Elysium Healthcare No.2 Limited

Gateway Recovery Centre

Inspection report

Bennetts Lane
Widnes
WA8 0GT
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

Our overall rating of this location went down. We rated it as requires improvement because:

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.

Right Support: Model of Care and setting that maximises people's choice, control and independence

Right Care: Care is person-centred and promotes people's dignity, privacy and human rights

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

- Patient care and support was not always provided in environments which were well-maintained and allowed them access to space to meet their mental health, sensory, physical and recovery needs.
- Staff did not follow policies on infection control.
- In the autism and learning disability service staff did not lessen risks within communal areas where there was not a clear line of sight.
- The provider did not have sufficient, appropriately skilled staff to meet patient needs and keep them safe. Agency staff were not effectively inducted into the ward or show how best to support patients.
- Medicines administration was not completed at a safe time (during lunch) or in private, as medicines were administered in the dining room on one ward. Medicines policies were not followed, and medicines risk assessments were not completed. Staff had not always accurately recorded patient allergies on prescription charts. Out of date medication was not always disposed of in a timely manner.
- Governance processes did not meet the requirements for fit and proper recruitment of staff. Information prior to December 2023 had been sent for storage and archiving, including observation records, cleaning records, community meeting minutes and complaints, this meant the information was not easily accessible.
- When restrictive practices were used, there were inconsistent approaches from staff and unclear rationales in adhering to the policy. Patients where unclear how decisions were made to try and reduce the use of restrictive practices and improve their recovery. There were not always comprehensive reviews to try and reduce the use of these practices.
- Patient care, risk management, treatment, and support plans, did not always reflect patients own words and experiences and used medical language and not plain English. In the In the autism and learning disability service care records did not always reflect patient's sensory, cognitive and functioning needs. There was not any accessible, easy to understand information for each patient setting out how best to support them.
- Staff supported patients through a model of care which was under review and needed additional benchmarking and refinement to provide clarity on the level of restriction and security being proportionate to the service being delivered.

However:

Summary of findings

- Patients were protected from abuse and poor care.
- Patient risks were assessed regularly and managed safely. Patients were involved in managing their own risks whenever possible.
- Patients made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- Patients received care, support and treatment that met their needs and aspirations. Care focused on patient quality of life and followed best practice. Staff used clinical and quality audits to evaluate the quality of care.
- Patients were provided with care, support and treatment from the providers trained regular staff and specialists able to meet patient needs. These staff were not irregular agency staff.
- Managers usually made sure staff had relevant training, regular supervision, and appraisal except for agency staff. In the In the autism and learning disability service and low secure services managers made sure staff received training, supervision and appraisal.
- Patients 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.
- Patients were in hospital to receive active, goal-oriented treatment. Patients had clear plans in place to support them to return home, back to services they were admitted from, or move to alternate community living. Staff worked well with services that provided aftercare to ensure patients received the right care and support when they went home. As a result, discharge was rarely delayed for other than a clinical reason.
- Patients received kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs. Patients had their communication needs met and information was shared in a way that could be understood.
- In the low secure the ward environments were safe and clean. The ward had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- The service had programmes of audit and assurance in place. Managers had access to up-to-date information and performance data.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Requires Improvement 	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. Right Support: Model of Care and setting that maximises people's choice, control and independence Right Care: Care is person-centred and promotes people's dignity, privacy and human rights Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives. SUMMARY Our rating of this service went down. We rated it as requires improvement because: • People's care and support was not provided in a safe, clean, well equipped, well-furnished and well-maintained environment which met people's sensory and physical needs. • Staff did not follow policies on infection control and mitigating risks within communal areas where there is not a clear line of sight. • The service did not have sufficient, appropriately skilled staff to meet people's needs and keep them safe. Agency staff were not effectively inducted into the ward and how best to support people. • When restrictive practices were used, there were not always comprehensive reviews to try and reduce the use of these practices. • People's care, treatment and support plans, did not always reflect their sensory, cognitive

Summary of findings

and functioning needs. There was not any accessible, easy to understand information for each person setting out how best to support them.

- Leadership was not always good, senior leaders were not visible on the wards.
- The service did not meet the requirements for fit and proper recruitment of staff.

However:

- People were protected from abuse and poor care.
- People's risks were assessed regularly and managed safely. People were involved in managing their own risks whenever possible.
- People made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- People received care, support and treatment that met their needs and aspirations. Care focused on people's quality of life and followed best practice. Staff used clinical and quality audits to evaluate the quality of care.
- The service provided care, support and treatment from trained regular staff and specialists able to meet people's needs. Managers ensured that staff had relevant training, regular supervision and appraisal.
- People and those important to them, including advocates, were actively involved in planning their care. A multidisciplinary team worked well together to provide the planned care.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.
- People were in hospital to receive active, goal-oriented treatment. People had clear plans in place to support them to return home or move to a community setting. Staff worked well with services that provide aftercare to ensure people received the right care and support when they went home.
- People received kind and compassionate care from staff who protected and respected their

Summary of findings

privacy and dignity and understood each person's individual needs. People had their communication needs met and information was shared in a way that could be understood.
- Staff supported people through recognised models of care and treatment for people with a learning disability or autistic people.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Our overall rating of this location went down. We rated it as requires improvement because:

- Patient care and support was not provided in an environment which was well-maintained and allowed them access to space to meet their mental health, sensory, physical and recovery needs.
- Staff did not follow policies on infection control.
- The provider did not have sufficient, appropriately skilled staff to meet patient needs and keep them safe. Agency staff were not effectively inducted into the ward or show how best to support patients.
- Medicines administration was not completed at a safe time (during lunch) or in private, as medicines were administered in the dining room on one ward. Medicines policies were not followed, and medicines risk assessments were not completed.
- When restrictive practices were used, there were inconsistent approaches from staff and unclear rationales in adhering to the policy. Patients where unclear how decisions were made to try and reduce the use of restrictive practices and improve their recovery.
- Patient care, risk management, treatment, and support plans, did not always reflect patients own words and experiences and used medical language and not plain English.
- Governance processes did not meet the requirements for fit and proper recruitment of staff.
- Staff supported patients through a model of care which was under review and needed

Summary of findings

additional benchmarking and refinement to provide clarity on the level of restriction and security being proportionate to the service being delivered.

However:

- Patients were protected from abuse and poor care.
- Patient risks were assessed regularly and managed safely. Patients were involved in managing their own risks whenever possible.
  - Patients made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- Patients received care, support and treatment that met their needs and aspirations. Care focused on patient quality of life and followed best practice. Staff used clinical and quality audits to evaluate the quality of care.
- Patients were provided with care, support and treatment from the providers trained regular staff and specialists able to meet patient needs. These staff were not irregular agency staff.
- Managers ensured staff had relevant training, regular supervision, and appraisal except for agency staff.
- Patients 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.
- Patients were in hospital to receive active, goal-oriented treatment. Patients had clear plans in place to support them to return home or move to a community setting. Staff worked well with services that provided aftercare to ensure patients received the right care and support when they went home.
- Patients received kind and compassionate care from staff who protected and respected their

Summary of findings

privacy and dignity and understood each person's individual needs. Patients had their communication needs met and information was shared in a way that could be understood.

Forensic inpatient or secure wards

Requires Improvement

We have not inspected this service previously. We rated it as requires improvement because:

- Staff did not follow all policies on infection prevention and control.
- Medicines were not always managed safely. Staff had not always accurately recorded patient allergies on prescription charts. Out of date medication was not always disposed of in a timely manner.
- Governance processes did not meet the requirements for fit and proper recruitment of staff.

However:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- 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.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service had programmes of audit and assurance in place. Managers had access to up-to-date information and performance data.

Summary of findings

Contents

Summary of this inspection

Background to Gateway Recovery Centre

Wards for people with a learning disability or autistic people.
Cedar ward is a ward for autistic men who have mental health needs. The ward focused on people's rehabilitation. All people admitted to the ward were detained under the Mental Health Act.

There was a registered manager of the service who was the hospital director.

There was a controlled drugs accountable officer who was the lead nurse.

The service is registered to provide the following regulated activities:

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

Treatment of disease, disorder or injury

The service was last inspected in June 2018 as part of the rehabilitation service, it was rated as good and there were no breaches of regulations.

At this inspection we have inspected the ward under the wards for people with a learning disability or autistic people methodology.

What people who use the service say

We spoke with 8 people and 4 carers. People said the service was clean and they felt safe on the ward. People told us that staff responded if there were incidents and there were staff available to support them.

People felt happy on the ward and said that they had the opportunity to do a variety of activities including walking, cooking, art and music.

Two people felt involved in their care and creating their plan.

People said the food had improved since there was a new chef. However, 2 people said there was still more improvement need with the food. One person told us that some staff are difficult to get along with.

Two people did not feel involved in their care, 2 people felt confused about the discharge plan, they felt they had achieved their actions but were still in hospital. Another person was disappointed with how long it took to find an appropriate placement to be discharged to. Another person would like staff to explain their medicines and treatment to them.

One person felt the housekeeping staff needed to ensure they protected their privacy and dignity and ensured it was appropriate for them to enter their room.

One person said due to staffing it can be difficult for staff to do activities with them.

Summary of this inspection

One person said there was no access to a minister of religion at the hospital.

What carers say

Carers told us that the service was very welcoming to them, communicated with them and arranged for visits to take place, even where that was a considerable distance.

They were involved in their loved one's care by contributing at the assessment and goal setting stage and regularly for reviews including Care Programme Approach reviews.

However, there was nowhere on site that they could get food and drink from.

Carers were not sure of the complaints process.

Carers told us that some staff do not understand how best to support their loved ones and they felt that agency staff may not have accessed all of the training that would help them.

Long stay/rehabilitation mental health wards for working-age adults.

The service provides long stay/rehabilitation mental health wards for working-age adults.

The service provides an assessment and rehabilitation pathway for women with complex mental health needs and personality disorders, as well as a specialist inpatient service for men with complex mental and physical health needs. There are four wards within this service:

Ash ward: specialist inpatient service for men with challenging behaviours, complex mental and physical health needs, and those with cognitive impairment.

Beech ward is a ten bed, safe and highly supportive environment for women with high risks of significant self-harm. Within Beech ward the focus is on reduction of acute risks of self-harm, aggression, and non-adherence to treatment by addressing core emotional and mental health problems.

Elm ward is a 12 bed, structured setting with routines and boundaries for patients who displayed significant risk but require slower stream rehabilitation due to complex difficulties.

Fir ward is a 12 bed, low dependency, rehabilitation ward with active therapy and interventions to facilitate recovery and community integration.

There was a registered manager of the service who was the hospital director.

There was a controlled drugs accountable officer who was the lead nurse.

The service is registered to provide the following regulated activities:

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

Summary of this inspection

Treatment of disease, disorder or injury

The service was last inspected in June 2018 and it was rated as good and there were no breaches of regulations.

At our last inspection in June 2018 the service was rated as good overall and good in all five domains.

We identified a 'should' do action to improve the language in care plans, which included jargon or terminology that might be confusing to patients.

What people who use the service say

Patients told us they were cared for by caring staff who went beyond their regular roles to support patient care and treatment. Staff were described as helpful but could do with more training to support patients after they had psychology sessions, to help patients lessen their distress. The psychological therapies were described as life changing by patients. The variety of food was described as both good and not offering healthier choices. Patients said they wanted more opportunities to have ward-based cooking of their own meals and education including literacy, maths, and opportunities to gain employment. Patients did not like to be supported by male agency workers, who they had nothing in common with and who did not attempt to engage with or get to know patients. Patients told us they experienced levels of restriction and security, which was not in keeping with a model of rehabilitation and did not reflect an individual approach to their care. Patients told us they wanted their care records to be written in plain English and use non-medical words. Patients told us they needed more clarity around how the care pathway supported them to move to a less restrictive and acute environment, to one where they felt they had more autonomy over personal decision making and were ready for discharge.

Forensic inpatients or secure wards

Dove ward is a low secure forensic ward. The ward provides care and treatment to men over the age of 18 and offers a slow-stream, low secure service for individuals who have been in secure services for a long period and who may have offences which make it difficult for them to move to step down services.

Dove ward is located at the Gateway Recovery Centre which is a wider hospital site including acute adult mental health wards and a ward for individuals with a learning disability and/or autism.

The service is registered to provide the following regulated activities:

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

The service has not been inspected before.

What people who use the service say

People who used the service were positive about the ward, staff and the care and treatment they were receiving. We spoke with 4 patients as part of our inspection. Patients described staff as kind, caring and considerate. They felt the service was helping them with their mental health and recovery.

Summary of this inspection

How we carried out this inspection

Wards for people with a learning disability or autistic people.

The inspection team comprised a CQC inspector, a medicines inspector, an expert by experience, a regulatory coordinator and a specialist advisor.

Prior to and following the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information including commissioners.

During the inspection visit, the inspection team;

- visited the service, looked at the quality of the environment and observed how staff were caring for people
- reviewed the medicines management and prescribing arrangements
- spoke with 8 people and 4 carers
- completed 2 Short Observation Framework for Inspection 2 (SOFI2) observations, which are structured observations which capture people's experience of care
- observed a morning meeting, a people's forum, an evening handover meeting and 2 ward rounds
- spoke with the ward manager and responsible clinician
- spoke with 12 other staff members including nurses, support workers, a speech and language therapist, a psychologist and an occupational therapist
- received feedback about the service from 4 stakeholders
- reviewed 7 care and treatment records of clients including care plans, risk assessments and documentation
- reviewed 4 prescription cards
- reviewed 3 staff personnel files and 5 staff supervision files
- looked at a range of policies, procedures and other documents relating to the running of the service.

This inspection was unannounced and covered all key questions.

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.

Long stay/rehabilitation mental health wards for working-age adults.

The inspection team comprised two CQC (Care Quality Commission) inspectors, pharmacist specialists, regulatory coordinator, two specialist advisors and an expert by experience.

Prior to and following the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information including commissioners.

During the visit, the inspection team.

- Visited the premises, looked at the quality of the environment and observed how staff were caring for patients.
- Toured all four wards, including the clinic room and medicines storage facilities.
- Reviewed the medicines management and prescribing arrangements.
- Observed a monthly medicines meeting and physical health care monthly meeting attended by clinical and medical staff and engagement meeting with patients who used the service.
- Observed interactions between staff and patients through our observation methodology.

Summary of this inspection

- Observed a safety huddle (Daily safety meeting amongst clinical and medical staff).
- Spoke with 16 patients.
- Spoke with the registered manager, medical director, and service manager.
- Spoke with 26 other staff members including ward manager, charge nurses, occupation therapist, physiotherapist, consultant psychiatrists, recovery coordinators, registered nurses, support workers and psychologist.
- Reviewed 18 care and treatment records of patients including care plans, risk assessments and documentation.
- Reviewed several staff recruitment files.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

This inspection was unannounced and covered all key questions.

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Forensic inpatients or secure wards:

During the inspection visit, the inspection team;

- Visited the ward and reviewed the physical environment.
- Spoke with the ward manager.
- Spoke to 6 other members of staff including registered nurses, a healthcare assistant, a medic, an occupational therapist and a psychologist.
- Reviewed 5 care records.
- Reviewed a range of patient documents including physical health charts, observation records and prescription charts.
- Observed a multidisciplinary ward round.
- We spoke with 4 patients.
- Reviewed the governance, policies and procedures used in the running of the service.

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

Areas for improvement

Wards for people with a learning disability or autistic people.

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

Action the service MUST take to improve:

- The service must ensure that staff have a clear line of sight on the ward, and that any blind spots are mitigated. (Regulation 12)
- The service must ensure that staff follow the dress code policy and maintain safe infection prevention control practices including being bare below the elbow. (Regulation 12)
- The service must ensure there is a comprehensive induction for all staff including agency staff to the ward, including the location of emergency equipment and how best to support people. (Regulation 18)

Summary of this inspection

- The multidisciplinary team must continue to review the search frequency and rationale for searches for each person on the ward, to ensure they are proportionate and justified. (Regulation 9)
- The service must ensure that the facilities are fit for purpose and decorated to a high standard. (Regulation 15)
- The provider must ensure that it meets the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 17)
- The service must ensure that it has access to historical information, particularly in relation to observations, complaints and community meeting minutes. (Regulation 17)

Action the service SHOULD take to improve:

- The service should ensure that they protect people's privacy and dignity when needing to access their room and conducting searches.
- The service should ensure there is accessible information available about how best to support people, to ensure staff can support people in their preferred way.
- The service should ensure that information on display regarding people and their restrictions is current to avoid unnecessary restrictions.
- The service should ensure that people can access spiritual support to meet their needs.
- The service should ensure that people are meaningfully involved in their care including ward rounds, discharge planning and understanding their treatment.
- The service should ensure that consideration is given to people's sensory sensitivities in relation to alarms going off and possible solutions.
- The service should ensure that learning from incidents and complaints is shared with the staff team.
- The service should ensure there is a presence of senior leaders at the service who support the staff team.
- The service should develop a process so that response staff know how best to support people they are responding to on other wards.

Long stay/rehabilitation mental health wards for working-age adults:

Action the service MUST take is necessary to comply with its legal obligations. Action a provider 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 staff follow medicine administration procedures and administer medicines individually, in a safe private place. (Regulation 12)
- The provider must ensure staff follow the dress code policy and maintain safe infection prevention control practices including being bare below the elbow. (Regulation 12)
- The provider must ensure there is a comprehensive induction for all staff including agency staff to the ward, including the location of emergency equipment and how best to support patients. (Regulation 18)
- The multidisciplinary team must continue to review the rationale for searches for each patient on each ward, to ensure they are proportionate and justified. (Regulation 9)
- The provider must ensure they meet the requirements for vetting the suitability of staff for employment to work with vulnerable adults and children as described in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 17)
- The provider must ensure they has access to historical information, particularly in relation to observations, complaints, and community meeting minutes. (Regulation 17)

Summary of this inspection

Action the service SHOULD take to improve:

- The provider should ensure patients are supported through a model of care which has a clear rationale for level of restriction and security being proportionate to the service being delivered.
- The provider should ensure they protect patient privacy and dignity when receiving personal care and protecting personal information.
- The provider should ensure the facilities are decorated to meet the needs of patients.
- The provider should ensure ward based governance checks includes digital equipment for monitoring patient health are calibrated to make sure readings are accurate, all equipment used is listed and sharps bins are dated when opened and medicine disposal bins are removed when full.
- The provider should ensure personal emergency evacuation plans (PEEP), a plan used for individuals who may have difficulties evacuating a building, are completed for all patients on Ash ward.
- The provider should ensure patients are meaningfully involved in their care including the use of plain English and reflecting patient words and experiences.
- The provider should ensure learning from incidents and complaints is shared with the staff team.
- The provider should ensure all staff including registered nurses and health care assistants on Ash ward have supervision completed within the four to six week timescale as per the provider policy.
- The provider should develop a process, so response staff know how best to support patients they are responding to on other wards.
- The provider should ensure patients have access to all areas of the wards that aid their recovery and should not be routinely locked.
- The provider should provide ward based accessible kitchen equipment so patients can self-cater.

Forensic inpatients or secure wards:

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

Action the service MUST take to improve:

- The service must ensure that staff follow the dress code policy and maintain safe infection prevention control practices including being bare below the elbow. (Regulation 12)
- Staff must ensure that all allergy statuses are up to date and correct on patients' prescription charts. (Regulation 12)
- The provider must ensure that it meets the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action the service SHOULD take to improve:

- The service should ensure that medicines that are no longer being used are disposed of in a timely manner.
- The service should consider mechanisms to report family member and carer feedback survey results at service and ward level.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement

Requires Improvement

Wards for people with learning disabilities or autism

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

Is the service safe?

Requires Improvement

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

Safe and clean care environments

People were cared for in wards that were mostly safe, clean, well equipped, well furnished, well maintained and fit for purpose. The IT room had bikes, a large empty cardboard box, coats and the security lockers in, there was also dirt on the wall. This meant the room was not welcoming for people to pursue IT activities.

The cleaning records showed that the IT room has been cleaned on the day of the inspection, however there was a large area of dirt on the wall.

Other areas of the ward required maintenance, work had been taking place on a drinks area in the communal part of the ward, there was a maintenance sign blocking off an area where work was in progress.

The communal bathroom had paint flaking off the wall and a cracked privacy screen on the window which meant people's privacy and dignity may be compromised. The flooring seal in the bathroom was lifting away from the wall.

The seclusion room had work being completed on it and this started on 16 October 2023, the contractors gave a six week completion date, it had been seven weeks at the time of inspection. This meant there was noise and disruption for people for longer than planned. The maintenance records showed the work was due to be completed in January 2024.

People were cared for in wards where staff had completed risk assessments of the environment and removed or reduced any identified risks. A current environmental and ligature risk assessment were in place. There was CCTV in use in the communal areas of the ward, however the CCTV did not cover the lounge area. This was not included in the environmental risk assessment and the ligature risk assessment dated October 2023. This meant staff did not have a clear line of sight in all ward areas.

People had easy access to nurse call systems and staff had easy access to alarms. Staff wore safety alarms and nurse call systems were in each room.

Requires Improvement

Wards for people with learning disabilities or autism

The servide did not always take sufficient action to prevent visitors from catching and spreading infections. There was antimicrobial hand sanitiser at the entrance to every ward, however we did not see any staff who escorted us around the site, using this. We did not see any staff bare below the elbow, we observed staff with jewellery, long sleeved tops and coats on. The organisation's dress code policy stated "12 CORONAVIRUS All clinical and ward-based staff should be bare from the elbows down. This includes no arm jewellery, watches or rings (wedding bands only can be worn)." This meant staff were not taking action to reduce the risk of spread of infection as required by the provider's policy.

The services infection prevention and control policy was up to dat and included information on how to respond to outbreaks.

The service admitted people safely to the service. Admissions were planned and assessments took place by staff, including a member of the multidisciplinary team prior to admission.

The service supported visits for people in line with current guidance. There was a family visiting room and some people went on leave in the local community with their family.

All relevant staff had completed food hygiene training and followed correct prodecures for preparing and storing food. Training compliance was 100%, we saw food was labelled in the fridge with the date of opening.

Staff checked, maintained, and cleaned equipment. We saw staff cleaning the ward during the inspection, records were in place to support this, and records showed medical equipment had been calibrated.

Safe staffing

The service had enough nursing and medical staff, who knew the people and received basic training to keep people safe from avoidable harm. There were 3 support worker vacancies and no other vacancies for the service.

The service had enough staff, including for one-to-one support for people to take part in activities and visits how and when they wanted. We reviewed allocations of staff which showed staff supporting people to college, appointments, and community activities. Staff were able to take their breaks.

The numbers and skills of staff mostly matched the needs of people using the service. We observed several staff who knew people well, however we observed that some agency staff did not know people well.

Staff recruitment and induction training processes did not promote safety. Managers did not make sure all bank and agency staff had a full induction and understood people's needs before starting their shift. Records showed that agency staff had not received a thorough induction to the ward. There was no ward checklist to show what staff had been shown when they first worked on the ward. Of the 4 staff we asked, 2 did not know where the ligature cutters or emergency bag were kept, this meant they would not be able to respond promptly in an emergency.

Every person's record did not contain a clear one-page profile with essential information so that new or temporary staff could see quickly how best to support them. We were told that essential information was contained in one page profiles for people, there was supposed to be a file in the office with all of the information in, however this could not be located. We were also told that helpful information regarding people was within the observations file. We reviewed this file and found there was only information for 4 out of 11 people. This meant staff, particularly agency staff, would not know how best to support people.

Requires Improvement

Wards for people with learning disabilities or autism

Permanent, regular staff knew how to take into account people's individual needs, wishes and goals. Staff knew people's hobbies and interests.

Managers accurately calculated and reviewed the number and grade of nurses and support workers for each shift. Additional support had been arranged for one person who found mornings difficult and required support to engage in activities and have a named member of staff to support them.

The ward manager could adjust staffing levels according to people's needs. Staffing levels included support for people to access college and prepare meals within the service.

People rarely had their escorted leave or activities cancelled, even when the service was short staffed. Allocations showed and we observed staff supporting people to access their regular community activities.

Staff shared key information to keep people safe when handing over their care to others. We observed a handover from day to night shift. The staff leading the handover gave a summary of each person, how they had been in the previous shift and if staff needed to be aware of anything.

The service had enough daytime and night-time medical cover, and a doctor was available to go to the ward quickly in an emergency. The responsible clinician oversaw the care and treatment for people on 2 wards in the hospital, they allocated a day a week for ward rounds, another day for additional appointments with people on this ward. There were on call arrangements in place for medical cover out of hours.

Staff had completed and kept up to date with their mandatory training. The training programme was comprehensive and met the needs of people and staff. Training included epilepsy, learning disability and autism awareness, compliance for all training courses was over 90%.

Assessing and managing risk to patients and staff

People did not live safely and free from unwarranted restrictions. All 11 men on the ward were searched. There was a list with search frequency for each person. Out of the 11 people using the service, 7 were randomly searched on return from escorted leave. The randomiser was set at 60%. Out of the 11 people using the service, 9 had monthly room searches. We reviewed 3 care records in relation to searches and found that 1 person was required to have a rub down on return from leave but was a minimal risk of secreting items. Nothing had been found in the last 7 searches. Another person's record showed he had had 22 searches since November 2023 and no risk items had been found.

Another person's record showed he had 3 searches since November 2023 and no risk items had been found. We observed a patient having a pat down in the dining room which had full windows and did not protect his privacy and dignity. We raised concerns with the service that this practice did not protect the person's privacy and dignity and the search practices were not promoting a least restrictive culture. During the ward round on 6 December 2023, we observed the multidisciplinary team were starting to review the frequency of searches for people.

People were involved in managing risks to themselves and in taking decisions about how to keep safe. This was discussed with people in their ward rounds, including access to restricted items and leave from the hospital.

People, including those unable to make decisions for themselves, did not have as much freedom, choice and control over their lives as possible because the service was based in a secure hospital. There was an air lock onto the ward and another air lock to get to reception. People had to be escorted off the hospital site, in the morning we saw people waiting at the door to go out with staff.

Requires Improvement

Wards for people with learning disabilities or autism

People's electronic care records helped them get the support they needed because it was easy for staff to access and keep high quality clinical and care records. Staff kept accurate, complete, legible and up-to-date records, and stored them securely. However, the paper records which bank and agency staff relied on, were not up to data and one page profiles and information on how best to support people was not easily available for every person.

The service helped keep people safe through formal and informal sharing of information about risks. Information was shared with the staff team, community team and commissioners as appropriate. We observed commissioners and care coordinators attending ward rounds.

Staff managed the safety of the living environment and equipment in it well through checks and action to minimise risk. However, at times rooms were locked off including the gaming room. People had access to outside space in the garden off the lounge area.

People's freedom was mostly restricted only where they were a risk to themselves or others, as a last resort and for the shortest time possible. However, the search practices were not promoting a least restrictive culture. The seclusion room was being refurbished and had been unavailable due to this since October 2023. The staff team supported the men on the ward to deal with emotional distress by alternative methods rather than physical intervention or seclusion. The last time seclusion was used on the ward was February 2023.

Staff could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe. We observed staff encouraging people to participate in games of pool, accessing the garden, gaming room, or watching something they enjoy on TV. Each person's care and support plan included ways to avoid or minimise the need for restricting their freedom. People had positive behaviour support plans in place.

Staff made every attempt to avoid restraining people and did so only when de-escalation techniques had failed and when necessary to keep the person or others safe. Since a person had been discharged who was unsettled on the ward and was inappropriately placed, there had been 5 incidents of physical intervention on the ward. These all involved the same person.

The ward staff had regard to the Mental Health Unit (Use of Force) Act 2018 and its guidance and complied with requirements. There was a leaflet for people accessing the service, about the use of force, this had plain English and symbols in it to make it as accessible as possible for people. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards including the requirements of the Mental Health Unit (Use of Force) Act 2018 and its guidance. This training was accredited by the British Institute of Learning Disabilities (BILD).

People were restrained only where evidence demonstrated it was necessary, lawfully justified, used for the minimum period of time, had a justifiable aim, and was in the person's best interest, and that it was used in a safe and proportionate way. Of the physical intervention used, records showed it was to response to incident of person on person incident. This was proportionate due to both people's safety.

All restrictions of people's freedom were documented, monitored and triggered a review of the person's support plan. Records showed the type of physical intervention were recorded and the duration of the holds.

Staff knew about any risks to each person, and prevented or reduced risks. This was reflected in the low levels of physical intervention and the calm atmosphere of the ward.

Staff identified and responded to any changes in risks to people or posed by them. This was discussed in handover and records showed documentation had been reviewed.

Where staff were trained in the use of restrictive interventions, the training was certified as complying with the Restraint Reduction Network Training standards.

People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so. There was a safeguarding lead at the hospital who understood their role in relation to safeguarding.

Staff had training on how to recognise and report abuse and they knew how to apply it. Training compliance for safeguarding adults and children was 100%.

People and those who matter to them had safeguarding information in a form they could use, and they knew how and when to raise a safeguarding concern.

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. We saw that safeguarding incidents were discussed at the daily morning meetings, which all ward managers, members of the multidisciplinary team and senior leaders attended.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Monthly meetings took place with the local safeguarding team and police representative to discuss safeguarding referrals, progress and updates.

Staff followed clear procedures to keep children visiting the ward safe. The social work team conducted risk assessments prior to children visiting the hospital, visits took place in the visiting room near reception.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The lead supported this process in office hours, out of hours the nurse in charge would make the referral.

Permanent staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic. Agency staff did not have the same access to electronic care records and relied on paper information which was not comprehensive for each person in the service.

Medicines management

Staff followed systems and processes to prescribe and administer medicines safely. All relevant legal paperwork was in place for the people we looked at.

Staff reviewed each person's medicines regularly and provided advice to people and carers about their medicines. The service had access to a range of easy-to-read leaflets available to give to people and carers to help them understand their medicines. A full review of people's medicines was undertaken when admitted to the service. For one person, pharmacogenetic testing was completed after first line treatment had failed.

Staff completed medicines records accurately and kept them up to date. There was a process in place for homely remedies and emergency medicines. For medicines that required extra monitoring before and after being administered this had been completed in the people's records we looked at.

Requires Improvement

Wards for people with learning disabilities or autism

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. A clear process was in place for people being admitted to the service. The use of people's own medicines was permitted after being screened and assessed on the ward using the appropriate paperwork.

Staff learned from safety alerts and incidents to improve practice. The most recent MHRA (Medicines and Healthcare Products Regulatory Agency) alert and guidance had already been actioned and people were given their options surrounding the prescribing of Sodium valproate.

Staff regularly reviewed the effects of medicines on each patient's mental and physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). A recent audit was carried out for each individual person.

Staff reviewed the effects of each person's medicines on their physical health according to NICE (National Institute for Health and Care Excellence) guidance. The service had 100% compliance with annual health checks for people with a learning disability or autistic people.

Track record on safety

People received safe care because staff learned from safety alerts and incidents. The organisation had created an Elysium North West services learning group round up which included lessons learned from serious incidents. Monthly positive learning bulletins were shared with all staff. However, learning from incidents was not regularly discussed at team meetings, we reviewed the minutes and there was no standard agenda.

The service managed incidents affecting people's safety well. Staff recognised incidents and reported them appropriately and managers investigated incidents and shared lessons learned. There had been no serious incidents in the 12 months prior to the inspection.

The service recorded any use of restrictions on people's freedom, and managers reviewed use of restrictions to look for ways to reduce them. The multidisciplinary had started to review the search frequency and rationale for all people on the ward. Records showed changes had been made to the frequency as previously there was a blanket approach, and all people were randomly searched following escorted leave, and all were searched following unescorted leave. Although this had changed in individual people's records, the at a glance board in the ward managers office had the blanket arrangements for searching, this meant staff may follow this rather than the updated search frequency which had been more personalised.

Staff reviewed all use of restraint and used the examples as learning in their restrictive intervention's reduction programme. Review of use of restraint was discussed at daily morning meetings.

Managers were aware of the Learning from Deaths Mortality Review (LeDeR) Programme.

Is the service effective?

Good

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

Requires Improvement

Wards for people with learning disabilities or autism

Assessment of needs and planning of care

Staff completed a comprehensive assessment of each person's physical and mental health either on admission or soon after. Pre-admission assessments were completed by members of the multidisciplinary team, we saw that these were detailed and comprehensive.

People had care and support plans that were personalised, holistic, strengths-based and reflected their needs and aspirations, including physical and mental health needs. People, those important to them and staff reviewed plans regularly together. People's care plans were goal orientated and individualised.

Care plans reflected a good understanding of people's needs, including relevant assessments of people's communication support and sensory needs. We saw for 1 person, they had a communication passport in place to explain how best to support them. We were told that all people had a one-page profile in place, for staff to know how best to support people in an overview document. However, these could not be located during the inspection which meant they were not accessible for staff to use.

Staff ensured people had up-to-date care and support assessments, including medical, psychological, functional, communication, preferences and skills. All the records we reviewed included current, recently reviewed documentation .

Support plans set out current needs, promoted strategies to enhance independence, and demonstrated evidence of planning and consideration of the longer-term aspirations of each person. Care plans were recovery focused and reviewed with individuals in their ward rounds.

There were clear pathways to future goals and aspirations, including skills teaching in people's support plans. Areas of support and focus included cooking, vocational silks and opportunities and access to education.

Best practice in treatment and care

Staff supported people with their physical health and encouraged them to live healthier lives. This included access to psychological therapies, support for self-care and the development of everyday living skills. There was a full multidisciplinary team and support was available from the occupational therapist, psychologists and speech and language therapist. Staff told us and records showed that people were being supported by the psychology team for anxiety and risk management and social skills support. The occupational therapy team were supporting people with exercise opportunities, assessing and meeting sensory needs, volunteering, cooking skills and attending college. The speech and language therapist was involved in completing communication assessments with individuals and making information more accessible for people.

There were six people from Cedar ward waiting for interventions from the speech and language therapist as they were also covering another hospital which had an impact on the time they could spend at the service.

Staff were aware of and followed best practice and the principles of Right Support, Right Care, Right Culture. However, the service was in a secure hospital setting with two airlocks to pass through before reaching the ward. The ward used the framework of the SPELL model (Structure, Positive, Empathy, Low arousal, and Links). Information on this was displayed at the entrance to the ward.

Staff understood people's positive behavioural support plans if they had them and provided the identified care and support. We saw positive behaviour support plans in place for people which regular staff were familiar with.

Staff made sure people had access to physical health care, including specialists as required. There was a physical health care team at the service. The physical health nurse was involved in the physical health assessment at admission. Dentists and GPs visited the hospital and appointments could be booked for people.

Staff helped people live healthier lives by supporting them to take part in programmes or giving advice. The hospital was a non-smoking site, some people still smoked, and this was discussed at their ward rounds and people were encouraged to stop smoking. Some people smoked e-cigarettes. The welcome booklet explained access to takeaways was limited to once a week to promote healthier eating. However, people could eat at places of their choice when on leave.

Staff took part in clinical audits, benchmarking and initiatives. Managers used results from audits to make improvements. The green light audit had been completed on the ward, this is for wards for people with a learning disability or autistic people.

Skilled staff to deliver care

People received good care as managers supported staff through regular, constructive clinical supervision of their work. The managerial supervision guidance stated that staff should receive supervision every four to six weeks. We reviewed five staff supervision files and found that staff were receiving supervision within the expected frequency.

People were supported by staff who had received relevant and good quality training in evidence-based practice. This included training in the wide range of strengths and impairments people with a learning disability and or autistic people may have. Staff has received training in professional boundaries, conflict resolution, epilepsy, autism and learning disability. The induction for permanent staff included sessions on positive behaviour support, learning disability, autism and personality disorder. The speech and language therapist was developing communication skills training to be delivered in 2024.

Staff could describe how their training and personal development related to the people they supported. Regular staff knew the individual needs of people and how best to support them, however agency staff had not been provided with all of the information needed to support people effectively.

Updated training and refresher courses helped staff continuously apply best practice to the people they cared for. Professional boundaries, conflict resolution and epilepsy awareness was reviewed annually.

If people were assessed to lack capacity to make certain decisions for themselves or had fluctuating capacity, staff made decisions on their behalf which were in their best interests. This was supported by effective staff training and supervision. Staff completed training in the Mental Capacity Act with 100% compliance. We saw examples of capacity assessments and best interest decisions in relation to the management of a person's epilepsy.

