Willows Green Healthcare Limited

Willows Green Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

This comprehensive unannounced inspection took place to follow up enforcement action from the last inspection.

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

- The provider had failed to provide a stable management team with four managers in less than a year as well as a changing multi-disciplinary team which had resulted in no continuity of improvement from the last inspection.
- The service did not provide safe care. The service did not have enough, appropriately skilled staff to meet people's needs and keep them safe. There was only one full time nurse employed by the service and the service was overly reliant on bank and agency staff. Incidents that occurred during our inspection all took place when the nurse in charge was agency staff.
- Staff did not assess and regularly review patient risks. We saw risk records were not updated after incidents. Managers did not complete investigations into incidents in a timely manner.
- The service did not provide trained staff to care, support and meet patient's needs. Occupational therapy staff did not have systems in place to ensure patients did not conceal prohibited items after sessions.
- The service was not well led, and governance processes did not ensure incidents were not repeated. Incidents were not immediately reported to safeguarding or the Care Quality Commission.
- The service was not well led, managers allowed a member of staff to come into contact and conduct observations of a patient whilst they were being investigated for a safeguarding allegation.
- Governance processes did not identify that care plans and risk assessments were not up to date and were inaccurate.
- The provider appointed a new hospital manager and they were awaiting their arrival. The deputy manager resigned leaving just one manager in post. Managerial tasks were not being completed in a timely way.

However:

- After the last inspection an extra member of staff had been added to the roster to allow staff to have a break from observations every two hours.
- After the last inspection staff now received face to face safeguarding training.
- The hospital introduced the use of a smart speaker so a patient could control their smart television without the need of a remote control.
- The ward environments were safe and clean.
- There was a full range of specialists required to meet the needs of patients on the wards.
- Managers ensured that staff received supervision.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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Summary of this inspection

Background to Willows Green Hospital

Willows Green Independent Hospital provides long term rehabilitation care and treatment. The hospital opened in March 2022. Willows Green Hospital has two female patients.

We previously inspected the hospital in August 2022 and rated safe, caring and well lead as inadequate. As a result, we issued a warning notice to the provider. We carried out this latest inspection to follow up on the progress made following the previous inspection.

On this inspection the hospital still had four wards but three are currently closed and the two patients are both nursed on the same ward.

Following the previous inspection, a new registered manager had been appointed.

The provider was 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.

What people who use the service say

We spoke to both patients and their carers.

One patient told us they slept poorly and despite the service agreeing to close the door to stop light from the corridor entering their bedroom, staff did not comply. The patient did a baking session and the cake mix was from a children's show which did not reflect that they were an adult. Another patient told us they felt they had gone backwards as they no longer cooked their own meals.

One carer had concerns that staff did not understand the needs of their loved one, especially at the weekend and evenings when more agency staff worked. Another carer complained that the hospital told them they had made changes when in fact they hadn't, such as closing the bedroom door.

How we carried out this inspection

We inspected this service in response to safety concerns that had been raised about the care and treatment of people using the service. We examined all five key questions and visited the hospital on one evening and the following day.

The team that inspected the service included two CQC inspectors, one medicines inspector and one occupational therapist specialist advisor.

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for feedback or information about the service.

During the inspection visit, the inspection team:

Summary of this inspection

- Looked at the quality of the environment and observed how staff were caring for people using the Short Observational Framework (SOFI) tool
- Spoke with both patients who were using the service
- Spoke with both carers of people who were using the service
- Spoke with the manager
- Spoke with 8 other staff members: including nurses, support workers, occupational therapist assistant, psychologist, chef and the consultant psychiatrist
- Spoke with two commissioners
- Looked at both patient care and treatment records
- Carried out a specific check of the medicine's management and
- Looked at a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Action the service MUST take to improve:

• The provider must ensure care is delivered in a safe way doing all that is reasonably practicable to mitigate any such risks such as preventing patients from accessing restricted items. (Regulation 12, (1)(2)(b))

• The provider must ensure staff conducting observations have the training and competency checked to complete observations. (Regulation 12, (1)(2)(c)).

• The provider must ensure the environment meets the needs of the patient, for example ensuring the noise of closing doors does not affect the wellbeing of the patients. (Regulation 9, (1)).

• The provider must ensure that its safeguarding policy is compatible with the standards of the local safeguarding board. (Regulations 13 (2)(4)(b)).

• The provider must ensure that systems and processes are in place to report and investigate safeguarding incidents quickly and efficiently to ensure those exposed to, or suffering abuse are safeguarded. (Regulations 13 (3)).

• The provider must ensure that there are enough suitably qualified, skilled, and experienced staff to meet the patient's needs. (Regulations 18(1)).

• The provider must ensure that staff receive an induction to Willows Green Hospital. (Regulations 18(1);17(1)(2)(a)).

• The provider must ensure that patients' risk assessments accurately reflect patients' risks and that these are reviewed and updated in line with the providers policy. (Regulation 12(2)(a)).

Summary of this inspection

• The provider must ensure that a leadership team remains in place to establish systems and processes to ensure compliance with the regulation. (Regulations 17(1)).

• The provider must ensure that care plans are contemporaneous, accessible, personalised, holistic and strengths based and reflect the assessed needs of the patient. (Regulations 17(1)(2)(a)(c); 9(3)(b)).

• The provider must ensure they quickly investigate, review, and reflect on incidents of restraint to ensure that patients are kept safe. (Regulations 17(1)(2)(a).

• The provider must ensure that lessons learnt on safeguarding, incidents, complaints, and reflective practice are shared with staff and that staff implement those lessons to prevent reoccurrence. (Regulations 17(1)(2)(a).

• The provider must ensure that governance processes operate effectively at team level and that performance and risk are managed well. (Regulations 17(1)(2)(a)(b)(f)).

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

Is the service safe?

