Partnerships in Care Limited

Elm Park

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?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Elm Park is a specialist neuro-rehabilitation service treating people with complex neurological needs following a traumatic or acquired brain injury. Elm Park provides individual treatment programmes for men with complex behaviour issues, and those with a forensic history including patients detained under the Mental Health Act or informal patients.

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

- The provider had not ensured that there had been sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirement of staffing. In 11% of shifts ward staffing numbers during the weekdays were below the required staffing levels of registered nurses. In 41% of shifts at the weekend there had been only one registered nurse on duty. In addition, 43% of early shifts did not have the required number of healthcare assistants on duty. There was one late shift in early May 2022 where the registered nurse arrived late, and the service was left without a registered nurse for a short period. We were concerned about the oversight at the service and the impact on patients. The service had a high staff turnover.
- Managers had not ensured that staff had been trained in stoma care, when they had a patient with stoma bag.
- The provider had not ensured that staff were in receipt of clinical supervision and appraisal. The figures for supervision between January and August 2022 were 47% for registered staff and 30% for unregistered staff. This included nursing, psychology and speech and language therapy staff.
- The patient call bell lead was not long enough to reach the bathrooms for patients with disability. A patient had to shout for help, and no one answered and had to help himself in the bathroom. This was not recorded as an incident. A patient with wheelchair was room bound for 2 days because the chair lift and main lift was broken.
- Due to current staffing levels, there had been no one to one individualised rehabilitation therapies for over six months. The treatment model of the hospital (as outlined in their mission statement) stated that therapies would be delivered on an individual basis. There were two occasions in the six-month period reviewed, when there was no registered nurse on duty. There was no incident reported in relation to these two occasions.
- The provider had not ensured that systems were in place to ensure that the cleaning of tumble drier lint, had been undertaken daily and had not ensured that all daily food safety checks and records had been completed.
- The medication key after a shift had been handed over to a non-clinical staff because there was no qualified nurse on the shift at the time of handover.
- There were gaps in the observation records of five patient records reviewed who were on different levels of observation.
- Managers had not ensured that patient emergency evacuation plans were in place for a patient who was unable to leave their room due to the ward lift being broken. Therefore, there were no plans in place to identify how staff should respond in the event of a fire.
- Managers had not ensured that systems and processes were in place to obtain feedback from staff, for the purposes of continuous evaluation and ongoing service improvements. Managers had not ensured that regular staff team meetings had taken place.
- Staff had not notified a patient of one incident involving a medication error in line with the duty of candour.

However:

- The clinic room was clean, organised and well equipped.
- The 'as required' (pro re nata; PRN) medication had been reviewed regularly with good prescribing practice.

Summary of findings

- The occupational therapist assistant group activity was well attended by patients, and a manual register and daily orientation sheet were kept by the occupational therapist assistant.
- All staff had good rapport with patients, they knew their patients and were caring. Staff interactions were positive, caring and kind with patients.
- The service had appointed a dietitian to meet the dietary needs of patients for food choices and meals for diabetes patients.
- The multi-disciplinary team (MDT) treatment reviews were comprehensive.
- The feedback survey from patients was positive and indicated that staff were caring and approachable.

The Care Quality Commission completed an inspection of the services provided by Partnerships in Care Limited (BRAND -Priory Group) as part of our inspection methodology. For this inspection we looked at the registered location, Elm Park in Colchester Essex. This inspection was unannounced, meaning the provider did not have advanced notice of the inspection.

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations. For this inspection, we looked at all domains, and have applied ratings to each domain and an overall rating.

Due to the concerns identified during the inspection, we served the provider with nine Requirement Notices in respect of Regulation 9, patient-centred care; Regulation 10, Dignity and respect; Regulation 11, Need for consent; Regulation 12, Safe care and treatment; Regulation 13, Safeguarding service users from abuse and improper treatment; Regulation 15, Premises and equipment; Regulation 17, Good governance; Regulation 18, Staffing and Regulation 20, Duty of candour.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to Elm Park

Elm Park is a specialist neuro-rehabilitation service treating people with complex neurological needs following a traumatic or acquired brain injury. Elm Park provides individual treatment programmes for men with complex behaviour issues, and those with a forensic history including patients detained under the Mental Health Act or informal patients. Elm Park has 17 beds and had nine patients at the time of our inspection. Elm Park is part of Priory Healthcare.

Elm Park provides the following regulated activities:

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

We previously inspected Elm Park on 26 June 2018. The service was rated good overall, being rated good for the effective, caring, responsive and well led domains. The service was rated requires improvement for safe. We identified a breach of the following regulation:

- Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

The provider had not ensured that management had identified and mitigated all ligature anchor points in the ligature risk assessment.

The provider had not ensured improvements were made to the physical environment and repairs were made in a timely manner.

We asked the provider to consider how staff could have clear lines of sight throughout the ward and to ensure that all areas of the hospital were kept to an appropriate standard.

What people who use the service say

We spoke with six patients and four carers.

The patients' comments about the service were generally positive. Patients said that staff were approachable and quick to address issues when raised. One patient said there were no negatives with staff, the food or activities at the service, but would like access to reading books or the library. Another patient said the two drivers at the hospital were both on leave which meant there were no drivers to take them out. The same patient said there were no call bells in the bathroom and there were times when he needed help in the bathroom and had to shout for help, but no one came.