People benefitted from reasonable adjustments to their care to meet their needs, and their rights were respected. This was because staff put their learning into practice. Staff understood that people on the ward may not want to participate in group activities, it was respected when people wanted to spend time in their rooms or in a low sensory environment, for example the games room with the light off.

Staff were knowledgeable about and committed to using techniques which reduced the restriction of people's freedom. However, we were concerned about the frequency of personal searches taking place. The service had started to review this, and we saw discussions taking place in people's ward rounds.

Staff received support in the form of continual supervision, appraisal and recognition of good practice. This created a positive work culture. There were staff who had completed additional training in assessment tools for autism, staff had also had the opportunity to attend the autism show and visit the autism bus which provided simulation experiences of what it was like to be autistic.

The service had clear procedures for team working and peer support that promoted good quality care and support. Allocations were made following handover so that people knew who was on security or supporting people to certain activities.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. The service had a full multidisciplinary team with a responsible clinician, occupational therapist for the ward and access to the psychology team for psychological assessment and intervention. The access to the speech and language therapist was on a referral basis. A social worker supported the ward and worked as a contact between the hospital and community, they were involved in liaising with family and carers, arranging and approving visitors to the service and safeguarding involvement. We observed a ward round for two people and found the team worked well together with shared decision making.

The ward team had effective working relationships with staff from services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge. We received feedback from four stakeholders who told us that the service was responsive and communicated effectively with them. They were invited to the ward rounds and Care Programme Approach reviews. They felt the multidisciplinary team knew people well, provided people with a range of meaningful opportunities and focused on their discharge.

Multidisciplinary team professionals were involved in or made aware of support plans to improve care. Care plans were reviewed within the ward rounds.

Staff shared clear information about people and any changes in their care, including during handover meetings. We observed an evening handover and found that all people were discussed, including their presentation during the day.

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

Staff understood their roles and responsibilities and were able to explain people's rights to them. Staff completed training in the Mental Health Act with 100% compliance. Support was provided to the service by a Mental Health Act administrator.

People had easy access to information about independent mental health advocacy, and people who lacked capacity to make decisions for themselves were automatically referred to the service. Information about the advocacy service was displayed on boards within the communal area of the ward and was included in the welcome booklet.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand, repeated it as necessary and recorded it clearly in the people's notes each time. Easy read resources were available if required.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or the Ministry of Justice or both. We saw people going out on leave during the inspection.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. This was discussed for 1 person in their ward round due to a change of medicines.

Requires Improvement

Wards for people with learning disabilities or autism

Staff stored copies of people's detention papers and associated records correctly, and staff could access them when needed.

Care plans included information about after-care services available for those people who qualified for it under section 117 of the Mental Health Act. Community placements were discussed as part of the discharge planning process.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. We reviewed the clinical governance meeting minutes and found that staff were involved in seclusion audits and restrictive intervention audits.

Good practice in applying the Mental Capacity Act

Staff completed training in the Mental Capacity Act with 100% compliance.

Staff supported people to make decisions on their care for themselves. They assessed and recorded capacity clearly for people who might lack the mental capacity to make certain decisions for themselves. For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any decisions made on their behalf in their best interests. We saw a completed capacity assessment for a person in relation to managing their epilepsy.

Staff empowered people to make their own decisions about their care and support and obtained people's consent in an inclusive way. People attended their ward rounds and were asked for their views.

Staff ensured that an Independent Mental Capacity Advocate was available to help people if they lacked capacity to make decisions for themselves and they had nobody else to represent their interests.

Staff followed best practice on assessing mental capacity, supporting decision-making and best interest decision-making.

For people lacking capacity to make decisions about their medicines, staff followed best practice. A second option appointed doctor (SOAD) was requested to review the decision of the responsible clinician when required.

Staff gave people all possible support to make specific decisions for themselves before deciding they did not have the capacity to do so. Assessments from the multidisciplinary team described how people processed information and how best to communicate with people.

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated people with compassion and kindness. They respected people's privacy and dignity. They understood people's individual needs of and supported them to understand and manage their care, treatment or condition**.** We completed two Short Observation Framework for Inspection 2 (SOFI2) observations in the service, which are structured

observations which capture people's experience of care. One was in the morning and another in the evening. We observed how staff were interacting with people. We saw in the morning, people were waiting to go out, standing near the door and asking staff when they could go out, staff told people what time had been agreed. We heard drilling from the building work taking place in the seclusion room. People seemed to tolerate this well.

We observed at times there were four staff in the office and no staff in the communal area. Staff helped people to understand when their agreed time for going out on leave was, by explaining what time the clock would be.

Staff were playing pool with people and chatting about the game and offering encouragement. However, we did observe 2 staff sat next to each other talking amongst themselves and not interacting with people for approximately 15 minutes.

We also saw pat down searches taking place in the dining room which had full windows, this meant people's privacy and dignity were not protected. Someone told us that housekeeping staff had entered their bedroom without knocking. They had not ensured they protected their privacy and dignity and ensured it was appropriate for them to enter their room.

Staff saw people as their equal and created a warm and inclusive atmosphere. Staff suggested to people activities they may like to do, for example playing on their computer game which was facilitated.

People received kind and compassionate care from staff who used positive, respectful language at a level people understood and responded well to. Regular staff knew people well, including their likes and preferences. Staff used succinct language that was clear and concise for people to understand.

Staff were patient and used appropriate styles of interaction with people. They were calm, focused, and attentive to people's emotional and other support needs and sensory sensitivities. Staff respected people's preference for activities they wanted to pursue or where they wanted to spend their time, including in the sensory room, gaming room or in their own room.

People felt valued by staff who showed genuine interest in their well-being and quality of life. People told us that there were always staff available and they supported them to pursue their hobbies and interests and develop their skills, especially in daily living, including cooking.

Staff showed warmth and respect when interacting with people. Staff provided reassurance to people, especially if they were anxious about going out on leave.

People had the opportunity to try new experiences, develop new skills and gain independence. There was a comprehensive activity timetable on display, which included group activities. People were also supported to pursue individual activities including attending college.

Each person had a support plan that identified target goals and aspirations and supported them to achieve greater independence including skills development. Care plans were individualised.

People's rights were upheld by staff who supported them to be independent and have control over their own lives. Staff involved people in their reviews, asking for their goals and wishes and giving clear responses to requests with a rationale for their decision.

Requires Improvement

Wards for people with learning disabilities or autism

Staff knew when people needed their space and privacy and respected this. We saw people spending time in different parts of the ward, including gaming room, sensory room, dining room, garden and their own rooms, staff respected this.

Staff supported people to understand and manage their own care treatment or condition. People attended their ward rounds however, there was no system in place to help people prepare for their meeting and remember what they wanted to discuss. There were 6 staff members in the meeting and the person, the room was quite small with a table that was not big enough for its purpose, therefore people may have felt intimidated and, when asked what they wanted to discuss, we observed that they became quite distracted.

Staff directed people to other services and supported them to access those services if they needed help. People attended local colleges, with support. People had been involved in voluntary work in the local community and people were involved in paid work at the hospital including gardening.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people. They felt able to talk to senior colleagues.

Staff followed the policy to keep people's information confidential. Care records were electronic. All paper documentation was stored in the locked office.

Involvement in care

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

All the people we spoke with told us they had access to advocates.

Community meetings took place. People said they wanted to go on more days out. Previous meeting minutes were not available on site as they had been sent to storage. This meant minutes were not available if people wanted to look back through previous meetings.

People were listened to, given time and supported by staff to express their views using their preferred method of communication. We saw staff were patient with people, allowing time for people to process information and then respond.

Staff took the time to understand and develop a rapport with people. Regular staff knew people well and encouraged them to pursue their hobbies and interests, including pool, gaming and cooking.

People were enabled to make choices for themselves. Staff ensured they had the information they needed. Evening snacks were made by staff, however people chose what food they had.

Staff respected people's choices and wherever possible, accommodated their wishes, including those relevant to protected characteristics – for example, due to cultural or religious preferences. However 1 person told us that ministers of religion did not visit the service and they would like the opportunity to practice their faith.

People were supported to access independent, good quality advocacy. People told us they were supported by the advocate, and they would support them in their ward round and other meetings if they wished.

Requires Improvement

Wards for people with learning disabilities or autism

People were empowered to make decisions about the service when appropriate and felt confident to feed back on their care and support. The provider had sent out a family, friends and carers experience survey, however the results were at a hospital level, therefore you did not know the views of people from Cedar ward.

We observed a people's forum where there were representatives from each ward. Issues raised were healthy foods: the food provided was not seen as healthy, with people wanting to lose weight and keep healthy, but feeling food choices did not support this. Smoking on escorted leave, people were not allowed to smoke on escorted leave. Bank and agency staff: people said they did not engage with them and referred to them by their initials or room number. Cancelled leave: the minibus had not been available over the last three weeks, due to requiring repair and there were not enough drivers, leaving to cancelled recovery activities. This feedback was from people across the hospital. Minutes were taken and actions created. The issue of bank and agency staff having limited knowledge of people was found on Cedar ward in relation to agency inductions and agency staff's knowledge of individuals and the information provided to them being limited.

People and those important to them took part in making decisions and planning their care and in risk assessments. Carers and relatives we spoke to, told us they were invited to the ward rounds and Care Programme Approach reviews for their loved ones. They were contacted by the service to contribute to the planning of care for their loved ones.

People felt listened to and valued by staff who engaged meaningfully with them. People said some staff who were new to the ward or not familiar with them, for example agency staff, did not engage with them the same as regular staff on the ward.

Staff supported people to maintain links with those important to them. People had visits with family, and for those whose leave allowed, they went out into the community with their family and others were supported to visit family at home or in a central meeting point.

Staff introduced people to the ward and the services as part of their admission. They were given a welcome book with relevant information in, including expectations and details of the ward.

Staff made sure people understood their care and treatment (and found ways to communicate with people who had communication needs). There was 1 person who had a communication passport in place, to help staff and external professionals understand how best to communicate with them.

Staff informed and involved families and carers appropriately. Carers told us that the service was very welcoming to them, communicated with them and arranged for visits to take place, even where there was a considerable distance.

They were involved in their loved one's care by contributing at the assessment and goal setting stage and regularly for reviews including Care Programme Approach reviews.

Staff helped families to give feedback on the service. Although there was a family, friends and carers experience survey, the results were at a hospital level, therefore you did not know the views of people from Cedar ward. You also did not know from the results whether that was the views of family or people at the service. The survey was at a high level of feedback.

Is the service responsive?

Requires Improvement

Wards for people with learning disabilities or autism

Good

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

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, people did not stay in hospital longer than needed, and discharge was rarely delayed for other than a clinical reason. Stakeholders told us that the service advocated for the discharge of people and encouraged the transition to a community placement.

Managers regularly reviewed people's length of stay to ensure they did not stay longer than needed. The longest admission had been since 2019, 4 people were admitted in 2020, 1 person was admitted in 2021, 3 people were admitted in 2022 and 2 people were admitted in 2023. Everyone had a discharge plan in place which was regularly reviewed and discussed with commissioners.

If a person was not from the local area staff supported them, in line with their wishes, to have regular contact with family, friends or an advocate. Staff facilitated home visits or enabled people to meet family at a central point if they lived a considerable distance away.

When people went on leave there was always a bed available when they returned. At the time of inspection there were 11 people admitted to the ward, with 1 empty bed.

Staff did not move or discharge people at night or very early in the morning. Admissions and discharges were planned for this service.

Staff carefully planned people's discharge and worked with care managers and coordinators to make sure this went well. Stakeholders confirmed this happened.

Staff supported people when they were transferred between services. Staff supported people to visit new services and move belongings as required.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people's 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. Including a quiet room, sensory room, games room and IT room. People had access to the internet, which was individually assessed, and we observed this was discussed at their ward rounds. However, the IT room had several items stored in it, including bikes, empty cardboard boxes, clothing and security lockers. There was dirt on the wall which looked like mud and the room was not a welcoming environment.

The food was of good quality and people could make hot drinks and snacks at any time. However, milk was not always freely available for people when making drinks, they had to ask staff for the milk as people had been drinking directly from the milk however no alternatives had been explored. The drinks making facilities were temporarily in the dining

room as there had been building work to construct a new drinks and snack area in the communal area, the work had not been completed with cracked tiles on the walls, and missing flooring with a sign saying maintenance in progress, there was no work taking place on this area during the inspection and the maintenance log did not have the work listed or a date for completion.

The service's design, layout and furnishings supported people and their individual needs. This included noise-reducing furnishings and calm diffused lighting, which supported people with sensory sensitivities. However, we heard alarms going off from neighbouring wards and no consideration had been made that the people on the ward could have sensory sensitivities to this. The building work on the seclusion room had been underway since October 2023 and we heard drilling and banging from this during inspection. This work was due to conclude in December 2023, however a revised date of January 2024 had been given for completion.

People's care and support was mostly provided in a safe, clean, well equipped, well-furnished and well-maintained environment that met people's sensory and physical needs. However, the communal bathroom had paint flaking off and a cracked privacy screen and flooring coming away from the wall, this was not recorded in the maintenance log. This meant people's privacy and dignity could be compromised and the bathroom environment was not decorated to a high standard.

The service had quiet areas and a room where people could meet visitors in private. There was a visitors room just off the main reception where visits could take place, including visits with children.

People could make phone calls in private. If risk allowed, people could access their own mobile phones.

The service had an outside space that people could access easily. There was a garden area off the lounge which was open, and people could access this freely.

Patients' engagement with the wider community

Staff supported people with family relationships and community activities outside the service, such as work, education and family relationships. The occupational therapy team supported people to develop links in the community, this included attending college and voluntary work. Support staff then provided support for people to attend.

Staff supported people to take part in their chosen social and leisure activities on a regular basis. The service also provided paid work opportunities within the service, people from the ward were involved in kitchen porter and gardening roles. Community activities including volunteering, college and exercise. Group activities included walking, football and jogging. People also had individualised music sessions where they were learning to play instruments.

Staff gave people person-centred support with self-care and everyday living skills. People were supported to develop their daily living skills, people told us about the shopping and cooking they did and discussed meals they planned to make.

People were encouraged and supported by staff to reach their goals and aspirations. Care plans were goal orientated, people talked positively about their activities including work opportunities, college and their skill development with the aim of moving on to a community setting in the future.

People who were living away from their local area were able to stay in regular contact with friends and family using the telephone, online voice or video calls, and social media. Individual mobile phone risk assessments and contracts were in place, access to mobile phones was agreed as part of the multidisciplinary meetings.

Requires Improvement

Wards for people with learning disabilities or autism

Clear plans and placement goals were developed with commissioners to enable people to move back to their local community as soon as possible. We saw commissioners attend ward rounds remotely via video call, progress was discussed and future aims. Feedback from stakeholders following the inspection confirmed regular communication took place regarding future placements for people, especially those who lived far from the service.

People were supported by staff to try new things and to develop their skills. Support was provided by the occupational therapist, recovery coach and support staff. Planned activities were on a weekly timetable which included symbols to make the plan as accessible as possible for people.

Staff enabled flexibility and helped people to have freedom of choice and control over what they did. One to one sessions enabled people to discuss their likes and preferences and discussions at ward rounds enabled the full multidisciplinary team to discuss the aims of individuals and how to support them to achieve them.

Staff enabled people to broaden their horizons and develop new interests and friends. Staff were committed to encouraging people, in line with their wishes, to explore new social, leisure and community-based activities.

Staff helped people to stay in contact with families and carers. This happened through remote contact, visits at the service and home visits. Where leave allowed people also had community access with their family and carers.

Meeting the needs of all people who use the service

The service met the needs of all people – including those with a protected characteristic. Staff helped people with communication, advocacy and cultural and spiritual support. Communication assessments took place, outcomes of assessments were discussed in ward rounds to enable the team to incorporate the recommendations of the report into their support. People accessed advocacy and contact details for the advocate were displayed on the ward. One person said they would like access to cultural and spiritual support, and they had not been able to access this since being at the service.

Staff did not use person-centred planning tools and approaches to discuss and plan with people how to reach their goals and aspirations. In the ward rounds we observed, people were asked for their views and contribution however, this had not been prepared prior to the meeting and seemed a difficult setting for people to think and contribute in. We were told one-page profiles were in use however these could not be located during the inspection. This meant people were not supported to be as meaningfully involved as possible within their ward rounds.

Staff discussed ways of ensuring targets for people were meaningful. They spent time with people understanding how they could be achieved. Discussions took place in one to one sessions.

People learned everyday living skills, understood the importance of personal care and developed new interests by following individualised learning programmes with staff who knew them well. The occupational therapist led on this, completing assessments of people's skills and abilities and developing aims and goals with people and provided support in an individualised way.

Staff identified people's preferences and appropriate staff were available to support people– for example, by having staff of people's preferred gender available to support them. People seemed comfortable with the staff who were supporting them to pursue community activities and work opportunities.

Staff spoke knowledgably about tailoring the level of support to an individual's needs. Regular staff we spoke to knew people well and how best to support them.

Requires Improvement

Wards for people with learning disabilities or autism

The service met the needs of all people using the service, including those with needs related to their protected characteristics. Support could be tailored to meet individual needs in relation to food requirements, access to community activities and interests. The ward was accessible as it was on the ground floor and was a wide-open space. Some consideration had been made to ensure a variety of spaces were available for people, for those who required a less stimulating environment.

Staff ensured people had access to information in appropriate formats, the timetable included symbols. Easy read resources were available.

There was 1 person with an individual communication plan/ passport that detailed effective and preferred methods of communication, including the approach to use for different situations.

Staff had good awareness, skills and understanding of people's individual communication needs. They knew how to facilitate communication and when people were trying to tell them something. All people at the service used speech to communicate, however staff were knowledgeable about communicating in a clear and concise way with people.

Staff made sure people could access information on treatment, local services, their rights and how to complain. Information was on display on the ward and also in the welcome booklet.

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

The service provided a variety of food to meet people's dietary and cultural needs.

People had access to spiritual, religious and cultural support. There was a multifaith room and staff told us that two people were regularly attending church, however another person said they would like support to access spiritual support.

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. This was included in the welcome booklet.

