Elysium Healthcare Limited

The Copse

Inspection report

Beechmount Close
Oldmixon
Weston Super Mare
BS24 9EX
Tel: 01934818070
www.elysiumhealthcare.co.uk

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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?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
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:

- Staff did not always feel safe on the wards and did not always adhere to policies and risk management plans to keep themselves and others safe. Staff felt there weren't enough staff to respond and provide support in an emergency. Managers had not ensured the environment was safe and that staff were aware of interventions to mitigate identified risks. Staff did not manage medicines safely and there were repeated medicine incidents.
- The service's reducing restrictive practice programme was only partially embedded. Managers did not fully assess the negative impact of restrictive practice on patients and take steps to reduce this as far as possible. Patients told us they could not access the garden except at allocated smoking times.
- Staff did not always understand the individual needs of patients or support them to manage their own care and treatment. Staff did not always respect patients' privacy and dignity. Patients told us that not all staff treated them with kindness and respect.
- Staff had not received specialised training required to meet the rehabilitation and recovery needs of patients. They were not working within the specified model of recovery and utilising best practice assessment and outcome tools routinely. Staff did not develop recovery oriented and person-centred care plans in response to assessments that were completed. The service did not have an occupational therapist in post and during the coronavirus pandemic the range of treatments, activities and therapies on offer had significantly reduced.
- Patients had limited opportunities to engage with the wider community. Carers and families did not feel involved in patient care and felt that communication from the service was poor. Staff did not develop comprehensive discharge plans and it was therefore unclear how staff were working with patients towards meaningful recovery and discharge into the community.
- Managers did not have a clear understanding of the expected length of stay for patients. There was a lack of governance processes in place to monitor how clinically effective the hospital was.

However:

- There had been significant improvements in the individual risk assessment and management of patients since our previous inspection in 2021. Patients had positive behavioural support plans in place, and assessment and management of risk was more comprehensively discussed at multidisciplinary reviews. Staff recognised incidents and reported them appropriately. Staff followed safeguarding processes, took action to protect patients from abuse, and worked well with other agencies to do so.
- Managers had ensured that mandatory training compliance had improved. Although there were vacancies within the staff team, the number of shifts that did not meet planned staff requirements had reduced in the previous three months.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff felt confident to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.
- The occupational therapy assistants were proactively working to increase engagement with the wider community and organising activities within the community. Over the previous month activities in the community had been restarted and some patients were engaging in internal employment and volunteer opportunities.

Summary of findings

- There was a new leadership team who had a clear plan in place for the site and had started to make progress. Although new processes had not had time to be embedded as yet, the new hospital director was aware of the risk areas and performance issues facing the service. They had reviewed the site improvement plan and had developed this in response to the identified areas for improvement, and progress with this was already evident. Staff said there had been a positive shift in culture.

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 	• Staff did not always feel safe on the wards and did not always adhere to policies and risk management plans to keep themselves and others safe. Staff felt there weren't enough staff to respond and provide support in an emergency. Managers had not ensured the environment was safe and that staff were aware of interventions to mitigate identified risks. Staff did not manage medicines safely and there were repeated medicine incidents. • The service's reducing restrictive practice programme was only partially embedded. Managers did not fully assess the negative impact of restrictive practice on patients and take steps to reduce this as far as possible. Patients told us they could not access the garden except at allocated smoking times. • Staff did not always understand the individual needs of patients or support them to manage their own care and treatment. Staff did not always respect patients' privacy and dignity. Patients told us that not all staff treated them with kindness and respect. • Staff had not received specialised training required to meet the rehabilitation and recovery needs of patients. They were not working within the specified model of recovery and utilising best practice assessment and outcome tools routinely. Staff did not develop recovery oriented and person-centred care plans in response to assessments that were completed. The service did not have an occupational therapist in post and during the coronavirus pandemic the range of treatments, activities and therapies on offer had significantly reduced. • Patients had limited opportunities to engage with the wider community. Carers and families did not feel involved in patient care and felt that communication from the service was poor. Staff did not develop comprehensive discharge

Summary of findings

plans and it was therefore unclear how staff were working with patients towards meaningful recovery and discharge into the community.
- Managers did not have a clear understanding of the expected length of stay for patients. There was a lack of governance processes in place to monitor how clinically effective the hospital was.

However:

- There had been significant improvements in the individual risk assessment and management of patients since our previous inspection in 2021. Patients had positive behavioural support plans in place, and assessment and management of risk was more comprehensively discussed at multidisciplinary reviews. Staff recognised incidents and reported them appropriately. Staff followed safeguarding processes, took action to protect patients from abuse, and worked well with other agencies to do so.
- Managers had ensured that mandatory training compliance had improved. Although there were vacancies within the staff team, the number of shifts that did not meet planned staff requirements had reduced in the previous three months.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff felt confident to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.
- The occupational therapy assistants were proactively working to increase engagement with the wider community and organising activities within the community. Over the previous month activities in the community had been restarted and some patients were engaging in internal employment and volunteer opportunities.
- There was a new leadership team who had a clear plan in place for the site and had started to make progress. Although new processes had

Summary of findings

not had time to be embedded as yet, the new hospital director was aware of the risk areas and performance issues facing the service. They had reviewed the site improvement plan and had developed this in response to the identified areas for improvement, and progress with this was already evident. Staff said there had been a positive shift in culture.

Summary of findings

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Summary of this inspection

Background to The Copse

The Copse is a long stay rehabilitation service that takes patients over the age of 18 with enduring mental health problems. The service aims to support patients to work towards recovery and transition to a less restrictive environment or community setting. Patients may be admitted from acute wards, low secure settings or directly from the community.

The hospital has 24 beds and is split into four, six bedded wards, three for men and one for women.

The service is registered to provide the following regulated activities:

Treatment of disease, disorder or injury

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

Diagnostic and screening procedures.

The service did not have a registered manager. The newly appointed hospital director was in the process of applying to be registered manager.

We undertook this unannounced comprehensive inspection of The Copse following concerns identified at our last inspection. Concerns had also been raised with us by former patients, carers and staff.

A focused inspection of the safe and well-led domain for this service took place in August 2021. Following this inspection, the service was rated requires improvement in both domains. We found that the service was not fully meeting the required standards of care of Regulations 12 (safe care and treatment), 13 (safeguarding services users from abuse and improper treatment), 17 (good governance) and 18 (staffing) of the Health and Social Care Act (regulated activities) Regulations 2014. We served 10 requirement notices and told the service it must take action to improve risk management, medicines management, use of restrictive interventions, training compliance, documentation, safeguarding and ensure there were enough suitably qualified staff to meet patients' needs.

The last comprehensive inspection of the service took place in July 2019. The service was rated good in all domains and overall.

What people who use the service say

Patients and carers told us that the hospital had been overly restrictive in response to the coronavirus pandemic. Patients and carers felt that meaningful activities and therapies had reduced since the start of the pandemic.

However, patients felt there had been some recent improvements since coronavirus restrictions had been stopped and new activities and community trips organised.

The majority of patients told us that there was enough staff to meet their needs and staff treated them with kindness. Patients told us that they felt involved in their care, and decision-making that impacted them.

Summary of this inspection

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the service. This comprehensive inspection was unannounced (the service did not know we were coming).

During the inspection visit, the inspection team:

- Spoke with the hospital director
- Spoke with seven patients and two carers
- Spoke with 15 staff members
- Looked at 13 care records, and 21 medicines records
- Observed three meetings, and care provided on the wards
- Looked at a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that environmental risk assessments are completed, kept up to date, actions completed, and that staff understand and adhere to processes identified to mitigate risk. Regulation 12(2)(d)
- The service must ensure there is enough staff to respond to requests for assistance in emergencies and that staff use personal alarms and pagers to maintain the safety of themselves and others. Regulation 12(2)(b)
- The service must ensure that there is an effective reducing restrictive practice programme embedded and restrictive interventions are proportionate, individually assessed and any negative impact on patients is reduced as far as possible. Regulation 17(2)(f)
- The service must ensure that medicines are managed safely. Regulation 12(2)(g)
- The service must ensure that staff develop person-centred and recovery oriented care plans, that are informed by a comprehensive assessment of individual patient's needs. Regulation 9(1)(3)(b)
- The service must ensure that staff collaborate with patients and their community teams to develop comprehensive discharge plans starting at the point of admission. Regulation 9 (1)(3)(b)
- The service must ensure that staff are aware of, and work towards, the service specification and chosen model of recovery and rehabilitation. Regulation 9(3)(b)
- The service must ensure that governance processes in place to monitor the clinical effectiveness of the service and areas for improvement are addressed in a timely way. Regulation 17(2)(a)

Action the service SHOULD take to improve:

- The service should ensure that all staff are up to date with safeguarding training.
- The service should ensure that staff only use approved techniques and avoid the use of prone position, during restraint.
- The service should ensure timely repairs and resolution of damage and maintenance issues.
- The service should complete a training needs analysis focused on how the needs of patients using the service are met, such as, recovery and rehabilitation.

Summary of this inspection

- The service should ensure patient's privacy and dignity during observations is maintained at all times.
- The service should provide opportunities for family and carer involvement, and take action to respond to feedback received.
- The service should ensure patients have regular opportunities to provide feedback on care received and service design, and managers respond to concerns and requests.
- The service should ensure that work to increase engagement with, and activities in the wider community continue and patients are involved in this.

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	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Requires Improvement	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	Requires Improvement
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 stayed the same. We rated it as requires improvement.

Safe and clean care environments

The service had completed risk assessments of the ward environment, but these were not always understood and adhered to by staff. One ward area had been damaged a month prior to the inspection and had not yet been repaired.

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

Safety of the ward layout

Staff completed and regularly updated, thorough risk assessments of all ward areas. However, not all risks, including ligature risks, had been removed or were mitigated against. The phone rooms on each ward contained ligature risks and could not be observed when in use. The environmental risk assessment identified that use of the room should be individually risk assessed for each patient and the room should be left unlocked, as the least restrictive option. Staff were unaware of this and told us that all phone room doors were kept locked. We found that three of the four doors were unlocked during our visit. There was a ligature risk within the communal bathroom on one ward. This had been identified as requiring removal in the 2021 ligature risk audit but had not yet been acted upon.

Staff could not observe patients in all parts of the wards. Staff told us that concave mirrors had been ordered to mitigate blind spots within bedroom corridors on Elm ward. There were a mix of full vision panels and magnified vision spots to observe patient bedrooms. On Birch ward we found that two of the viewers were not working. Staff and managers were unaware of this.

The ward complied with mixed sex guidance and there was no mixed sex accommodation. There were three male wards and one female ward. Bedrooms were ensuite and communal bath and shower rooms were also available.

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

Maintenance, cleanliness and infection control

The wards were clean, and staff made sure cleaning records were up-to-date.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff followed infection control policy, including handwashing. Managers completed spot checks of the wards and infection prevention and control processes. Staff completed extra two hourly cleaning of the wards in response to the coronavirus pandemic.

The wards were generally well maintained. However, on Elm ward a fire door had been damaged and removed. During the same incident a window had also been broken. The replacement and repair of the damaged items had not been carried out for over one month and staff on the ward did not know when this was due to take place. Managers told us that replacements had been ordered the day after the incident, but there had been a delay in receiving this due to supply issues.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service had vacancies within the nursing team and relied on agency and bank staff to keep the service safe.

Nursing staff

The service had 13 healthcare worker and two registered nurse vacancies. The service relied on the use of agency and bank staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. However, staff and patients told us that agency healthcare workers did not know patients' individual needs and risks and therefore did not always manage or meet these well. Managers had recently contracted regular agency nurses to ensure staff were familiar with the service.

Managers monitored safer staffing levels. In the seven months before the inspection 73% of shifts met the planned staffing requirements. 27% of shifts that did not meet requirements were deemed by the service to still be safe. Managers and multidisciplinary members of staff supported the wards where there were absences. The number of shifts that did not meet planned staff requirements had reduced over the last three months.

The ward manager could adjust staffing levels according to the needs of the patients.

Although the service had enough staff on each shift to carry out any physical interventions safely, staff told us they did not always feel safe on the wards. Healthcare workers and members of the multidisciplinary team told us there was not always enough staff to respond (from other wards) to emergencies or incidents. Staff also told us that they didn't wear their personal alarms at all times because they knew that there would not be enough staff on other wards to respond to them. Staff told us that nursing staff often left their pagers in the office. Staff told us they relied on the other staff on their ward only to respond to emergencies.

Staff told us that incidents increased during the evening as the hospital had less staff at these times due to staff breaks being facilitated.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients told us that they rarely had their escorted leave or activities cancelled, even when the service was short staffed. However, staff from Birch ward told us that due to staff undertaking enhanced observations, patients could not always be supported to access escorted leave at the time they requested.

Staff shared key information to keep patients safe when handing over their care to others. Staff attended twice daily handover meetings. The multidisciplinary team attended handovers every weekday morning and shared key information about patient needs, risk and staffing.

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.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with the majority of their mandatory training. However, 29% of staff were not up to date with their safeguarding training. Managers had identified this training need and identified future courses for staff to attend. Following our last inspection, we served a requirement notice for poor compliance with immediate life support training. Registered nurses at the service attended training in March 2022, and only two staff were out of date with this training.

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

Assessing and managing risk to patients and staff

There had been improvements over the previous three months in how staff assessed and managed individual risks to patients and themselves.

The providers restrictive interventions programme was in its infancy and its principles had not yet been embedded. The service did not achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. During our last inspection of the service we found that staff did not regularly and fully assess risk. We found that the quality and regularity of risk assessments for patients had improved.

Management of patient risk

Staff knew about risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. Staff discussed risk and incidents as part of monthly reviews and updated management plans to reflect their assessments.

All patients had positive behavioural support plans in place which had been completed collaboratively with patients and the multidisciplinary team.

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

Use of restrictive interventions

The provider's restrictive interventions reduction programme was in its infancy. The provider had held two reducing restrictive practice meetings. The first meeting was an initial meeting where the terms of reference for the group were discussed. Staff had discussed actions and goals during the second meeting, but these referred to goals that were not relevant to The Copse and the proposed agenda had not been followed.

The service did not achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff, carers and patients told us that they had experienced significant distress due to the restrictiveness of whole hospital 'lockdowns' in response to coronavirus outbreaks. The service had previously managed outbreaks by cohorting exposed patients and wards separately. In August 2021, following an outbreak of the virus amongst patients, managers made the decision in consultation with the local health protection team to isolate the whole hospital for 28 days. During this time the service followed Elysium policies that stipulated patients could not use section 17 leave and visitors were not allowed to the hospital. Following further positive tests, the restrictions were extended until early October 2021. In late October 2021, there were positive cases amongst staff only, however restrictions for patients continued up until November 2021. During this time no patients accessed section 17 leave and visits to the hospital were restricted, despite no wards having positive cases amongst patients. Patients and carers submitted complaints regarding the negative impact the lockdown had on their mental health and wellbeing.

Following this outbreak, managers did not review their contingency plans to manage future outbreaks or reintroduce plans to cohort wards or patients. In January 2022, there was a further outbreak of coronavirus amongst staff only. The manager of the service at the time implemented the provider 'outbreak status' policies to the entire hospital for a planned 28 days. At the time, the local health protection team and government guidance recommended a 10-14 day period for isolation of inpatients exposed to coronavirus. The new hospital director reviewed these restrictions and attempted to reduce restrictions after 14 days. The new hospital director also proposed allowing visits from one essential carer, as included in care home outbreak guidance. This proposal was agreed in consultation with the local health protection team and recovery testing organised to enable the service to exit outbreak status.

Staff, patients and carers told us, and we saw evidence of these increased and extended restrictions impacting on patients' mental state and leading to increased incidents and slowed progress towards recovery. Despite an increase in some patients' risk behaviours and deterioration of their mental state, staff had not developed individualised risk management plans or care plans in relation to the impact of restrictions. The service had highlighted coronavirus on the risk register and discussed the impact on patient's wellbeing and level of incidents in governance meetings. However, the risk register did not include reference to the impact of coronavirus on patients' wellbeing or recovery. Staff had not discussed coronavirus and the restrictions during 'outbreaks' in the two reducing restrictive practice meetings that had taken place, despite this being identified as an action during clinical governance meetings.

During our tour of the environment, we found that garden and outdoor access doors were locked. Managers told us that patients could access fresh air at any time. Five patients told us that they could only access the garden at allocated times. The service was a non-smoking site and therefore there were allocated smoking and vapeing times for each ward.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The levels of restraint and rapid tranquilisation were reducing. There had been an increase in the use of restrictive interventions on Birch ward throughout September to November 2021. Following a change to management plans, and patients moving to more appropriate placements, the number of interventions significantly reduced in December 2021. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff told us they were not taught to use restraint in the prone position. However, there had been three incidents of prone restraint in the previous six months. Staff told us this was to enable administration of medicine. Following the inspection, we were told that prone restraint was taught as a last resort and the risks of this outlined.

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

Staff followed NICE guidance when using rapid tranquilisation.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

The service did not have a seclusion area and no patients had been secluded in the previous six months.

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 not all up to date with their safeguarding training but knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

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 make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

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

Patient notes were comprehensive, and all substantive and bank staff could access them easily. However, agency staff could not access the electronic records. Staff had created paper files with essential information easily accessible by agency staff.

Managers had developed a proforma for contemporaneous notes and the multidisciplinary review meetings. We saw that the content and quality of care records had improved, and records were more detailed.

Records were stored securely.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Medicines management

Medicines were not always administered, recorded and stored safely. Staff regularly reviewed the effects of medicines on each patient's mental and physical health. The service had systems in place to ensure medicines were prescribed safely.

There had been repeated medicines errors recorded in the previous six months. These had included the wrong medicine dose being administered, and medicine being administered to the wrong patients. These incidents were quickly identified by staff, and additional advice obtained to support and monitor patients to minimise any potential harm. Staff had applied the duty of candour following these incidents. Managers had investigated incidents and identified learning. We were provided an example of changes to processes to reduce the number of incidents. All staff were up to date with their medicines management training, but managers had requested all nurses repeat the training due to the ongoing incidents.

An external pharmacist visited the ward weekly and audited prescription charts and medicines management. There had been an improvement since the last inspection in the timeliness of staff response to these audits.

We reviewed prescription charts and saw that staff did not always complete medicines documents safely. Some staff did not always sign to say medicine had been administered or did not detail reasons for not administering some medicines. We observed, and patients and staff told us that medicines were not always administered on time. Staff told us that this had previously led to an increase in some incidents, as patients had not received essential medicine on time.

We also saw that some medicines were repeatedly not administered due to being out of stock, this included medicines for side-effects and allergies. Managers were aware of issues with stock management and completion of documents. Managers had highlighted issues during staff supervisions and delegated ordering responsibility to more staff members.

Staff did not always store medicine safely. There had been two incidents during the previous two months of patients accessing medicine that wasn't prescribed for them. Managers were investigating these incidents and initial learning had been identified and actions plans put in place.

The service ensured patient's behaviour was not controlled by excessive and inappropriate use of medicines. Staff monitored patients prescribed high dose antipsychotic treatment and reviewed these during multidisciplinary reviews.

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

Track record on safety

The service had an improving track record on safety.

Reporting incidents and learning from when things go wrong

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.

At the last inspection we found that staff did not always recognise or report incidents. We found that staff were reporting incidents appropriately and discussed these during handover and multidisciplinary meetings.

Staff reported serious incidents clearly and in line with the provider's policy.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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.

Managers debriefed and supported staff after any serious incident.

Prior to the new hospital director starting, incidents had not been investigated thoroughly and the service did not always learn from incidents. There had been a recent improvement in investigations and learning from incidents. Recent incidents have been investigated more thoroughly and in a timely manner. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents through team meetings.

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

There was evidence that changes had been made as a result of feedback. This included changes to medicine administration processes following medicine errors.

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 all patients on admission. However, these assessments did not always lead to care plans that reflected patients' assessed needs. Some care plans were generic and most were not person-centred and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Although staff developed a holistic range of care plan types, these did not always reflect patients' assessed needs, and were not personalised and recovery oriented. There had been an improvement in the quality of discussions and assessment of patient needs and planned interventions during multidisciplinary team reviews. However, this improvement had not yet been embedded within care plan development and reviews.

Where patients did have discharge and recovery plans in place, these were vague. The care plans we reviewed did not always identify how staff would support patients to regain the skills and confidence to live successfully following their discharge in the community. Staff had not developed care plans that considered how they were working with other agencies to support recovery and social inclusion in the community. It was therefore unclear how staff were working with patients towards meaningful recovery and discharge into the community. Managers had identified this as an area for improvement and regional care records audits had been implemented to monitor quality and drive improvement.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Best practice in treatment and care

Patients were not always provided a range of treatment and care based on national guidance and best practice. Not all patients had access to psychological therapies, support for self-care and the development of

everyday living skills and meaningful occupation. Staff did not routinely use rating scales and best practice tools to assess and record severity and outcomes. Staff supported patients with their physical health and encouraged them to live healthier lives. Managers participated in clinical audit, benchmarking and quality improvement initiatives.

Staff and patients told us that since the start of the coronavirus pandemic the range of care and treatment options at the service had reduced significantly. A weekly timetable of activities was in place for each patient, but most activities offered had not been personalised or were not meaningful for their recovery. The majority of activities were identified as mealtimes and ward social activities, which included sessions such as pampering and quizzes. Patients told us that they used to do many activities but that these had not taken place for a 'long time'.

Although plans were in their infancy, staff had identified future community visits and activities and sign-up sheets were present on the wards. Occupational therapy assistants had started to create some links with external community resources to provide leisure and vocational rehabilitation opportunities.

Staff had supported some patients to develop independent living skills such as cooking, self-medication programmes, and shopping. A couple of patients were also accessing paid work and volunteer opportunities in the community. However, most patients were not yet accessing these.

Patients were unsure what therapies were available and how these related to their recovery. Patients and carers told us that occupational therapists and the psychologist were not always available to provide one to one therapy. The majority of patients did not have a personalised timetable for individual therapies and goals.

Best practice assessment, screening and outcome tools such as the model of human occupations screening tool (MOHOST), malnutrition universal screening tool (MUST) and the recovery star were not routinely completed and used to guide treatment and care provided.

Staff and managers were unable to identify what recovery model and outcomes tools the service used. The service had a clinical specification document which highlighted a recovery approach incorporating the recovery star model. We saw that some care plans referenced use of the recovery star as an intervention. However, this outcome measure had not been routinely used since 2019 and staff were unsure on the service expectations for this. Staff had reviewed care plans that referred to the use of the recovery star and not made any changes to these. The provider induction included a session on the recovery model but the content of this was basic and applicable to all mental health services. Staff did not receive any specialised training in relation to rehabilitation, or the recovery model.

Positive behavioural support plans (PBS) were in place for patients. Staff and patients worked collaboratively to develop these.

Staff made sure patients had access to physical health care, including specialists as required. Staff used the national early warning score 2 (NEWS2) tool to monitor patients' physical health. Managers had completed an audit on the use of the tool and identified this as an area for improvement. Extra NEWS2 training had been identified and discussed with staff.

Managers had recently employed a practice nurse, and a general practitioner visited the hospital weekly. Staff supported patients to attend any medical appointments as necessary.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Skilled staff to deliver care

The ward teams did not have access to the full range of specialists required to meet the needs of patients on the wards. Managers generally supported staff with appraisals, and supervision. Staff had limited opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had not had an occupational therapist for two months. There were four occupational therapy assistants who provided activities on the wards. Managers were advertising for a new occupational therapist.

The service had one psychologist who provided group and one to one therapy. Not all patients had access to the psychological therapies.

Although staff could access Elysium online learning courses, staff had not attended any specialised training on the subject of rehabilitation or recovery. Managers had not completed a training needs analysis for the whole service.

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

Managers supported ward based staff through regular, constructive appraisals of their work. However, occupational therapy assistants did not feel fully supported through supervision and appraisal since the occupational therapist had left.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

Since the last inspection two ward managers had been recruited, and each covered two wards. Ward managers had implemented monthly team meetings and made sure staff attended these regularly.

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

Multi-disciplinary and interagency teamwork

Staff told us that multidisciplinary team working was still disjointed but there had been some recent improvements. Multidisciplinary team meetings had become more regular and all disciplines were invited to these. Staff had begun supporting each other to make sure patients had no gaps in their care. Staff had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Most members of the multidisciplinary team were invited to monthly reviews for each patient. However, since the occupational therapist had left, the occupational therapy assistants had not always been invited to the reviews and staff identified this as an area requiring improvement.

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 external teams and organisations. Staff communicated clearly and regularly with community teams and care coordinators.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

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 told us that the advocate for the service had left and they were unsure whether there was a new advocate.

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 stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

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

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

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 had discussed the Mental Capacity Act, best interests decisions and two specific cases during the reducing restrictive practice meetings.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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.

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.

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

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion and support

Staff did not always understand the individual needs of patients or support them to manage their own care and treatment. Staff did not always respect patients' privacy and dignity.

Although patients told us that the majority of staff treated them with kindness and respect, they also told us that some staff had a 'poor attitude' and were unhelpful.

We observed staff being caring, respectful and responsive to patients. However, patients and carers told us that some staff were aggressive in manner, unhelpful and 'unprofessional'. Carers and patients told us that agency and locum staff did not always understand their needs and were less responsive to their requests for information being shared.

In the 2021 patient survey, nine out of 15 respondents felt listened to and understood by staff, and agreed that they were treated with compassion, dignity and respect.

Staff did not always close patients' bedroom doors when completing night time observations. We observed a sign on a communal door which referred to the observation level of a specific patient that could be read by other patients.

Patients felt confident to approach staff with any concerns or complaints. Staff gave patients, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us they felt involved in their care planning and decision making.

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

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.

Patients did not have easy access to independent advocates.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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 plans and risk assessments.

The advocate for the service had recently changed. Patients were unaware of who the advocate was for the service and how they could contact them.

Staff had not ensured community meetings were held regularly and that the appropriate staff attended. Staff told us that patient input into community meetings was limited. The minutes from community meetings were incomplete and were used as a request book. There was an expectation that occupational therapy, managers, the lead nurse and patients should attend community meetings. However, staff told us that not all staff attended these. In the last 12 months there had been one community meeting on Willow ward, two on Elm ward, and four on Birch and Oak wards. Managers told us these had not taken place regularly due to there being limited space on the wards and social distancing requirements. The community meetings had restarted in January 2022 and ward managers had requested these take place fortnightly during team meetings. However, only one ward had recorded more than one meeting in 2022.

Managers ensured feedback from patients was collected through an annual patient survey. However, only eight out of 15 respondents felt confident that the service would use their feedback to improve the service. An action plan had been developed in response to the patient survey findings. However, some actions had been signed off as complete, but did not involve any change in processes that were in place at the time of the patient survey.

Involvement of families and carers

Although there had been a recent improvement, the involvement of carers and families had reduced during the coronavirus pandemic.

Staff and carers told us that carers and families were not routinely invited to monthly patient reviews but did attend care programme approach (CPA) meetings. Prior to the pandemic the service held a regular carers forum. The new hospital director had reintroduced the forum and held the first meeting during the week of inspection.

The carers that we spoke with told us that communication with the service was poor. They did not feel involved in their family members care, and were unsure what therapies and activities were provided.

Staff did not always keep families and carers informed of what was happening with their family member and there was little evidence detailed in the care plans we reviewed of family involvement.

Carers felt that managers did not support involvement of families and carers due to not having facilities to support comfortable visits to the site or using their preferred methods of contact. The new hospital director responded to the environmental concerns at the carers forum and an action plan was developed.

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 did not plan and manage patient discharge well. Managers did not regularly monitor length of stay and could not be assured that patients did not stay longer than they needed to.

The clinical specification and brochure for the hospital described the service as a medium-term locked rehabilitation unit. The service had an admission criterion and managers completed face to face assessments for referred patients.

Managers could not be assured that patients did not stay longer than they needed to. Managers were unsure on the model of recovery and outcome tools used, and there was no consensus between managers and staff on the expected length of stay for patients. Managers did not regularly review length of stay. The range of length of stay for patients at the hospital was between three months and six years. The average length of stay for patients was 26 months.

The new hospital director had recently reviewed length of stay for discharged patients in response to an external organisation information request. This had reduced over the previous three years. There had been 20 patients discharged from the service since July 2020. Of the 20 patients, eight were stepped down to a community placement or independent living. Nine patients were transferred to more acute or secure services.

Managers submitted data to the provider on delayed transfers of patients' care. However, managers were not clear on when a patient's discharge would be considered delayed, and which wards had the most delays.

Staff did not develop comprehensive discharge plans with patients within three months of admission. However, once discharge had been agreed, staff worked well with care managers and coordinators to ensure discharge went well.

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.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward didn't fully 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. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

Occupational therapy staff told us that there was limited space to provide activities. The activities room had been removed to extend the hospital kitchen, so activities took place on the wards. All wards had a small communal space for the lounge and dining. Staff provided activities in this area but were limited on the type of activities that could be provided due to lack of space.

Visits did not take place on the ward. Visitors could meet with patients during section 17 leave, in the multi faith room in the hospital or in the administration house next door. However, the administration house was accessed by different members of staff and was not private. The room was also used for multidisciplinary meetings, and visitors told us it was not a comfortable environment. Carers had also reported that there was no shelter to meet patients outside and protect them from the elements.

Managers were looking in to providing a visiting shelter outside and planning permission had been granted for further rooms within the hospital.

Patients could make phone calls in private.

The service had an outside space but some patients told us this could only be accessed at specific times.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. Patients told us the food was good and that they could discuss their preferences with the chef.

Patients' engagement with the wider community

Patients had limited access to activities outside the service, such as work, education and family relationships.

Staff and patients told us that activities outside of the service had reduced significantly due to the coronavirus pandemic. The occupational therapist post for the service was vacant. Staff had liaised with local leisure centres, and organisations to start organising more group trips and activities outside the service. Patients were positive about recent increases in available activities. A couple of patients had access to internal employment opportunities within the service, such as gardening and newspaper delivery. Managers had recently organised a volunteer opportunity for one patient in the community.

Staff had not ensured that care plans identified opportunities, activities or goals for engagement with the wider community.

The service did not have any links with the local colleges or the recovery college, although staff told us this had previously been in place.

Staff helped patients to stay in contact with families and carers. However, during outbreaks of the coronavirus amongst staff, the service restricted patients from visits and home leave for up to 28 days.

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, cultural and spiritual support.

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

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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them but did not always learn lessons from the results.

Patients, relatives and carers knew how to complain or raise concerns. However, two people told us that they did not feel their complaint was responded to adequately or resolved. Patients were aware that there was an independent advocate for the service but didn't who they were or when they visited.

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. Patients submitted informal complaints in a ward based book. Staff ensured the outcome of the complaint was recorded in the majority of cases. However, staff did not record actions or lessons learned and an outcome and audit of complaints had not taken place on Willow and Birch ward.

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

There had been recent changes to the management team and structure. Prior to these changes the leadership had been inconsistent and had not been effective in meeting patient and staff needs.

The new leadership team had the skills, knowledge and experience to perform their roles. They were visible in the service and approachable for patients and staff.

There had been three hospital directors in the previous 24 months. Staff spoke positively about recent changes in leadership and felt that leaders were visible and taking action to improve the service.

Staff felt the service was not recovery focused and leaders were unclear on what the rehabilitation and recovery model for the service was.

Vision and strategy

Staff did not know or understand the provider's vision and values and how they were applied to the work of their team.

Staff told us that a vision and strategy had previously been developed but that they had not been engaged in this process and were unaware of the outcome.

The new hospital director had completed and reviewed audits and initiated action plans to target areas for improvement. The leadership were reviewing and updating a comprehensive site improvement plan based on risk areas and concerns raised at the last CQC inspection. However, new processes were not yet fully embedded and managers were having to prioritise certain areas for improvement to ensure the safety of the hospital. This meant that areas such as care planning, engagement with families, carers and creating links with the local community could not be focused on.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Culture

The culture had improved with majority of staff feelingrespected, supported and valued. They felt they could now raise any concerns without fear.

Staff spoke positively about a recent change in culture following changes to the leadership structure. Staff felt supported by the ward managers, hospital director and regional lead. Staff told us that there had previously been a punitive culture within the hospital. The majority of staff told us that they felt able to raise concerns, and report incidents without fear of blame or punishment.

However, we were told and observed some disjointed working between the multidisciplinary team, with not all members feeling supported and valued equally within the team.

Managers provided the outcome of a recent closed culture audit at the service. The service had scored low for risk of closed culture. However, there were items referred to in the audit that were not available or could not be evidenced. This included the annual training needs analysis for the service, and COVID-19 restrictions being in line with guidance and the negative impact of the restrictions being identified and reduced as far as possible.

We reviewed the service in line with CQC's closed culture guidance and were concerned there were risk factors for a closed culture to develop. We had concerns that previous inconsistent management, the service's approach to restricting visiting during the COVID19 outbreaks , and the lack of discharge and rehabilitation planning, indicated a poor culture that could put patients at risk of harm. Some of these indicators had improved since the last inspection while some required further improvement.

Governance

Although a number of quality improvement plans were in place, the actions had not yet been embedded. Our findings from the other key questions demonstrated that governance processes had not been operating effectively at team level, and performance and risk were not managed well.

There was evidence that positive changes to governance processes had taken place since our last inspection. This included improved training compliance, individual risk assessment and management, and safeguarding reporting. