilst detained. **Regulation 9(1)(3)(b)**
- **Action the service SHOULD take to improve:**
- The provider should ensure that they display the list of restricted items on the ward so that it is always visible for patients.
- The provider should ensure that generic statements are kept to a minimum in patients care and treatment records and that goals are always specific, measureable and achievable.
- The provider should ensure that staff are aware of the restrictive practices on the ward.

Summary of this inspection

- The provider should consider adopting a smoke-free policy on the premises in line with public health best practice guidance.
- The provider should ensure that patients are aware of their discharge plans.
- The provider should ensure they further improve and embed governance arrangements so that auditing and monitoring is robust and brings about improvements in the quality and safety of the service.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Good

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

Is the service safe?

Good

Safe and clean care environments

The ward was 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 ward areas and removed or reduced any risks they identified. Staff had completed a fire risk assessment which identified key risks. Staff participated in quarterly fire drills. Fire drills were frequent to ensure new staff and agency staff had an opportunity to participate in a fire drill. The last fire drill was in November 2022. The development manager also provided on-site fire safety training for all staff in addition to mandatory training. All patients had a personal emergency evacuation plan located in reception.

Staff completed an up to date ligature risk assessment to manage and reduce the risk of ligature anchor points. For example, staff ensured high risk areas, such as the kitchen, were kept locked.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The provider had taken steps to reduce the number of ligature points on the ward, by fitting bedrooms and bathrooms with anti-ligature fittings such as collapsible curtain rails and anti-ligature door handles. Staff were aware of the ligature cutters and where to access them.

Staff could not easily observe patients in all parts of the wards. Staff mitigated this risk with regular observation of patients. The ward had installed convex mirrors to help staff see patients in different parts of the ward. There was closed circuit television (CCTV) monitoring in communal areas for staff to safely observe patients. During the inspection, staff had not displayed a sign to make patients and visitors aware that CCTV monitoring was in use. Staff responded by displaying a sign in the communal area for everyone to see.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff had personal alarms and radios to use in an emergency. Patients had call alarm bell in their bedrooms so they could summon assistance.

Long stay or rehabilitation mental health wards for working age adults

Good

Maintenance, cleanliness and infection control

The ward was clean, well maintained, well-furnished and fit for purpose. The ward was visibly clean and clutter free. Staff made sure cleaning records were up-to-date and the premises were clean. The service had employed full time domestic staff to clean the premises. Domestic staff kept cleaning records up to date and these demonstrated that staff cleaned the ward daily.

Staff followed infection control policy, including handwashing. Hand sanitiser and personal protective equipment was readily available for staff to use. Staff disposed of sharps waste appropriately.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Equipment included an emergency grab bag, oxygen cylinders, an automated defibrillator and a breathalyser. Staff carried out daily safety checks for the clinic room equipment and emergency medicines. For example, the breathalyser had been calibrated to ensure it worked.

Staff checked, maintained, and cleaned equipment. Staff monitored the temperature of the medicine fridges. Some gaps were noted in these records. However, these gaps had been identified in the weekly pharmacy audit and followed up as needed.

Safe staffing

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

Nursing staff

Although the unit had a high number of nursing vacancies, the service had enough staff on each shift to support patients safely. The ward had an establishment of 22 whole time equivalent registered nurses and non-registered nurses reflecting the current number of patients. As of December 2022, the service had a vacancy rate of 22%. The ward had 6 full time vacancies for registered nurses and 2 vacancies for nursing assistants. The service had just recruited a deputy nurse manager to help the registered manager with daily nursing tasks and oversight. The service turnover rate was 34%.

To tackle the service's nursing vacancies, the manager had recruited 6 nurses from overseas. Two of these new nursing staff had started shortly after the inspection visit and the rest of the nursing staff would be arriving by the end of February. The overseas nurses would work as nursing assistants whilst they completed their qualified nurse training. The service would sponsor the staff to get their work visas. The manager planned to support and train these new starters with a comprehensive induction programme, including shadowing complex cases. The manager provided a framework for their medicine's competencies, English language training and computer-based training. In addition, the programme would include pastoral care with support for housing and social needs that the overseas staff would need.

The service still used a high rate of bank and agency nurses and nursing assistants. These helped cover the vacant nursing posts. Even though the service employed a high number of agency staff, these staff were regular and knew the patients. For example, the agency nurses had been employed at the service long term. This provided consistency for patients.

The manager had a system in place to regularly monitor the use of temporary staff and to manage the risks associated with high numbers of bank and agency staff working with patients.

Long stay or rehabilitation mental health wards for working age adults

Good

The ward manager requested staff familiar with the service and made sure all bank and agency staff had a full induction to understand the service before starting their shift. The ward employed regular agency staff. New staff read and completed an induction booklet containing policies and important information about the service. Staff signed to confirm they had completed it with the nurse in charge. In addition, the service had introduced a buddy system as part of the induction for new staff.

Managers supported staff who needed time off for ill health. Staff sickness was low. A staff member had recently taken time off after a patient assaulted them. The manager supported them to return to work when they felt able to.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Because the provider had not yet filled all the bed capacity, the manager calculated the number of staff they needed based on the current number of patients admitted to the hospital.

The ward manager could adjust staffing levels according to the needs of the patients. The day shift consisted of two registered nurses and three non-registered nurses. At night, the ward allocated one registered nurse and four non-registered nurses. Additional staffing was booked if a patient required a higher level of observation or there were pre-booked activities, which affected staffing, such as longer escorted day leave.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients reported that they were taken out on leave and their leave was never cancelled due to staff shortages. Each morning staff facilitated a planning meeting with patients to ensure that escorted leave took place.

The service had enough staff on each shift to carry out any physical interventions safely.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The hospital had a full-time consultant psychiatrist working Monday – Friday during office hours. The consultant also provided out of hours support to staff when they needed assistance in a psychiatric emergency.

Managers could call locums when they needed additional medical cover. When the consultant psychiatrist was on leave or off sick, the service used a locum doctor as medical cover.

The consultant psychiatrist planned to employ a grade staff doctor full time to support with additional clinical duties, such as for physical health monitoring.

Mandatory training

Staff had completed and kept up to date with their mandatory training to keep patients safe. Overall, registered nursing staff had completed 97% of their mandatory training. Mandatory training included safeguarding adults, prevention and management of violence and aggression, breakaway, moving and handling, basic life support and health and safety.

Staff participated in emergency scenario training to train staff how to respond to a medical emergency on the ward. Two of these training exercises had taken place since March 2022 and were unannounced.

Managers monitored mandatory training and alerted staff when they needed to update their training, but there was not always protected time for staff to attend their training courses.

Long stay or rehabilitation mental health wards for working age adults

Good

Assessing and managing risk to patients and staff

Staff managed risks to patients and themselves well. Staff had made improvements to their restrictive practices since the last inspection in September 2022. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed.

However, staff had not displayed a sign to inform patients of what items were prohibited. Not all staff knew about what restrictive practices there were on the ward.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool. Risk assessments included several areas of possible risk and a had a rating scale to measure the severity of each risk. Each patient had a risk assessment in place.

Management of patient risk

Staff recorded risk management plans to help reduce the risks to patients. We looked at 6 patient risk assessments. One patient was at risk of severe self-neglect related to physical health conditions and the purchase of energy drinks consumed late at night, which impacted upon their ability to sleep. Staff had not clearly recorded a risk management plan for this patient outlining interventions that staff would need to take to help reduce the risk of self-neglect.

Staff attended daily handover meetings where each patient's risk level was discussed. Due to the nature of challenging behaviour on the ward, the psychology assistant had developed positive behavioural support plans with the patients to include their early warning signs, triggers and how staff should de-escalate the situation.

For patients assessed as having physical health risks, staff used the national early warning score (NEWS) system to record patients' physical health observations. We looked at three patients' NEWS records. They showed that staff completed these observations weekly and escalated any high scores to clinicians. This reduced the risk of patients' physical health deteriorating rapidly unnoticed.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff followed the provider's policy and procedures when carrying out patient observations. The multidisciplinary team assessed the level of observation patients required. All patients were observed every hour or subject to random checks four times every hour. At the last inspection, we found that staff were recording intermittent observations at regular and predictable intervals which was not in line with best practice. At this inspection, staff had made improvements and were now recording intermittent observations at random and unpredictable intervals. This helped to reduce the risk to patients. Two patients were subject to one-to-one observations as they had a high level of risk. This was to reduce the risk of harm to themselves or to others.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Where planned, staff searched patients when they returned from leave.

Use of restrictive interventions

The manager had implemented a new strategy to managing violence and aggression, including more robust de-escalation techniques. Staff worked towards the requirements of the Mental Health Unit (Use of Force) Act 2018 and its guidance. The senior management team recently provided training to staff on the Use of Force Act to give them practical support and guidance.

The manager completed a monthly restrictive practice audit to monitor the use of restrictions placed on patients. However, we spoke to 4 staff about restrictive practices. Staff either did not know of any restrictive practices in the service or said there were not any restrictive practices in place. Staff did not understand what restrictive practices there were so could not ensure that patients were not being restricted unlawfully.

The service had a list of prohibited items that restricted what patients could bring onto the ward. Restricted items included lighters, batteries and sharp objects. However, during the inspection we observed that staff had not displayed a sign to inform patients of what items were prohibited. We raised this with the manager after the inspection.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff received approved training in reducing restrictive intervention breakaway to prepare them for physical restraint. For the months of October and November there had been 13 incidents involving physical restraint. These restraints were low-level, redirection holds and one in the supine position. These were attributed to 4 patients. Staff had not restrained patients in the prone position.