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them. Opportunities were provided at the community meetings, people's one to one meetings with staff and at the people's forum.

People, relatives and carers knew how to complain or raise concerns. People told us they knew how to complain, and people gave examples of complaints they had made which had been listened to and resolved.

The service clearly displayed information about how to raise a concern in areas used by people. This was displayed on the notice boards in the communal area.

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

Requires Improvement

Wards for people with learning disabilities or autism

Staff knew how to acknowledge complaints, and people received feedback from managers after the investigation into their complaint. We reviewed the complaints log from 2023 and found there had been 5 complaints, the log recorded the summary of the complaint, the action taken to resolve it, timescales and if the person was satisfied with the outcome. If people were unhappy with the locally managed complaints process, they could submit a formal complaint, we saw this happened on one occasion and the service followed the complaints process.

It was difficult to locate the complaints log as it had gone for archiving and the current book was empty, therefore it was difficult for staff to have access to information at a ward level. The complaints log was located during the inspection.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, these were not shared these with the whole team and wider service. We reviewed team meeting minutes and found there was no standard agenda and complaints were not included in the meetings, this meant staff were not informed of the feedback about the service and any changes in practice they needed to implement.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs and oversight of the services they managed. Management and staff put people's needs and wishes at the heart of everything they did. Leaders were knowledgeable and had accessed specific training in how best to support autistic people.

Leaders worked hard to instil a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish. However, information was not available for new or temporary staff to enable them to promptly understand how best to support people.

Managers were not always visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. Staff told us that senior leaders were not visible on the ward, and we observed that when a senior leader visited during the inspection they had to introduce themselves to people on the ward.

Leaders and senior staff were not alert to the culture in the service and as part of this did not spend time with staff/ people and family members discussing behaviours and values. We observed that mangers and leaders spent significant time in meetings, attending training and facilitating training. We reviewed the last 3 team meeting minutes and found that the ward manager did not attend the meetings.

Managers worked directly with people and led by example. We observed that the ward manager knew people well and explained to people CQC's presence on the ward.

Vision and strategy

Staff knew and understood the provider's vision and values and how to apply them in the work of their team. The acronym used for the values was KITE: Kindness, Integrity, Teamwork and Excellence. Staff were aware of this.

Requires Improvement

Wards for people with learning disabilities or autism

The provider had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible. The welcome pack explained that the service's goal was to support people through their rehabilitation process.

Managers were developing a culture that valued reflection, learning and improvement. They were receptive to challenge and welcomed fresh perspectives.

Culture

Staff did not always feel respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. Staff felt there was a disconnect between senior leaders and the ward-based staff, it seemed that senior leaders focused on the negatives and staff felt they made decisions about people they did not know. Staff would welcome more presence and support from senior leaders.

The provider invested in staff by providing them with quality training to meet the needs of all people using the service. Staff said the training was very good and they had been given the opportunity to attend the autism show and the autism bus to increase their knowledge of autism and how to support autistic people. Staff training compliance levels were high with over 90% completion.

Staff felt able to raise concerns with managers without fear of what might happen as a result. We saw staff approaching the ward manager and charge nurses for support.

Staff did not always feel respected, supported and valued by senior staff, staff said senior leaders were not that visible on the ward and because the ward was quite settled, staff could be asked to support other wards, we saw staff having to respond to alarms from other wards and they did not always know how best to support the people on the other ward they were responding to. We saw staff trying to manage competing demands with attending meetings, responding to people's requests, completing documentation and demands from staff across the service.

Governance

Governance processes were not effective and did not always help to hold staff to account, keep people safe, protect their rights or provide good quality care and support. Although audits and records had been completed, we were not assured about their accuracy, for example the IT room was dirty with marks on the walls and the cleaning record showed the room had been cleaned.

Documentation had been removed prior to December which meant there was no access to complaints information, observation records and community meeting minutes, this did not allow for comparison of data or review of progress or previous topics discussed for people at the community meeting.

We were told one-page profiles were in place for each person and were stored in a file for staff to read, however this could not be located.

Governance processes did not ensure the service was meeting Schedule 3 of the Health and Social Care Act Regulated Activities Regulations 2014. We reviewed 2 staff files, they did not include evidence of qualifications and did not include a full employment history including gaps. We were sent a spreadsheet following the inspection which was used to monitor the renewal of registration for professionals required to be registered with a regulator, this did not include the

date for renewal or check for General Medical Council. The spreadsheet did not include all of the requirements of Schedule 3, for example references, health screening or full work history. This meant the service could not be assured that staff they recruited were fit and proper as there was no oversight of staff records and the records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The team meetings did not have a standard agenda and feedback from incidents, compliments and complaints was not routinely shared, we reviewed minutes and found that people in the service were discussed and in 2 meetings staff wellbeing was discussed, another meeting also included audits, restrictive interventions, safeguarding, and activities. This meant ward-based staff were not receiving regular consistent updates.

The provider kept up to date with national policy to inform improvements to the service. The ward manager and responsible clinician were working towards applying for the Royal College of Psychiatrists' Standards for Acute Inpatient Services for Working Age Adults (AIMS)and National Autistic Society accreditations.

Staff used recognised audit and improvement tools to good effect, which resulted in people achieving good outcomes. The service used the HONOS-LD (Health of the Nation
Outcome Scale for people with a learning disability), care plans were goal focused, which were reviewed in the ward rounds.

Staff did clinical audit, benchmarking and quality improvement work to understand and improve the quality and effectiveness of care. Audits took place in relation to health and safety, the environment, files and compliance with the Mental Health Act.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care or use that information to good effect. One-page profiles were not available. The observation file, which agency staff were reliant on to know how to support people, only included information for 4 out of the 11 people on the ward, this meant information was not easily accessible for people. The patient 'at a glance' board in the ward manager's office was out of date with details of a person that had been discharged and the same search arrangements for everyone, however they were becoming more personalised. This meant staff could be more restrictive than necessary with people.

Staff were committed to reviewing people's care and support continually to ensure it remained appropriate as people's needs and wishes changed. Regular ward rounds and Care Programme Approach meetings took place. We saw people, their relatives, commissioners and community teams were involved in these meetings.

We reviewed senior managers meetings where searching was discussed, Cedar ward was noted to be doing routine searches in July 2023 and this was actioned to be reviewed and discussed at the next meeting. We reviewed the following meeting's minutes and found it was not discussed there. This meant actions were not always being followed up.

Senior staff understood and demonstrated compliance with regulatory and legislative requirements. Notifications were submitted from the service and the responsible clinician understood the process to request a Second Opinion Appointed Doctor to review the prescribing arrangements for people who could not consent to their treatment.

Regular staff were able to explain their role in respect of individual people without having to refer to documentation. They gave good quality support.

Staff did not always act in line with best practice, policies and procedures. Staff were not bare below the elbow and did not follow the dress code policy.

Information management

Staff collected and analysed data about outcomes and performance and engaged in local and national quality improvement activities. Ward managers and senior leaders had access to a variety of dashboards and reports which showed their performance. Information about staffing, incidents, complaints, compliments, and changes in people at the service were discussed at the morning meeting with senior staff, ward managers and members of the multidisciplinary team.

Engagement

People and those important to them worked with managers and staff to develop and improve the service. People could give individual feedback at their ward rounds and Care Programme Approach reviews. People at a ward level shared their views and ideas at the community meetings and people contributed to feedback at a hospital level at the people's forum meetings.

Staff encouraged people to be involved in the development of the service. This was through the people's forum meetings.

The provider sought feedback from people and those important to them and used the feedback to develop the service. Feedback questionnaires were distributed however these were collated at a hospital level and were not able to be filtered to a ward level. This meant it was difficult to know which ward the feedback was relevant to.

The service worked well in partnership with advocacy organisations/other health and social care organisations, which helped to give people using the service a voice/improve their health and life outcomes. The advocate visited the ward and people told us they had access to the service. The service linked with community opportunities for people including voluntary work opportunities and college courses which several people from the ward accessed.

Staff engaged in local and national quality improvement activities. The service was moving towards using the national Patient Safety Incident Response Framework and the updates were discussed at the senior managers' meetings. The ward manager alongside the practice development nurse facilitated a training session to colleagues on positive behavioural support.

Learning, continuous improvement and innovation

The provider kept up-to-date with national policy to inform improvements to the service. Updates were discussed in senior managers' meetings.

The provider did not invest sufficiently in the service, embracing change and delivering improvements. The ward needed updating, the work on the drinks area had not been completed, painting, decorating and maintenance was required in the communal bathroom. Storage solutions needed to be explored due to the excessive amount of items in the IT room. The meeting room was not conducive for ward rounds, with a small table and not enough chairs. This meant the ward did not provide the best environment for people to recover.

The provider had a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible. This was within the welcome booklet and focused on people reaching their potential, we saw people making progress in their individual journeys with 1 person ready for discharge to a community placement.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Is the service safe?

Requires Improvement

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

Safe and clean care environments

Patients were cared for in wards that were mostly safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Twice daily walk arounds were completed by staff to review health, safety, and environmental standards on the ward. Risk assessments of the environment were updated regularly.

Staff could not observe patients in all parts of the ward due to the layout. Staff carried out hourly observations or patients were monitored more frequently or continuously supervised by staff, dependent upon individual risk. Communal areas including bedroom corridors were covered by close circuit television (CCTV), which was not constantly monitored by staff, but could provide information if accidents or serious incidents occurred.

The wards were three female wards and one male ward and complied with guidance on mixed-sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. A current environmental and ligature risk assessment was in place. Beech, Elm, and Fir wards had a security nurse who monitored ligature points within the wards and some areas of the wards were locked to prevent unsupervised access to them.

Staff had their own personal alarms, there were nurse call alarms located in each bedroom.

Maintenance, cleanliness and infection control

The ward areas were clean, furnished and fit for purpose. However, the décor of the wards was tired in appearance with areas of bare filler or plaster where repairs has been made. On Ash ward we saw bedroom doors with flaking paint. On Ash ward we saw staff coats and personal items were being stored in the telephone room and this room was used to store food supplements. This also contained out of date defibrillator pads and large supplies of personal care protective

items. The family room on Ash ward used had a double layered window which couldn't be cleaned and there was a collection of dirt and dead flies in it. This was raised with the provider at the time of the inspection, as we were reassured by the registered manager this would be replaced. In addition, the ceiling was stained due to a leak. On Beech ward the telephone room was being used as a staff cloak room.

Cleaning records showed the wards were cleaned daily, and we saw domestic staff cleaning the wards during the inspection.

The provider did not always take sufficient action to prevent visitors from catching and spreading infections. There was antimicrobial hand sanitiser at the ward entrance to every ward, however, we did not see any staff who escorted us around the site and to and from wards using this. We did not see staff were bare below the elbow, we observed staff wearing jewellery, long sleeved clothing and hoodies on the wards. The provider dress code policy stated, '12 CORONORVIRUS ALL clinical and ward-based staff should be bare from the elbows down. This included no arm jewellery, watches, or rings (weeding bands only could be worn)'. Therefore, staff were not taking action to reduce the risk of the speard of infection as required by the provider policy.

The provoder infection and control policy was up to date and included information on how to respond to outbreaks. Staff training complianceon infection control was 98%. However, in the ward bathroom on Ash ward we found a dirty bowl left in the bathroom after a patient had a wash.

Seclusion room

Beech ward seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. The low stimulation area adjacent to the seclusion room had a safety pod. This was essentially a bean bag that supported safe care of patients during times where de-escalation and restraint was considered. This helped the patients' body maintain a safe body shape and reduce the risk of injury. This could be supplemented by weighted blankets, to provide comfort to patients and was used as an alternative to seclusion. Elm ward had a low stimulation area.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Staff recorded and audited records for cleaning, medicines, temperature monitoring, waste, and medicines disposal. There was clinical equipment necessary for care and treatment available and was maintained. However, we could not find records on any of the wards to clarify that digital equipment for monitoring national early warning scores (temperature, blood pressure and oxygen saturation) were calibrated to make sure readings were accurate. On Ash ward, we found the blood glucose monitoring device was not listed on the 'devices list' for checking its functionality. Sharps bins were not dated when opened and medicines disposal bin was full to overflowing.

Safe staffing

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Nursing staff

The service had enough nursing and support staff to keep patients safe. The staffing levels each day were one qualitied nurse and two healthcare support workers during the day and one qualified nurse and one healthcare support worker at night.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift. Senior managers told us agency staff completed a provider induction on site before they were allowed to work with patients. This included an optional monthly reflective practice session, which was either face to face or via Teams. Between 1 June and 30 November 2023 Ash and Beech wards used 5% of agency and 23% bank staff for registered nurses and health care assistants (HCA). Elm ward used 33% agency and 16% bank staff and Fir ward 2% agency and 24% bank staff. Safe staffing levels were recorded at 100%.

The service had low sickness rates. Sickness rates from 01 December 2022 to 30 November 2023 were Ash 4%, Beech 6%, Elm 2%, and Fir 8%.

The provider had reducing turnover rates. The staff turnover rate for the whole service was 33%. The number of permanent staff across the whole service was 211 on 01 December 2022. On 30 November 2023 the total number of permanent staff was 221. Beech ward had a 0.5 whole time equivalent (WTE) registered nurse vacancy and 2.5 WTE HCA vacancies. Elm ward had 6 HCA vacancies and Fir ward a 0.5 WTE registered nurse vacancy and 4 WTE HCA vacancies. A WTE registered nurse and 7 WTE HCAs (Health Care Assistants) had been recruited.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Staffing levels were reviewed at the daily safety huddle meeting and additional staff could be brought in dependent upon the levels of acuity and risk on each ward.

Patients told us they believed there was enough staff on the ward for them and leave was, or appointments were not cancelled due to staffing. We saw patients use unescorted leave.

The main issue raised by patients was the quality of the agency staff used. Patients told us agency staff did not always engage with them and there were cultural barriers related to the agency staff country of origin. Because of the irregularity of working with familiar agency staff patients told us they did not form a supportive relationship.

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

Patients had regular one-to-one sessions with their named nurse. In patients' records we reviewed we noted there was regular named nurse, health care assistant, therapy, and recovery staff sessions. These included details of patient involvement in planning activities, leave and care plans.

Medical staff

The provider had enough daytime and nighttime medical staff cover and a doctor available in an emergency.

The consultants were contracted with the provider organisation. The hospital had four full-time consultants employed and they were on site at least four days a week, which included the multidisciplinary team (MDT) meetings. There was always consultant cover at the service. Out of hours support was available through the regional on call roster for the psychiatrists employed by the provider organisation.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

In a physical health emergency, staff would call 999 or take the person to hospital. All patients were registered with a GP, who provided an onsite clinic for their physical healthcare needs.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The provider had a compliance rate of 97% completion for Ash and Beech wards, 97% for Elm ward and 95% for Fir ward.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training included managing conflict and management of physical intervention training, as well as breakaway training and de-escalation techniques. Training included autism and learning disability awareness.

Staff had received basic life support with a 98% training completion rate and immediate life support training with a 93% training completion rate.

Managers monitored mandatory training and alerted staff when they needed to update this.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves effectively. Otherwise patients were admitted to the service Staff 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

The provider admitted patients safely to the service. Admissions were planned and assessments took place by staff, including a memebrof the multidisciplinary team (MDT) prior to admission, using a recognised tool, and reviewed this regularly, including after any incident. All patients had a detailed risk assessment in place which clearly identified all risks and had a clear risk management plan to mitigate risks. Risk assessment were not usually written in plain English that could be understtod by patients.

Upon referral to the service, the MDT reviewed the current risk assessment along with occupational therapy assessments and psychology assessments. These assessments were reviewed to determine if the provider could meet the needs of the patient and an MDT decision was made to agree the suitability of a referral.

Management of patient risk

Staff knew about any risks to each person and acted to prevent or reduce risks. The care records identified each person's risks and staff we spoke with knew the person well. Staff said they could keep up to date with any changes to risk as ward managers attended daily safety huddles and this information was shared at ward-based handover. In addition, handover notes and risk assessments were available to staff. On Ash ward two of the five care records we reviewed did not have a personal emergency evacuation plan (PEEP) a plan used for individuals who may have difficulties evacuating a building to a place of safety without support or assistance from others. We did not see information to show these two patients had been assessed to identify if they required such assistance in an emergency, but patients were admitted safely.

Where a patient had a significant risk of violence this was identified in the historical, clinical and risk management

Staff identified and responded to any changes in risks to, or posed by, patients. We saw agency staff were provided with records to document patients were being observed at required intervals or supervised by a staff member and recorded observations levels within the organisation policy. Agency staff were not provided with a physical copy of risk assessments so they could refer to individual patient risk.

All staff we spoke with told us how they would identify and respond to any changes in risks to, or posed by, patients, for example, the personal alarms could alert staff to another staff member requiring assistance. The wards had a radio to contact other wards for assistance in a medical or mental health emergency.

Staff followed procedures to minimise risks where they could not easily observe patients. Patients were placed on observation levels decided by the medical and clinical staff. The provider had an observation policy which set out the minimum levels of observation, which was agreed for each patient.

Use of restrictive interventions

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. Patient care records demonstrated staff clearly attempted de-escalation and distraction techniques with patients during incidents to good effect. Staff we spoke with understood patient triggers and were aware of personalised distraction and de-escalation techniques for each person.

We saw good examples of advanced decisions and positive behaviour support plans that included patient involvement and decisions around the use of restrictive practices and how these were managed.

Staff understood the Mental Capacity Act definition of restraint and worked within it. We saw patient records and positive behaviour support plans had individual guidance around the use of restraint within patient plans. This linked to the organisational description and guidance around the types of restraint that should not be used, for example, face down restraint.

Staff followed the national institute for clinical and health excellence (NICE) guidance when using rapid tranquilisation to monitor patients' health after they had been given medicine to rapidly clam their distress. There was a provider policy and procedure on the use of rapid tranquilisation. On our checks of the clinic rooms, we saw staff had access to equipment to monitor patients, post rapid tranquilisation.

The service was considered a high-risk environment, with seclusion services on site. When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. At the time of the inspection no one was placed in seclusion. The ward staff participated in the provider's restrictive interventions reduction programme.

The provider had reduced the use of rapid tranquilisation since December 2021. We found the physical health monitoring after administration did not always comply with the procedure in the rapid tranquilisation policy. This issue had already been raised in the medicines management meeting and work was ongoing to educate staff.