Inadequate

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

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The ward consisted of a long corridor, off which were all the bedrooms and communal spaces such as lounge or dining area. Staff nursed patients in separate areas of the ward for clinical reasons and the wishes of the patient. There was a double door halfway down the corridor which separated the patients.

Staff could observe patients in all parts of the wards. Both patients were under constant 2:1 observation.

There was no mixed sex accommodation. All patients were female. On the last inspection we saw all male healthcare assistants observing the female patients. On this inspection we did not see this. The majority of healthcare assistants were female and where there was a male observer their role was secondary to support the female member of staff if required. For example, the female healthcare assistant would enter the room if the patient utilised the bathroom and the male would stay outside within earshot ready to support.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems. Patients were observed by two members of staff including when they visited the occupational therapy kitchen which was located off the ward.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished, and fit for purpose. The nurses station door now closed softly reducing the noise levels. However, the ward was a long corridor and while it was clean and well maintained, it had not been adapted to reflect patients' sensitivity to noise and light.

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

Staff followed infection control policy, including handwashing. Hand sanitiser was available on entry/exit to the ward and staff were wearing appropriate personal protective equipment.

Seclusion room

There was not a seclusion room at the hospital.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The most up to date British National Formulary was available in the clinic room, as were relevant guidance about medication requirements. Medication cupboards were not over-stocked and medication was in date. Emergency drugs were available and within date. Oxygen and resuscitation equipment, including defibrillators, were all maintained and recently checked.

Staff checked, maintained, and cleaned equipment. The clinic room was clean, tidy, and equipment requiring calibration had stickers to show when it was last checked. Sharps boxes were all in date, and not overly full.

Safe staffing

The service did not have 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 on the rota but there was only one full time employed nurse and staff were mostly agency and therefore not all staff had sufficient knowledge of the patients to keep them safe. At the last inspection we found that the provider did not have enough staff. There was one nurse and five health care assistants on duty for both days and nights. Four of these staff members were on observations which meant they could not leave the patient they were allocated to support. There was one additional health care assistant. We saw this meant that the staff were on observations for more than two hours continuously. National Institute for Health and Care Excellence (NICE) guidance recommends staff should not be on continuous observations for more than two hours.

There was now one nurse and six health care assistants on days and nights, with one of the healthcare assistants working as a supervisor. This meant that the six health care assistants could now take a break from observations after two hours complying with the National Institute for Health and Care Excellence (NICE) guidance.

The service had high vacancy rates. The service required 4.5 nurses but only employed one and also required 28 healthcare assistants but had 17 in post.

The service had high rates of bank and agency support staff. The service used its own agency to staff the service and fill the staffing gaps. Managers said that where possible, they used agency and bank staff that were familiar with the patients in the service.

At the time of inspection only one nurse was employed by the hospital. Another nurse had been block booked from the agency since October 2022, another agency nurse was transitioning to a permanent role, with another nurse recruited but not yet in employment. There were another seven agency nurses who had been offered full time employment at the hospital and who worked regularly mostly on nights.

We reviewed a selection of rotas from 30 January 2023 to 31 March 2023. This covered 64 days of both the day and night rota.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

During this period the staffing levels were one nurse and six health care assistants on each shift.

During the 64 days we examined the number of health care assistant shifts covered by bank and agency staff was 42% (159) of all shifts on days and on nights 55% (210) of all shifts compared with 50% and 54% at the last inspection.

On 11 occasions there were five healthcare assistants and on one occasion four healthcare assistants.

Managers did not ensure all bank and agency staff had a full induction and understood the service before starting their shift. Agency and bank staff were expected to complete the same training and induction as permanent staff. New starters had five days of classroom learning followed by one week of shadowing before working on the wards. However, this induction process took place at another location. The hospital was unable to provide evidence that agency staff had completed an induction to work at Willows Green Hospital or that their competency to observe patients had been assessed.

The service had low turnover rates with 6.67% of staff leaving in the six months prior to the inspection.

Managers supported staff who needed time off for ill health. There was one member of staff who was away from the workplace for a long period and managers were able to describe how they supported that member of staff.

Levels of sickness were low at 6.14%, and this mostly related to one long term period of sickness.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Since the last inspection the number of health care assistants had been raised from five to six.

The manager could adjust staffing levels according to the needs of the patients. Managers told us they could bring in extra staff if they felt it was necessary. For example, if staff reported sick, they could easily access replacement agency staff.

Patients had regular one- to-one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. There were occasions when leave could be delayed while the vehicle returned from elsewhere, but no leave had been cancelled as a result of staff shortages.

The service had enough staff on each shift to carry out any physical interventions safely. All members of staff including permanent and agency staff attended the same Management of Aggression or Potential Aggression (MAPPA) training course.

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

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The psychiatrist worked full time for the provider, working four days at another location and one day a week at Willows Green. There was also a speciality doctor. They could respond to incidents and provided on call cover and both lived a short distance away.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers could call locums when they needed additional medical cover and managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. Overall mandatory training was 88.9% at the time of the inspection. At the last inspection only 5% of staff completed mental health capacity and Deprivation of Liberty Safeguards training, on this inspection only 4 newly appointed members of staff had not completed the training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Autism spectrum training was now a yearly course and face to face safeguarding training had been introduced. Training also included infection control and basic life support. However, staff only completed positive behaviour support training on initial induction and this was not a yearly course.

Managers monitored mandatory training and alerted staff when they needed to update their training. The hospital had a mandatory training dashboard which monitored compliance and training records.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. They did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating, and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, but not always after incidents.

At the last inspection we found staff completed a handwritten incident report after each incident and gave this to the nurse in charge. The nurse in charge forwarded these to the manager and these were added to the hospital incident recording record on an ad hoc basis by administration staff. This was still the case with administrative support being provided weekly.

There were incidents involving patients inserting items into bodily parts and a violent incident outside the hospital while on leave that were not logged on the hospital incident system but were still with the hospital manager.