Staff recorded incidents of restraint in line with the requirements of the Mental Health Unit (Use of Force) Act 2018. For example, how the restraint was to be carried out, which staff were involved and for how long.

Staff followed NICE guidance when using rapid tranquilisation. There had been one incident of rapid tranquilisation in the last 3 months. Staff ensured they followed best practice and completed the patient's post administration physical health observations at the required intervals, in line with national guidance.

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. All staff had completed training in how to recognise abuse in children. Staff also received training in how to recognise abuse in vulnerable adults.

Staff followed clear procedures to keep children visiting the ward safe. The service had a visitors welcome area. Visits could take place in meeting rooms, the multi faith room or off site. Visits by children were risk assessed and took place in rooms outside of ward areas. The service had plans to develop the site to include additional visitor facilities.

Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them. For example, staff had reported an incident of abuse where a patient had suffered harm. The service kept a tracker of any reported incidents of abuse. Staff uploaded incidents of allegations of abuse and discussed this at the monthly clinical governance meetings.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Between March – December 2022 there had been one reported incident of alleged abuse. This included an incident of patient on patient violence and aggression. Staff discussed allegations of abuse with the local authority safeguarding team to ensure it was an appropriate referral.

Staff access to essential information

The provider had worked hard to improve staff access to essential clinical information. Patient notes were comprehensive. The provider had plans in place to install a new electronic recording system.

Patient notes were comprehensive. Staff used a clear format in patient care and treatment records to ensure staff could consistently and readily access pertinent patient information. Patient records had an index page at the front to help staff locate information easily.

The provider was awaiting the setup of a new electronic system to store all patients' care and treatment records. This new system was due to be up and running over the coming month. In addition, the provider planned to implement a new electronic incident reporting system to support staff to effectively report incidents in the service.

Records were stored securely.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicine administration records accurately and kept them up to date. We reviewed 7 patient medicine administration records. The records included patient information, such as allergies, and were kept with records of patients' blood tests and electrocardiograms. Staff had pictures of patients with the drug charts to assist in identifying them. This meant that when medicines were prescribed, information regarding patients' physical health was readily available. Staff initialled the prescription charts to show that medicines were administered as prescribed. Medicine records were screened by an external pharmacist weekly to ensure medicines were prescribed safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents safely. Staff had a clear system in place to safely manage the storage of controlled drugs. Staff kept a record of the controlled drugs kept in the clinic room and stored them in a locked cabinet. Staff appropriately restricted access to the medicine's storage areas.

An external pharmacist attended the hospital once a week and completed medicine audits. Staff scrutinised the findings of the audits and acted to make improvements. The findings of these audits were discussed in the staff meetings.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Information relating to medicines were sent prior to patients being admitted to the hospital. The doctor used this information to prescribe medicines and write the drug chart. Nurses checked this information for discrepancies prior to giving medicines. When the pharmacist attended the ward, they also conducted medicines reconciliation.

Staff learned from safety alerts and incidents to improve practice. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff told us that giving medicines for managing aggression and agitation was a last resort. There were positive behaviour plans in place. If medicines were given, oral medicines were offered first before intramuscular medicine.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. We looked at the records for 2 patients who had been prescribed clozapine to manage their mental health. Staff checked the side effects of this medicine by ensuring the patient had their bowel movements and bloods checked regularly. This ensured patients did not suffer adverse side effects.

Long stay or rehabilitation mental health wards for working age adults

Good

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Since the last inspection, staff had received additional support and training to report incidents. Between October and November 2022 staff had reported 53 incidents. These were mostly incidents involving violence and aggression.

Managers debriefed and supported staff after any serious incident. Staff reported that they debriefed after incidents. Staff debriefed after a recent incident where a patient's physical health deteriorated. As a result, staff had called the emergency services and the patient was admitted to hospital.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff regularly met with family members and updated them if a patient had been involved in an incident.

Staff met to discuss the feedback from incidents and look at improvements to patient care. Lessons learned from incidents was a standard agenda item in the monthly clinical governance meetings. There was evidence that changes had been made as a result of feedback. For example, a new incident form had been introduced by senior managers to make it easier for staff to complete and ensure the pertinent information is contained within them.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Is the service effective?

Requires Improvement

Assessment of needs and planning of care

Staff developed a comprehensive mental health assessment for each patient that met their mental and physical health needs on admission. Each patient was supported to identify recovery goals.

We looked at 6 patient care plans. Care plans included 'my physical health', 'my mental health', 'my medication' and 'my move plan'.