Staff followed organisational policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. However, we sought additional clarity on the use of searching patients from consultant psychiatrists, the registered manager and ward managers. For example, on Elm ward we saw patients were being searched on return from leave. On Ash ward patient rooms were searched every three months as this was organisational policy, yet the patients due to their mental health, did not pose a risk requiring their bedrooms to be searched. We were informed this decision would be removed from the risk-based audit for Ash ward.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients were made aware of the search policy at the service prior to admission. Feedback from patients was the searching of them was too restrictive, inconsistent, and excessive. The search randomiser button located at the entrance to each ward was used to decide if patients were searched on returning to the ward from leave. The local policy protocol described the process as patients being searched on a 'truly random bases. The local policy described the randomiser could be set from 0.5% to 99.9%. And the percentage of searches carried out would be decided by the ward MDT. However, ward managers on Beech and Elm ward described different levels of percentages for these wards. The beech ward manager described a 30% chance of being searched and the Elm ward manager 80%. There was no consistent application of the local policy.

The local policy described the process where the patient pressed a large red button on the randomiser on return to the ward. The light presented as green or red. Presenting as green meant no search, and if red a personal search was necessary. This could be a rub down or metal detector or both types of search dependant on the individual risk assessment for each person and parameters agreed for leave. The parameters for individual patient searches were determined by the search frequency risk assessment agreed by the multidisciplinary team.

The local policy explained the process of using the search randomiser would not be carried out if the staff member has reasonable suspicion, through observation or information received the patient was not in possession of a high risk, illegal or unauthorised items. If staff had a reasonable suspicion, then an appropriate search would be carried out with the correct level of authorisation and accompanying documentation completed in line with the local and provider search policies.

In related care records we noted one person on Elm ward was searched five times in one month when returning from leave. Their care records specified if the person refused to cooperate with the search they could be taken to a private area, isolated and searched under restraint. We observed a person on Beech ward who had returned from leave agreeing for their belongings to be searched, the person told us they agreed to this because it was part of the search practice within the service. The local policy explained patients would be asked to use the randomiser, should they consent to this then the process for searching would be followed. The searches were risk led, however, patients told us they were overly restrictive when Elm ward was identified as caring for patients in a less restrictive environment due to patients having fewer complex needs and risk to self and others.

In response to patient concerns about the use of restrictive practices raised in MDT meetings, community and quality meetings about restrictions being unclear, too many and inconsistently applied, the provider shared details on a project that had been completed with patients by the lead psychologist. This included reflective practice sessions with staff. The psychologist gathered further patient and staff views, focusing on Elm ward, and put together a draft, for the medical director and consultant psychiatrist for the female service wards. The guidelines were reviewed in various settings, forums, and meetings. Patient feedback was incorporated into the final version, which was only recently shared via MDT's, ward community meetings and other patient and family forums. Easy read versions and posters were made. Due to the recent role out of this guidance a review will be completed six months after implementation.

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. Staff kept up to date with safeguarding adults and children training. Staff had received additional face to face training provided by the local authority.

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

Staff knew how to recognise adults and children at risk of or experiencing harm and worked with other agencies to protect them. The provider and local authority held monthly safeguarding review meetings to discuss referrals, outcomes and agreed actions or action plans. Monthly meetings were supplemented by weekly telephone calls with the local authority safeguarding team to discuss incidents and potential referrals.

Staff followed clear procedures to keep children visiting the ward safe. There were safeguarding policies for adults and children in place and guidance that staff could access.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider had a contact at the local authority who could assist if they had questions around a safeguarding referral.

Staff access to essential information

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

Patient notes were detailed, and all staff could access them easily. The provider had an electronic patient record system that clearly documented each person's journey and any changes to risks and plans.

The electronic patient record system was password protected and could only be accessed by staff from the service. Records were stored securely.

Medicines management

The provider generally used systems and processes to safely prescribe, administer, record and store medicines. Staff generally reviewed the effects of medications on each patients' mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely, but on one ward, blood glucose readings were found not to be recorded consistently. One care plan stated blood glucose readings were to be done 5 times a day via the medicine monitoring system. Recording of blood glucose readings on the electronic system did not always show this had taken place. On one ward patients were queuing to have their medicines administered outside of a clinic room on a main corridor. We observed this as lunch was being served in the dining room and the clinic room stable door was open. We discussed this practice with a nurse who advised this was common practice on the ward. We asked why patients medicines were not administered in private. The nurse said the clinic room would be too much of a risk due to the space allowed and access to items that could cause harm. We were told patients could have medicines in the privacy of their bedroom.

Staff reviewed each person's medicines regularly and provided advice to patients and care staff about their medicines. For one person, bowel monitoring was being recorded, but there was no evidence in the care plan or prescribing documents about when to administer medicines to relieve constipation. This meant there was a risk that laxatives were not being given consistently. For one person receiving medicines covertly (hidden in food or drink), we found there was a detailed care plan and appropriate advice had been sought from a pharmacist to enable this to be administered safely.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff did not always complete medicines records accurately; we were told on one ward that thickening agents (powder added to patient drinks when at risk of choking) were not always recorded when a thickening agent had been used. Therefore, we could not be sure every drink had been thickened as prescribed.

We were told there was no recorded process in place for the rotation of pain patches. Therefore, there was a risk patches would not be applied and rotated as per manufacturers guidelines.

Staff generally stored and managed all medicines and prescribing documents safely. On one ward we found 2 bottles of eye drops, 1 bottle was out of date and the other bottle did not have the date of opening so we could not be sure when this was opened. We found a cream with a date opened but no label to say which patient this was for.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. On admission patient medicines were reconciled by the doctor admitting the person. Staff had access to patient electronic records to check on their prescribed medicines when transferring between wards.

Staff learned from safety alerts and incidents to improve practice.

The provider ensured patient behaviour was not controlled by excessive and inappropriate use of medicines. There had been a reduction in the use of rapid tranquilisation across the service for 2023

Staff reviewed the effects of each patient's medicines on their physical health according to the Nice guidance. There was a physical health lead nurse and monthly physical health monitoring meeting. Meeting minutes for October 2023 recorded diabetic patients were having podiatrist visits. Testing kits for bowel cancer were provided and cervical smear tests were being carried out on site. Patients with a high body mass index (BMI) continued to be monitored. The December 2023 meeting we observed, discussed NICE guidance on reducing the risk of hospital acquired venous thromboembolism (VTE), a condition that occurred when a blood clot formed in a vein. The NICE guidance made specific recommendations for patients with psychiatric illness, specifically the recommendation that all patients admitted to a psychiatric hospital were assessed for risk of VTE and thromboprophylaxis was prescribed where needed. These discussions were an ongoing theme of these meetings.

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 provider had been an early adopter in the use of the patient safety incident response framework (PSIRF). This framework was used for responding to patient safety incidents for the purpose of learning and improving patient safety. There were key aims regarding patient safety incidents, which included compassionate engagement and involvement of those affected. A system-based approach to learning, considered proportionate responses and supportive oversight focused on strengthening response and improvement. We had already received a serious incident reported through this framework and the provider was in the process of investigating, learning, and developing an action plan. Thirteen incident reported related to the wards, with one being investigated through PSIRF.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff knew what incidents to report and how to report them. Staff were aware to report any incident that appeared untoward and could give clear examples of issues they would report. Staff knew how to use the provider incident reporting system and what information was relevant to include. Staff informed us all staff had the responsibility to report incidents and staff member involved or who witnessed the incident should complete the incident report. Agency staff informed us they would report any incidents to the registered nurse or senior manager on the ward and they would complete an incident report.

Staff understood the providers policy on being open and transparent with patients, called the duty of candour. They were open, transparent and gave patients and families a full explanation if things went wrong. The provider had a duty of candour policy in place that staff could access.

Managers would debrief and support staff after any serious incident. Staff were supported through reflective practice sessions held with groups or individual staff. This included the psychologist being involved in formulation of support plans for staff. The physical interventions policy outlined support was available to staff, patients, families, and carers. Serious incidents were reviewed by the service manager and registered manager and at daily safety huddles.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The meetings with the local authority safeguarding team included safeguarding incidents and action plan progress.

There were evidence changes made due to patient feedback. Feedback about over the counter medicines being brought into the service by a family were discussed and shared across the three different services.

Managers shared learning with their staff about serious incidents called 'never events' that happened elsewhere. Feedback was shared with staff in team meetings or, if deemed urgent, during safety huddles and ward handover. The provider shared and reviewed its processes were lessons from deaths in other provider organisations were highlighted. For example, patients ordering items from the internet were encouraged to open them in the presence of staff, in case they contained hazardous substances or items. This was following the death of a person in another independent service when the patient died by inhalation of a toxic substance.

Is the service effective?

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Pre-admission assessments were completed by members of the multidisciplinary team, we saw these were detailed and comprehensive.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The patient would undergo a physical health check by the physical health lead or medial staff within 48 hours of admission. Staff discussed the results in multi-disciplinary meetings and used them to inform care plans and make referrals to more specialist services if required.

The provider had access to laboratories testing of blood samples, so could receive blood test results back quickly.

The provider had a physical health lead who carried out and co-ordinated the physical health checks. In addition, there was a monthly physical health meeting consisting of the lead medical and clinical staff, and ward managers. Patients were referred for eye and hearing tests via their GP, who attended weekly or as needed, as well as a local dentist, podiatrist, and optician services.

On Ash ward mobility reviews were regularly completed as part of occupational therapist (OT) clinic., Falls and mobility care plans were reviewed during ward rounds and by a patient's named nurse.

The nursing team highlighted any concerns to MDT/OT and a review took place. For patients with complex mobility issues, a private physiotherapist reviewed and prescribed equipment and exercises. These were then supported by both OT/OT assistant and ward-based staff.

On admission the OT and MDT completed a baseline falls risk assessment and a person handling assessment. This highlighted patient baseline functions and was reviewed in line with community mental health reviews and could be adjusted should there be a significant decline or improvement with mobility. Reviews were reflected in patient care plans.

Patient care plans were goal orientated and individualised. Care plans we reviewed showed evidence of active patient involvement; they were holistic, and recovery orientated. Care plans reviewed were recovery based and promoted independence. The identified activities and occupational interventions were tailored to meet the individual patient needs. We saw a good example of a positive behaviour support plan for a patient, which was completed in an easy read format and guided staff on how to respond and support one person move back into community living. However, there were examples of the care plans using medical language, which was not in keeping with plain English language. Three patients we spoke with told us they had copies of their care plans but did not agree with the words used. One person told us they had written their own care plan using their own words, but this had not been used. Patients told us care plans could be more support focused and include activities they would like to be more involved in if the wards had ward-based facilities to support them. For example, cooking facilities and ward based vocational skills and/or opportunities and access to ward-based education.

Staff regularly reviewed and updated care plans when patient needs changed. All the records we reviewed included current, recently reviewed documentation. Care plans were recovery focused and reviewed with individuals in their ward rounds.

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 supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They participated in clinical audit, but benchmarking and quality improvement initiatives around the service model could be improved.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

We assessed the effectiveness of the current model of care based on our observations, care records, risk management, patient engagement and the use of restrictive practice. We requested additional clarification on the model of care relating to the referral inclusion and exclusion criteria to the service and for each ward. This was due to the level of risk identified with each ward and level of security and restriction on each ward.

Prior to the inspection we met with the registered manager as part of our monitoring programme. We were informed the care pathway for the rehabilitation service was being reviewed. This included each ward having a specific role to support females with complex needs. We were provided with information on the revised clinical model which described the service as a specialist inpatient care for women with complex mental health and emotional needs who required inpatient admission due to significant risks associated with their condition.

The MDT researched other models of care, for example, the Royal College of Psychiatry service tiers, NICE guidance, and Care Quality Commission brief service guides. The research supported the provider in identifying patients admitted who usually had a diagnosis of personality disorder and/or severe mental illness and their needs were not readily met in a general psychiatry service including acute inpatient units, community mental health teams or community personality disorder services. The providers main source of referrals was from acute psychiatric inpatient units, psychiatric intensive care units (PICUs), forensic services, and patients had previously had cycles of admissions to these services.

The model had been refined to continue to provide in-depth psychological treatment addressing underlying difficulties and sustaining long-term changes. This involved trauma-focused interventions and emotional and relational difficulties. Treatment was aimed at between 18 months and 24 months and care being more community focused and involve transfer to the lower dependency rehabilitation focussed ward, or discharged directly back to the community. The admission criteria for the women's service were reviewed so referrals were for women requiring treatment in a locked inpatient setting due to risk, were diagnosed with a personality disorder with or without co-morbid mental illness and neurodevelopmental disorders and severe mental illness. This included patients with complex emotional needs and risks and who were detained under the Mental Health Act at the point of admission, but the section could be terminated and patient free to leave the service. The referral exclusion criteria was clear for commissioners in explaining the patients who were not suitable for the service.

The model included safety at the point of admission, where patients assessed had a high risk of self-harm and required support to maintain their safety and may not be ready to assume responsibility for their safety. This explained restrictions were used responsibly to maintain safety or security and reviewed them in community meetings and in individual care planning meetings with patients, so decisions around restrictive practices were fair and transparent and made with patients. This model had not been signed off at the time of the inspection and the registered manager and medical director agreed the provider statement of purpose would be amended and sent to the Care Quality Commission once it had been agreed.

The team delivered person centred recovery focused care, treatment pathways and plans were identified as early as practicable. These were based upon a formulation of individual person's needs. As the provider aimed to reduce length the of stay where possible, discharge planning was already in consideration at pre-admission. On admission patients would start setting their goals which supported patients to be aware of what they needed to do in order to achieve their goals for recovery. All care pathways, led by the MDT, were holistically focused to ensure all aspects of health were catered for.

The model of the male service was described as a high dependency service for patients who would need longer term and or end of life care, but this needed further clarification from the medical director and registered manager, both who agreed this was not a rehabilitation service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Support was from the MDT, occupational therapist, psychologists and speech and language therapist and dietician. A physiotherapist was available through a contract arrangement. Staff told us and records showed patients were being supported by the psychology team for anxiety, risk management, social skills, relationship support and family therapy. . Each person had an occupational therapy assessment in place, which identified the needs of patients as well as their interests. Patients were able to engage in life skills and education and supported to access social, cultural and leisure activities such as attending the local gym, swimming, and local groups. In addition, recovery staff led activities outside of the service including walking and cycling groups. Staff delivered care in line with good practice and NICE. The occupational therapist used recognised assessments tools such as the Model of Human Occupation Screening Tool and the recovery Support Time and Recovery.

Staff provided a range of care and treatment suitable for the patient in the service. Patients received individualised treatment, interventions, and practical support to aid with their recovery. Patients were able to access Dialectical Behaviour Therapy and Cognitive Behavioural Therapy.

At the time of the inspection 93% of the women on the female care pathway had engaged in psychological therapies and 100% have engaged at some point during their admission to Gateway. Seventy three percent of these patients continued to engage in trauma treatment, with over 50% of females having had 2 or more therapists involved, and had more than one session per week.

On the male service, 74% of male patients had engaged in psychological therapies at the time of inspection, and this included Ash ward. Across all the services at the hospital approximately 30% had a diagnosis of a learning disability and/or autism and therapies were adapted to meet the needs of these patients, including a speech and language therapist and positive behaviour support practitioner who were involved supporting these patients.

Reflective practice and formulation sessions with ward staff were facilitated by the psychology team. In the three months prior to the inspection there had been 16 sessions of reflective practice/formulation sessions, across the hospital.

Staff identified patient physical health needs and recorded them in their care plans. The service had a physical healthcare lead who coordinated physical health monitoring for the service. This included monthly observations and annual health checks, and made sure patients had access to physical health care including any specialists required.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The provider had links to smoking cessation, a healthy diet, physical activity, weight loss, well-being, and addiction support provided by the local council. The dietician provided advice and guidance on healthy eating.

Staff used recognised rating scales to assess and record the severity of patient symptoms, and the outcomes of treatment. This included the Health of the Nation Outcome Scales . Other ratings scales and tools were used to monitor patient progress included the CORE-10 (a short screening tool used to quickly review a patients or to monitor progress between sessions), the Generalised Anxiety Disorder-7 scale, and the Patient Health Questionnaire-9 tool for monitoring the severity of depression and anxiety.

Staff were using digital technology to monitor patient physical health.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Skilled staff to deliver care

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

he provider had a full range of specialists to meet the needs of the patient on the wards. The provider had a consultant psychiatrist five days a week and on call arrangements for out of hours cover. Psychologist and occupational therapist support was arranged on an individual basis. The psychologist team included a family therapist and family link worker, who bridged the gap between patient and families. The occupational therapist was supported by ward-based staff who were supported by recovery workers to enable patient recovery. In addition, there were therapy staff to support patient access to the onsite facilities.

There was a physical health lead along with nursing and healthcare support workers. In addition, there was a speech and language therapist, dietician, and a physiotherapist available to patients.

Staff supported ward administrative functions.

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

Managers supported staff through regular, constructive appraisals of their work.

The managerial supervision guidance stated staff should receive supervision every four to six weeks. We reviewed nine staff supervision files and found five staff were receiving supervision within the expected frequency. Four staff on Ash ward did not have supervision within the four-to-six-week timescales and several months gaps in one registered nurse records. This was fed back to the provider at the time of our inspection and the registered manager clarified they would discuss this with the relevant ward manager.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge along with access to any specialist training for their role. Staff had received specialist training in autism and could request additional training they believed to be appropriate for their role.

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 MDT meetings to discuss patients and improve their care. Meetings were held weekly for patients, and all staff relevant to the patient's care would attend. Other specialists would be invited to the meeting when required, such as social workers, care co-ordinators and family would be invited.

Staff made sure they shared clear information about patients and any changes in their care, including during daily safety huddles and ward-based handover meetings.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Ward staff had effective working relationships with other teams in the organisation. Ward managers or charge nurses attended the daily safety huddle and monthly medicines and physical health meetings. In addition, the psychologist team provided support to help staff formulate risk management and care and treatment plans, as well as reflective practice meetings.

Ward staff had effective working relationships with external teams and organisations. For example, voluntary organisations and the local authority safeguarding team.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Training compliance for the Mental Health act was at 100%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff requested an opinion from a Second Opinion Appointed Doctor when they needed to.