This meant that patients' risk assessments were not up to date with all the information on patient risk.

Staff used a recognised risk assessment tool. The hospital used the Salford Tool for Assessment of Risk (STAR).

Management of patient risk

Staff did not know about any risks to each patient and did not always act to prevent or reduce risks. We observed three hospital daily flash meetings. The nurse on days met with the hospital manager to discuss the daily tasks ahead. During one of these, it became clear the nurse in charge was not aware of the risks associated with a patient and the hospital manager corrected them. There was a written handover sheet which contained risks and advice to observing staff but the incidents recorded showed that staff did not understand the risks or were oblivious to the risks.

There was conflicting advice about some prohibited items and no advice on how to use board games containing small pieces with a patient who inserted items into body cavities. The doctor who had written a care plan about prohibited items told us another member of staff must have added an extra line about board games into his original work.

On our first visit the STAR risk assessment did not contain all incidents that occurred and was not up to date. On our return visit, despite giving this information during feedback, we found that further incidents that occurred between our visits had not been updated on the risk assessments for the patients. These included two incidents of items being concealed in body cavities and one violent staff assault requiring police attendance.

Staff did not always identify and respond to any changes in risks to, or posed by, patients. To prevent one patient swallowing batteries the provider had addressed this issue by using a voice controlled smart speaker which could turn other electrical items like televisions on and off reducing the need for remote controls. Despite there being a full-time occupational therapist, no-one thought to remove the small board games pieces and replace them with paper equivalents. This resulted in an incident where one patient required a medical procedure in hospital.

Staff could observe patients in all areas.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff only conducted searches if they believed there was a risk to patients.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff completed a restrictive practice assessment for each patient covering the use of metal cutlery, ceramic dining plates, glass cups and use of kettle, section 17 leave, money, other contraband items, possession of mobile phone and observation levels.

However, while the multi-disciplinary team were keen to lift restrictive interventions where possible, there was no clear advice to staff about how to assess a patient. Staff granted section 17 leave to one patient, as usual, despite them being involved in a number of incidents and during a weekend that all acknowledged was a trigger for that patient. This patient was involved in an incident during leave that required police intervention. Only after this incident was further advice given to staff that leave should only be granted after an incident free 24 hours and how to use the hospital vehicle while transporting that patient.

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. We saw that staff made efforts to avoid using restraint by using de-escalation techniques however, there had been incidents of restraint. There were incidents in which patients alleged staff assault and other incidents where staff reported assaults and racial abuse to the police. We did see in incident reports that staff had tried to use de-escalation techniques.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff were aware of least restrictive practice and applied blanket restrictions on patients' freedom only when this was clinically justified. The provider restricted some items on the ward but many items were individually risk assessed.

Staff followed National Institute of Health and Care Excellence guidance when using rapid tranquilisation. The hospital as a policy did not use intramuscular tranquilisation.

There was no seclusion.

There was no long-term segregation.

Safeguarding

Staff did not understand how to protect patients from abuse and the service did not always report incidents as promptly as possible to other agencies. 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. At the last inspection staff only received on-line training for safeguarding and no member of staff was trained to level four. On this inspection all staff, including agency staff, completed the same face to face course. All health care assistants were level two trained, nurses were level three and the registered manager level four trained.

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 report safeguarding incidents internally but did not always manage the risks posed to patients with repeated incidents of a similar nature occurring. Staff discussed any incidents in the previous 24-hours at daily safety huddles to ensure all safeguarding concerns were captured. Staff knew how to make a safeguarding referral and who to inform if they had concerns but they did not always do this promptly. On our visit on the 9 March, we were aware of incidents that had occurred on the 4 and 5 March. These incidents had still not been reported to safeguarding and when we were given the paper incident reports we were told the managers intention was to report them.

Staff followed clear procedures to keep children visiting the ward safe. A specific visiting room was available to book for visits with children which were separate from the ward.

Managers did not always take part in serious case reviews or make changes based on the outcomes. At the time of inspection, the provider had not completed all investigations into safeguarding incidents including ones from 2022.

Staff access to essential information

Staff did not have easy access to clinical information which was mostly paper-based.

Patient notes were not comprehensive but all staff could access them easily. The provider kept a daily notes system online but had paper records for all other records such as risk assessments and care plans. These were kept in a large lever arch file in the nurse's office.

Despite only having two patients the patient notes were organised differently so if a member of staff wanted to use some information from a care plan, for example, they had to look in different places depending on who the patient was. We were told neither of the two systems being used was the system managers implemented.

We found errors in care plans and risk assessments such as conflicting advice about care and, incidents missing from the risk assessments.

Records were stored securely.

Medicines management

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff followed systems and processes to prescribe and administer medicines safely. The service had a paper system for prescribing and administering medicines. Staff stored and managed all medicines and prescribing documents safely. Pharmacy staff attended at regular intervals to ensure stock was managed appropriately and available when needed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacists attended when required and were available to meet with patients to discuss and provide information around medicines. This included leaflets in easy read formats and different languages.

Staff completed medicines records accurately and kept them up-to-date. The medication charts we reviewed were well maintained, with nothing of concern noted.

Staff stored and managed all medicines and prescribing documents safely. We saw evidence of the checks carried out by the community pharmacist, and clinic checks conducted during the inspection found that medication was being stored properly, all were within date, and cupboards were not overstocked.

Staff learned from safety alerts and incidents to improve practice so patients received their medicines safely.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Patients' medication was monitored at review by the responsible clinician, as well as the community pharmacists who attended the service.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence guidance. On the last inspection we found that physical health charts were not fully completed on four occasions. We found no errors in physical health charts on this inspection.

Track record on safety

The service did not have a good track record on safety.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did recognise incidents and report them appropriately. Managers did not always investigate incidents and share lessons in a timely manner. When things went wrong, staff did apologise and give patients honest information and suitable support.