One patient regularly drank caffeinated drinks late in the evening which affected their sleep. The care plan did not describe what interventions staff would take to support the patient with their sleep and reducing their caffeine intake. Staff support interventions were reduced to generic statements and did not specify what staff would do to help patients meet their needs. Patient goals, whilst present, were not always specific, measurable or achievable.

Each patient was supported to identify recovery goals. Progress on their recovery journey was monitored in a variety of ways, including key working sessions, ward reviews and CPA meetings.

Three patients said they knew who their key nurse was, but they did not see them on a regular basis for key work sessions. This meant staff could not effectively support the patient with their recovery journey.

The manager said they were improving these sessions to make them more meaningful and provide better consistency amongst staff.

Staff developed a comprehensive mental health assessment for each patient that met their mental and physical health needs on admission. Although these needs were not always addressed in their care plans. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff used the positive behavioural support (PBS) model to understand patients' behaviours which challenge. The multidisciplinary team and patients contributed to their PBS plans. For example, PBS plans included the patients' early warning signs and what staff can do if the situation escalates.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

However, staff did not always provide support to help patients live healthier lives.

The service had a statement of purpose which described the type of service they offered. This outlined the treatment pathways, therapeutic interventions and the multidisciplinary staff team required to provide support to patients.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance. Psychologists based treatment pathways on best practice guidelines, including psychological therapies. Medical staff used best practice to inform their treatment pathways for managing patients with severe trauma, self-harm, anxiety, and depression.

The service encouraged patients' recovery through teaching greater independent living skills. Occupational therapists (OT) conducted a range of different activities and groups in addition to individual sessions to support patients' recovery, improve self-management or rehabilitation and every-day living skills. Staff facilitated regular mindfulness sessions with patients, a smoothie making group and a quiz.

We spoke to five patients. One of these patients said that staff supported them with their budgeting, cooking and shopping needs. At the time of the inspection 1 patient was self-administering their medicines. Patient care and treatment records showed that support was being offered to develop these activity of daily living skills.

Staff made sure patients had access to physical health care, including specialists as required. Staff often supported patients to attend the local acute hospital for medical assistance after a medical emergency or to facilitate a routine medical appointment. Staff registered all patients with the local GP on admission. Physical health records showed that staff carried out weekly vital sign monitoring and more often for patients that required it. Staff supported diabetic patients effectively through blood glucose monitoring.

Staff did not always provide support to help patients live healthier lives. Staff supported patients to access the local leisure amenities. The occupational therapist provided patients with support around cooking and their nutritional intake. Staff had previously discussed smoking reduction with patients in a group setting, but nicotine replacement therapy was not offered at the hospital. Patients had to be referred to their GP if they wanted support to quit smoking. The hospital site was not smoke-free as patients could still smoke in the garden area. This was not in line with public health best practice guidance.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the Health of the Nation Outcome Scales (HoNOS), the recovery STAR and patient health questionnaire and general anxiety disorder. Staff used these tools to report certain outcomes for patients such as social skills and self-care. The occupational therapist assessed patients assisted daily living skills to help improve their care and treatment outcome. The clinical psychologist and psychology assistants collected data on patients receiving psychological interventions for the year to assess patients' outcomes.

Staff used technology to support patients. The service was installing a new de-escalation room. Staff planned to include a tablet device in this room for patients to use to help reduce stimulation and calm them.

Staff took part in clinical audits, such as care planning, risk assessments and the Mental Health Act paperwork. These audits helped staff to look at the results and learn from them. However, more work was needed to ensure the results from these audits helped staff to learn from them and make improvements. The care plan audits did not identify the areas of improvement needed in patients' goals and interventions meeting their needs.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of people undergoing rehabilitation and recovery. The team included a consultant psychiatrist, nurses, a clinical psychologist, an assistant psychologist, an occupational therapist and an assistant occupational therapist.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. We checked the employment records of three staff members, including agency staff. The managers carried out comprehensive recruitment checks before the staff member commenced employment. These included a criminal record check, suitable reference checks and nursing registration.

Managers gave each new member of staff a full induction to the service before they started work. All staff, including agency staff, had a comprehensive induction to the service, which covered key aspects of caring for the patients on the ward.

Managers supported staff through regular, constructive clinical supervision of their work. Staff reported that they received regular clinical supervision and found it supportive and useful. The managers monitored whether staff received monthly supervision. As of December 2022, over 90% of staff had received supervision. Managers recognised poor performance, could identify the reasons and dealt with these.

Managers said they were starting to introduce regular reflective practice sessions for staff facilitated by a clinical psychologist. This would give staff a space to reflect on incidents that had happened on the ward.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings occurred once a month and staff were encouraged to attend. Managers moved the time of the team meeting to allow staff from the day shift and night shift to attend. In the recent staff meeting minutes it was noted that staff had been turning up late to the meetings. The manager decided to look at the rota to ensure continuity.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers made sure staff received specialist training for their role. Specialist training included dialectical behavioural therapy for assistant psychologists. Nursing staff had extra training in suicide prevention and self-harm and learning disability and autism. The psychologist had recently provided training to staff on personality disorders. This helped to improve their knowledge of the patients they supported.