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

Information about how to access an independent mental health advocate was available to all patients on the information boards on each ward.

Staff explained to each person their rights under the Mental Health Act in a way they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. All records we reviewed had evidence of patients being informed of their rights.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician. Physical copies of section 17 leave forms were kept in the office along with a recording sheet and log, this enabled staff to track how much leave the patient had taken. Patients told us they were always able to take their leave. Photographs of patients were stored within the patient electronic notes. A description of the clothing patients wore was taken before they went on leave, so a full and accurate description of the patient could be given should it be necessary.

Staff stored copies of patient detention papers and associated records correctly and staff could access them when needed. The provider used an electronic records system, although they kept a physical file for staff with information on the patient's Mental Health Act status.

Informal patients knew they could leave the ward freely and staff informed us they would regularly remind informal patients of their right to leave the ward. However, this was complicated by the level of onsite security, so patients were reliant upon staff to exit each ward and the secure entrance to the main reception.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers and staff made sure they applied the Mental Health Act correctly by completing audits and discussing the findings. The provider completed self-audits monthly, as well as an annual audit from the provider regional Mental Health Act administration team and an annual peer audit by another provider location.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. All staff we spoke with had a clear understanding of the Mental Capacity Act.

All patient records reviewed showed evidence of consideration of capacity and assessments of capacity, where required. The provider had a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. There were no Deprivation of Liberty Safeguards applications made in the last 12 months.

Staff on Ash ward gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

Is the service caring?

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They usually respected patients' privacy and dignity, though on Ash ward we saw examples when patient's privacy and dignity was not protected. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were not always discreet, respectful, and responsive when caring for patients. On Ash ward we saw a person being assisted to the toilet and the staff member did not close the door. The staff member could be seen supporting the patient to stand while the person was in a state of undress. This matter was raised with the registered manager who clarified the staff member could not close the door as they were holding onto the patient. We observed the staff member had time to close the door before assisting the person.

We spoke with 16 patients, who said regular staff were respectful and there for them. Patients said they did not like being supervised by male agency staff, who they had nothing in common with and did not attempt to talk or socialise with them. Patients had raised concerns about male agency workers speaking to one another in their first language and not using English, so patients were excluded from conversations.

Staff gave patients help, emotional support and advice when they needed it. We were told all requested support was given, and staff were always available.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us they were involved in their treatment and took an active role in care plan preparation. One patient spoke of how staff would talk with them about medicine issues if raised during medicine rounds.

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

Patients said regular staff, which include regular bank and agency staff, treated them well and were kind.

Staff understood and respected the individual needs of each person. Each patient we spoke with felt they were in the right place and were receiving the right treatment but may not agree with being detained under the Mental health Act.

Staff felt they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients. The culture allowed for easy reporting, but none of the patients spoken with had raised any such concerns. We observed staff on Ash ward being racially abused and staff responded to this respectfully and appropriately in reminding patients about the use of discriminatory language.

Staff usually followed policy to keep patient information confidential. However, one patient had confidential information on display outside of their bedroom. Staff explained this was legacy information when neighbouring bedrooms were not occupied, these bedrooms were now occupied so could see this confidential information. This was fed back to the provider and the information removed.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients we spoke with told us they had been supported to familiarise themselves with ward facilities on admission or as soon as they were well enough to do so. A patient told us they still had their introduction pack in the drawer and knew what the service had to offer.

Staff involved patients and gave them access to their care plan and risk assessments. Patients we spoke with told us of their active role in their care planning, however, they did not always see care plans written using plain English. We saw examples of patients helping to identify treatment which benefited them and setting specific, measurable, achievable, relevant, and time-bound objectives, and agreeing the support and actions required to achieve them. Care records demonstrated patients had been offered copies of their care plans and relevant documentation, and if they wanted to keep a personal copy.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Patients told us they were involved in their care planning, though the use of clinical language made it harder for them to understand some of the process and information given to them.

Staff involved patients in decisions about the service, when appropriate. We observed a community meeting, with patients being listened to. We observed patients were able to provide their feedback on areas they identified for

improvement. Patients could provide feedback or raise concerns during weekly community meetings and completed patient exit surveys. Patients we spoke with told us they would raise issues with staff when they came up. The wards had a 'you said, we did' boards which detailed changes that had been made following patient feedback. Actions included a review of the e-cigarette protocol and the replacement of cups.

Patients could give feedback on the service and their treatment with staff supporting them to do this. The introduction pack and the community meetings directed patient to be able to give feedback.

Staff made sure patients could access advocacy services. Patients were familiar with the advocate who supported each ward. In addition, patients detained under the Mental Health Act had access to an independent Mental Health Act advocate.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families or carers. Patients told us their families were involved in their care. One patient spoke about the psychologist involving them and their family in family therapy sessions and the positive impact this had.

We observed a patient forum meeting, present were patient representatives and staff from each ward. The main issues discussed were healthy foods and feedback given on the quality of the menu. Smoking on escorted leave, as patients were not allowed to smoke, as detailed on leave care plans. Bank and agency staff was raised, as patients complained these staff did not engage with them and referred to them by their initials or bedroom number. Cancelled leave, was raised as the providers minibus had not been available over the last three weeks, due to requiring repair and there were not enough drivers, leading to cancelled recovery activities. Activities on Elm ward were raised as there was a reported lack of staff prepared to partake in activity between 0900 to 1700, and the activity nurse had been used for observation of patients. Patients had reported this to the ward manager but felt nothing had been done about their concern. Minutes were taken and were to be circulated to each ward as part of 'You Said, We Did' response.

We requested additional information for cancelled activities or section 17 leave during the weeks the minibus was not available. The information received recorded only 1 activity for Beech and Fir ward that was rearranged during this period.

Staff helped families to give feedback on the service. The 2023 family, friends and carers experience survey for the service had 12 respondents who gave mixed feedback. Thirty three percent of respondents agreed they received information about the service and how to get involved. Eight percent of respondents agreed they received information about issues on consent and confidentiality and 42% disagreed. Seventeen percent of respondents agreed they received information on how to provide feedback or complain and 50% disagreed with this statement. Other percentage rates were that 40% of respondents were being listened to, respected, and offered one to one time with staff. Positive feedback was received about the cleanliness and comfort of the service and being encouraged and supported to visit.

One patient? spoke about the positive aspect of family involvement, and this was always considered by the service. Another patient told us they only wanted their family to attend some clinical meetings when necessary and information was shared with their family with the patient's consent. Results were presented at hospital level which meant they were not specific to the rehabilitation service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Is the service 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' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers made sure bed occupancy did not go above 85% and had limited the number of beds on the female rehabilitation wards due to the levels of acuity. All beds were commissioned through integrated care boards, and this included patients who were placed outside of their local area.

Demand meant that referrals were triaged so patients were placed in the appropriate ward to reflect their level of need. Often the wards would be full. the provider was re-working the admission, discharge and transfer procedures used and included commissioners in the process so the transfer between service prior to discharge were clear. For example, the referral inclusion and exclusion criteria for each ward were clarified.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Length of stay was reviewed in multi-disciplinary patient reviews and captured in monthly performance reports.

Discharge planning began on admission and was carried out collaboratively with the patient and other stakeholders. Discharge and discharge plans were reviewed and updated on a regular basis. We observed an interview with a patient and saw discharge planning was considered and discussed.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the person. Staff did not move or discharge patients at night or early in the morning. Discharges and transfers were planned and took place at an agreed time. Staff supported patients when they were transferred between services. This included facilitating visits to new placements and using stepped approaches to transfers and discharges where appropriate.

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

When patients went on leave there was always a bed available when they returned. Patient admission and discharge included communication and coordination with local community services and those links remained in place.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Patients did not have to stay in hospital when they were well enough to leave. The service did not have any discharges or transfers at time of the inspection.

Staff carefully planned patient discharge and worked with care managers and coordinators to make sure this went well. The provider tried to ensure patients being discharged were given the correct support and appropriate signposting whilst in the community. Should a patient be discharged to accommodation in the community, the provider would ensure the patient had time to familiarise with the location so the discharge could be as smooth as possible.

Data provided by the service noted 50% of patients admitted to Fir ward were discharged straight back to the community. We noted in patient records indicative discharge dates were recorded, but these timescales could be delayed due to individual circumstances or reasons complicated by social care or housing.

Staff supported patients when they were referred or transferred between services. The provider followed national standards for transfer.

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 access hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each person had their own bedroom, which they could personalise, and we saw several examples of patient artwork, personal possessions, and items in bedrooms. All bedrooms had an ensuite shower. All patients had access to their bedrooms, with personal keys to secure the rooms. Patients had a secure place to store personal possessions in their rooms. In addition, there was a locked storage facility for high-risk items, however, this was locked, and patients had to request staff assistance to access this storage.

Staff used a full range of rooms and equipment to support patient care and treatment . The service was described as a rehabilitation service, and this was not consistently reflected in the space and activities available. For example, on Beech and Ash wards the telephone booths were used as staff storage facilities. On the female wards other than the dining rooms, other rooms including the bathrooms and activities rooms were locked. However, there were large lounges and separate dining facilities, quiet room, and meeting rooms. We saw artwork from patients displayed and other artwork showing relaxing scenery. Furniture was comfortable, home-like, and non-clinical in appearance, but suitable to the location.

Patients could make phone calls in private. Patients had their own mobile phone, unless they were risk assessed as not having access to a mobile phone. Each ward had a phone for patient use if they did not have a mobile phone.

The premises had an outside space that patients could access easily. Each ward had access to an enclosed courtyard, which was not overlooked. Access to garden areas were routinely locked, so patients had to rely upon staff to access additional spaces.

Patients could make their own hot drinks and snacks and were not dependent on staff. There was a kitchen area patients could use at any time. On all wards we saw there were smaller kitchens to make drinks but did not have facilities so patients could prepare their own meals. On Elm ward we saw there was a tabletop electric hob and air fryer locked in the ward managers office, described as for patient use, however, patients could not freely access this equipment. We saw the same example on Beech ward where an air fryer was stored in the staff office.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The provider offered a variety of food with a varied menu. Patient feedback was provided to staff about the quality of food. The food provided was not seen as healthy, with patients wanting to lose weight and keep healthy but felt food choices did not support this. Most patients we spoke with told us the food was good.

The premises had quiet areas and rooms where patients could meet with visitors in private.

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. The patient welcome pack included educational courses, getting involved in hobbies, interests, and volunteering. Patients told us there were lots of activities to do outside of the ward environments, some which required support from staff.

Staff helped patients to stay in contact with families and carers. It was clear family and carer involvement was encouraged and families were offered psychological support by the provider.

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

Meeting the needs of all 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 made adjustments for disabled patients and those with communication needs or other specific needs. There were adapted facilities such as accessible toilets and bathrooms for patients with mobility needs. There were staff who supported patients with physical health needs. This included bariatric equipment for patients.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The patient welcome pack contained all relevant information regarding local services and how to complain. Patients told us staff gave details of treatment and included the patient view during care planning.

The provider had information leaflets available in languages spoken by the patients and local community. Staff had access to a language service that enabled patients with limited English to be understood and to voice concerns or views.

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

There was a variety of food choices available to meet the cultural needs of individual patients. However, patients who wished to eat healthier options told us choices could be improved. Patients were actively encouraged and assisted to make their own meals, but not in the smaller ward based kitchens.

Patients had access to spiritual, religious, and cultural support. The patient welcome pack outlined that support would be given to observe and celebrate religious activities and cultural norms.

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

Requires Improvement

Patients, their relatives, and care staff knew how to complain or raise concerns. The patient welcome pack showed patients how to make complaints.

The provider clearly displayed information about how to raise a concern in patient areas. There was also 'you said we did' process displayed, informing patients how to make complaints, raise issues and the providers response to this.

Staff understood the policy on complaints and knew how to handle them. The provider had a policy and flow chart that clearly explained the way in which to deal with complaints both formally and informally.

Managers investigated complaints and identified themes. The ward managers explained the way in which more serious complaints would be directed to regional management or safeguarding to investigate.

Staff protected patients who raised concerns or complaints from discrimination and harassment. There was no evidence of any discrimination or harassment of patients for any reason, and patients spoken with told us they knew how to make a complaint.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint was complete.

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

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

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

Leaders were knowledgeable and had accessed specific training in how best to support autistic patients.

Leaders worked hard to instil a culture of care in which staff valued and promoted patient individuality, protected their rights, and enabled them to develop and flourish. However, information was not available for new or temporary staff to enable them to promptly understand how best to support patients.

Managers were visible in the service, approachable and took a genuine interest in what patients, staff, family, advocates, and other professionals had to say. Staff told us senior leaders were visible within the service and approachable.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Leaders and senior staff were aware of the proposed changes to the clinical model and staff were identified to engage with patients, staff, and family members regarding the changes to the clinical model. This included consulting patients, staff, and family members, on discussing behaviours and values that would support a less restrictive model of care. We observed managers and leaders spent time in meetings, attending or facilitating training. We reviewed the last three team meeting minutes for the wards and found ward managers attended these meetings.

Managers worked directly with patients and led by example. We observed the ward manager knew patients well and explained to patients the Care Quality Commission presence on the ward.

Vision and strategy

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

Staff knew and understood the provider's vision and values and how to apply them in the work of their team. The acronym used for the values was KITE; Kindness, Integrity, Teamwork and Excellence. Staff were aware of this.

The registered manager, medical director and leadership team had a clear vision for the direction of the service that demonstrated ambition and a desire for patients to achieve the best outcomes possible. The welcome pack explained the service goal was to support patients through their rehabilitation process.

Managers were developing a culture that valued reflection, learning and improvement. They were receptive to challenge and welcomed fresh perspectives. We were told debriefs took place by managers and most staff we spoke with said these did occur.

Culture

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

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 described the ward managers, registered manager, and senior medical staff as supportive. Staff described a disconnect between what the service was meant to deliver and what was being delivered. For example, the service was described as a rehabilitation service, but staff described patients they cared for as having high levels of complex needs and higher levels of security.

The provider invested in staff by providing them with training to meet the needs of all patients. Staff said the training was very good and they had been given the opportunity to attend the autism show and the autism bus to increase their knowledge of autism and how to support autistic patients.

Staff felt able to raise concerns with managers without fear. We saw staff approaching the ward manager and charge nurses for support.

Staff did not always feel, supported, for example, they said they were valued by senior staff, but could be asked to support other wards. For example, when incidents occurred on Beech or Elm wards, and they did not always know how best to support the patients on the other wards they were responding to.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Governance

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

Governance processes were not always effective and did not always help to hold staff to account, keep patients safe, protect their rights or provide good quality care and support. Although audits and records had been completed, we were not assured about their accuracy. For example, documentation had been removed prior to December 2023 which meant there was no historic complaints information prior to this date. Observation records and community meeting minutes were available.

Governance processes did not ensure the service was meeting Schedule 3 of the Health and Social Care Act Regulated Activities Regulations 2014. We reviewed 2 staff files, they did not include evidence of qualifications and did not include a full employment history including gaps. We were sent a spreadsheet following the inspection which was used to monitor the renewal of registration for professionals required to be registered with a regulator, this did not include the date for renewal or check for General Medical Council. The spreadsheet did not include all of the requirements of Schedule 3, for example references, health screening or full work history. This meant the service could not be assured that staff they recruited were fit and proper as there was no oversight of staff records and the records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Team meetings did not have a standard agenda and feedback from incidents, compliments and complaints was not routinely shared, we reviewed minutes and found patients in the service were discussed as well as staff wellbeing, audits, restrictive interventions, safeguarding, and activities. This meant with no standard agenda, ward based staff were not receiving regular consistent updates.

The provider kept up to date with national policy to inform improvements to the service. The ward managers, clinical directors and consultant psychiatrists had looked at the Royal College of Psychiatrists quality improvement network standards. There were no specific standards based on rehabilitation services. The clinical director advised during post inspection feedback, that in reviewing the model of care the standards that applied to the revised model it would reference research by the community of communities , This was a quality improvement and accreditation programme for therapeutic communities. These standards covered providers working with adults with a range of complex needs including personality disorder, offending behaviour, addictions, learning disabilities and severe mental illness. Benchmarking against these standards would have to be agreed as part of the review of the clinical model.

Staff used recognised audit and improvement tools to good effect, which resulted in patients achieving good outcomes. The provider used the health of the nation outcome scales, a 12-scale clinician-rated measure developed by the Royal College of Psychiatrists to guide everyday clinical practice and measure health and social care outcomes in secondary care mental health services for working-age adults. Care plans were goal focused, which were reviewed in the ward rounds.

Staff did clinical audit, benchmarking, and quality improvement work to understand and improve the quality and effectiveness of care. Audits took place in relation to health and safety, the environment, care records and compliance with the Mental Health Act.

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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Teams did not always have access to the information they needed to provide safe and effective care or use that information to good effect. The observation sheets, which agency staff used to know how to support patients, only included information about the levels of observation patients were being monitored on and not copies of risk management or positive behaviour support plans.

Staff did not always act in line with best practice, policies, and procedures. Staff were not bare below the elbow and did not follow the dress code policy.

Staff were committed to reviewing patient care and support continually to ensure it remained appropriate as patient needs and wishes changed. Regular ward rounds and working within the community mental health framework 2019 took place. Meetings took place involving statutory community services which supported patients and commissioners who commissioned care. We saw patients and their relatives were involved in these meetings.

We reviewed senior managers meetings for medicines and physical healthcare, and these identified risks monitoring VTE and diabetes in patients.

Senior staff understood and demonstrated compliance with regulatory and legislative requirements. Notifications were submitted from the provider and the responsible clinician understood the process to request a second opinion appointed doctor to review the prescribing arrangements for patients who could not consent to their treatment.

Regular staff were able to explain their role in respect of individual patients without having to refer to documentation. They gave good quality support.

Information management

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

Staff collected and analysed data about outcomes and performance and engaged in local and national quality improvement activities. Ward managers and senior leaders had access to a variety of dashboards and reports which showed their performance. Information about staffing, incidents, complaints, compliments, and changes in patients were discussed at the morning meeting with senior staff, ward managers and members of the MDT.

Engagement

Managers engaged actively 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.