Staff did know what incidents to report and how to report them, but the recording and management of those incidents had not changed. The hospital had made no changes to its incident recording process since the last inspection. The hospital kept records of incidents on a spreadsheet updated in an ad hoc manner from a written proforma completed by staff immediately after an incident. This record was not up to date.

The service had no never events on any wards.

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. At the last inspection the provider had not complied with their obligations to write to patients to apologise following incidents that required a duty of candour response. On this inspection we found the provider was compliant with its obligations.

Managers debriefed and supported staff after any serious incident.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers did not always investigate incidents thoroughly. Patients and their families felt they were not involved in these investigations. Families told us they received conflicting information. One family was unsure as to whether a member of agency staff had been disbarred from working at the hospital. Managers told them this would only happen in an emergency but eventually, they were disbarred.

Following a recent incident, managers were still awaiting a staff statement six days after an incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Wes aw evidence that managers sent out emails regarding lesson learnt but we saw a repeat of incidents indicating staff were not learning lessons.

Staff met to discuss the feedback and look at improvements to patient care. Staff met daily with the manager to discuss patient care.

There was evidence that changes had been made as a result of feedback. Following a serious assault on staff and the hospital vehicle having to park on the motorway, a new assessment required the patient to be incident free and staff were given instructions not use the motorway.

Is the service effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

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 not always reviewed regularly through multidisciplinary discussion and updated as needed.

Care plans did not always reflect patients' assessed needs, and they did not contain the detailed instructions staff needed.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Staff completed a pre-admission screening assessment document for both patients. Doctors completed an admission document which covered circumstance prior to admission, the patient's presentation, patient history, physical health, medication, and risks.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Care records showed that staff completed physical health assessments on-going from admission, with weekly checks on weight, pulse, blood pressure and other aspects of physical healthcare, with the patient's consent.

Staff developed a comprehensive care plan but did not always keep them up to date for each patient that met their mental and physical health needs. Staff had written 17 care plans for one patient and 12 for the other. None of these were newly written but they were constantly updated. This meant they often conflicted either with each other or within the same care plan. The access to risk items care plan, gave staff instructions on how to monitor the patients use of a pencil. In the next sentence, it said the patient was not allowed a pencil under any circumstances.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff were unable to provide the care and treatment required due to the number of care plans and conflicting information.

The number of care plans and the conflicting information within those care plans meant that new staff were unable to understand the patients' needs quickly, which had resulted in patients obtaining prohibited items on a regular basis and receiving unsafe care as a result.

Staff did regularly review but did not update care plans when patients' needs changed. At the last inspection we found that care plans were not updated after incidents. On this inspection we found this was till the case. Staff had not updated any of the care plans we reviewed following incidents. Staff updated all care plans on a monthly basis with many sharing the same review date.

Care plans were personalised, but not always holistic and recovery-orientated. In the care plan around treats, sweets and chocolate staff outlined a plan where a patient would be rewarded with a bag of sweets for engaging with the multi-disciplinary team.

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. However, these audits had not improved record keeping such as care plans from the last inspection.

Staff provided a range of care and treatment suitable for the patients in the service. All treatments for patients were relevant to the acute setting.

Staff did not always deliver care in line with best practice and national guidance. On our first inspection visit we found that activities delivered in the activity room were not monitored correctly by the occupational therapy staff. For example, there was no system for recording what equipment the patient had accessed during a session and if that equipment was returned at the end of the session. Therefore, there was a risk that patients could secrete prohibited items during these sessions without the staff being aware.

There was also a weekend activity box for staff to use with patients, this was not individualised to the needs of each patient and contained small games pieces. Inspectors giving feedback after the first visit raised concerns to senior managers that a patient with a risk of secreting items should not be given access to this weekend box because of the small pieces.

In between our inspection visits this patient was allowed access to a board game and they inserted game pieces requiring a medical procedure to remove them.

Staff identified patients' physical health needs and recorded them in their care plans. Staff completed physical healthcare plans. This includes specialist asthma care.

Staff made sure patients had access to physical health care, including specialists as required. Staff registered patients with a local doctor's surgery, dentist and optician and we saw that they had accessed these services.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Patients' dietary needs were discussed in multi-disciplinary meetings. The hospital became concerned about patients putting on weight and spending money on treats or takeaways. Staff created a care plan to reduce the daily spending figure and monitor the purchasing of treats.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. One patient took a dog for a walk as part of a dog therapy session and the chef was able to reflect any changing needs such as providing vegan or vegetarian meals.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the Liverpool University Neuroleptic Side-Effect Rating Scale (LUNSERS) to monitor medication-induced side effects. They also used Salford Tool for Assessment of Risk, a mental capacity assessment tool, Health of the Nation Outcome Scale (HoNOS) and the recovery star.

Staff used technology to support patients. Both patients had access to laptops and phones.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Local audits took place such as audits of clinic room fridge temperatures and infection control.

Managers did not always use results from audits to make improvements. We saw evidence of audit discussion and actions recorded in governance meeting minutes. Managers did not use these audits to identify that care plans and risk assessments were not updated and reassessed after every entry.

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 did not make sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision but there were no opportunities to update and further develop their skills.

Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. There was a psychiatrist, specialty doctor, psychologist, and an assistant occupational therapist.

Managers did not ensure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. On the days of our inspection, we asked to see the agency staff profile for the agency staff working. Two of these records showed that restraint and autism awareness training was out of date. One patient's care plan stated only staff trained in restraint could provide observation.

Managers did not give each new member of staff a full induction to the service before they started work. The hospital was unable to provide any evidence that staff received an induction when they attended Willows Green for the first time. They were able to provide a proforma but had not yet put this in place. They were also unable to provide evidence that new staff had an observation competency check.