Managers recruited, trained and supported volunteers to work with patients in the service. The service had recently recruited an expert by lived experience on a voluntary basis once a fortnight. The staff member reported that the senior managers supported them very well and regularly checked in with them.

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. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The consultant psychiatrist held a weekly ward round, which consisted of nursing staff, ward doctors, therapists and education staff. These meetings reviewed the patients' care and treatment including risk, recovery goals, capacity and medicines. Staff invited patients to these meetings and carers were given the opportunity to provide feedback.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. At the start of each shift, nursing staff handed over pertinent information regarding the patients' wellbeing, risks and observation levels. In addition to handovers, members of the MDT and the management team met every morning to hand over risk information about the ward. We observed this morning meeting which was focused on risk and well attended.

The hospital had effective working relationships with each other. Staff on the ward met every month to discuss business continuity and complex cases. Discussions in the minutes included

The hospital had effective working relationships with external teams and organisations. For example, the hospital invited community teams to Care Programme Approach (CPA) meetings to keep them updated on the latest treatment plan.

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

Staff generally understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

However, staff did not always record that a patients' rights had been repeated to check they understood them. Mental Health Act audits did not effectively monitor how the Mental Health Act was implemented at the hospital.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of the inspection, all staff had received training in the Mental Health Act.

During the inspection, 9 of the 10 patients were detained under the MHA. Staff understood their roles and responsibilities under the MHA and the Mental Health Act Code of Practice and discharged these well.

Long stay or rehabilitation mental health wards for working age adults

Good

Records did not always show that where patients were detained under the Mental Health Act, staff explained their rights in line with their policy. The manager said that staff should explain to detained patients their rights on admission and every 3 months after that. Unless the patient did not understand them, then staff needed to repeat them. We reviewed 3 patients records. In 2 patients' records staff had not recorded that their rights had been repeated, in line with their policy, to check that they had fully understood the information. For one patient that had communication needs, staff had not used communication aids to ensure they understood their rights.

Three out of 5 patients said that staff had explained their rights and they understood them.

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 met with the patients every day to discuss their section 17 leave and ensure there was enough staff to escort them to the local community. Patients and staff confirmed that leave was rarely cancelled due to staff shortages or delays in having their leave granted or changed.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. For some patients, urgent treatment had been provided without the patients consent under section 62 of the Mental Health Act. In line with guidance, a SOAD had been requested to review the continuation of treatment without the patients' consent.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Staff authorised and administered medicines for detained patients in line with the requirements of the Mental Health Act and its regulations. For example, staff completed consent to treatment forms (T2) accurately. This meant they were detained and treated lawfully.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Staff supported patients to access the local advocacy service and displayed signs in the communal lounge with information about the advocate.

Informal patients knew that they could leave the ward freely. During the inspection, staff had not displayed a sign explaining to informal patients that they could leave the ward freely. We raised this with the manager at the time of the inspection and they addressed this immediately.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who the Mental Health Act administrator was and when to ask them for support. Staff also referred to the manager for support in the Mental Health Act. 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.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits. However, the audit did not effectively monitor how the Mental Health Act was implemented at the hospital. We reviewed the recent Mental Health Act file audit dated 20 October 2022. It was unclear from the audit whether patients' rights had been read to them regularly and repeated, especially if they could not understand their rights. No actions had been documented as a result of the audit. This audit did not effectively monitor the use of the Mental Health Act because it did not provide assurances that improvements in the recording of the Mental Health Act would be implemented.

Good practice in applying the Mental Capacity Act

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

Long stay or rehabilitation mental health wards for working age adults

Good

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and had a good understanding of at least the five principles. The service provided training to staff in capacity and consent and all staff had completed training in the MCA and Deprivation of Liberty Safeguards.

Staff knew to seek advice from the senior management team and nurse leads on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff completed capacity assessments for patients that might have impaired capacity. These were time and decision specific. Staff understood the need to seek consent from patients before providing care. For example, staff prompted and encouraged patients with their personal care needs. This meant staff worked with patients to encourage them with their daily living skills.

When staff assessed patients as not having capacity, they made decisions in the best interests of patients and considered the patient's wishes, feelings, culture and history. For a patient who did not have capacity, staff ensured they involved them in their care and treatment. Staff consulted their family, where appropriate, to ensure their wishes, feelings and cultural needs would be met.

Is the service caring?

Good

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. Staff spoke with understanding, compassion and empathy when talking about the patients they were caring for. Staff discussed optimism for patients' recovery. We spoke with 6 patients on the ward. Patients said staff treated them well and behaved kindly. Patients said staff were willing to listen and that they felt respected.

