Waterloo Manor Limited

Waterloo Manor Independent Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The ward environments were not always safe or clean and staff were not always following guidance in relation to infection control.
- The premises did not always promote privacy and dignity for all patients.
- Staff on Cedar and Maple wards did not consistently assess and manage risk well.
- Although staff engaged in clinical audit to evaluate the quality of care they provided, audits were not always effective in identifying issues.
- Not all checks following rapid tranquilisation were accurately recorded on Cedar ward.
- Not all care plans on Maple ward were comprehensive.
- Care plans did not accurately reflect the assessed physical health needs of all patients
- Staff did not always understand and discharge their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Not all staff had received up to date supervision or had access to regular team meetings.
- Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.
- Staff did not always feel respected or valued.

However:

- The wards had enough nurses and doctors. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- In the main staff developed 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.
- 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 and appraisals.
- 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.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	Our rating of this service stayed the same. We rated it as requires improvement because: • The ward environments were not always safe or clean and staff were not always following guidance in relation to infection control. • The premises did not always promote privacy and dignity for all patients. • Staff did not consistently assess and managed risk well. • Not all checks following rapid tranquilisation were accurately recorded on Cedar ward. • Although staff engaged in clinical audit to evaluate the quality of care they provided audits were not always effective in identifying issues. • Not all care plans were comprehensive. • Staff did not always understand and discharge their roles and responsibilities under the Mental Capacity Act 2005. • Not all staff had received up to date supervision or had access to regular team meetings. • Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well. • Staff did not always feel respected or valued. However: • The wards had enough nurses and doctors. They minimised the use of restrictive practices and followed good practice with respect to safeguarding. • Staff developed 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.

Summary of findings

- 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 and appraisals.
- 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 mainly 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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

- Not all wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.
- Staff were not always following guidance in relation to infection control.
- The premises did not always promote privacy and dignity for all patients.
- Not all staff had received regular supervision or had access to regular team meetings.
- Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.
- Staff did not always feel respected or valued.

However:

- 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.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers

Summary of findings

ensured that these staff received training 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 developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Summary of findings

Contents

Summary of this inspection

Background to Waterloo Manor Independent Hospital

Waterloo Manor Independent Hospital is an independent hospital for up to 54 women who have a mental illness and/or personality disorder. At the time of our inspection 49 beds were in use. Some of the women may have a learning disability in addition to a mental illness. All patients are detained under the Mental Health Act.

There are 25 forensic/low secure beds across two wards:

• Cedar - 12 bed low secure ward primarily for women with a diagnosis of personality disorder

• Maple - 13 bed low secure ward primarily for women with a mental illness

There are 22 rehabilitation beds across two wards:

• Larch – eight bed high-dependency rehabilitation ward primarily for women with a diagnosis of personality disorder

• Hazel – 14 bed locked rehabilitation ward for patients with a diagnosis of personality disorder and/or mental illness. 2 of the beds were not in use at the time of this inspection.

There are seven further beds that offer less restrictions and semi-independent living:

• Lilac – four beds

• Holly – three beds (annexed to Hazel ward)

15 secure beds are commissioned by the West Yorkshire collaborative, the remaining 10 are for spot purchase by any appropriate commissioning teams country wide. Patients are admitted to the rehabilitation wards from across the country, by individual clinical commissioning groups.

Waterloo Manor Independent Hospital has been registered with the Care Quality Commission since 2011. It is provided by Waterloo Manor Limited, which are part of the Inmind Healthcare Group.

It is registered to provide the regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; treatment of disease disorder or injury; and diagnostic and screening procedures.

The service had a registered manager at the time of our inspection.

We have previously inspected Waterloo Manor Independent Hospital nine times since its current registration began. The service was last inspected by the Care Quality Commission in April 2021. It was rated as requires improvement overall; requires improvement in the safe and well lead domains, and was unrated in effective, responsive and caring domains.

At the last inspection we found that the hospital was not meeting all the Health and Social Care Act (Regulated Activities) Regulations 2014. We issued the provider with a requirement notices under regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment and regulation 17 HSCA (RA) Regulations 2014 good governance.

Summary of this inspection

We carried out this unannounced comprehensive inspection because we had not carried out a comprehensive inspection since 2018.

What people who use the service say

We spoke to 19 patients who were using the service.

Seven patients on the rehabilitation wards told us that permanent staff in general were caring and compassionate, three patients said staff were the most compassionate they had ever encountered. However, all patients told us that there were too many agency staff and this impacted on continuity of care.

Patients on the rehabilitation wards said there was a good range of activities available and they said that section 17 leave was only ever cancelled due to changes in risks, never because of staff shortages.

Patients on the rehabilitation wards told us that they thought the furniture and décor on the wards needed to be updated. They also told us that there was a lack of quiet and private space. Some patients said the wards were not very clean.

Seven patients on the low secure wards told us that staff were supportive, and that staff would sit with them when they needed support. Two patients felt that staff were uncaring, and one patient said they did not feel safe on the ward.

Most patients on the low secure ward told us the ward was unkempt and several patients told us the shower made the toilet seat wet, and that they needed a bigger fridge.

Patients on the low secure ward provided a mixed response to activities available on the ward.

We spoke to five families or carers of patients who were using the service.

Families and carers told us that they were offered the opportunity to be involved in patients care where it was appropriate, however, one person told us that they had not been invited to take part in MDT meetings.

Families and carers that had visited the hospital said it was clean and tidy. They told us that generally staff were friendly and helpful and responsive to patient's needs, but one person told us that staff did not communicate well with them.

How we carried out this inspection

The team that inspected the service comprised of five CQC inspectors, a Mental Health Act reviewer, one expert by experience and two mental health nurse specialist advisors.

During the inspection, the inspection team:

- visited all wards
- spoke to 19 patients who were using the service
- spoke with the registered manager, clinical director and the consultant psychiatrists
- spoke with four ward managers
- spoke with five carers/relatives

Summary of this inspection

- spoke with 26 staff members including nurses, support workers and therapists and the service user involvement worker.
- spoke with one worker from external agencies
- looked at 15 care and treatment records and three seclusion records for patients.
- attended meetings specific to patient care and the running of the service
- looked at a range of policies, procedures, and other documents relating to the running of the service.

Visits were unannounced and took place on 22 and 23 March 2022.

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.

Outstanding practice

We found the following outstanding practice:

- Patients had been involved in and consulted with on recent recruitment of senior staff at the hospital. The patients had produced their own interview questions and patient's feedback on interviews had been weighted at 40% of the overall score for the posts.