We spoke with four carers of patient's using the service. One carer told us that members of staff were always available to talk to them, and that they believed patients' felt safe and happy in the hospital. Another carer told us they were happy with the care and treatment received. During a home visit, two members of staff who accompanied the patient, were supportive. Carers felt they were able to speak to nurses whenever they needed to and were kept informed of any incidents relating to their relatives. However, one carer told us they were dissatisfied with the care of their relative as whenever they visited the hospital, they found their family member either with stained clothes or wearing someone else's clothes despite having bought new clothes for them.

Summary of this inspection

How we carried out this inspection

The inspection team visited Elm Park on the 9 and 10 of August 2022. A series of planned virtual meetings took place with the Priory East of England regional director on 22 August and the hospital director on 22 and 24 August 2022.

During the inspection we:

- Visited the wards and observed how staff cared for patients
- toured the clinical environments, including the clinic room and reviewed emergency equipment
- looked at the medicine management on the ward, including nine treatment cards
- reviewed five patient care records
- spoke with six patients
- spoke with four carers
- observed one group activity
- observed one staff handover and one Multi-Disciplinary Team review meeting.
- interviewed a variety of staff including the Consultant Psychiatrist, nurses including the lead nurse, rehabilitation workers (Healthcare Assistants), Occupational therapy assistants, an assistant psychologist, the Mental Health Act administrator, Independent Mental Health Advisors (IMHAs), the quality improvement lead, the head housekeeper, the regional director and the Hospital director.
- reviewed policies and procedures relevant to the running of the service.

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

Areas for improvement

Action the provider MUST take to improve.

- The provider must ensure that Patients have access to call alarms and that these are kept within the patient's reach. Regulation 9 (a)(b)(c).
- The provider must ensure that patients had access to opportunities for education and employment in the community. Regulation 10 (2)(b).
- The provider must ensure that patient observations are recorded in line with trust policy. Regulation 12 (1) (2) (a) (b).
- The provider must ensure that plans are in place for disabled patients to be able to leave the ward, and to have blood tests done when the service lift is non-operational. Regulation 12 (1) (2) (d) (e).
- The provider must ensure the proper and safe management of medicines. Regulation 12 (2) (g).
- The provider must ensure that all staff (including bank and agency) have access to the patient information system (patient records) before commencing work on the wards. Regulation 12 (2) (i).
- The provider must ensure that there is a registered nurse of duty at all times.
- The provider must ensure that staff report any safeguarding concern via the provider's incident reporting system. Regulations 13 (1) (2) (3)(4)(a)(b)(d)
- The provider must ensure that staff complete patient emergency evacuation plans for all patients with a disability. Regulation 15 (1) (a) (b) (e).
- The provider must ensure that managers have adequate oversight of clinical care delivery in relation to the undertaking and recording of patient observations. Regulation 17 (2) (d)

Summary of this inspection

- The provider must ensure that they obtain feedback from staff for the purposes of continuous evaluation and ongoing service improvements. Regulation 17 (2)(e).
- The provider must ensure that there is a qualified nurse on every shift. Regulation 18 (1) (2).
- The provider must ensure that persons employed by the service received appropriate support, training, professional development, supervision and appraisal to enable them carry out the duties they are employed to perform. Regulation 18 (1)(2)(a).
- The provider must ensure that patients were notified when an incident about their treatments and care had happened. The provider had not notified a patient involved in a medication error in line with the duty of candour. Regulation 20(1)(2).

Action the provider SHOULD take to improve.

- The provider should involve carers where appropriate.
- The provider should ensure that there are enough drivers to ensure that patients can access leave into the community.
- The provider should ensure that senior managers are visible on the ward.
- The provider should ensure that care plans or risk assessments of patients were updated regularly, and after a fall.
- The provider should ensure that interpreters for non-English speaking patients were available for most time of the day and weekends to improve patients' communications and their quality of life.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

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

Requires Improvement

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

Safe and clean care environments

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

All wards were clean, well equipped, well-furnished and well maintained.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed any risks they identified. We reviewed the ligature risk audits completed in April 2022, the local risk register, internal inspection audit of the service, human resources (HR) audit, and estates audit. Ligature risks were identified and mitigated and in others, there were ongoing action plans and completion dates. Ongoing actions for more than two months. Staff had mitigated ligature risks. A ligature risk is a fixed item to which a patient might tie something for the purpose of self-strangulation.

Staff could observe patients in all parts of the wards. The ward layout did not allow staff to observe all parts of the ward, however, there were mirrors in the corridors that mitigated against blind spots.

The ward complied with guidance and there were no mixed sex accommodation. The service provided a male only accommodation.

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. Staff had access to alarms and radios to be able to summon help and communicate with other staff if required. However, there were no call bells in patients' en-suite bathroom. One patient reported being unable to seek assistance when it had been required, whilst in the bathroom because the lead of the call bell from the bedroom was not long enough to the bathroom.

Maintenance, cleanliness and infection control

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Ward areas were not all cleaned, well maintained, well-furnished and fit for purpose. The service had not followed the provider's housekeeping policy which set out standards to promote high quality, consistent, service levels. The cleaning records of the two dryers in the laundry room were incomplete.

Staff had not ensured that cleaning records were up-to-date, and the kitchen and laundry equipment cleaned. The records of the daily food safety checks in the main kitchen were not up to date. All fridges and freezers food safety checks between 1 July 2022 and 9 August 2022, were not completed. Staff had not ensured that the cleaning records of the daily lint removal from the laundry tumble dryers were up to date. There were no daily lint remover records for dryer 1 between 22 and 30 June 2022, and between 1 and 4 August 2022. There were no records for both dryer 1 and 2 for the whole of July 2022. This posed a risk of fire at the premises.

Staff followed infection control policy, including handwashing. There was hand washing gel in the ward, on entrance to the ward and in the toilet area.

Seclusion room

There was no seclusion room at the service.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Emergency medicines were available. There was an up-to-date stock list, and medicines cupboards and trolleys were locked when not in use. There were no expired medicines and stock lists were checked weekly by nurses for expiry dates. However, during staff interviews, a member of staff told us of an incident where the medication key was handed over by staff to a non-clinical staff member at the end of a shift, as there were no qualified nurses available for the next shift. This was not reported as an incident.

There were checks of the clinic room, the stock of medicine storage matched the clinic room audit, daily checks of the fridge and room temperature, emergency drugs and documentations.

Staff checked, maintained, and cleaned equipment. The medicines fridge was locked, and the fridge temperatures were monitored daily. Sharp bins were available and annotated with date of opening and location. Medicines disposal bin were available inside locked room. There was a controlled drug policy in place and controlled drug destruction were managed by pharmacy.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had not provided enough nursing and support staff to keep patients safe.

The service did not ensure safe staffing levels. In the six months prior to the inspection, there were instances on the staff rota where the service worked below their establishment level of two registered nurses and six rehabilitation workers (healthcare assistants) during the day and three at night. In the six months from February to July 2022, there were 37(11%) shifts out of 350 where the service worked below their establishment level of two registered nurses. This comprised of 22 late shifts and 15 early shifts. During weekends, there were 15(41%) shifts where there was one

registered nurse on duty. There was one late shift in early May 2022 where the registered nurse arrived late, and the service was left without a registered nurse for a short period. In the same period, there were 152 (43%) early shifts and 10 (3%) late shifts where the service worked below their establishment level of six rehabilitation workers in the day and three at night.

The service had high vacancy rates. In the last six months from February to July 2022, the number of vacancies full time equivalent required for rehabilitation workers was thirteen (77%) and the number of vacancies full time equivalent required for registered nurses was three (38%). The rehabilitation workers or healthcare assistants were unregistered nursing assistants either employed by the provider or sourced as bank or agency staff.

The service had high rates of bank and agency nurses. In the six months prior to this inspection, from February to July 2022 there were 155 (44%) shifts filled by bank and agency qualified staff.

The service had high rates of bank and agency rehabilitation workers. In the six months prior to this inspection, from February to July 2022 there were 331(95%) shifts filled by bank and agency rehabilitation workers.

Managers had not limited their use of bank and agency staff and had not always used staff familiar with the service. 25% of carers told us that the nurses changed a lot and they as carers had not felt involved in the care and treatment of their relative.

Managers had ensured that all bank and agency staff had a full induction and understood the service before starting their shift. During this inspection, we witnessed a newly employed locum staff who had not received a full induction before seeing patients on the ward. However, the member of staff had been given a full handover of each patient and was aware of the risks for the patients and continued on to complete the induction.

The service had high turnover rates. In the 12 months prior to the inspection, the staff turnover rate decreased from 30% in August 2021 to 29% in January 2022, and thereafter rose to 42% in July 2022. The highest staff turnover was 84% among the senior managers in April 2022. The psychologist had been on maternity leave for over six weeks without a locum cover. The service had been without an occupational therapist for over six weeks, and there had been no occupational therapy referrals as a result. At the time of inspection, the service did not have a ward manager in post as they had left the service in April 2022. The advertisement for the role had been released and the service was in the process of recruiting to the post. The previous ward manager left the post in June 2022 and there was a new hospital director in post.

Managers supported staff who needed time off for ill health.

Levels of sickness were reducing. Staff sickness rate in the 12 months prior to the inspection increased from 1% in August 2021 to 10% in January 2022 and reduced again to 6% in July 2022. Sickness levels were highest among the remaining managers with a sickness rate of 48% in November 2021.

Managers accurately calculated and reviewed the number and grade of nurses and rehabilitation workers for each shift. Managers could adjust staffing levels according to the needs of the patients. However, staffing numbers had not always been met to meet the needs of the patients. The medication key was left with a non-clinical staff after a nurse finished her shift. There were unfilled shifts in the last six months rotas where the service had numbers below their establishments level and two instances where there was not a registered nurse on shifts.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff and patients told us that patients had their escorted leave or activities cancelled due to the lack of drivers to drive the bus and the lack of occupational therapist and psychologist. However, the occupational therapist assistants (OTAs) therapeutic group activities were well attended by patients, and a manual register and daily orientation sheet were kept by the OTA.

Staff shared key information to keep patients safe when handing over their care to others. We observed this during a multi-disciplinary team (MDT) ward round and daily multidisciplinary (flash) meeting.

Medical staff

The service had daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The service had one consultant who was part-time and covered physical health emergencies. The out of hours physical health emergencies were covered by the on-call doctor at the nearby general practitioner (GP) service and/or access to paramedics.

Mandatory training

Staff had completed and kept up to date with their mandatory training. We reviewed the staff mandatory training from January to July 2022, the average compliance rate for all courses was 86%.

The mandatory training programme was not comprehensive and had not met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, staff told us that training sessions were not well planned, and shift work was left vacant for staff members to attend training sessions. These were evidenced in the staff rota where shifts were unfilled due to staff absence on leave or attendance at training sessions. Staff had no training in the use of stoma bag for patients.

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 after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme, a talking therapy.

Assessment of patient risk

Staff completed initial risk assessments and a comprehensive mental health assessment for each patient on admission using a recognised tool. The risk assessments were reviewed after any incident. We saw evidence of these in the five care records we reviewed.

Staff used a recognised risk assessment tool. The brain injury risk assessments in care notes and later pulled from the incident recording system.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. However, risk assessments were not always updated after incidents. In one care record out of the five we reviewed, one patient risk assessment and care

plan following a fall was not updated. Managers were aware of the risk of falls for this patient but did not effectively manage this risk. Although managers provided an extendable call bell for this patient to use in the bathroom in case of fall, the call bell did not reach all the way into the bathroom. This meant the patient was not always able to reach the call bell in the bathroom. This did not fully mitigate the risk of falls for this patient.

Staff identified and responded to any changes in risks to, or posed by, patients. A blood sugar monitor was provided to a diabetic patient to help the patient self-managed his care plan and monitor changes in blood sugar level. However, we spoke to one patient who had not had their care plan or falls risk assessment updated despite having a recent fall.

Staff followed procedures to minimise risks where they could not easily observe patients. There were convex mirrors in the corridors so that staff could view blind spots on the wards. Staff were allocated to remain in the upstairs corridor to observe patients and to be available if required. We reviewed three sets of observation records which covered the end July and beginning of August 2022. The records were in paper format in the nurse's office. There were only three patients on observations at the time of our visit. All other patients were checked intermittently and generally between one and two hours. At the time of our inspection, one patient was on level one observation (a general observation level, the minimum acceptable level where the location of the patient should be known to the staff every 60 minutes), two patients were on level two observation (an intermittent observation of the patient by a staff member every 15-30 minutes), and the other patients were on general observation. However, there were gaps in three sets of records where there were no observations. There were six occasions where there were no observations recorded within the time allocated.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patients had locked lockers with their initials on them to keep personal items not allowed in the bedrooms.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff were trained in restraints. In the 12 months prior to the inspection, from August 2021 to July 2022, the number of restraints was 22, and there had been no prone restraints. In the last six months, from January to July 2022, the average compliance rate in reducing restrictive intervention breakaway training for staff was 49%.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The service provided de-escalation techniques and talking therapy.

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 service provided more redirection and de-escalation techniques than physical restraints.

Staff understood the Mental Capacity Act definition of restraint and worked within it. We saw evidence of this in the care records. Where an issue with capacity was identified, staff carried out capacity assessment, and patients were given hard copies in their folders and on the system. A best interest decision was made only for patients without capacity.

Staff had not used rapid tranquilisation in restrictive interventions of patients in the past 12 months prior to the inspection.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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. However, staff had not reported all safeguarding incidents.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training. In the last six months, from January to July 2022, the average compliance rate for safeguarding adults (eLearning) was 91%, safeguarding children (eLearning) 93% and safeguarding combined face to face full report training 78%.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the service safe. There was an area for visitors with children, in the cabin lodge outdoor play area.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The social worker oversaw all safeguarding referrals at this service. However, during inspection we found that a patient had been unable to leave their bedroom on the second floor, as the ward lift was broken. This had not been raised as a safeguarding incident.

Managers took part in serious case reviews and made changes based on the outcomes. In the last six months prior to the inspection, from January to July 2022, there were 15 serious incidents recorded by the service, two around medications, two around security, four around staffing, four around patients' aggressions, one around clinical care, one absconding and one unclassified. External professionals were updated in medicine overdose, where the member of staff involved commenced a medication supervision competency test after the investigation into the incident.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic. However, staff told us where bank and agency staff log in pin numbers arrived late. The bank and agency staff were unable to access clinical information of patients' promptly.

Patient notes were comprehensive, and not all staff could access them easily.

Records were stored securely. The electronic care notes of patients which contained their clinical information, treatments and care plans, Mental Health Act and Mental Capacity Act papers were accessible to staff with login pins.

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 used physical health observation after they have administered medicines. However, in the event of physical emergencies, patients were sent to on call doctors at the GP surgery or access to paramedics.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff followed systems and processes to prescribe and administer medicines safely. All registered nurses completed a medicine competency test. The service completed a medicines audit which was conducted weekly, and the pharmacist conducted a three-monthly audit. We reviewed the last three months pharmacy audit from May to July 2022.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Doctors liaised with other services to ensure medicine prescriptions on admission were correct. Medicines audits were carried out weekly by the pharmacist.

Staff had not stored and managed medicines and prescribing documents in line with the provider's policy. Managers had not ensured that staff had followed the provider's medication management policy and procedures at all times. Staff told us of an incident which occurred where keys to the clinic room and medicines cupboard were left with a non-clinical member of staff. This was due to the fact that there had been no registered nurse on shift.

Staff followed current national practice to check patients had the correct medicines. Each patients' NHS number, initial and date of birth was included on their prescription cards with detailed medicines administered to each patient.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff monitored patients and discussed with them prior to giving as required (pro re nata; PRN) medication. The ward practiced 'safe words' approach, where patients were encouraged to list three things they could try before having PRN medication.

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

Track record on safety

The service had not provided a good track record on safety.

Reporting incidents and learning from when things go wrong

The service had not managed patient safety incidents well. Staff had not recognised incidents and reported them appropriately. Managers investigated incidents and had not 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 had not recognised what incidents to report and how to report them. The incident when the lift was broken and the patient on wheelchair was room-bound for days. Staff did not report this, it was noted and reported as a safeguarding alert by the advocate. There was another incident where the call bell lead did not extend to the bathroom, and the patient needed assistance but could not reach the call bell and no one came to his assistance. This was not reported as an incident.

Staff reported serious incidents clearly and in line with trust policy. There were two missed patient blood tests; INRs (International Normalised Ratio (measure of blood clotting time)) for a patient who had been prescribed warfarin. However, a safeguarding alert had been raised with the local authority safeguarding team, and a statutory notification had been sent to the CQC.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service did not have never events on the ward.

Staff had not always followed the duty of candour. We viewed an incident where there had been a medicines error relating to a patient on warfarin. There was no evidence of the duty of candour after the incident and no evidence that lessons learned were shared among staff members. However, staff commenced physical health observations and the care plan and risk assessments were updated.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff had received feedback from investigation of incidents, both internal and external to the service. Staff received monthly emails with lessons learned and safeguarding meeting minutes. However, staff did not have access to regular team meetings. There had not been any team meetings between April and July. A meeting had been planned for July however, staff did not turn up.

Senior managers met to discuss the feedback and look at improvements to patient care. There was evidence of this in clinical governance meetings.

Are Long stay or rehabilitation mental health wards for working age adults 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 some patients on admission. They developed individual care plans which were reviewed regularly through MDT meetings 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 on admission to the service. We reviewed five care records, which showed that staff had completed a comprehensive patient assessment on admission.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We saw this recorded in their care records.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We found that there were a lack of one to one psychology assessment and occupational therapy input on the ward, as there had been no psychologist or occupational therapist in post for over six months. However, the provider had ensured that psychological treatment had been provided via group therapy.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Care plans were personalised, holistic and recovery orientated. We found care plans for a variety of needs including mobility, physical health and chronic diseases such as diabetes, epilepsy and visual impairment that were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff had provided a range of treatment and care for patients based on national guidance and best practice. Staff provided access to group psychological therapies, support for self-care and the development of everyday living skills. 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. There were regular group therapeutic activities and workshops provided by the assistant occupational therapists and assistant psychologist. However, there were no personalised goal-oriented psychology input as stated in the service provider treatment model because of the lack of a permanent psychologist and occupational therapist in post to give personalised psychology and occupational therapy inputs to patients and provide clinical supervision to staff.

Staff delivered care in line with best practice and national guidance (from relevant bodies e.g., NICE). The feedback survey from patients was positive, caring and approachable, and the MDT treatment plan was comprehensive. 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. There was access to physical health care at the GP surgery and to specialist treatment.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The provider had recently employed the services of a dietician to assess the nutritional needs of patients.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service had a therapy cabin that was used as an occupational therapy kitchen. Patients who had been risk assessed, and under supervision, were able to attend to cook and do laundry.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used a variety of tools to assess risk including the overt aggression scale- modified for neuro rehabilitation (OAS-MNR) to rate behavioural incidents in brain injury, the St Andrew's sexual behaviour assessment (SASBA) scale to rate sexualised overfamiliar behaviour and the St Andrew's-Swansea neurobehavior outcome (SASNOS) scale to measure neuro disability across several cognitive sub-scales. These were updated during care programme approach (CPA) meetings.

Staff used technology to support patients. The care note system formulated personalised care plans. The provider used an incident reporting system, which recorded incidents, serious incidents and to capture lessons learned.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The pharmacist had conducted a weekly medicine audit. Other audits included ligature and cleaning audits.

Managers used results from audits to make improvements. For example, following two recent incidents of medicine errors the staff involved received training in administering medicines to patients.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Skilled staff to deliver care

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

We reviewed the last 12 months induction report from August 2021 to July 2022, the completion rate was 93%. However, during inspection we found that one locum staff had not received a full induction and had been asked to see patients on the ward. The locum staff was not included in the staff induction list of all staff. Therapy staff told us they had not received regular clinical supervisions and appraisals because of the lack of a psychologist and occupational therapist in post. Staff had not attended a team meeting for over six months.

The service had not provided access to a full range of specialists to meet the needs of the patients on the ward. The ward team included a doctor and nurses, social workers, pharmacists, a speech and language therapist, a dietician, a physiotherapist, employed Polish interpreters and peer support workers. However, there were no clinical psychologists and occupational therapists in post for over six months.

Managers had not always ensured that staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. During inspection we found that staff had received no training for managing a patient with a stoma bag.

Managers had not provided each new member of staff a full induction to the service before they started work.

Managers had not supported staff through regular, constructive appraisals of their work. Managers had not provided regular clinical supervision (meetings to discuss case management, to reflect on and learn from practice and for personal support and professional development). Staff told us they did not have supervision for over six months due to the absence of both lead psychologist and occupational therapist.

The provider's supervision data provided was from January to August 2022, the supervision rates for all permanent registered nurses and rehabilitation workers was 47% and 30% respectively. Some of the nurses and rehabilitation workers had not received clinical supervision since March 2022. Monthly supervision was not regular.

Managers had not supported staff through regular, constructive appraisals of their work. Staff told us that they had no appraisals. There were no appraisal records provided.

Managers had not ensured that staff attended regular team meetings. In the six months prior to the inspection, there were no staff team meetings held, however, two clinical governance meetings took place.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers had not ensured that staff received specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these. We saw examples where managers had investigated incidents surrounding poor performance and took action to address this.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended an MDT meeting which was attended by a patient and an interpreter, a doctor, a social worker, Independent Mental Health Advisors (IMHAs), physiotherapist, and a speech language therapist (SLT).

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We attended the morning MDT flash meeting and handover meeting attended by the various healthcare professionals. During the handover meetings staff from the previous shift discussed patient treatments, care plans, incidents and risk management plans with the incoming shift.

The ward teams had effective working relationships with external teams and organisations such as the local authority social services, GP services, dental and chiropodist services.

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

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

Staff received training but had not kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and the Code of Practice guiding principles. The average Mental Health Act (MHA) training compliance rate from January to July 2022 was 89%, however, there were no training records provided for the month of February.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff made referrals to IMHA and advocacy services.

Staff knew who their MHA administrators were and when to ask them for support. We were told by carers that they found it accessible to contact the Mental Health Act administrator for every information needs about the hospital

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 service made referrals to the independent mental health advocacy service for people under Section 2 and 3 of the MHA and for Deprivation of Liberty Safeguards (DoLS).

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. We saw examples of staff informing people of their rights.

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

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw copies of requested second opinion appointed doctor records.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We saw completed records of mental health detention papers and consent to treatment records for patients.

Informal patients did not know they could leave the ward freely, because the service had not displayed information to inform patients of this. We did not see the evidence that staff had provided them information about their right to leave the ward freely.

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

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 (MCA) 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received training in the Mental Capacity Act and had a good understanding of at least the five principles, however, they were not kept up to date with their Mental Capacity Act training. The average compliance rate for Mental Capacity Act training was 86% from January to July 2022. The service had no training records for the month of February.

There were 29 Deprivation of Liberty Safeguards applications made in the 12 months prior to the inspection and managers knew which ward made the highest number of applications. Managers monitored applications to ensure that these had been completed correctly.

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

The provider had a policy on the Mental Capacity Act, including DoLS. Staff were aware of the policy and had access to it.

Staff knew where to get accurate advice on the Mental Capacity Act and DoLS. The advocate and the Independent Mental Health Advisors (IMHAs).

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. We saw a variety of capacity assessments for different decisions.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw records of mental capacity assessments and best interest meeting minutes.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. Mental Capacity Assessments were completed by the clinical team and Best Interest decisions were completed by the MDT during MDT meetings. The capacity assessments were reviewed when DoLS were applied for. The MHA administrator had a spreadsheet which showed the completion dates of the MHA paperwork. We saw evidence of the three-monthly MHA paperwork audits.

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

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. Information and communication needs of patients were provided in patients' care records with speech and language therapy (SLT) input and care plans were developed if needed. A dietician had been recently employed to oversee patients' food menu and choices for those patients who required this support. A coffee machine was recently provided in the dining area for patients to access drinking facilities and access to other drinks

Staff gave patients help, and emotional support. For example, there was availability to attend church service nearby and a mosque when requested.

Staff supported patients to understand and manage their own care treatment or condition. We were told that the service had information leaflets on the care treatments to support patients to understand and manage their own treatment or condition, however, we did not see the leaflets on the notice board.

Staff directed patients to other services and supported them to access those services if they needed help. Doctors referred patients to their local general practitioner and other services when needed. Physical health needs were provided by the local General Practitioner service.

Patients said staff treated them well and behaved kindly. We spoke with six out of the nine patients in the service, four told us staff members were good and "there were no negatives" about them.

Staff understood and respected the individual needs of each patient. There were Polish interpreters available two hours on weekdays that facilitated language and communication support for the two Polish speaking patients at the service. We used a translator to speak with the patients. The service had also provided a translating device for the Polish patients which improved their communications in the absence of the interpreters.

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.

There was no evidence that staff involved patients and gave them access to their care planning and risk assessments. Out of five care records reviewed, patient involvement was minimal in developing care plans and risk assessments.

Staff made sure patients understood their care and treatment. Patients had a risk management plan and a crisis plan with action to be taken in a crisis for each patient. Patients had Positive Behaviour Support plans (PBS) for behaviours that challenge with interventions to manage the behaviours.

Staff involved patients in decisions about the service. Staff asked the patients to give feedback about the service. For example, patients were not satisfied that their activities were being cancelled as there were no available drivers to take them out. The provider agreed to obtain taxi's when drivers were unavailable, however, there were no evidence of this. The stair lift was under repair at the time of the inspection.

Staff supported patients to make decisions on their care. Patients were supported to make decisions on their care. For example, some patients complained about limited food choices, and the service employed a dietician to support with this. However, we did not see the evidence that the menus had changed.

Staff made sure patients could access advocacy services. We spoke with two IMHAs trained in the MHA 1983 who supported people to understand their rights under the Act and to participate in decisions about their own care and treatments. We were told the provider had not requested IMHA feedback.

Involvement of families and carers

Staff had informed and involved all families and carers appropriately. Out of the four carers we spoke with, two were not happy with the care and treatment given to their relatives or that they were not informed of the care and treatment they received. However, two of the carers felt that the service did keep them well informed of the care and treatment their relatives received, and they were happy the way the service managed incidents between patients at the service.

Staff had supported, informed and involved all families or carers. We were told by 75% of carers that they obtained information about their relatives from staff in the hospital, and that the staff were accessible.

Staff helped families to give feedback on the service. One carer originally wanted to move their patient closer to home but after seeing his progress at the service, they wanted him to continue with his treatment at the service.

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

Requires Improvement

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Access and discharge

Staff had planned and managed discharge. They had liaised with services that would provide aftercare and had been assertive in managing the discharge care pathway. However, for reasons other than clinical, patients had excessive lengths of stay and discharge was delayed.

Bed management

Managers had regularly reviewed length of stay for patients, however, patients stayed longer than they needed to. Patients stayed in hospital when they were well enough to leave because they had no-where to go. We were told that the commissioners were aware of this delay. Currently there were seven patients on delayed discharge list, their discharge dates ranged between December 2021 and July 2022.

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.

Discharge and transfers of care

In the 12 months prior to the inspection from August 2021 to July 2022 there were seven delayed discharges from the service, and the average length of stay was 512 days. The reasons for delayed discharge ranged from commissioners unable to find suitable placements and waiting on funding for care package.

Staff had 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.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

The food was of a good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. Each patient had their own bedroom with an en-suite bathroom. The ward had quiet areas which patients could access and could meet visitors in private.

Patients had a secure place to store personal possessions. Patients had access to secure lockers outside their bedrooms.

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

Staff used a full range of rooms and equipment to support treatment and care.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients could make their own hot drinks and snacks when they wanted to. The service had no PLACE survey score on food quality. Patients told us that they did not have many food choices, however one patient told us that they had the option of requesting what they wanted.

We were told by one of the patients who attended monthly community meetings, that the ward had been given a coffee machine, after patients had requested it during one of the community meetings.

Patients could make phone calls in private and had access to mobile phones if appropriate.

Patients' engagement with the wider community

Staff supported patients with activities outside the service such as going for shopping or community activities.

Patients had no access to educational or work opportunities in the community.

Staff helped patients to stay in contact with families and carers. Staff supported patients to visit families or for families to visit the service.

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.

Staff helped patients with their communication needs, non-English speaking patients were given translation devices to aid their communication needs, and there was access to Polish interpreters two hours a day, except on weekends.

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

Staff referred patients to advocacy services, and to the IMHAs.

Patients could access cultural and spiritual support. The service provided opportunity for Christian patients to attend church and provided a prayer room for Muslim patients.

The service could access information leaflets in different languages if required. Although these were not displayed at the service, these were available if needed.

A stair lift was in place to support patients with wheelchairs. However, this was under repair at the time of inspection.

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

The service provided a variety of food to meet the dietary and cultural needs of individual patients. The service recently employed a dietician to provide oversight of the dietary needs of patients.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients, relatives and carers knew how to complain or raise concerns. Staff implemented recommendations from patients' feedback. For example, patients wanted to access computers and now had a space to do this. The service provided a space for patients to be able to use a computer with support from staff.

The service clearly displayed information about how to raise a concern in patient areas. We observed information displayed on the ward which provided advice on how to make a complaint on the ward.

Staff understood the policy on complaints and knew how to handle them. Staff had a whistleblowing help line for anonymity. Staff were aware of the complaint process and policy, and their rights.

Managers investigated complaints and identified themes. In the last twelve months prior to the inspection, there had been seven complaints in total. Three were upheld and/or partially upheld. The service did not have complaints referred to the Ombudsman.

Staff protected patients who raised concerns or complaints from discrimination and harassment. There were access to advocacy and IMHAs.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The patients complained about the absence of drinks in the ward, and a coffee machine was brought in by the provider.

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

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

Requires Improvement

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. The service provided specialist training for staff to perform their roles. However, staff told us that they felt that leaders were not visible or approachable.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. We interviewed senior leaders, and they explained clearly how the teams worked. However, the highest staff turnover in the service was for senior managers, with a turnover rate of 84% in April 2022.

Leadership development opportunities were not available for staff below team manager level. We found evidence that the service provider gave staff opportunities for development and career progression. A charge nurse had been promoted to director of clinical services and opportunities for mentorship to support staff with career progression had been offered.

Vision and strategy

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in the service. The senior leadership team had communicated the vision and values of the organisation to managers, during management supervision. However, front line staff told us that they did not know what the mission statement, vision and strategy were, as due to there being no ward manager, there had been no communication between the ward staff and other members of the MDT.

Staff had no opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. There had been no staff team meetings and action plan to suggest contribution were made about the service.

Staff could explain how they had worked and delivered high quality care within the budgets available.

Culture

Staff had not felt respected, supported and valued. Staff members told us they did not feel respected, supported and valued, and that the service provider had not promoted equality and diversity in daily work. Staff told us the rota management was poor, shifts were left uncovered, and that staff retention had been a concern. Staff were concerned with the rate of turnover of staff and felt that retention of staff was poor.

Staff had not felt positive and proud about working for the provider and their team. We were told, there was a culture of blame in the service.

Staff were not able to raise concerns without fear of retribution. There were no speak up guardians, and staff told us that they had not raised concerns because of fear.

The provider had not recognised staff success within the service, for example, there were no staff recognition awards.

Governance

There was a framework of what must be discussed at a ward, team or directorate level in the local governance meetings to ensure that essential information such as learning from incidents and complaints were shared and discussed. We saw the minutes of the meetings including action plans discussed, however, there had been no staff team meetings for over six months.

Staff had participated in clinical audits to provide assurance, and that they acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the provider and external to meet the needs of the patients. Staff worked within the MDT and with chiropodists, dentists and GPs to meet the needs of patients.

Management of risk, issues and performance

Staff members had access to the information they needed to provide safe and effective care and used that information to good effect. However, there were delays in getting login details to the care notes, for bank and agency staff.

Information management

Staff had access to the equipment and information technology needed to do their work. Staff had had access to patient clinical information both paper and care notes systems.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Information governance systems included confidentiality of patient records.

Staff made notifications to external bodies as needed. Statutory notifications of incidents had been sent to the CQC. However, safeguarding concerns had not always been identified and raised with the local authority safeguarding team. The incidence of a patient being unable to leave their bedroom for two days, due to a broken lift had not been reported as a safeguarding incident. We also found that two medicine errors also had not been reported as an incident.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used, through the intranets, bulletins, leaflets etc.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients' feedback was given in the weekly community meetings. Carers had access to nominated staff members to contact and to voice their concerns.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Staff received monthly lesson learnt and safeguarding meeting information. Summary emails were sent to staff on lessons learnt from incidents.

The service did not participate in national audits relevant to the service and learned from them such as the Acquired Brain Injury scheme, however, they participated in regular study days and events such as the psychological care of patients with traumatic brain injury.

The ward did not participate in accreditation scheme relevant to the service such as the National accreditation for inpatient rehabilitation unit.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13: Safeguarding service users from abuse and improper treatment.** • The provider must ensure that patients were protected from abuse and improper treatments and systems and processes established and operated effectively to investigate immediately upon becoming aware of any allegation or evidence of such abuse. Regulations 13 (1)(2)(3)(4)(a)(b)(d). • Lack of incident reporting. The room bound patient was not reported as a safeguarding incident by staff but was escalated by the advocate.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12: Safe care and treatment:** • The provider must ensure that patient observations are recorded in line with trust policy. Regulation 12 (1) (2) (a) (b). • The provider must ensure that the premises are safe to use for their intended purpose and the equipment used are provided in a safe way for service users, and well maintained. Regulation 12 (1) (2) (d) (e). • The provider must ensure the proper and safe management of medicines. Regulation 12 (2) (g). • The provider must ensure that all staff (including bank and agency) have access to the patient information system (patient records) before commencing work on the wards. Regulation 12 (2) (i).

This section is primarily information for the provider

Requirement notices

- There were gaps in the observation records of the patients on different levels of observation.
- A patient with wheelchair was room bound for 2 days because the chair lift and main lift was broken.
- The medication key was kept with a non-clinical staff because there was no registered nurse on shift.
- The provider had not ensured that staff were in receipt of clinical supervision and appraisal. The figures for supervision between January and August 2022 were 47% for registered staff and 30% for unregistered staff. Regulation 18 (2) (a) (b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15: Premises and equipment** • The provider must ensure that all premises and equipment used were clean, secure and properly maintained. Regulation 15 (1) (a) (b) (e). • The provider must ensure that plans are in place for disabled patients to be able to leave the ward, and to have blood tests done when the service lift is non-operational. Regulation 15 (1) (c)(e)(f). • There was no PEEP (patient emergency evacuation plans) in place for a patient who was 'room bound'. All patient should have patient emergency evacuation plans (PEEP) in place to remove them from their rooms when the chair lift broke. Therefore, there were no plans in place to identify how staff should respond in the event of a fire.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Requirement notices

Regulation 10: Dignity and respect:

- The provider must ensure that patients had access to opportunities for education and employment in the community were provided. Regulation 10 (2) (b).
- The patients had no access to educational opportunities nor work/vocational opportunities to help them in their rehabilitation.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18: Staffing** • The provider had not ensured that there had been sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirement of staffing. In 11% of shifts ward staffing numbers during the weekdays were below the required staffing levels of registered nurses. In 41% of shifts at the weekend there had been only one registered nurse on duty. In addition, 43% of early shifts did not have the required number of healthcare assistants on duty. Regulation 18 (1) • The provider had not ensured that staff had been trained in stoma care, when they had a patient with stoma bag. Whilst the patient had been trained in his own stoma care, staff found that he was unable to look after his own stoma. Regulation 18 (1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17: Good governance**

This section is primarily information for the provider

Requirement notices

- Managers did not have adequate oversight of patient observations. Whilst clinical audits of patient observations had been undertaken, managers had not identified the gaps in patient observation records which were found on inspection.
- The provider had not ensured that systems were in place to ensure that the cleaning of tumble drier lint, had been undertaken daily and had not ensured that daily food safety checks and records had been completed. Regulation 17 (2) (d)
- The provider had not ensured that systems and processes were in place to obtain feedback from staff, for the purposes of continuous evaluation and ongoing service improvements. The provider had not ensured that regular staff team meetings had taken place. Regulation 17 (2)(e).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9: Person centred care:** The provider must ensure that the care and treatment of patients are appropriate, and fully meet their needs and reflect their preferences. Regulation 9 (a)(b)(c). • The call bell lead was not long enough to reach the bathrooms for patients with disability. A patient had to shout for help, and no one answered and had to help himself in the bathroom. This was not recorded as an incident. • Due to current staffing vacancies and maternity leave, there had been no one to one individualised rehabilitation therapies for over six months. In response to current staffing issues, the service had delivered group therapies and was in the process of trying to recruit to the vacant posts and bring in locums. The treatment model of the hospital (as outlined in their mission statement) stated that therapies would be delivered on an individual basis.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **Regulation 20: Duty of candour.** • The provider had not notified a patient of one incident involving a medication error in line with the duty of candour. Regulation 20(1)(2).