The provider continued to work closely with the integrated care board and the local authority. The provider held weekly calls and a monthly meeting with the local authority to look at safeguarding actions plans. Commissioners were invited to the community mental health framework 2019 meetings to discuss patient care and treatment.

Patients and those important to them worked with managers and staff to develop and improve the service. Patients could give individual feedback at their ward rounds and community mental health framework 2019 reviews. Patients at a ward level shared their views and ideas at the community meetings and patients contributed to feedback at a hospital level at the patient forum meetings.

Staff encouraged patients to be involved in the development of the service. This was through the patient forum meetings.

The provider sought feedback from patients and those important to them and used the feedback to develop the service. Feedback questionnaires were distributed; however, these were collated at a hospital level and were not able to be filtered to a ward level. This meant it was difficult to know which ward the feedback was relevant to.

The provider worked well in partnership with advocacy organisations/other health and social care organisations, which helped to give patients a voice/improve their health and life outcomes. The advocate visited the wards and patients told us they had access to the service. The provider linked with community opportunities for patients including voluntary work opportunities and college courses which several patients from the wards accessed.

Staff engaged in local and national quality improvement activities. The provider was moving towards using the national Patient Safety Incident Response Framework and the updates were discussed at the senior managers meetings. The ward managers alongside the practice development nurse facilitated a training session to colleagues on positive behavioural support.

Learning, continuous improvement and innovation

The service had systems and processes in place to encourage learning, continuous improvement and innovation. There was evidence of learning from when things had gone wrong. Significant incidents and lessons learnt were a standing agenda item at team quality meetings.

The provider continues to refine the model of care and will inform the CQC through the submission of an up to date statement of purpose to clarify when this is completed.

Requires Improvement

Forensic inpatient or secure wards

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

Is the service safe?

Requires Improvement

We have not inspected this service previously. We rated it as requires improvement.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of the ward. The ward manager completed an environmental risk assessment which was reviewed a minimum of three yearly or in response to any change in the environment or patient base. The ward had a comprehensive and in date environmental risk assessment in place. Staff completed daily, weekly, and monthly checks of the environment as well as security and fire safety systems.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff managed risk through individual risk assessment, observations, and supervised access to specific rooms such as the laundry room. Staff we spoke with were able to access a copy of their ward's assessment and were knowledgeable about the environmental and security risks that were present.

Staff could not always observe patients in all parts of the wards. Not all areas of every ward could be observed from the nursing station or main communal area. Staff mitigated this risk through individual assessment, the use of observations and CCTV.

Staff had easy access to alarms. There were processes to manage, monitor and check staff alarms. Patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

The ward area was clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date. Staff we spoke with told us that cleaning staff were responsive and quick to address any spillages or concerns that did arise.

Staff made sure equipment was well maintained, clean and in working order. There were records of regular checks, maintenance and cleaning of equipment.

The service did not always take sufficient action to prevent visitors from catching and spreading infections. There was antimicrobial hand sanitiser at the entrance to every ward, however not all staff who escorted us around the site and onto the ward, used this. We did not see any staff bare below the elbow, we observed staff wearing jewellery, long sleeved clothing, and coats on the wards. The providers' dress code policy stated '12 CORONAVIRUS All clinical and ward-based staff should be bare from the elbows down. This includes no arm jewellery, watches or rings (wedding bands only can be worn)'. Therefore, staff were not taking action to reduce the risk of spread of infection as required by the provider's policy.

Seclusion room (if present)

The ward had a seclusion facility although this was rarely used. The seclusion room allowed clear observation and two-way communication. The seclusion room had a toilet and clock visible to the patient.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The ward had an emergency response bag. This contained emergency medicines and resuscitation equipment including a defibrillator.

Staff checked, maintained, and cleaned equipment. Staff monitored the temperature of clinic rooms and fridges containing medicines. Equipment that required regular maintenance, checks or calibration had been identified. Records we reviewed showed that the relevant checks were up to date. There were appropriate policies and procedures for the management of clinical waste. Clinic rooms had sharps bins in place which were in date and not overly full.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. The service operated a two-shift pattern. Staffing levels were two qualified nurses and four support workers on the day shift and one qualified nurse and two support workers on the night shift.

The service had low and reducing vacancy rates. At the time of our inspection there were vacancies for two support workers (out of an establishment of 12).

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. The nurse in charge of each shift submitted safe staffing figures for that shift which were reviewed by the ward manager and scored either red, amber or green. These were discussed in the hospital daily staffing huddle. If required there were processes to transfer staff across wards to meet patient need and ward acuity. In addition, the ward manager had access to bank and agency staff where required.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service had low rates of bank and agency nurses. In the period between 1 June 2023 and 30 November 2023 the service had used bank nurses to cover 0.4% of shifts (33 out of 7,543) and agency nurses to cover 0.2% of shifts (15 out of 7,543). The service had low rates of bank and agency support workers. In the period between 1 June 2023 and 30 November 2023 the service had used bank support workers to cover 33% of shifts (6,875 out of 20,906) and agency support workers to cover 2% of shifts (489 out of 20,906).

Requires Improvement

Forensic inpatient or secure wards

Levels of sickness were low. The sickness rate in the service between 1 December 2022 to 30 November 2023 were 6%. Managers supported staff who needed time off for ill health. Staff had access to human resources and support services through the provider company.

The service had reducing turnover rates. The hospital provided turnover rates for the whole site but did not provide the turnover rate for specific wards and services. The staff turnover for the hospital site between the period 1 December 2022 and 30 November 2023 was 33%. The ward manager in the service told us that there had recently been a large programme of international recruitment to address vacancies and reduce the use of bank and agency staff.

The service had enough staff on each shift to carry out any physical interventions safely. Shift rotas were prepared in advance and included information on staff training in restraint. This ensured there was always enough staff on shift who were appropriately trained.

Patients rarely had their escorted leave or activities cancelled. We spoke with 4 patients. They did not raise concerns about having activities cancelled and told us their leave was facilitated when they wanted to take it. Patients had regular one to one sessions with their named nurse.

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

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. The ward had a dedicated medic who acted as the responsible clinician for patients. They attended the ward daily and attended weekly multidisciplinary care reviews. Staff and patients that we spoke with told us they were able to access a medic when they needed to.

Managers could call locums when they needed additional medical cover. Out of hours support was available through the providers regional medical cover roster.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Average compliance with the provider's core mandatory training was 97%. The mandatory training programme was comprehensive and met the needs of patients and staff. The mandatory training programme included basic and immediate life support, conflict resolution and professional boundaries.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to up-to-date training data. Staff were alerted by email when training was coming up for renewal.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and 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. The ward staff participated in the provider's restrictive interventions reduction programme.

Requires Improvement

Forensic inpatient or secure wards

Assessment of patient risk

Staff completed risk assessments for each patient during transfer or on admission, using a recognised tool. Staff completed both a short-term assessment of risk and treatability (START) risk assessment and a the historical, clinical and risk management tool – 20 (HCR-20) risk assessment. The START risk assessment was nursing and medic led. The HCR-20 risk assessment was led by psychology. We reviewed five clinical records during the inspection. All records had full risk assessments in place. Risk assessments were comprehensive and included appropriate risk management plans.

Staff reviewed the risk assessment regularly. START risk assessments were reviewed a minimum of three-monthly or in response to an incident or change in presentation or circumstance. HCR-20 risk assessments were reviewed a minimum of six-monthly or in response to an incident or change in presentation or circumstance. Records we reviewed demonstrated regular review of risk assessments in line with the set timeframes. We also saw examples where risk assessments had been reviewed following an incident or deterioration in a patients' mental state.

Management of patient risk

Staff identified and responded to any changes in risks to, or posed by, patients. Staff identified changes through regular staff patient engagement, such as one-to-one named nurse sessions and through ongoing assessment and monitoring. Staff shared updated information on patient risk during handovers.

Staff followed procedures to minimise risks where they could not easily observe patients. This included individual risk assessments and the appropriate use of observations.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff assessed patients individually in relation to the frequency and type of searches that were appropriate to their presentation and level of risk. This was reviewed within multidisciplinary care reviews. Where patients were on a random search plan there was a randomiser button at the entrance to the ward that was used to determine whether a search would be completed or not when the patient returned from leave. The randomiser was set at 20%. Managers told us that this level was regularly reviewed but there was no clear rationale for why the level had been set at 20%.

Use of restrictive interventions

Staff received training around restraint, least restrictive practice, and the provider's strategy as part of their induction and on-going training requirements. There was access to a prevention and management of violence and aggression lead within the hospital. They supported staff in the development of relevant care plans, risk management strategies and positive behavioural support plans and helped review and identify learning from incidents.

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 utilised verbal de-escalation and diversionary activities identified in care plans for each patient. Staff we spoke with understood patients triggers and appropriate de-escalation techniques.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff worked with patients to develop positive behavioural support plans. We reviewed three positive behavioural support plans during the inspection. They were comprehensive and identified appropriate responses.

Requires Improvement

Forensic inpatient or secure wards

Staff participated in the provider's restrictive interventions reduction programme. Levels of restrictive interventions were low. In the period between 1 December 2022 and 30 November 2023 seclusion was only used once. When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Staff we spoke with were aware of the seclusion procedure and were able to describe the different steps and required assessments and clinical reviews.

The service had a register in place which detailed existing restrictive practice on the ward. The register included a rationale and justification for each restrictive practice and a timescale and process for review. The register was discussed in monthly quality meetings or in response to specific issues or incidents. There was patient representation in the quality meeting.

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. Staff were kept up-to-date with their safeguarding training. Training compliance for safeguarding adults and children training was 95%. Staff we spoke with during the inspection had completed relevant safeguarding training. There were systems in place to prompt staff members and the ward manager if safeguarding training was due for renewal or was overdue.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were knowledgeable around safeguarding and associated issues. In the period January 2023 to December 2023 the ward had raised 3 safeguarding referrals that met the section 42 threshold for safeguarding review by the local safeguarding body. There was an identified social worker who worked with the ward and led on safeguarding concerns. In addition, staff had access to a safeguarding lead within the wider hospital site.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with gave examples of how patients had been protected including the separation of patients where required and the development of safeguarding action plans. They reported positive relationships with local safeguarding authorities. Staff we spoke with had an understanding of safeguarding concerns in relation to patients protected characteristics and gave examples of concerns they would raise including racially discriminatory language or behaviour.

Staff followed clear procedures to keep children visiting the ward safe. Child visits were individually risk assessed and held in a dedicated family visiting room away from the ward environment. Child visits were supervised where appropriate.

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

Staff access to essential information

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

Patient notes were comprehensive and all staff could access them easily. Records were clear, up-to-date and easily available to all staff providing care. Staff had easy access to clinical information and were able to maintain and access clinical records. Clinical records were both paper and electronic. Records were stored securely. Paper records were kept in locked rooms or cupboards and electronic records were password protected.

When patients transferred to a new team, there were no delays in staff accessing their records. When patients were transferred within the hospital pathway staff had access to records on the electronic care records system.

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. All relevant

legal paperwork was in place for the service users we looked at.

Staff generally completed medicines records accurately and kept them up to date, although for 1 person we found that the allergy status recorded on the prescription chart was incorrect. This meant that the service may have been at risk of harm if prescribed medicines they were allergic or sensitive to. Regular audits identified that there was still an inconsistency in recording on Clozapine monitoring forms. This had been raised in the medicines management meeting and work was ongoing to improve compliance.

Medicines were stored safely in clinic rooms; however, we saw there were medicines that were no longer needed and were not disposed of in a timely way. We also found weekly audits indicated that disposals had been completed but we found this was not correct.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. This was clearly outlined in the medicines policy, although we found for 1 service user that attended a hospital this policy was not followed. The medicine policy stated that 'The service users medicines should be transported in its entirety and in its original packaging.' We were told that the service users medicine was put into the white boxes and directions handwritten so that doses were not missed when they attended A&E.

Staff learned from safety alerts and incidents to improve practice. Incidents were raised in the regular medicines management meetings and any actions documented. Safety alerts were included in the meeting. Alerts were then circulated and embedded in the minutes.

Staff reviewed the effects of each patient's medicines on their physical health according to The National Institue for Health and Care Excellence (NICE) guidance. Service users had access to a physical health Nurse and GP on site.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the provider's policy. Staff we spoke with were aware of incident reporting policies and processes. Staff reported incidents electronically. Staff reported incidents such as health and safety incidents, the use of restraint, prescribing or medication errors and incidents of aggression.

Requires Improvement

Forensic inpatient or secure wards

Adverse incidents were reviewed by ward managers and the wider senior management team. Serious incidents were reviewed by the service manager and registered manager and at daily safety huddles. Incidents were discussed within team meetings. Governance forums monitored adverse incident reporting for trends and themes.

Managers debriefed and supported staff after any serious incident. Managers provided informal debrief sessions and staff had access to psychology led reflective practice reviews. Staff we spoke with told us they were supported after incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers reviewed incidents and identified those that required further investigation. Managers we spoke with had received training in conducting investigations. There were governance processes in place to ensure investigations were reviewed and ratified. Processes were in place to monitor the implementation of identified actions.

The provider organisation has been an early adopter in the use of the patient safety incident response framework (PSIRF). PSIRF is a new national system and process for managing and responding to patient safety incidents. The focus of PSIRF is on learning and improving patient safety. Managers we spoke with had received training in the new system and methodologies.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Staff discussed the outcome of investigations in team meetings and one to one supervision sessions. Information on identified learning was also shared via email and in monthly lessons learnt bulletins.

There was evidence that changes had been made as a result of feedback. Staff we spoke with gave examples of post incident improvements including lessons that had been learnt following an incident where a patient swallowed tinfoil that had been used to cover food.

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. The provider had a duty of candour policy in place that staff could access.

Is the service effective?

Good

We have not inspected this service previously. We rated it as good.

Assessment of needs and planning of care

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

Requires Improvement

Forensic inpatient or secure wards

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed five clinical records during our inspection. Each record had a comprehensive and multidisciplinary assessment in place. Assessments were holistic, completed in a timely manner and subject to regular review. In addition to nursing assessments patients were also assessed by the wider multidisciplinary team including psychology and occupational therapy.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We reviewed five clinical records. Each patient had a physical health assessment completed on, or soon after admission. Patients had access a Practice Nurse within the hospital site who contributed to physical health assessments and care plans and managed liaison with GPs and specialist services where required.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed five clinical records during our inspection. Each record contained a range of care plans covering treatment and needs identified through the assessment process.

Care plans were generally personalised, holistic and comprehensive. Care plans demonstrated specialist input where appropriate, for example care plans developed with psychology and occupational therapy services. Where appropriate patients had positive behavioural support plans in place. We reviewed three positive behavioural support plans during our inspection. The plans were comprehensive, written collaboratively with patients and subject to regular review.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance (from relevant bodies eg NICE). The service offered a range of interventions dependent on patient need. This included psychological therapies such as cognitive behavioural therapy and dialectical behaviour therapy. Therapies were mainly delivered on a one-to-one basis. Patients also had access to sessions to develop social and life skills through occupational therapy and recovery coaches.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. We reviewed 5 clinical records during our inspection. Patients had a physical health assessment on admission and relevant physical health care plans in place. Physical health care plans we reviewed were of a good quality and evidenced involvement of relevant physical health specialists. Patients had access to physical health care services including GPs, podiatry, and diabetes nurses. There was a hospital-wide practice nurse who acted as physical health lead. They provided advice and support, managed liaison with other professionals and completed annual health checks.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There was a lifestyles champion on the ward who facilitated access to services such as smoking cessation and who supported sessions around nutrition, healthy eating, and portion control. Patients had access to walking groups.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. This included the Health of the Nation Outcome Scales Secure and the Patient Reported Outcome Measures (PROMS) as well as tools used by specific professionals such as occupational therapy and psychology.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. There was an ongoing programme of audits including audits around risk assessments, care planning and medical prescribing. Managers used results from audits to make improvements. For example, the ward had undertaken work on the wording of care plans following the findings of audits.

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 ward had access to a full range of specialists to meet the needs of the patients on the ward. This included psychiatrists, psychologists, occupational therapists, social workers, and recovery coaches. Specialists worked effectively and collaboratively with ward and nursing staff.

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. Managers gave each new member of staff a full induction to the service before they started work. Staff completed an induction programme and a 13-week probation period. During the probation period staff completed competency assessments in a range of areas including the undertaking of observations, medicines management and key security.

Managers supported staff through regular, constructive clinical supervision of their work. The provider's policy stated staff should receive supervision every 4 to 6 weeks. Compliance with supervision at the time of our inspection was 100%. Staff we spoke with told us they had regular supervision and felt supported in their role. Formal supervision sessions were supported by additional ad-hoc sessions such as reflective practice reviews facilitated by psychology staff.

Managers supported staff through regular, constructive appraisals of their work. At the time of our inspection the wards compliance with annual appraisals was 100%. Staff we spoke with told us they had completed appraisals starting from the induction process.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff we spoke to had undertaken training around areas such as psychosocial therapies, phlebotomy and venous thromboembolism (VTE) risk assessment. There was a skills development pathway for healthcare assistants which included undertaking the care certificate. The care certificate is a national framework to ensure support workers are appropriately skilled.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings were held monthly and generally facilitated by the ward manager. Team meetings were used to update staff, share performance information, and discuss lessons learnt.

Managers recognised poor performance, could identify the reasons and dealt with these. There were appropriate policies in place to support the management of poor performance and disciplinary procedures. Managers could access support from the provider's human resources team.

Requires Improvement

Forensic inpatient or secure wards

Multidisciplinary and interagency team work

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 team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff held weekly multidisciplinary ward reviews of each patient. Patients were reviewed weekly by the multidisciplinary team for the first 12 weeks of their admission and then monthly thereafter. We observed one multidisciplinary review meeting during our inspection. Reviews were structured and considered all relevant information. Staff from relevant disciplines attended or submitted reports for consideration.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handovers occurred between each shift and were nurse led. Handover sheets were available to staff who were unable to attend. We reviewed handover sheets for the week prior to our inspection. The sheets provided information on each patient including presentation, changes to risk and updates on any ongoing issues.

Ward teams had effective working relationships with external teams and organisations. Staff maintained contact with care co-ordinators, commissioners and other providers to share information and facilitate transfers. We received feedback from stakeholders who told us that the service was responsive and communicated effectively with them. There were good links and pathways with other services.