Staff gave patients help, emotional support and advice when they needed it. Staff understood and respected the individual needs of each patient. For example, staff discussed supporting a patient with their personal hygiene in a respectful and considered way. During the inspection, staff interacted with patients in a thoughtful way. Staff provided emotional support to patients to minimise their distress. We observed staff calmly de-escalating a patient who was in distress.

Staff directed patients to other services and supported them to access those services if they needed help. One patient had been supported by the occupational therapist to participate in a voluntary workplace interview. Another patient was supported to open a bank account in the local community.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff felt they could be open when discussing complex and challenging behaviours.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff followed policy to keep patient information confidential. Staff did not display any patient personal or confidential information in communal areas.

Involvement in care

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

However, improvements were needed to ensure that staff communicated effectively with patients who had communication difficulties.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients and their relatives and carers were given a welcome pack when they first arrived to orientate them to the ward.

Staff involved patients and gave them access to their care planning and risk assessments. Whilst patients reported that they knew about their care plans, 3 patients reported that they had not been given a copy. Staff completed positive behavioural support plans with patients to ensure staff knew how to intervene in a stressful situation.

Whilst staff made sure patients understood their care and treatment, they did not always find ways to communicate with patients who had communication difficulties. The welcome booklet detailed important information about the ward such as visiting times and the role of the professionals on the ward. However, for one patient with a complex and enduing mental health condition staff had not found a way to communicate with him in a way he understood. For example, staff had not offered him an easy read version to ensure he understood his rights under the Mental Health Act. Two patients reported that they did not know what medicines they took.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff facilitated weekly community meetings with patients. The minutes of this was displayed in the communal noticeboard for patients to have easy access. We looked at the minutes of these meetings for the month of November. Patients' fed back about occupational therapy and education trips, staff issues, maintenance and repairs, a lack of activities at evenings and weekends. Staff had organised community trips and carried out maintenance as a result of patient's feedback in these meetings.

Staff involved patients in decisions about the service, when appropriate. Staff supported patients' wishes in the upkeep of the garden in an environmentally friendly way. For example, staff purchased electric mower instead of petrol mower and a compost bins for grass and organic waste.

Staff made sure patients could access advocacy services. A poster of the local advocacy service was displayed in the communal area. The advocate attended the ward once a week. Patients reported that they knew who the advocate was and had used them for support and advice.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. For example, through inviting to and attending ward rounds. If they could not attend, they could give feedback in writing or over the telephone.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff helped families to give feedback on the service. Families and carers could regularly meet with the multidisciplinary team at care plan approach meetings and when they visited their loved ones. One patient who needed support to make decisions about his care and treatment, staff had adequately involved his family in decision making.

Is the service responsive?

Good

Access and discharge

Staff planned and managed patient discharge. They worked with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Whilst staff planned and managed patients' discharges, some patients told us that they did not know what their discharge plan was.

At the time of the inspection, the service had 10 patients admitted. The provider used inclusion and exclusion criteria to guide them on which patients they could safely admit. For example, staff would not admit patients with a severe eating disorder or with a recent history of carrying or using weapons.

Most patients were from the north west area of London. Four patients were from out of London. This was because the patient had been already living in the north west London area before being admitted to the hospital.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Staff said they aimed that patients would stay for a period of 6-24 months. For patients who had been discharged, their average length of stay was 173 days.

The service had only been set up for 9 months, so they did not have any patients that had overstayed their projected discharge date.

Managers and staff worked to make sure they did not discharge patients before they were ready. Staff supported patients with their discharge by granting overnight leave to ensure that they had a smooth transition when they left. When patients went on leave there was always a bed available when they returned. Staff did not move or discharge patients at night or very early in the morning.

Staff had transferred 3 patients to a psychiatric intensive care unit as they required more intensive care and staff could no longer meet their needs.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and took action to reduce them. The service did not have any delayed discharges.

Four patients had been discharged from the service since the service opened in March 2022. However, only one patient had been discharged to supported accommodation. Three patients had moved to a more intensive, higher support inpatient unit to better meet their needs.

Whilst staff planned and managed patients' discharges, some patients told us that they did not know what their discharge plan was.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Discharges were planned through the care programme approach (CPA) framework. The multidisciplinary team (MDT) met regularly to discuss patient discharges, this included input from the patient and their families. One patient required extra specialist support, so staff had identified a placement to meet his needs. The MDT produced reports for care managers and coordinators to update them on the patients' care and treatment. However, records did not always include discharge discussions. Three patients reported that they did not know what their discharge plan was.

Staff supported patients when they were referred or transferred between services. For example, when patients required admission to an acute general hospital for their physical health needs staff supported them during their stay or outpatient appointment.