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:

Forensic inpatient or secure wards

- The hospital must ensure that the premises are clean, that effective infection control measures are in place and being observed and that the environment and furnishings are well maintained. Regulation 12(2)(d)(e)(h)
- The hospital must ensure that seclusion rooms are well maintained, clean and fit for purpose
- The hospital must ensure that defibrillators are regularly serviced and safe to use
- The hospital must ensure that care plans reflect the assessed physical health needs of all patients
- The hospital must ensure that effective governance processes are implemented and followed to ensure safe care and treatment of patients. Regulation 17(2)(a)(b)

Long stay or rehabilitation mental health wards for working age adults

- The hospital must ensure that the premises are clean, that effective infection control measures are in place and that the environment and equipment are well maintained and safe to use. Regulation 12(2)(d)(e)(h)
- The hospital must ensure that seclusion rooms that they use are well maintained, clean and fit for purpose
- The hospital must ensure that effective governance processes are implemented and followed to ensure safe care and treatment of patients. Regulation 17(2)(a)(b)

Summary of this inspection

Action the service SHOULD take to improve:

Forensic inpatient or secure wards

- The service should ensure that staff are following the seclusion policy and the mental health code of practice when secluding patients.
- The service should ensure that risk information in patient records is clearly identified and up to date.
- The service should ensure that all patients checks are carried out and recorded accurately and in line with national guidance following the use of rapid tranquilisation.
- The service should ensure that all staff are offered regular supervision and the opportunity to attend regular team meetings.
- The service should ensure that where required staff carry out Mental Capacity Assessments with patients.
- The service should ensure that effective audits are being carried out and that identified improvements are effectively actioned.
- The service should consider carrying out physical health treatments such as depot injections in a suitable space away from patient's bedrooms.

Long stay or rehabilitation mental health wards for working age adults

- The service should ensure that agency staff are adequately inducted and supported to be able to carry out their role
- The service should ensure that staff are following guidance in relation to infection control
- The hospital should ensure that premises continue to promote privacy and dignity for all patients.
- The hospital should ensure that all staff are offered regular supervision and the opportunity to attend regular team meetings.
- The hospital should ensure that all physical health monitoring is carried out as instructed in care plans or directed by medical and nursing staff.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Requires Improvement

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

Safe and clean care environments

All wards were not safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all ward areas. Staff completed security checks of the ward environment twice a day. The fire alarms were tested weekly and patients had personal emergency evacuation plans. Management carried out an annual risk assessment of the premises.

Staff could observe patients in all parts of the wards. Blind spots were mitigated by mirrors and staff presence.

The service had completed a ligature risk assessment for both wards which was in date and identified potential ligature anchor points and risk mitigations.

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

Maintenance, cleanliness and infection control

We found some ward areas that were not clean, the wards were not well maintained or well furnished. The seclusion room in Maple ward was dirty, although other areas of the ward were visibly clean. The walls contained marks where holes had been filled but not decorated over and there were no curtains or blinds in the quiet room on Maple ward which meant the room was very warm as there was no protection from the sun.

The furniture was tired and some of the furniture was stained, cracked and visibly damaged which meant it was not possible to clean. There was a large area of the laminate floor that had been ripped up on cedar ward and one of the windows had a crack in it. The service employed maintenance staff who carried out minor repair work.

When we highlighted these issues to the registered manager, they told us they were aware of the issues and had costed new furniture and maintenance work to fix the problems with the physical environment on the ward.

Some of the windows overlooked the courtyard and there was no barrier to prevent someone from seeing directly into patient's rooms when the curtains were not closed. When we highlighted this, the manager obtained and installed some privacy film, which prevents direct observation into patient's rooms.

Although staff made sure cleaning records were up-to-date and we saw cleaning being carried out the damage to the ward meant that cleaning was not able to be carried out effective in some areas of the ward.

Staff did not always follow infection control policy. Not all staff were wearing masks on the wards. This was particularly concerning because one of the wards had patients who were Covid positive and there was a risk of this being spread due to insufficient infection prevention control measures. We did see staff washing their hands and hand gel was available on the wards.

Seclusion room

There were two seclusion rooms, one on Maple ward and one on Cedar ward. The seclusion room on Maple ward did not allow clear observation. It was difficult to observe what was happening in the seclusion room because there was a reflection from one window in the other and clear observation was only possible if the light was turned off. The observation to the ensuite is through a spy hole. This limited staff ability to maintain a clear line of sight at all times.

There was an intercom system in place which enabled two-way communication and the room contained a toilet and shower. The shower drained away from the plughole which meant water remained in the room. The room did not have a clock that patients could see although staff told us they could use the clock in the staff office. Both seclusion rooms had mattresses and blankets and pillows were available.

The blinds to the seclusion room on Maple ward could only be operated from inside the room which could be difficult to access if a patient was distressed. The door to the outside area contained a large window pane which could not be covered. This meant the level of lighting in the room could not be adjusted. There were many areas which a patient would be able to access and cause damage by picking at the environment. This included battens on the wall corners, cracks in the plaster, peeling filler in cracks. This made the environment unsafe. The secure garden area on Cedar ward contained a broken settee.

When we discussed this with the registered manager, they were aware of the concerns about the seclusion room and told us that four safety pods had been purchased. These were to be used for patients that were a risk to themselves. Patients who were a risk to others would still be placed in the seclusion room as a last resort. Patients who were likely to be secluded had comprehensive care plans in place to attempt to avoid this intervention.

Clinic room and equipment

Clinic rooms were not fully equipped, with accessible resuscitation equipment. There was no suction machine on Cedar ward and if staff needed a suction machine had to get one from Larch ward. Suction machines are used to remove an obstruction from a person's airway. This was a potential risk to patients on the ward because some patients were identified as being at risk of choking. We highlighted this to the provider, and they obtained a suction machine for Cedar ward on the second day of our visit.

Staff did not always check and maintain, equipment. The defibrillators had not been serviced since 2020 and the defibrillator pads on Maple ward were out of date. A defibrillator is used to treat someone in an emergency that has gone into a cardiac arrest. We pointed this out to staff whilst we were onsite and following our inspection, we received confirmation that the defibrillators had been serviced.

However, the clinic rooms were clean and tidy. The drugs cupboard and fridge were in good order and temperature checks had been carried out. Medicines were in date and staff checked emergency drugs regularly and these were in date. Equipment was clean and stored correctly.

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 had high vacancy rates. Cedar ward had two registered nurse vacancies, one senior support worker and six health care worker vacancies. Maple ward had two registered nurse vacancies, one senior health care support worker and seven health care worker vacancies.

Recruitment strategies were in place and the provider had recruited a number of international nurses.

The service had high rates of bank and agency nurses. Managers attempted to mitigate this by requesting regular agency staff, who were familiar with the service. Some agency staff had an established shift pattern on the ward which helped with consistency. Staff told us there was less consistency at night and the rotas showed that there was sometimes only one permanent member of staff on shift.

Managers made sure all bank and agency staff had an induction and understood the service before starting their shift.