The hospital opened in March 2022, so no appraisals had taken place but we saw staff had had regular supervision meetings with managers.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers supported medical staff through regular, constructive clinical supervision of their work. We spoke with the psychologist and the provider paid for regular external clinical supervision.

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

We did not see any evidence that managers identified any training needs their staff had outside of mandatory training and did not give them the time and opportunity to develop their skills and knowledge.

Managers did not provide staff with any specialist training for their role. No member of staff could give an example of specialist training they had received.

Managers did not recognise and deal with poor performance. A member of staff, following an incident was allowed to work on the same ward, and still come into contact with the patient they were prohibited from working with. Managers did not conduct the investigation quickly. Managers were only aware that the member of staff was working against their orders when there was an incident between the patient and the member of staff. We were told the member of staff was already under investigation and about to receive a written warning. Managers only took action after the incident.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients.

Staff attended weekly multidisciplinary meetings to discuss patients and improve their care. Those involved in the patient's care both internal and external to the service were invited to attend as well as the patients themselves. We saw carers, family members and commissioners dialled into the meetings.

Staff did not always share clear information about patients and any changes in their care, including during handover meetings. We looked at the daily handovers sheets and the incident reporting sheets. Often these varied in detail about an individual incident. Staff used different terms to describe secretion of objects which left the reader confused as to the severity of the incident. Handover sheets did not contain outcomes from incidents. Staff described one incident as "put medication down pants" with no outcome recorded as to what happened with the medication.

The hospital had effective working relationships with both external and internal teams and organisations.

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.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The service had a Mental Health Act administrator, that staff knew, who was easily accessible and provided support.

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The advocate attended the hospital regularly and had a good working relationship with staff and patients in the service. They also attended safeguarding meetings giving information about the patient's perspective of incidents

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. Assessments were in place to record a patient's capacity to consent to treatment.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Discussions around section 17 leave were recorded with the multi-disciplinary meeting minutes. Both patients enjoyed leave and had been on numerous excursions.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw evidence in records that they had been consulted appropriately.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. The Mental Health Act administrator made sure the service applied the Mental Health Act correctly by completing audits and sharing the findings.

There were no Informal patients.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. There was one patient who had been assessed as not having capacity around money and there was strict guidance on how much money they could spend on a daily basis.

There were no Deprivation of Liberty Safeguards applications made in the last 12 months.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff confirmed these were available for them on the hospital's intranet.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Consent to treatment and a patient's capacity were clearly recorded in all patient records.

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. Capacity decisions were discussed in the weekly multi-disciplinary teams meeting.

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Is the service caring?

Requires Improvement

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

There was a lack of continuity of staff, so they were not familiar with the patients they were caring for. Staff had little understanding of the wellbeing and needs of people using the service.

Kindness, privacy, dignity, respect, compassion and support.

Staff did not always treat patients with compassion and kindness. They did not respect patients' privacy and dignity. They did not understand the individual needs of patients and did not support patients to understand and manage their care, treatment or condition.

Staff were mostly discreet, respectful, and responsive when caring for patients. However, the hospital had allowed staff under investigation to continue to work on the ward resulting in a further incident that negatively impacted on a patient.

At the last inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. On those observations we found staff did not proactively communicate with patients, and mostly staff talked amongst themselves. At no time did we see staff on observations attempt any therapeutic activity with the patient.

On this inspection we completed two observations and we saw staff engaging with the patients. One health care assistant was providing a beauty therapy session for one patient and staff made written entries into a book belonging to a patient who preferred that method.

However, we became aware that one health care assistant was not allowed to work with one of the patients due to an investigation into an incident where the patient had alleged that the staff member had bruised them. This member of staff was still working on the ward and the patient told the advocate that they were distressed by seeing the staff member.

There was also an incident which occurred because the member of staff was allowed to observe this patient in breach of the hospital rules. This caused the patient distress as they alleged the member of staff threatened to arrange a sexual assault.

Staff did not always give patients help, emotional support and advice when they needed it. Patients told us that some staff were good but others did not engage with them. Carers told us they did not believe the hospital understood the needs of their loved ones. One family was clear their loved one had suffered distress and pain as the hospital had not updated that patients' hospital passport to identify they needed specialist needles to withdraw blood. The other patient's family raised concern particularly around staff working weekends and their lack of understanding of their needs.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff did not always support patients to understand and manage their own care treatment or condition. For example, one patient at their previous placement had been independent enough to occasionally cook their own meals. Carers were particularly concerned that since they had been at Willows Green, they no longer cooked their own meals.

Staff directed patients to other services and supported them to access those services if they needed help. Patients accessed GP services, dentists, and opticians.

Patients said some staff treated them well and behaved kindly. However, both patients and their carers were generally negative about their experience of the service. Patients went on leave and enjoyed trips to the theatre and pet therapy.

Staff did not always understand or respect the individual needs of each patient. At the last inspection we had concerns about the skills and knowledge of staff on duty in relation to the patients they were caring for. Staff undertaking observations were not provided with important information they needed to keep patients safe and provide the care they needed.

At the last inspection staff members undertaking observation with patients did not know the individual risks relating to the patient they were observing. When asked, staff told us they were there to prevent self-harm, however they had no knowledge of the patients.

On this inspection staff completing observations did have information about the patient with them and were able to explain to inspectors what risks they were there to monitor.

Staff prohibited a long list of items for one patient but there were numerous incidents where they had obtained these items and secreted them. Staff conducting observations had advice about the patients in the form of a one-page information sheet. There was conflicting advice on these.

The changing staff, be they bank or agency, meant that staff had not been fully briefed or there was not a system in place to ensure they were fully briefed. During the inspection we found an agency nurse relatively new to the service. They did not know where the patient care plans were and asked about giving one of the patient's money, when it was clear in the patient's documentation, they were not to be given access to money. In another incident the nurse in charge allocated inappropriate staff for observation. Managers advised this was due to a new nurse not understanding that was inappropriate. What was not clear was why the staff member had not identified that they could not do that task when asked to do so.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. They said that managers had an open-door policy and staff could go to them to share any concerns.