The service followed national standards for transfer. When patients needed less support, they moved to a step-down placement. Patients were able to discharge gradually. The hospital had a self-contained flat which was used as a step-down living space to support patients who were approaching discharge.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. Bedrooms included ensuite toilet facilities. Staff used a full range of rooms and equipment to support treatment and care. The ward area was split into the main ward area and the high dependency unit. The high dependency unit contained a nursing office, clinic room and separate lounge area. The main ward had a small nursing office upstairs. This nursing office could not be used to observe the ward or for a group of nurses to work from. In addition, both parts of the wards contained a lounge, dining area and games room. Staff could access a range of rooms to complete administrative tasks. The managers told us about plans to extend a building in the garden to create more space. They hoped these planned works would start soon but there was no date for when this would start.

The service had an outside space that patients could access easily. Patients could access a spacious garden through double doors in the main lounge and dining area. The garden had gym equipment that the patients could use.

Patients had a secure place to store personal possessions. Patients had a lockable space in their bedrooms for their belongings and space in fridges and freezers to store their own food. Patients could make their own hot drinks and snacks and were not dependent on staff.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could use the multi-faith and games room on the first floor of the ward if they wanted quiet space. However, there was no dedicated area for visitors to meet with patients off the ward. The registered manager said that they could book a room at the local community centre to facilitate visits for patients if they wanted to.

Patients could make phone calls in private. Patients could access a cordless telephone or their own basic mobile phones to make personal phone calls.

The service offered a variety of good quality food. Patients said the quality of food was good. Patients chose their meals each day and all meals were cooked onsite by a dedicated chef. Staff supported some patients to self-cater. Each week the occupational therapist facilitated a sandwich making group.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients had access to therapeutic activities. The occupational therapist developed a timetable for patients to take part in a range of activities. Activities included cinema trips, cooking, music and art. The occupational therapist reviewed the timetable every three months to include any activities that patients had suggested. The occupational therapist encouraged patients to attend the local college to access vocational courses.

Staff helped patients to stay in contact with families and carers. Families could visit the service at evenings and weekends. Staff arranged to support a patient to return home for the Christmas period.

Staff tried to encourage patients to develop and maintain relationships both in the service and the wider community. For example, family members. Staff completed equalities training and some tailored training addressing LGBTQ+ issues from Stonewall. We saw that when developing care plans staff had engaged with patients to discuss their sexual identity and any needs they may have.

Meeting the needs of all people who use the service

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

The ward supported disabled patients. The service had a bespoke bedroom for disabled access on the ground floor.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Staff displayed information for patients in the communal notice board which included how to complain, minutes of the recent community meeting and an activities timetable.

Managers made sure staff and patients could get help from interpreters or signers when needed. Written information could also be translated if a patient's first language was not English.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients said the food was good quality and excellent. The service had a dedicated chef that cooked patients' meals for them. Although patients were not self-catering at the time of the inspection, the occupational therapist supported patients to cook their own snacks and cold meals, such as sandwiches and smoothies. Patients could also store their own food in the kitchen fridge and cupboards.

Patients had access to spiritual, religious and cultural support. The service had a multi-faith room. Staff supported patients to attend places of worship should they want this.

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.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients, relatives and carers knew how to complain or raise concerns. We spoke to 5 patients. They said they knew how to complain, with some stating they had complained previously.

The service clearly displayed information about how to raise a concern in patient areas. Information on how to complain was displayed on the ward noticeboard and included in patients' welcome packs.

Staff understood the policy on complaints and knew how to handle them. Since the service opened, the service had received 9 formal complaints. These included complaints from families about poor communication and care and treatment plans. One of these was partially upheld and the other 8 were not upheld.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The provider had a complaints policy which outlined the process and timescales of receiving an outcome. The manager wrote to the patient and verbally discussed the outcome with them.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff kept a log of all complaints, formal and informal, received about the service. The managers discussed complaints with staff at their monthly team meetings and shared any learning that had resulted.

Is the service well-led?

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. The senior managers were visible in the service and approachable for patients and staff.

The managers had the skills, knowledge and experience to perform their roles. Since the last inspection in September 2022, the service had employed a clinical services manager. This eased the workload for the registered manager and helped with frontline tasks such as medicines management, staff supervision and training. The responsible clinician (consultant psychiatrist) worked full time at the service and had extensive experience working in rehabilitation settings. The nominated individual was a clinical psychologist with a background in forensic settings.

The senior multidisciplinary staff were visible within the service and provided training to staff in specialist areas such as personality disorders and rehabilitation. Senior managers facilitated regular supervision with other members of the multidisciplinary team. Staff reported that senior managers were visible on the ward and they were able to approach them if they needed support.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. The provider values included, being respectful so the patient felt valued and understood. Valuing the patient's absolute worth, regardless of history. Involving the patient in all elements of their care and being professional.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff treated patients with dignity and respect. Staff spoke about the importance of team working to provide the best outcomes for the patients. Staff had the opportunity to contribute to discussions about the strategy for the service. The provider had a service description which outlined what care would look like for patients when they were admitted to the service.