The service had high turnover rates. 52 staff left the hospital in 2021-22 and there were 22 new starters in that time. There was evidence that staff were leaving permanent positions and returning to work for the hospital through the agency because of the better rates of pay.

Levels of sickness were low and / or reducing. Staff told us that although managers supported staff who needed time off for ill health, the hospital did not provide sick pay to staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The establishment levels on each ward at the time of our visit were one qualified nurse, one senior support worker and seven health care workers for each ward. This was higher than the baseline establishment levels due to the acuity and needs of the patients on the ward. The ward manager could adjust staffing levels according to the needs of the patients.

Patients had one to one sessions with their named nurse. Most patients told us they received one to one time when they needed it.

Patients rarely had their escorted leave or activities cancelled on Cedar ward because there was enough staff to facilitate these activities. However, we were told that leave and activities, that were not ward based were sometimes cancelled or moved around on Maple ward.

The service had enough staff on each shift to carry out any physical interventions safely. The service had an alarm system in place which meant staff could summon help from other wards.

Requires Improvement

Forensic inpatient or secure wards

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. There were three consultant psychiatrists in the hospital and they operated an on-call system when they were not present on the ward.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of most patients and staff.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. 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. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed seven patient records. Staff completed risk assessments for each patient on admission / arrival, using a recognised tool. Although risk assessments had been reviewed regularly on Cedar ward including after incidents, risk assessments had not always been regularly updated for Maple ward. We found two risk assessments that had not been updated for over a year and another risk assessment that had been updated in January but had not been updated for over a year before that. However, we found that risk management plans were updated more frequently. We were told that risk assessments should be updated monthly or following incidents. In addition, the doctors completed a start risk assessment which needed to be updated every three months.

We found that the different risk assessments and risk management plans did not always contain the same information. For example, we found contradictory information about self-harm on a patient's risk management plan and their My Shared Pathway form. We also found incidents that were documented in patients care plans but not documented in their risk assessments which could be confusing for staff.

Management of patient risk

Staff knew about risks to each patient and acted to prevent or reduce risks. Risks to each patient were discussed at the MDT meetings and discussed and documented at each handover meeting. Some basic information was also recorded in the observation folder. However, there were several documents containing patient risk information and the information was not always consistent across documents which could lead to staff having inaccurate information.

Staff did not always identify and respond to any changes in risks to, or posed by, patients. We found some incidents that were not updated in patients risk assessment. However, some risk assessments were up to date and were accompanied by current risk management plans.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. However, staff seemed unclear about when patients mail should be searched. Some staff told us that staff observed all patients opening their mail whilst other staff referred to individual restrictions. We found that documentation regarding whether patients needed to be observed opening their mail was inconsistent, with

contradictory information in different documents. We also found one section 17 leave form which required staff to complete a full search of a patient, including their undergarments, on return from leave. This was contrary to the organisation's policy which stated that out layers of clothing only should be removed for a search that is agreed to and no clothes should be removed when a patient does not give consent to a search.

Use of restrictive interventions

Levels of restrictive interventions were reducing.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restraining patients only when these failed and when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff did not always follow NICE guidance when using rapid tranquilisation. One rapid tranquilisation record on Cedar ward showed that staff did not record the patient's pulse or their breathing rate due to the patient being asleep and refusing the checks, although they recorded their level of alertness and that they could see breathing, these records lacked detail and were incomplete. This was concerning because the medicine administered can cause respiratory depression and staff were not monitoring the patient's pulse or recording their breathing rate.

When a patient was placed in seclusion, staff kept clear records but did not always follow best practice guidelines. We found one example of seclusion where there was no evidence in the care record that the seclusion was authorised or terminated by the psychiatrist. This was not in line with the mental health code of practice.

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. Staff received adult and children safeguarding training at appropriate levels for their job roles in line with the intercollegiate guidance.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The hospital had a good relationship with the local safeguarding authority and responded openly when information needed to be shared.

Staff followed clear procedures to keep children visiting the ward safe. Children visiting patients used the visitors' room and did not go onto the ward. Visits were planned in advance with support from the social work team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital had a social work team who managed safeguarding referrals and there were two safeguarding leads who could offer support to staff who had any safeguarding queries or concerns.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain clinical records but they were not always comprehensive or consistently stored – whether paper-based or electronic.

Requires Improvement

Forensic inpatient or secure wards

Patient notes were not always comprehensive. Staff wrote up notes once every shift which meant that there was no record of each interaction throughout the day between staff and patients. Not all incidents had not been written up in the patients notes, however we found incidents that had not been recorded were logged in the handover.

All staff could access the patient records easily and 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 medicines on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely.

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

Staff did not always complete medicines records accurately. We found that medicines were accurate and up to date on Cedar ward, however we found that some medicines errors on Maple ward including a depot prescription that had not been signed by the prescriber and patient names that were spelt inconsistently on different documents.

Staff stored and managed all medicines and prescribing documents safely.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behavior was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

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. They used an electronic system to input information which was then shared with relevant staff.

Staff reported serious incidents clearly and in line with the provider policy. We saw examples of serious incident investigations. These were detailed and included a summary of lessons learnt and related actions.

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. They kept detailed logs of incidents and complaints and it was clear that ever effort was made to ensure that families were kept informed when it was necessary.

Managers debriefed and supported staff after any serious incident.

Requires Improvement

Forensic inpatient or secure wards

Managers investigated incidents thoroughly.

Staff received feedback from investigation of incidents, both internal and external to the service. Feedback was usually discussed in supervision sessions and staff debriefs. There was evidence that changes had been made as a result of feedback. For example, managers increased staffing levels following an increase in aggression between patients on the ward. This change proved effective, and we saw the number of incidents had decreased.

Are Forensic inpatient or secure wards effective?

Requires Improvement

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

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 were personalised and recovery oriented but did not always fully reflect patients' assessed needs. Some contained a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a care plan for each patient that met most of their mental and physical health needs. However, the care plan did not always give clear guidance regarding more complex physical health needs. For example, we found that care plans did not give clear guidance to staff regarding how to support patients with diabetes or eating disorders.

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

Care plans were personalised and recovery orientated. We saw some of evidence of patient involvement in care plans, however there were several generic statements that were used which did not seem to reflect the individual patient's voice.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They did not consistently ensure that patients had good access to physical healthcare. Staff supported patients to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, although these were not always effective and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff offered a range of therapies including Dialetical Behaviour Therapy, trauma focused Cognitive Behavioural Therapy and Compassion Focused Therapy. Patients were offered both individual and group sessions and were able to choose the best session for them.

Staff delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans.

Requires Improvement

Forensic inpatient or secure wards

Staff did not always make sure patients had access to physical health care, including specialists. We saw evidence of patients accessing health care professionals including access to optometrists and chiropodists. Staff were not consistently monitoring the blood sugar levels of a patient with diabetes and there were no clear plans in place to support staff to take action when the patient's blood sugar levels were very high, for example for them to seek specialist support or advice. We highlighted this during our inspection and the service provided us with a new copy of the patient's care plan following the inspection.