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

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

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of our inspection, ward compliance with Mental Health Act training was 95%. Staff we spoke with were knowledgeable about the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. There was a Mental Health Act administrator at the hospital and up-to-date policies and procedures that reflected legislation and the Mental Health Act Code of Practice.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff were sent reminders by the Mental Health Act administrator when rights were due to be read. We reviewed 5 care records during our inspection. Each record demonstrated that staff had discussed rights with patients in line with legislation.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Advocacy services were advertised on the ward and attended regularly.

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. Leave was individually risk assessed and supported by staff where required. We saw patients leaving the ward for periods of leave during the inspection. Patients we spoke with told us they regularly accessed agreed leave.

Requires Improvement

Forensic inpatient or secure wards

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We reviewed 5 care records during our inspection and found that patient's prescription charts and related mental health documents were present and up to date. Paperwork relating to the Mental Health Act was stored securely by the Mental Health Act administrator.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. These were completed by ward staff and the Mental Health Act administrator. They included audits against the use of seclusion and restrictive practice as well as scrutiny of Mental Health Act paperwork.

Good practice in applying the Mental Capacity Act

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

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of our inspection, ward compliance with Mental Capacity Act training was 95%. Staff we spoke with demonstrated a good understanding of the application of the Act in their day-to-day work with patients.

There was a clear policy on the Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff we spoke with told us policies were accessible on the providers intranet and support was available from managers, psychiatrists, social workers, and the provider's Mental Capacity Act lead.

Staff gave patients 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. Care records we reviewed included capacity assessments where concerns had been identified. Assessments were decision specific and subject to regular review. Staff gave examples of this process including an assessment of a patient refusing the COVID-19 vaccination who was deemed to have capacity. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw examples of best interest decisions in the care records we reviewed in relation to financial management. Best interest meetings and decisions were multidisciplinary and where feasible included input from carers and family members. They were decision specific and subject to regular review.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good

We have not inspected this service previously. We rated it as good.

Requires Improvement

Forensic inpatient or secure wards

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 we spoke with discussed patients under their care with compassion and in a respectful manner. We observed staff discussing patients in a respectful manner during a multidisciplinary care review meeting.

Patients said staff treated them well and behaved kindly. We spoke with 4 patients during our inspection. Patients generally spoke positively about staff. They reported that staff were kind, caring and considerate.

Staff gave patients help, emotional support and advice when they needed it. Staff understood and respected the individual needs of each patient. We spoke with 1 patient who discussed how staff were able to support and de-escalate him when required using methods he had agreed with them.

Staff supported patients to understand and manage their own care treatment or condition. Patients were involved in discussions about their care and treatment in one-to-one sessions with their named nurse as well as in ward rounds and care reviews. Care plans we reviewed during the inspection demonstrated patient involvement in assessment and care planning. We observed one multidisciplinary care review meeting. Patients who attended were given space and assistance to express their opinions and views and given time to do so. Patients were able to discuss their medicines with their consultant.

Staff directed patients to other services and supported them to access those services if they needed help. Care records we reviewed demonstrated referral to additional services, especially in relation to physical health care.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff that we spoke to demonstrated an awareness of issues or concerns to be aware of and told us they would be confident to raise a concern if it was appropriate.

Staff followed policies to keep patient information confidential. Staff completed training around information governance and confidentiality. Patient information within nurse's offices was not visible through windows. Client records were stored securely, and computer systems were password protected.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients we spoke with told us they had been orientated to the ward on admission or as soon as they were well enough to do so. Some patients we spoke with referenced receiving a welcome pack with information about the service.

Staff involved patients and gave them access to their care planning and risk assessments. Care records we reviewed demonstrated that staff had sought to involve patients and carers in both the assessment and care plan processes. We saw evidence of patients helping to identify treatment or intervention goals and agreeing the support and actions required to achieve them. Care records demonstrated that patients had been offered copies of their care plans and

relevant documentation. Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Patients we spoke to were generally aware of the contents of their care plan and the objectives of their treatment. We observed patients being given space to ask questions regarding their treatment during a multidisciplinary care review meeting.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could provide feedback or raise concerns during weekly community meetings and also completed patient exit surveys. Patients we spoke with told us they would also raise issues with staff when they came up. The ward had a 'you said, we did' board which detailed changes that had been made following patient feedback. Actions included a review of the e-cigarette protocol and the replacement of cups.

Staff made sure patients could access advocacy services. Advocacy services were advertised on each ward. Patients we spoke with were generally aware of the independent advocate that visited their ward.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Patients told us their families were involved in their care. Care records we reviewed demonstrated that the opinion and involvement of families and carers had been sought, captured on records and used in the formulation of risk assessments and care plans. Family members and carers were invited to attend relevant meetings where appropriate.

Staff helped families to give feedback on the service. Families and carers could complete a family, friends and carers experience survey. However, the results were presented at hospital level which meant they were not specific to Dove ward or the low secure service.

Staff gave carers information on how to find the carer's assessment. The service had an allocated social worker who led on carer liaison and completed referrals for carers assessments.

Is the service responsive?

Good

We have not inspected this service previously. We rated it as good.

Access and discharge

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

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Length of stay was reviewed in multidisciplinary patient reviews and captured in monthly performance reports.

Managers and staff worked to make sure they did not discharge patients before they were ready. Discharge planning began on admission and was carried out collaboratively with the patient and other stakeholders. Discharge and discharge plans were reviewed and updated on a regular basis. We observed a discussion with a patient regarding onward placements as part of the patient's multidisciplinary review.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning. Discharges and transfers were planned in advance and took place at an agreed time. Staff supported people when they were transferred between services. This included facilitating visits to new placements and implementing stepped approaches to transfers and discharges where appropriate.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Patients did not have to stay in hospital when they were well enough to leave. In the period 1 December 2022 to 30 November 2023 the ward had one delayed discharge. The discharge was delayed by 22 days and was caused by delays in securing an onward placement.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Care records we reviewed evidenced a collaborative approach to planning and facilitating discharge. Discharge plans were reviewed and updated in ward rounds and multidisciplinary meetings.

Staff supported patients when they were referred or transferred between services. This included the provision of information, support to visit onward placements prior to transfer and one to one work with members of the multidisciplinary team including psychology to help address patients concerns or uncertainty. The service followed national standards for transfer.

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.

Each patient had their own bedroom, which they could personalise. We saw examples of where patients had personalised their bedrooms with photographs, artwork and personal belongings. Patients had a secure place to store personal possessions.

The service had a range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. Patients had access to lounge areas, a dining room, an interview or quiet room and laundry facilities. The service was in the process of relocating the Activities of daily living (ADL) kitchen and turning its former location into an IT suite.

Patients could make phone calls in private. Staff individually risk assessed patients access to mobile phones and provided an alternative if the patient did not have a mobile phone or it was deemed unsafe.

The service had an outside space that patients could access easily. This outside space was well maintained.

Patients could make their own hot drinks and snacks and were not dependent on staff. Pump flasks with hot water had been made available following patient feedback and requests.

Requires Improvement

Forensic inpatient or secure wards

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. The hospital had held a jobs fair event to encourage and develop employment skills such as completing application forms, writing curriculum vitae and interview techniques. The hospital offered a range of posts for patients to apply for including roles within house-keeping, maintenance and catering. One patient from the ward secured a paid role helping to maintain the hospital grounds.

Staff supported patients to access volunteering opportunities within the wider community. Patients from the ward had volunteered at a local Church and one had volunteered at a local food bank. Staff also supported access to educational courses. There was one patient due to attend an induction at the local college and another exploring a brick laying course.

Staff helped patients to stay in contact with families and carers. Patients were able to contact their families via phone and had access to a dedicated family visiting room off the ward environment. Families and carers were invited to care review meetings where appropriate.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff worked one to one with patients where support was needed. Patients had access to the community through agreed section 17 leave.

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 service could support and make adjustments for disabled people and those with communication needs or other specific needs. The ward was on the ground floor and had an accessible bedroom and bathroom for those with limited mobility or who required wheelchair access.

The service had information leaflets available in languages spoken by the patients and local community. Information on display within the ward was predominately in English. However, staff had access to translation services that could provide translated versions of documentation and information leaflets as required. Managers made sure staff and patients could get help from interpreters or signers when needed. The same translation services could provide translators either in person or via telephone or video link. Staff we spoke with knew how to access translation services.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. This included appropriate meals for those who were vegetarian or vegan or who suffered from specific food intolerances. The service provided culturally appropriate meals such as halal meat.

Patients had access to spiritual, religious and cultural support. There was a multi-faith room off the ward environment and access to items such as holy books from different religions and prayer mats. There was 1 patient on the ward who was being supported to attend a local place of worship.

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.

Requires Improvement

Forensic inpatient or secure wards

Patients, relatives and carers knew how to complain or raise concerns. Staff protected patients who raised concerns or complaints from discrimination and harassment. Patients we spoke to told us they would not have any concerns about raising a complaint if they felt it was necessary. Most patients we spoke with told us they would raise a concern with the ward manager in the first instance. The service clearly displayed information about how to raise a concern in patient areas. There were posters displayed on the ward advertising the advocacy service and the provider's complaints process and team.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff completed training on complaints management and the complaints process as part of their mandatory training programme. There was a policy and flowchart to support staff if required.

Managers investigated complaints and identified themes. A complaint officer was identified to carry out investigation complaints. The complaint officer was always someone external to the ward. Managers we spoke with had received training in the management and investigation of complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was shared with staff in one-to-one meetings and supervision. Findings and recommendations from complaints were discussed within team meetings. Recommendations from complaint investigations were captured on the monthly lessons learnt bulletins.

Is the service well-led?

Requires Improvement

We have not inspected this service previously. We rated it as requires improvement.

Leadership

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

Leaders within the service had the skills, knowledge and experience to perform their roles. They were able to describe how the service was working to provide quality care. Leaders we spoke with demonstrated an understanding of the patient group they cared for and were able to identify challenges the service faced.

Staff we spoke with told us that senior managers were visible within the service. Staff referenced regular visits by the hospital's practice development nurse and clinical lead. Staff told us that managers were approachable and supportive.

Staff and leaders had access to specialised training, development and leadership courses. The ward manager we spoke with told us they felt supported in their development.

Vision and strategy

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

Requires Improvement

Forensic inpatient or secure wards

Staff knew and understood the provider's vision and values and how they applied to their ward. Staff were able to describe the provider's values using the acronym KITE and able to describe the individual aspects of kindness, integrity, teamwork and excellence. The provider's values were discussed as part of the induction programme for new staff.

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 we spoke with felt respected, supported and valued. They spoke positively about the ward and hospital managers. They described positive team working across disciplines and felt good about their roles and the care and treatment they provided.

The provider invested in staff by providing them with quality training to meet the needs of all people using the service. Staff we spoke with were positive about the mandatory training programme and further training and carer development offered by the provider. Staff members we spoke with had undertaken additional training, qualifications or carer development opportunities.

Staff felt able to raise concerns with managers without fear of what might happen as a result. Staff we spoke with were aware of policies and processes to support them raising concerns and told us they believed that any issues raised would be responded too properly.

Governance

Governance processes were not always effective and did not always help to hold staff to account, keep people safe, protect their rights or provided good quality care and support. We found concerns around document retention as well as in relation to the oversight and monitoring of staff as fit and proper to practice.

Governance processes did not ensure the service was meeting Schedule 3 of the Health and Social Care Act Regulated Activities Regulations 2014. We reviewed 2 staff files, they did not include evidence of qualifications and did not include a full employment history including gaps. We were sent a spreadsheet following the inspection which was used to monitor the renewal of registration for professionals required to be registered with a regulator, this did not include the date for renewal or check for General Medical Council. The spreadsheet did not include all of the requirements of Schedule 3, for example references, health screening or full work history. This meant the service could not be assured that staff they recruited were fit and proper as there was no oversight of staff records and the records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed clinical audit, benchmarking and quality improvement work to understand and improve the quality and effectiveness of care. In the three months prior to our inspection the service had completed audits around seclusion, risk assessments, care plans and national early warning score charts. The service submitted performance data to the regional provider collaborative for secure services and was benchmarked against other services. The provider kept up to date with national policy to inform improvements to the service.

Staff were well supported and had access to regular supervision and appraisal. The service supported staff's professional development. Staff had access to a suite of policies and procedures to support them in their work. Policies and procedures were appropriate and up to date.

Requires Improvement

Forensic inpatient or secure wards

Management of risk, issues and performance

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

Managers had access to up-to-date performance data and performance dashboards. Systems were in place to flag when training was required and audits were due. The service monitored length of stay and delayed discharges. The MHA Administrator flagged when patients were due their rights to be read.

The service had a risk register in place. Staff were able to raise issues for inclusion on the risk register. Staff concerns matched those on the risk register. Managers we spoke with demonstrated a good understanding of the risks the service faced and could describe actions in place to mitigate them.

The service had plans for emergencies such as adverse weather, loss of information technology systems or closure of premises.

Senior staff understood and demonstrated compliance with regulatory and legislative requirements. Notifications were submitted from the service and the responsible clinician understood the process to request a Second Opinion Appointed Doctor to review the prescribing arrangements for people who could not consent to their treatment.

Staff did not always act in line with best practice, policies and procedures. Staff were not bare below the elbow and did not follow the dress code policy.

Information management

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

Staff had access to the information they needed to provide safe and effective care and used that information to good effect. The service used systems to collect data from the wards which were not onerous for frontline staff. Managers had access to performance data that enabled them to support the service and identify areas for improvement. This included a range of performance dashboards and regular performance reports produced as part of the hospital's governance processes. The service also submitted performance reports to commissioning bodies.

Staff had access to the equipment and information technology needed to do their work. Electronic documents were password protected. Paper records were stored securely. Staff followed policies and procedures to protect patient confidentiality.

Engagement

Managers engaged actively 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, patients and members of the public had access to up-to-date information. Information was available via the provider's website and social media channels. Information was also displayed on site. Staff attended meetings at all levels and information was also shared via email and through lessons learnt bulletins.

Requires Improvement

Forensic inpatient or secure wards

Patients and carers could give feedback on the service by completing surveys or through community meetings and ad-hoc groups. Staff could give feedback on the service through a staff survey and during supervision sessions and learning events.

The service worked closely and collaboratively with other local providers. The service was part of the regional provider collaborative for adult secure care services. They attended meetings and submitted performance reports into the collaborative. The provider worked closely with the integrated care board and the local authority. The provider held weekly calls and a monthly meeting with the local authority to look at safeguarding actions plans. The service had good links with other local third sector providers within their area.

Learning, continuous improvement and innovation

The service had systems and processes in place to encourage learning, continuous improvement and innovation. There was evidence of learning from when things had gone wrong. Significant incidents and lessons learnt were a standing agenda item at team quality meetings.

The service linked in the with provider's quality improvement team. Recent quality improvement initiatives included a project related to enhanced observations. This had been delivered following an increase in incidents whilst staff were carrying out patient observation. The project reviewed policy and documentation and developed new staff training around meaningful engagement with patients.

The service was not actively involved in research projects at the time of our inspection. Research projects within the previous 12 months had been hospital wide rather than service specific.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment In wards for people with a learning disability or autistic people. Long stay/rehabilitation mental health wards for working-age adults. Forensic inpatients or secure wards How the regulation was not being met: Staff were not bare below the elbows and were not following the providers dress code policy. In wards for people with a learning disability or autistic people. How the regulation was not being met: There was not a clear line of sight in the communal area, and this was not mitigated. In wards for people with a learning disability or autistic people. Long stay/rehabilitation mental health wards for working-age adults. Forensic inpatients or secure wards How the regulation was not being met: Staff were not following medicine the medicine administration policies and were administering medicines in communal areas and not in a safe private place. Staff were not making sure patient's allergy statuses were up to date and correct on patients' prescription charts.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment In wards for people with a learning disability or autistic people. Long stay/rehabilitation mental health wards for working-age adults. How the regulation was not being met: The IT suite was used to store bikes, coats, empty boxes and security lockers, there was a dirty mark on the wall and the room was not welcoming or a conducive space for people to use. The cleaning record showed that it has been cleaned, however this was not clean. Telephone rooms were being used to store staff coates and dietary suppliments. Other areas of the wards required maintenance: Work had been taking place on a drinks area, flooring was missing, tiles were cracked, there was no date for completion and no work taking place during the inspection. The communal bathroom had paint flaking off the wall and a cracked privacy screen. The flooring and seal in the bathroom were lifting away from the wall. The seclusion room had work being completed on it and this started on 16 October 2023, the work had not been completed by the initial completion date, revised date of completion was January 2024. This meant maintenance tasks were not being prioritised or completed promptly.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	In wards for people with a learning disability or autistic people. Long stay/rehabilitation mental health wards for working-age adults. Forensic inpatients or secure wards. How the regulation was not being met: The spreadsheet used by staff to review compliance of staff records did not include all of the requirements of schedule 3. We reviewed two staff files who had involvement in the ward and found that in both files there was no evidence of qualifications and not a full employment history including gaps. Staff records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Information prior to December 2023 had been sent for storage and archiving, including observation records, cleaning records, community meeting minutes and complaints, this meant the information was not easily accessible.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing In wards for people with a learning disability or autistic people. Long stay/rehabilitation mental health wards for working-age adults. Forensic inpatients or secure wards How the regulation was not being met: Lack of agency induction, there were no checklists in place to show if staff had been inducted to the ward and what the induction covered. We spoke with agency staff who did not know the location of the emergency bag and ligature cutters and did not know the names of people or their

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individual needs. We were told all of this information was in the observation file. We reviewed the observations folder and found that there were only details of specific needs for 4 people out of 11 on Cedar ward.

Agency induction checklist was a hospital based one and not ward specific, in the agency induction they were shown outside the wards but not in the wards, the induction mainly focused on observations and key management. The checklist did not include the location of the ligature cutters or emergency bag. This meant agency staff were not provided with the information they needed to safely care for people. Agency staff were not provided with copies of individual patients risk assessments.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care In wards for people with a learning disability or autistic people. Long stay/rehabilitation mental health wards for working-age adults. How the regulation was not being met: All people were subject to personal and room searches. The rationale and frequency of this for each person had not been regularly reviewed and findings from searches were not incorporated into the decision making.