The service had recently introduced the role of the staff representative. The staff representative would then attend the clinical governance meetings each month to provide staff feedback.

Culture

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

Staff felt respected, supported and valued. Staff spoke about how proud they were to be supporting patients with their recovery and to live independently. Staff spoke positively about the senior management team.

Staff felt able to raise concerns and knew about the provider's whistleblowing policy and procedures. The senior management team were visible on the ward and staff felt able to approach them with any concerns they had. Staff said they received regularly supervision but could also speak to senior management informally about patient care.

The service had recently allocated a Freedom to Speak Up champion within the organisation, who was independent of the staff team at Ashness House.

Managers dealt with poor performance when needed. The manager explained the process they would follow to manage poor performance.

Staff reported that the service promoted equality and diversity in the workplace and provided opportunities for career progression. Development opportunities were available for staff. Staff who were healthcare assistants had been supported into roles such as senior healthcare assistants.

Staff had access to support for their physical and emotional wellbeing in the workplace. The service had an external occupational health service that staff could access confidentially. The service offered a range of support and guidance, including being able to book individual counselling sessions. The staff sickness rate was relatively low with only one staff being on long term sick leave since March 2022.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level.

The service had a clear framework for what must be discussed at senior management and ward level. For example, monthly clinical governance meetings followed a structure where pertinent issues such as incidents, complaints, best practice and performance data were discussed. This information was cascaded down into the monthly staff meetings. For example, the managers had provided extra training in the Mental Health Unit (Use of Force) Act 2018 after improvements were identified in recording of physical restraint.

Long stay or rehabilitation mental health wards for working age adults

Good

Examples of audits included care planning and risk assessment audits, prescription chart audits and environmental audits. However, the service did not always use results from audits to make improvements, for example, they had not documented actions after noting staff had not read patients their rights under the Mental Health Act as per their policy.

The service had a statement of purpose which described the type of service they offered. this outlined the treatment pathways, therapeutic interventions and the multidisciplinary staff team required to provide support to patients.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at ward level. For example, staff were reminded of the of the legal framework surrounding informal patients and restraint. Staff were also signposted to training when a need was identified.

Management of risk, issues and performance

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

Staff maintained a risk register at provider level. The risks on the register included commissioning investment planning, COVID-19 and recruitment of qualified staff. The risk register was discussed in the monthly clinical governance meetings.

The service had contingency plans in place to manage any emergency for example, extreme weather conditions.

Information management

The service used systems to collect data about the performance of the ward. Staff had access to equipment and information technology needed to do their work.

The service used systems to collect data about the performance of the wards. Staff recorded patient care and treatment information in different paper formats. Staff used a paper sheet to look at patient information immediately. Information included admission dates, Mental Health Act status and date of birth.

The service planned to move to an electronic recording system which would ease the burden of staff recording patient information in several handwritten formats.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff stored patient records confidentially.

Staff made notifications to external bodies as needed, including the Care Quality Commission. The service made safeguarding referrals to the local authority safeguarding team when they were concerned about possible abuse of their patients.

Engagement

Managers engaged actively with staff, patients and carers. Patients and carers had opportunities to give feedback on the service they received. Although managers had access to informally receive feedback from staff, there was no formal mechanism for which staff could feedback about working at the service. The manager planned to facilitate an annual staff survey in March 2023.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff and patients had access to up to date information about the work of the provider and the services they used. Staff were kept up to date through team meeting and emails. Patients were kept up to date through community meetings. Due to the small size of the hospital managers were able to meet with staff and patients regularly.

Patients and carers had opportunities to give feedback on the service they received. As the service had not been open for 12 months yet, staff had not conducted an annual survey for patients. The manager planned to conduct an annual staff survey in March. Patients could provide feedback via the weekly community meetings, at daily planning meetings and complaints. Carers were able to provide feedback at any time by calling the ward as well as during their meetings with staff.

Managers and staff had access to the feedback from patients, carers and staff and they used it to make improvements. Patients had consulted on the new electric lawn mower and compost bins for the garden. Also, patients could make suggestions for the weekly activities timetable.

Patients and staff could meet with members of the hospital's senior leadership team to give feedback. The service had recently employed an expert by lived experience to represent the patients' voice. The expert by lived experience planned to attend the monthly clinical governance meetings to feedback on what patients told them about their stay on the ward. The role was still relatively new.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider must ensure that staff provide clear information to detained patients in line with their policy and the Mental Health Act code of practice. For patients with communication needs, the provider should explore appropriate ways to support them to understand their rights whilst detained.