Staff met patients' dietary needs but did not consistently assess those needing specialist care for nutrition and hydration. For example, staff did not always carry out weight checks or have clear plans in place to support patients, where there were concerns about their food intake.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff encouraged patients to join group activities promoting active lifestyles including going to the gym, attending a healthy group, personal training sessions and a walking group.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Six staff members were being trained to carry out auditing. There was a programme of audits in place. However, most audits did not identify any issues with the service. When we pointed this out the service they provided us with some audits they had carried out which demonstrated problems that had been identified and improvements that had been made as a result of these audits.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, not all staff had received up to date supervision.

The service had access to a full range of specialists to meet the needs of the patients on the ward.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Staff received a programme of training including mandatory training and role specific training. Managers had recently provided training regarding blanket restrictions and personality disorder training. Agency staffed were not included in training provided by the service.

However, some staff told us they had not received training to support patients with autism and learning disabilities and with physical health problems such as diabetes which they felt would be helpful as they supported patients with these needs.

Managers gave each new member of staff a full induction to the service before they started work. Agency staff received a shorter induction which involved going through a training folder. Managers told us they allocated new agency staff to lower risk patients until they were more familiar with the service.

Requires Improvement

Forensic inpatient or secure wards

Night shifts were often covered by large percentages of agency staff and there were some concerns raised about the competency of some agency staff. Inductions of agency staff at night were generally carried out by health care workers which put extra pressure on those staff when they were also supporting the needs of patients.

Managers supported staff through regular, constructive appraisals of their work. Managers had provided appraisals to 85% of staff on Cedar ward and 79% of staff on Maple ward.

Managers supported staff through regular, constructive clinical and managerial supervision of their work. Supervision levels in February were 77% on Cedar Ward and 64% on Maple ward, however the new ward managers told us these figures had improved.

Managers did not make sure staff attended regular team meetings or gave information from those they could not attend. Staff told us that team meetings did not occur regularly. Staff meetings although recorded did not appear to have a clear agenda or actions to share with staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers had recently identified and provided training on blanket restrictions and personality disorder training.

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

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These were held five days a week and were thorough and patient centred.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external 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. 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. 74% of staff had undertaken recent mental health act training.

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.

Requires Improvement

Forensic inpatient or secure wards

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

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 service between three and four days a week and attended ward rounds and CPAs.

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 made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

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

Staff did not store all copies of patients' detention papers and associated records correctly. We found some problems with section 17 leave forms on Maple ward. This included leave forms that did not state Ministry of Justice restrictions on them, missing Ministry of Justice forms and a form within the folder with a different home leave address that could have caused some confusion. We found other detention paperwork was completed and stored correctly. We did not find any issues with the detention paperwork on Cedar ward.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. Staff linked in with the community teams to ensure patients were discharged with appropriate support.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. Not all staff understood the policy on the Mental Capacity Act 2005 and staff did not always assess 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. 89% of staff had undertaken recent mental capacity act training.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards.

Staff did not assess and record capacity to consent consistently. We saw examples of staff identifying concerns about patient capacity, for example concerns were raised about a patient giving other patient money. This did not result in formal capacity assessment. Staff also did not complete a capacity for a patient who had limited insight into their physical health condition. This was concerning because the patient was sometimes refusing physical health monitoring which could have a direct negative affect on their health. However, we saw that some capacity assessments had been carried out, for example capacity assessments were in place in relation to medication authorisation.

Staff audited how they applied the Mental Capacity Act, however the audit did not identify any issues and therefore no changes were made.

Requires Improvement

Forensic inpatient or secure wards

Are Forensic inpatient or secure wards caring?

Good

Our rating of caring went down. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff mainly 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 and respectful, when caring for patients.

Staff on Maple ward did not always give patients help, emotional support and advice when they needed it. We observed patient's being told to wait with no explanation being given for this. However, we also observed positive and respectful interactions with patients and most patients told us that staff supported them when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Patients were fully involved in discussions regarding their care and treatment during ward rounds and we observed conversations between staff considering the most appropriate and sensitive ways to encourage patients to be involved in their own care.

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

Most patients said staff treated them well and behaved kindly. We spoke to nine patients, seven patients told us that staff were supportive, and that staff would sit with them when they needed support. Two patients felt that staff were uncaring, and one patient said they did not feel safe on the ward.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff did not always follow policy to keep patient information confidential. For example, staff allowed a patient to make a phone call in the office where patient information was clearly visible.

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. Prospective patients were able to visit the ward to help them make a decision about whether to come to the hospital. Patients were allocated one of the other patients as a buddy.

Requires Improvement

Forensic inpatient or secure wards

Staff involved patients and gave them access to their care planning and risk assessments. Staff discussed patient's goals with them and patients were involved in care plans and ward round meetings.

Staff made sure patients understood their care and treatment.

Staff involved patients in decisions about the service, when appropriate. Patients had been trained to carry out interviews and their scores were weighted at 40% as part of the interviewing process. The ward managers who had recently been appointed told us that they had been interviewed by patients. Some patients had been trained as ward reps and the service held monthly ward rep meetings to provide patients with an opportunity to provide feedback about the hospital.

Patients could give feedback on the service and their treatment and staff supported them to do this. There were feedback forms available on the ward. In addition, patients were able to submit requests at the morning meetings to speak with senior managers.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Not all patients wanted family members and carers involved but for those that did, staff made effort to include them as much as possible in patient's care.

We spoke to several family members and carers and overall, the feedback about the hospital was mainly positive. Families and carers generally spoke positively about their experiences of staff and of the experience that patients had whilst at the hospital.

Staff helped families to give feedback on the service. Most of the feedback that we saw was either positive or very positive and families and carers said they felt involved and listened to.

The service user involvement worker was working on ways to include families and carers. For example, patients and staff put on a Christmas event where families and carers were invited to a Christmas market at the hospital.

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

Are Forensic inpatient or secure wards responsive?

Good

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

Requires Improvement

Forensic inpatient or secure wards

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.

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.

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.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed. Delays tended to occur for reasons that were external to the service such as patients not having suitable accommodation to move to.

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. Staff offered patients a longer discharge period where needed to ensure the patient was appropriately supported during the transition.

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support 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.

Patients had a secure place to store personal possessions.

The service did not have a full range of rooms and equipment to support treatment and care. The wards had a lounge and a quiet lounge where patients could relax. Patients could also access a gym. There were limited rooms for therapies and activities on the ward but there were rooms that were used off the ward for these purposes.