Staff followed policy to keep patient information confidential.

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. The hospital had an admission pack to give to patients. They also had staff information boards with information and pictures of staff.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff involved patients and gave them access to their care planning and risk assessments. Care records showed that patients were always offered copies of care plans, and risk assessments showed evidence of patient involvement.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. One patient was selectively mute and staff either communicated with her by writing in a journal she kept or through email.

Staff involved patients in decisions about the service, when appropriate. Community meetings were held and we saw minutes from the meetings. These showed consideration of patients' thoughts and outlined attempts to include patients on improving the service.

Patients could give feedback on the service and their treatment and staff supported them to do this. The hospital manager was well known to the patients and they saw him on daily basis and were able to communicate issues directly to him.

Staff supported patients to make decisions on their care. Patients attended multi-disciplinary meetings where care plans were discussed with them.

Staff made sure patients could access advocacy services. We saw the advocate visited the hospital and spoke with patients.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always support, inform, and involve families or carers. One family felt that following an incident they were left confused as to the outcome of the investigation and how the member of staff had been disciplined. The hospital told them the member of staff would no longer be used except in an emergency, they felt this was inappropriate. The hospital eventually advised the member of staff had been removed completely in a safeguarding meeting. The family felt they received conflicting information and had been told that staff changed their relative's hospital passport when it had not been.

Staff helped families to give feedback on the service. We saw that families attended multidisciplinary meetings either in person or online and were able to give their feedback.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good

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

Access and discharge

Staff planned for patient discharge. There had been no discharges since the hospital had opened.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers made sure bed occupancy did not go above 85%. The hospital admitted two patients since opening in March 2022 and discharged none. The same two patients were at the hospital at the time of inspection.

The service had no out-of-area placements. Patients came from the North West of England.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. There were long term plans for the patients to be discharged into community care.

Managers and staff worked to make sure they did not discharge patients before they were ready. There had been no discharges since the hospital had opened.

Discharge and transfers of care

Managers had plans to monitor the number of patients whose discharge was delayed, however at the time of inspection there had been no delayed discharges.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We saw that discharges had been discussed with commissioners.

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 had access to hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw examples of patient bedrooms containing personal items including pictures and patients told us staff supported them to make their rooms more homely. We saw each patient had a blackboard on the wall and staff wrote messages on the board about what was happening on the ward that day.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. There was a dedicated occupational therapy room outside the ward and a small occupational therapy kitchen. One of the patients told us they felt their development had been hindered by this as they used to cook their own meals regularly before being admitted to the hospital. We were told there were plans to build a new occupational therapy kitchen.

The service had quiet areas and a room where patients could meet with visitors in private. Visitors met patients outside the ward environment in a dedicated meeting room.

Patients could make phone calls in private. Patients had mobile phones and used them whenever they wished.

The service had an outside space that patients could access easily. There was a large, grassed area outside the ward.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patients could not make their own hot drinks and snacks and were dependent on staff. This was consistent with the threat of patients throwing hot drinks over staff and in line with physical health care plans to tackle obesity.

The service offered a variety of good quality food. There was a chef at the hospital and they tailored the meals to reflect the patients' needs and requests.

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. At the last inspection we saw patients could go out on trips and had taken part in activities such as horse riding, visits to football stadia and attended college. Patients continued to go out on activities and they had been on other excursions including to the theatre.

Staff helped patients to stay in contact with families and carers. Both patients were in regular contact with their families.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. However, both patients were known to each other before being admitted to the hospital. They did not like each other and had not developed a relationship despite being nursed on the same ward.

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. There was access to adapted bedrooms and bathrooms to support those with mobility needs. Staff told us that easy read information about medication and some other topics were available and were printed off for patients when required.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. There were notice boards and leaflet racks, which included a range of information. This included information about the ward, treatments, medication, advocacy, and complaints.

The service had information leaflets in different languages and arrangements in place for interpreters or signers when needed. The hospital had not needed to use these services, but they were tried and tested at another hospital operated by the same owners.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service did not always treat concerns and complaints seriously, investigate 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

Inadequate

Patients, relatives, and carers knew how to complain or raise concerns. At the last inspection we were told by patients, families, and commissioners they had concerns about staff treatment of the patients. There were outstanding safeguarding enquiries at this inspection which had not been completed from these incidents.

Patients and carers at this inspection told us they still had concerns. We found repeated incidents and several outstanding safeguarding enquiries including some persons in a position of trust (PIPOT) referrals which related to allegations against staff.

Families told us they were not confident that what they were told accurately reflected what had happened. They received different accounts in different forums.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they tried to deal with complaints informally in the first instance, if possible, but would then raise a complaint to senior staff if it became necessary.

Managers were not responsive when investigating complaints and identifying themes. Managers did not act quickly to investigate complaints or allegations. When questioned about incidents that had occurred, they said they were waiting to interview staff about those incidents.

Staff did not protect patients who raised concerns or complaints from discrimination and harassment. Managers had allowed staff subject to complaints to continue working on the ward and the nurse in charge had allocated that nurse to directly observe a patient they were alleged to have assaulted. The staff member themselves had started to observe the patient without recognising this was inappropriate.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they were informed about complaints and incidents in handovers, supervision and team meetings. However, this did not effect change. Patients still obtained prohibited items and staff still worked with patients after they had been told not to.

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

Is the service well-led?

Inadequate

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Leadership

There had been a constantly changing leadership team which had resulted in the current leadership team still completing investigations for incidents that had occurred months before their appointment. There were not enough leaders and those in post did not have the skills, knowledge, and experience to perform all the leadership tasks required. Leadership within the service was inconsistent. Managers did not immediately investigate incidents and hold staff accountable. Roles and responsibilities within the service were not clear.