However, there were no clinic rooms on either of the wards and patient bedrooms were being used for physical health interventions such as depot injections. There was a clinic room which was off the ward, but we were told this was rarely used. We were told that there were plans in place to ensure this could be used for physical health treatment in the future so that patient's bedrooms did not have to be used for physical health treatments.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. There was telephone room, however this was mainly used as a storage room. Most patients had their own mobile phones and the manager had purchased a phone system that could be used in patient's bedrooms for those that did not have their own phones.

The service had an outside space that patients could access easily.

Patients on Maple ward could not make their own hot drinks and snacks and were dependent on staff for this. We were told that patients were risk assessed as to whether they could use the kitchen. The kitchen was opened for those who were able to use it and staff monitored the area so that patients who were at risk of self-injury could not go in while other patients were using the kitchen.

Patients told us their showers made the toilet seat wet, that there were no shelves for toiletries in the bathroom and that there was not enough room in the fridges.

The service offered a variety of good quality food, including vegetarian options and could cater for specialised diets.

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. Some patients accessed college and staff linked into Leeds recovery college. Some patients were supported to carry out voluntary work in the local community. We were also told the service was in the process of linking in with a college in order to offer NVQ qualifications for patients.

Staff helped patients to stay in contact with families and carers. Most patients and carers told us patients were supported to have contact with the family either through visiting the hospital or through home visits. This was limited during the Covid -19 pandemic when patients could only contact family by phone.

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

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 provider put a wetroom into one of the rooms on Cedar ward to support a patient with mobility issues.

Requires Improvement

Forensic inpatient or secure wards

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The service had employed a service user involvement lead who was increasing links with the community and working with patients to improve patient information. For example, patients had been involved in developing a new welcome pack for patients and a new complaints flowchart had been developed.

The service could access information leaflets available in languages spoken by the patients and local community.

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

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. For example, one patient was supported to go to one of the local churches.

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.

Patients, relatives and carers knew how to complain or raise concerns. It was clear that people knew how they could complain and that they were listened to and responded to if they did so.

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.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Managers told us they could deal with patient complaints anonymously if the patient felt uncomfortable being identified.

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.

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

Are Forensic inpatient or secure wards well-led?

Requires Improvement

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

Requires Improvement

Forensic inpatient or secure wards

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.

Since our last inspection the provider had appointed registered manager for the hospital. The manager had created new ward manager posts for each ward to improve the management structure. Both ward managers were newly in post. We were told there were plans to create team leader posts to further improve the structure of the teams.

Staff told us that senior managers were approachable and visited the ward. We were also told that patients could request to speak with senior managers in the morning meeting.

Vision and strategy

Not all staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Senior staff told us the values for the provider were about patient engagement, compassion, care, honesty and patient centered care and that there was a focus on improving the quality of the service. They told us there was a renewed focus on data and openness. It was unclear whether all the staff understood the provider's vision and values, as there was a lack of structured team meetings to enable staff to discuss these.

Culture

Staff did not always feel respected or valued. The provider did not provide opportunities for development and career progression. They said the provider promoted equality and diversity in daily work. Staff told us they felt supported and that they could raise any concerns without fear.

Staff told us senior management were supportive and most staff said they enjoyed working at the service and that it felt like a family. However, staff told us that the service struggled to keep staff because of the pay level. Many staff left the service, in order to work for agencies. There were limited opportunities for career progression in the service, however the manager told us that plans were in place to create new career progression opportunities.

Governance

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

The provider held regular governance meetings. The governance minutes we reviewed were comprehensive and demonstrated meaningful reviews of key governance issues including safeguarding, restraint and training. The general day to day running of the service was managed through the MDT meetings which were comprehensive and well run.

Management of the environment was ineffective. We identified numerous issues with maintenance which had not been addressed for long periods of time. For example, the furniture was in poor condition, the defibrillator had not been calibrated for over a year and there was an issue with the boilers which had been on the risk register since 2017, although we were told that this had now been fixed. However, the registered manager had carried out a review of the environment and there were plans in place to purchase new furniture and address the poor décor and environmental issues.

Requires Improvement

Forensic inpatient or secure wards

The staff carried out audits regularly but many of these audits did not appear to identify any of the issues, we identified during our visit. This meant that auditing was ineffective and did not give the opportunity for staff to address concerns. When we pointed this out, the manager was able to provide us with some examples of more meaningful audits that had taken place where lessons had been learned.

Patient record systems were confusing with information stored in different places which was sometimes contradictory.

Team meetings did not occur regularly which meant staff and managers had little opportunity to discuss governance issues together and to share information. However, information on the day to day running of the organisation was shared at morning meetings which were open to all staff.

Policies were not always followed, and we found some issues with some of the providers policies for example the Seclusion and Longer – Term Segregation Recording pack and Policy was out of date, and the search policy did not include guidance for all the searching activities that staff were required to carry out, the infection control policy appeared to be incomplete and did not provide staff with relevant guidance in relation to infection control.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect.

The provider had a risk register in place which identified key concerns. A number of the items on the risk register had identified for several years, for example failure to complete display screen equipment training and no person identified to carry out health and safety oversight had been on the risk register since 2017 and it was unclear whether any actions had been taken to resolve the issue. However, there was evidence of recent action being taken regarding items on the risk register, for example the boilers had been fixed.

Although we found a number of issues that related to safety, it was clear that new systems and processes were beginning to take effect and enable staff to make improvements where they were necessary. The hospital was already aware of many of the issues that we highlighted and there were plans in place to address some of the risk issues we highlighted.

Systems were in place to identify risks and carry out safe care. However, some of the systems were running parallel to one another which meant there were multiple forms to capture risk. The information was not always consistent across different forms which could be confusing to staff.

Information management

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

There was evidence that the hospital had started to carry out more substantial quality improvement initiatives and was using data gathered to make improvements where they were needed, for example to the quality of the care records that were held for each patient.

Some staff were receiving auditing training with the aim of creating an auditing team. We saw that key performance data was collated on areas such as restraint and medicines management and that this was being analysed and reviewed in governance meetings.

Requires Improvement

Forensic inpatient or secure wards

Engagement

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

Learning, continuous improvement and innovation

The management team were in the process of reviewing several of the identified issues and had plans in place to carry out improvements to the service. For example, staff were being trained to carry out audits, and there were plans in place to improve the physical environment. There was also a focus on patient involvement and patients were consulted on many of the proposed changes. Managers were also reviewing the team structure and plans were being implemented to improve the operational effectiveness of the service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Are Long stay or rehabilitation mental health wards for working age adults safe?

Requires Improvement

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

Safe and clean care environments

Not 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 environmental risk assessments of all wards areas and removed or reduced any risks they identified. Staff completed security checks of the ward environment twice a day. The fire alarms were tested weekly, and patients had personal emergency evacuation plans. Management carried out an annual risk assessment of the premises.

Staff could observe patients in all parts of the wards. 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. We observed a number of incidents where staff from other wards were called to support and responses appeared to be timely.

Maintenance, cleanliness and infection control

Ward areas were not always clean, not well maintained, furniture was in need of replacement. Settees in patient lounges were worn through to the foam in places and dining tabletops were worn through to the wood underneath. This meant that it was difficult to ensure that surfaces were clean. In some communal areas the floors were worn away and looked dirty. The walls of many of the communal areas were in need of painting, there was visible dirt on the walls, exposed plaster where holes had been repaired and patches where posters and notices had been up and taken down. In outside areas of the ward there were lots of cigarette butts discarded on the floor.

Staff made sure cleaning records were up to date, but the poor conditions of the wards and furniture meant that it was difficult for them to maintain good standards of cleanliness.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff did not always follow infection control policy. Although when we visited the majority of staff were wearing masks as per covid guidance, we observed a small number of staff that were not, reasons for this discretion had not been documented. We were also told by a number of staff that prior to the inspection staff were not routinely following guidelines on wearing masks in clinical areas.

Seclusion rooms

There were no seclusion rooms on the rehabilitation wards, but patients occasionally used the seclusion suites on the forensic wards.

There were two seclusion rooms, one on Maple ward and one on Cedar ward. The seclusion room on Maple ward did not allow clear observation. It was difficult to observe what was happening in the seclusion room because there was a reflection from one window in the other and clear observation was only possible if the light was turned off. The observation to the ensuite is through a spy hole. This limited staff ability to maintain a clear line of sight at all times.

There was an intercom system in place which enabled two-way communication and the room contained a toilet and shower. The shower drained away from the plughole which meant water remained in the room. The room did not have a clock that patients could see although staff told us they could use the clock in the staff office. Both seclusion rooms had mattresses and blankets and pillows were available.

The blinds to the seclusion room on Maple ward could only be operated from inside the room which could be difficult if a patient was distressed. The door to the outside area contained a large window pane which could not be covered. This meant the level of lighting in the room could not be adjusted. There were many areas which a patient would be able to cause damage by picking at the environment. This included battens on the wall corners, cracks in the plaster, peeling filler in cracks. This made the environment unsafe. The secure garden area on cedar ward contained a broken settee. The door to the garden area had a mat fixed to the floor on the inside of the seclusion room. This is something that could be picked and damaged by patients.

When we discussed this with the registered manager they were aware of the concerns about the seclusion room and told us that four safety pods had been purchased and were to be used for patients that were a risk to themselves in order to try and mitigate some of the risk. Only patients who were a risk to others would be placed in the seclusion room.

Clinic room and equipment

Clinic rooms on Larch and Hazel ward were well equipped with emergency drugs that staff checked regularly and they were both clean. However, the defibrillators had not been serviced since 2020 therefore it was not clear that the machines were safe to use. A defibrillator is used to treat someone in an emergency that has gone into a cardiac arrest. We pointed this out to staff whilst we were on site and they took immediate action to rectify the matter.

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 had high vacancy rates. Across rehabilitation wards there were eight registered nurse vacancies and 17 health care worker vacancies.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Recruitment strategies were in place and the provider had recruited a number of international nurses.

The service had high rates of bank and agency nurses. Managers requested regular agency staff, who were familiar with the service. Some staff had an established shift pattern on the ward which helped with consistency.

Managers made sure all bank and agency staff had an induction and understood the service before starting their shift.

The service had high turnover rates. 52 staff left the hospital in 2021-22 and there were 22 new starters in that time. There was evidence that staff were leaving permanent positions and returning to work for the hospital through the agency because of the better rates of pay.

Managers supported staff who needed time off for ill health. Levels of sickness were low.

Managers accurately calculated and reviewed the number of nurses and healthcare workers for each shift. The ward manager could adjust staffing levels according to the needs of the patients. For example, if a patient needed additional staffing which was over and above the established levels, it was always possible to bring in additional staff.

There was evidence that patients were having some one- to-one sessions with their named nurse but given the low numbers of permanent nursing staff this was not always as frequent as it should have been.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Staff and patients said that were activities or leave was occasionally cancelled it was always rearranged at the earliest opportunity.

The service had enough staff on each shift to carry out any physical interventions safely. The service had an alarm system in place which meant staff could summon help from other wards.

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. There were three consultant psychiatrists in the hospital and they operated an on-call system when they were not present on the ward.

Mandatory training

Staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

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

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 in order to facilitate patients' recovery. 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. The ward staff participated in the provider's restrictive interventions reduction programme.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Assessment of patient risk

We reviewed eight risk assessments across the rehabilitation wards. Staff had completed risk assessments for each patient but it was not always clear when these had been carried out. There was evidence that some reviewing of risk assessments was being carried out but not always very frequently. For example, one patient's risk assessment had only been reviewed annually over a period of six years and another patient had gone a year without having their risk assessment reviewed.

We also found examples of recorded incidents that had been documented in the patient record but had not always triggered a review of the risk assessment or risk management plan.

Management of patient risk

Despite the issues with recording that we found with risk assessments, staff knew about any risks to each patient and acted to prevent or reduce risks. Risks to each patient were discussed and documented at each handover meeting. Some basic information was also recorded for each patient in the observation folder.

Staff identified and responded to any changes in risks to, or posed by, patients. It was clear that incidents were being recorded and discussed, either at handover or during regular ward round meetings. However, the current risk assessment was not always adjusted to reflect recent incidents.

Staff followed the organisation's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. 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. The hospital was also undertaking some pieces of work to support staff to develop their practice in this area. For example, restraints had been added as a standard agenda item to be reviewed at each morning meeting.

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

Staff followed NICE guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

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.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The hospital had a good relationship with the local safeguarding authority and always responded openly when information needed to be shared.

Staff followed clear procedures to keep children visiting the ward safe. Children visiting patients used the visitors' room and did not go onto the ward. Visits were planned in advance with support from the social work team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital had a social work team who managed safeguarding referrals and there were two safeguarding leads who could offer support to staff who had any safeguarding queries or concerns. Social work staff also attended MDT meetings to ensure a useful exchange of information was taking place across the hospital.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records, the majority of the patient record was paper based.

Patient notes were comprehensive and all staff could access them easily. However, there were a number of different ways to store the same information across the paper records and we found that some records did not always match others. This was mainly an administrative problem that could have caused confusion for staff.

Records were stored securely.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up to date.

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

Staff stored and managed all medicines and prescribing documents safely on all wards apart from on Lilac ward. The medicines cabinet on this ward was stored in an unused bedroom and was not screwed to the wall. The bedroom did not have air conditioning which meant it would be difficult to control the temperature of warmer days, some medications need to be stored between certain temperatures.

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

Staff learned from safety alerts and incidents to improve practice. Staff met regularly to discuss the findings of audits and actions were documented as a result of these discussions.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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. They used an electronic system to input information which was then shared with relevant staff.

Staff reported serious incidents clearly and in line with hospital policy. We saw a number of examples of serious incident investigations , they were detailed and included a summary of lessons learnt and related actions.

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. They kept detailed logs of incidents and complaints and it was clear that ever effort was made to ensure that families were kept informed when it was necessary.

Managers debriefed and supported staff after any serious incident.

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. They did this through several different methods. Staff had daily morning meetings where they had the opportunity to discuss previous incidents and there was also evidence that some recent team meetings were taking place. However, a lot of staff told us that historically the service had not been carrying out team meetings very regularly if at all.

Are Long stay or rehabilitation mental health wards for working age adults 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.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

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. Staff used a number of different methods and recognised tools to assess patients' physical health. However, in two patient records that we looked at, food and fluid charts that were meant to be completed were not. There were multiple gaps where nothing had been recorded on them but had been noted in the handwritten daily notes. We thought this could be confusing and meant the MDT might not receive the right information about a patient.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans when patients' needs changed. Staff used daily meetings and regular MDT meetings to review progress and incidents that might require a change to a care plan.

Care plans were personalised, holistic and recovery-orientated. Care plans were focused around recovery, building skills and planning for discharge. Although there were some generic statements across different patients care plans, they were generally focussed on each patients' specific needs and reflected the needs of each particular patient. Care plans were broken down in a way that gave each patient the opportunity to contribute to the process.

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 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 offered a range of therapies including Dialectical Behaviour Therapy, trauma focused CBT and Compassion Focused Therapy. Patients were offered both individual and group sessions and were able to choose the best session for them.

Staff were also making efforts to improve patients daily living skills through use of section 17 leave and encouraging involvement in decision making. For example, a patient involvement forum had been created which fedback to the hospital management team about changes that patients would like to see to the way the hospital operated.

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.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Specific plans had been made to support a number of patients who had eating related needs, the documentation in relation to these plans was not always kept up to date, for example food and fluid charts not completed.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There was a gym on site and staff offered regular walking groups in and around the local and wider area. The hospital menu was varied and included a range of healthy options. Patients that smoked were offered advice about alternatives.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Six staff members were being trained to carry out auditing. However, there was a programme of audits which had previously been carried out by staff which were not effective in highlighting improvements.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Not all staff had regular supervision. 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. Although a small number of positions remained vacant this did not appear to have an impact on how care was delivered.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Staff received a programme of training including mandatory training and role specific training. Managers had recently provided training regarding blanket restrictions and personality disorder training. Agency staff were not included in training provided by the service. However, agency staff were expected to have taken part in elements of mandatory training to ensure that they were suitable to work on the wards.

Managers gave each new member of staff a full induction to the service before they started work. Agency staff received a shorter induction which involved going through a training folder. Managers told us they allocated new agency staff to lower risk patients until they were more familiar with the service. The hospital also block booked agency staff so it was more likely they would know the service well.

However, some staff told us that night shifts were often covered by large percentages of agency staff and that they were not always confident in their ability to work on the wards. Staff told us that agency staff were not always supportive and on occasion fell asleep.

Managers supported staff through regular, constructive appraisals of their work. 98% of staff had an appraisal in the last year. Staff that we spoke to said that this process was meaningful.

Managers did not always support staff through regular, constructive clinical supervision of their work. 78% of staff were showing as having had an up-to-date supervision session. However, there was evidence that some group supervision was taking place which staff could access.

Managers did not make sure staff attended regular team meetings or give information from those who could not attend. Staff told us that team meetings did not occur regularly. Staff meetings although recorded were infrequent and did not appear to have a clear agenda or actions to share with staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers had recently identified and provided training on blanket restrictions and personality disorder training.

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

Multi-disciplinary 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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These were held five days a week and were thorough and patient centred.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings and daily planning meetings that were held across the hospital

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external 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. 74% of staff had undertaken recent mental health act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The advocate attended the service between three and four days a week and attended ward rounds and care programme approach meetings.

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 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. However, one patient on Hazel ward was making use of section 17 leave but staff had not ensured that all necessary restrictions had been copied over to the section 17 leave form. There was not always a copy of the MoJ authorisation in the leave file.

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

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. All patients had discharge plans but some were more detailed than others. Some of the discharge plans detailed ongoing work with other agencies in relation to accommodation and support that would be required as part of a discharge plan.

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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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. 89% of staff had undertaken recent mental capacity act training.

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

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Good

Our rating of caring went down. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients and they gave patients help, emotional support and advice when they needed it. Throughout our inspection we observed lots of interventions between staff and patients and there appeared to be a good rapport, staff were approachable and friendly and supported patients when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. It was clear that staff were making efforts to engage patients in their treatment plan, either through the care planning process or through the regular MDT's that took place on the wards.

Staff directed patients to other services and supported them to access those services if they needed help. This was particularly visible for those patients that were approaching discharge, ensuring that they were in touch with services that would support them in the community.

We spoke to patients on each of the wards and patients said staff treated them well and behaved kindly towards them.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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.

Staff involved patients and gave them access to their care planning and risk assessments.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example there were some documents and posters that had been converted to make them easier to ready for patients with communication difficulties.

Staff involved patients in decisions about the service, when appropriate. We saw a number of different way that staff had carried this out. There were regular community meetings which appeared to contain actions which had been acted on to help improve the patient's experience. Patients had been actively involved in recent recruitment processes and patients' fedback about how valuable this was to them. Also, the service was implementing a programme of environmental improvements which was clearly taking into consideration the thoughts and feelings of patients that this would impact upon

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff gathered feedback from patients in a number of ways. They did this through surveys, forms and letters. These showed a range of feedback which was mostly positive. Where the service had received complaints it was clear that they had been taken seriously, investigated and acted upon where necessary.

Staff made sure patients could access advocacy services. Whilst we were on site, we saw an advocate working across the wards, interacting with patients and staff and it was clear that they were well known.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers where it was possible. Not all patients wanted family members and carers involved but for those that did, staff made effort to include them as much as possible in patients care.

We spoke to a number of family members and carers and overall the feedback about the hospital was positive. Families and carers generally spoke positively about their experiences of staff and of the experience that patients had whilst at the hospital.

Staff helped families to give feedback on the service. Staff did this through online surveys and handwritten forms and they appeared to responded well . The majority of the feedback that we saw was either positive or very positive and families and carers said they felt involved and listened to.

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

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Good

Our rating of responsive stayed the same. 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' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. It was clear from care records, including MDT notes, that length of stay and discharge was an important aspect of treatment for patients. Managers and staff worked to make sure they did not discharge patients before they were ready.

The service had low out-of-area placements.

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

Patients were moved between wards during their stay only when there were clear clinical reasons or it was in the best interest of the patient. The hospital had a range of different wards and this gave them the flexibility to ensure patients were on a ward that offered them the right type of environment and clinical approach.

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

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.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services. We saw examples of how staff had arranged transition meetings and sessions which would enable staff from new services to get to know patients in an environment they felt comfortable in.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always supported patients' treatment, privacy and dignity. Not all wards had a quite area for privacy. However, each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. The food was of good quality but patients could not make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Each patient had their own bedroom, which they could personalise. However, some of the windows to the bedrooms were overlooked by communal courtyards, which meant patients could be easily observed in their own bedrooms. We pointed this out to staff during the inspection and they took steps to immediately rectify this, this action ensured the privacy of the patients using these bedrooms.

Patients had a secure place to store personal possessions either in their rooms or in a secure cupboard which they could access when they wanted to.

Staff used a full range of rooms and equipment to support treatment and care. However, not all wards had a quiet space that could be used for privacy or to carry out one to one appointments.

The service had rooms where patients could meet with visitors in private, located off the wards.

Patients could make phone calls in private, they could either use their own mobile phones in their room or access a ward telephone.

The service had an outside space that patients could access easily. Each ward had a separate courtyard which included some green space. The hospital also had some private grounds which patients could access if they made use of section 17 leave.

Patients could make their own hot drinks and snacks but were dependent on staff to unlock the kitchen door. We were told that this was because all of the patients who had access to the kitchen area needed it to be locked for safety and security reasons but this was not detailed in every care plan that we reviewed.

The service offered a variety of good quality food.

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. Some patients accessed college and staff linked into Leeds recovery college. Some patients were supported to carry out voluntary work in the local community. We were also told the service was in the process of linking in with a college in order to offer NVQ qualifications for patients.

Staff helped patients to stay in contact with families and carers. Most patients and carers told us patients were supported to have contact with the family either through visiting the hospital or through home visits. This was limited during the Covid –19 pandemic when patients could contact family by phone.

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

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. On one of the wards, they had made adjustments to one bedroom and made sure it was available for anyone that had limited mobility. All wards would be accessible to patients with a disability.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Examples of these were located around the ward areas and were in a format that was easy to understand.

The service had information leaflets available in languages spoken by the patients and local community.

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

The service provided a variety of food to meet the dietary and cultural needs of individual patients. For example, one of the patients had very specific preferences around food and staff made effort to ensure they knew what these were and that they were provided where possible.

Patients had access to spiritual, religious and cultural support.

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.

Patients, relatives and carers knew how to complain or raise concerns. We saw a lot of evidence that the complaints process was robust. It was clear that people knew how they could complain and it was clear that they were listened to and responded to if they did so.

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.

Managers investigated complaints and identified themes.

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

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.

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

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Requires Improvement

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

Leadership

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Since our last inspection, the provider had appointed a registered manager for the hospital. The manager had created new ward manager posts for each ward to improve the management structure. Ward managers were newly in post. We were told there were plans to create team leader posts to further improve the structure of the teams and to help embed some of the recent changes to the way the hospital operated.

Staff told us that senior managers were approachable and visited the ward. We were also told that patients could request to speak with senior managers in the morning meeting.

Vision and strategy

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

Culture

Staff did not always feel respected or valued. The provider did not provide opportunities for development and career progression. They said the service promoted equality and diversity in daily work. Staff told us they felt supported and that they could raise any concerns without fear.

Staff told us senior management were supportive and most staff said they enjoyed working at the service and that it felt like a family. However, staff told us that the service struggled to keep staff because of the pay level. Many staff left the service, in order to work for agencies. This meant that a large number of staff were agency staff and did not receive supervision or training from the service. There was little opportunity for career progression in the service, however the manager told us that plans were in place to provide new career progression opportunities.

Governance

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

The provider held governance meetings although these appeared to be sporadic as there was a meeting held in March 2022 and the meeting before was held in December 2021. The minutes that we reviewed of the governance meetings were comprehensive and demonstrated meaningful reviews of key governance issues including safeguarding, restraint and training. The general day to day running of the service was managed through the MDT meetings which were comprehensive and well run.

Management of the environment was ineffective. We identified numerous issues with maintenance which had not been addressed for long periods of time. For example, the furniture was in poor condition, the defibrillator had not been calibrated for over a year and there was an issue with the boilers which had been on the risk register since 2017 although we were told that this had now been fixed. However, the registered manager had carried out a review of the environment and there were plans in place to purchase new furniture and address the poor décor.

The staff carried out audits regularly but many of these audits did not appear to identify any of the issues we identified during our visit. This meant that auditing was ineffective and did not give the opportunity for staff to address concerns. When we pointed this out, the manager was able to provide us with some examples of more meaningful audits that had taken place where lessons had been learned.

Patient record systems were confusing with information stored in different places which was sometimes contradictory.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Policies were not always followed, and we found some issues with some of the providers policies for example the Seclusion and Longer – Term Segregation Recording pack and Policy was out of date, and the search policy did not include guidance for all the searching activities that staff were required to carry out, the infection control policy appeared to be incomplete and did not provide staff with relevant guidance in relation to infection control.

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.

The provider had a risk register in place which identified key concerns. A number of the items on the risk register had been identified for several years, for example failure to complete display screen equipment training and no person identified to carry out health and safety oversight had been on the risk register since 2017 and it was unclear whether any actions had been taken to resolve the issue. However, there was evidence of recent action being taken regarding items on the risk register, for example the boilers had been fixed.

Although we found a number of issues that related to safety, it was clear that new systems and processes were beginning to take effect and enable staff to make improvements where they were necessary. Many of the issues that we highlighted, the hospital was already aware of and there were plans in place to address some of these risk issues. .

Systems were in place to identify risks and carry out safe care. However, some of the systems were running parallel to one another which meant there were multiple forms to capture risk. The information in these forms was not always consistent which could be confusing to staff.

Information management

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

There was evidence that the hospital had started to carry out more substantial quality improvement initiatives and was using data gathered to make improvements where they were needed, for example to the quality of the care records that were held for each patient.

Some staff were receiving auditing training with the aim of creating an auditing team. We saw that key performance data was collated on areas such as restraint and medicines management and that this was being analysed and reviewed in governance meetings.

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.

Learning, continuous improvement and innovation

The management team were in the process of reviewing several of the identified issues and had plans in place to carry out improvements to the service. For example, staff were being trained to carry out audits, and there were plans in place to improve the physical environment. There was also a focus on patient involvement and patients were consulted on many of the proposed changes. Consideration was also being given to the team structure and plans had started to be implemented in order to improve the operational effectiveness of this.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The ward environments were not always safe or clean and staff were not always following guidance in relation to infection control. Seclusion rooms were not fit for purpose. Defibrillators had not been serviced and were therefore not safe to use.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans did not accurately reflect the assessed physical health needs of all patients