Leadership roles at the hospital were constantly changing. Since the hospital had opened in March 2022 there had been four managers in place and two deputy managers. At the time of our inspection there was no deputy manager in post. We were told that another hospital manager was due to take over the managers role and a clinical lead would also be in place by April 2023.

At the time of this inspection this meant that the hospital was being run by one manager, with support from a senior management team dividing its time between two hospitals and visiting Willows Green one day a week. This meant the leadership team for Willows Green did not have sufficient support, knowledge or experience to perform their role. For example, the hospitals safeguarding contract with the local safeguarding board had been identified in January 2023 as not meeting the required standard. At the time of our inspection the provider had made no progress in updating the policy to meet the local requirements. Safeguarding leads at the local authority told us the manager had cancelled a meeting with them due to other commitments.

At the last inspection staff were not suitably trained in safeguarding and managers had not ensured all staff received face to face training. However, investigations into safeguarding incidents were still concluded as quickly as possible. We saw incidents where staff statements had not been collected as soon as possible. There were still several outstanding investigations of Persons in a Position of Trust (PIPOT) safeguarding referrals which the local safeguarding board had been unable to close as the hospital had been unable to conclude their enquiries.

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 vision and values of the team and organisation.

Staff had the opportunity to contribute to discussions about the strategy for their service.

The provider's vision and values were displayed on team meeting minutes and there were posters on the premises. Staff we spoke with told us these were included in the induction program.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity and they could raise any concerns without fear. However, it was unclear how senior managers prevented closed cultures from developing.

All staff we spoke with said they felt supported and valued at the service, with both management and staff saying they felt the staff team were happy. Staff told us the role could be stressful, but that they were managed and supported by colleagues and senior staff.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

There were no reports of bullying or harassment at the service, and all staff we spoke to knew how to use the whistleblowing process. All staff told us that they felt they could raise concerns to management about the service without fear of retribution.

We were not reassured managers were able to demonstrate they were doing everything possible to prevent a closed culture developing at the service. The same staff worked nights and we saw evidence that staff did not always follow managers instructions, such as allowing staff prohibited for working with certain patients being able to do so. There was only one manager at the time of inspection, and nurses on nights were in the majority bank or agency staff, so it was not clear how they could closely supervise those working nights to ensure they represented the providers culture on all occasions.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

There was a clear set agenda for senior management clinical governance and corporate governance meetings. The corporate governance group should be attended by the nominated individual, shareholder representatives and lead consultant. However, in 6 months prior to the inspection no member of the senior management team had attended the clinical governance group with the registered manager the most senior member of staff present.

Within the structure of the corporate governance group the hospital manager reported on the following areas, Clinical Effectiveness and Research, Audits, Risk Management, Education and Training, Service User and Public Involvement, Health and Safety, Information and IT, Covid Safety, Staffing & Management Facilities and any other business. Safeguarding was an item within risk management but it was difficult to identify corporate scrutiny of investigations as in two out of three minutes provided the recorded minutes were “Safeguarding – As Above “. There was no further information about investigations within those minutes.

Managers failed to put in systems which ensured all care plans and risks were identified and followed. We saw incidents where staff had not followed management instructions. For example, allowing patients to obtain prohibited items. We examined incidents that occurred at the time of or immediately before, our inspection. Managers told us these incidents occurred because the nurse in charge was often bank or agency and new to the service. We saw evidence of this when a nurse asked in a daily briefing how much money they could give to a patient whose care plan clearly outlined they were not to be given money under any circumstances.

At the last inspection we found investigations were still on going after several weeks and this was still the case, with one investigation ongoing from 2022. At the time of this inspection there was one manager responsible for the hospital. We found they struggled to complete relatively straight forward investigations quickly. One patient complained a member of staff had said something inappropriate to them, the patient was under 2:1 observation and six days after the second member of staff who observed the incident had not submitted a statement.

Staff undertook or participated in local clinical audits. However, audits did not always identify issues. For example, staff rewrote care plans, recorded confusing information and did not update risk assessments.

Management of risk, issues and performance

Staff did not always have the information they needed to provide safe and effective care.

Managers discussed and monitored risk daily at morning handover meetings, and risk was regularly discussed at clinical governance meetings.

The star risk assessment for each patient, available to staff on the ward, did not contain all incidents recorded in the hospital incident register and vice a versa. When the incident form and the risk register were compared the information about the incident often varied. As at the last inspection we were not assured that the information available to staff reflected an accurate record of the risks that the patient presented to themselves or others.

The service had a local risk register to capture operational issues relevant to the location. Staff could escalate issues to a regional and national risk register as appropriate. The risk register recognised the need for more female staff, the need to reduce agency staff for continuity of care, management restructuring changes, maintenance issues and covid infection control.

As we found at the last inspection incidents were not always reported, and appropriate notifications were not always made to external bodies when required. Safeguarding leads and the Care Quality Commission received notifications several days after incidents.

The service had plans for emergencies, for example, adverse weather or a flu outbreak. There were continuity plans in place for all service areas.

Information management

Staff collected analysed data about outcomes and performance. There was no central incident recording system and the provider did not make notifications to external bodies as soon as possible.

The service used systems to collect data which were not onerous for frontline staff.

Leaders had access to information that supported them to adapt and develop performance. They used the information gathered to generate improvement.

Staff had access to the equipment and information technology needed to do their work. There was an electronic daily notes record system. All staff had access to the system. Other records such as care plans and risk assessments were paper records. As at the last inspection the hospital was still reliant on administrative support which was usually one day a week to update records such as incident registers. This meant managers and staff did not have access to up-to-date information about patient incidents.

The provider did not have a central system for recording incidents, including organisational incidents or to collect and manage data on adverse events. There was a separate system for recording staff incidents and again these were handwritten reports.

Managers could use dashboards to evaluate information across the service and any issues.

Information governance systems included confidentiality of patients' records.

Staff did not make notifications to external bodies as needed. We saw that safeguarding reports were often submitted days after incidents. On our visit on the 9 March, we saw safeguarding incidents from the 4 and 5 March which had still not been reported. We saw notifications where the service had called the police, but these had not been submitted in a timely manner.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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 hospital was engaged with several partner organisations to develop and improve the service. This included weekly visits from commissioners and the local safeguarding board held regular meetings to discuss safeguarding incidents.

Learning, continuous improvement and innovation

The service included quality improvement information within its governance meeting structure.

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider must ensure that its safeguarding policy is compatible with the standards of the local safeguarding board. (Regulations 13 (2)(4)(b)). The provider must ensure that systems and processes are in place to report and investigate safeguarding incidents quickly and efficiently to ensure those exposed to, or suffering abuse are safeguarded. (Regulations 13 (3)).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure that staff receive an induction to Willows Green Hospital. (Regulation 17(1)(2)(a)). The provider must ensure that a leadership team remains in place to establish systems and processes to ensure compliance with the regulation. (Regulations 17(1)). The provider must ensure that care plans are contemporaneous, accessible, personalised, holistic and strengths based and reflect the assessed needs of the patient. (Regulations 17(1)(2)(a)(c). The provider must ensure they quickly investigate, review, and reflect on incidents of restraint to ensure that patients are kept safe. (Regulations 17(1)(2)(a). The provider must ensure that lessons learnt on safeguarding, incidents, complaints, and reflective practice are shared with staff and that staff implement those lessons to prevent reoccurrence. (Regulations 17(1)(2)(a).

This section is primarily information for the provider

Requirement notices

	The provider must ensure that governance processes operate effectively at team level and that performance and risk are managed well. (Regulations 17(1)(2)(a)(b)(f)).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must ensure the environment meets the needs of the patient, for example ensuring the noise of closing doors does not affect the wellbeing of the patients. (Regulation 9, (1)). The provider must ensure that care plans are contemporaneous, accessible, personalised, holistic and strengths based and reflect the assessed needs of the patient. (Regulation 9(3)(b)).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider must ensure that there are enough suitably qualified, skilled, and experienced staff to meet the patient's needs. (Regulations 18(1)). • The provider must ensure that staff receive an induction to Willows Green Hospital. (Regulations 18(1).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure care is delivered in a safe way doing all that is reasonably practicable to mitigate any such risks such as preventing patients from accessing restricted items. (Regulation 12, (1)(2)(b))

This section is primarily information for the provider

Requirement notices

The provider must ensure staff conducting observations have the training and competency checked to complete observations. (Regulation 12, (1)(2)(c)).

The provider must ensure that patients' risk assessments accurately reflect patients' risks and that these are reviewed and updated in line with the providers policy. (Regulation 12(2)(a)).

This section is primarily information for the provider

Enforcement actions

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans were not rewritten and when they were updated, previous care instructions remained within the care plans which contradicted current care instructions. We saw health care assistants undertaking observations following an undated care plan which provides information about items patient A might use to insert or ingest. The care plan instructs staff they should assess the patients' presentation before they could have prohibited items. It is not clear who should decide if the patient is allowed access to prohibited items. Staff conducting observations were also in possession of a patient profile which for patient A gave conflicting advice as to whether the patient could have possession of pens, pencils and crayons. Staff were unsure as to what the patients could or could not have. We witnessed a briefing where the nurse asked the registered manager if patient A could have some money for leave that day. The care plans state explicitly that the patient is not allowed money due to the risk of them ingesting or inserting coins. Patient B had a hospital passport dated November 2022, within that passport there was no information to alert other health professionals that they required a specialist needle to give blood samples. They had attended hospital for five days in January 2023 and the patient's family told us that Patient B had become distressed as staff tried to take samples with ordinary needles. The family told inspectors that they had been told the hospital passport had been updated since the visit in January. It had not been.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments were not up to date, they were entered manually onto the risk register. The risk assessments did not contain all incidents. Staff did not prevent Patient A from completing acts of self harm. Patient A had undergone two medical procedures in a week to remove items from their vagina. On the 2 March 2023, Care Quality Commission inspectors told the hospitals senior management team, they were concerned that Patient A had access to small board game pieces and that the service should reassess that risk. On the 5 March 2023, Patient A inserted some small board game pieces into her vagina. Staff had not followed standard procedures for counting objects so they could assure themselves that all items were recovered. Patient A returned some items to staff after de-escalation but several hours later required hospital admission to remove another object from her vagina.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was unable to provide records relating to people employed. There were no completed induction checklists to show that staff had been inducted into the hospital and understood key information about the running of the service including safety. There was no competency check of staff ability to complete patient observations safely. There was no central system for recording all incidents, including organisational incidents or to collect and manage data on adverse events. The provider responded to our urgent concerns raised formerly on 10 March 2023. They provided updated care

This section is primarily information for the provider

Enforcement actions

plans and risk assessments, but there is a gap between documentation and practice which has resulted in Patient A continuing to ingest or insert objects despite being under 2:1 observation.

The provider an action plan, on the 12 March 2023 addressing immediate concerns. However, actions around competency of staff for observation had been graded as complete. No assurance was provided that staff had been trained and their competency assessed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have a safeguarding policy in place which met the standards of the local safeguarding board. The registered provider did not have effective systems and processes to ensure it had oversight of safeguarding. There was no overview of safeguarding investigations other than those recorded by the registered manager. The incidents on the 4 and 5 March 2023 had still not been reported to the local safeguarding board by 9 March 2023. Safeguarding incidents being investigated were kept on a separate spreadsheet populated by the registered manager. It was not clear how this system ensured other members of the senior management team were aware of how safeguarding incidents were investigated if the registered manager became absent. For example, the only person who knew that the incidents on the 4,5 March 2023 had not been been reported to the local safeguarding board was the registered manager.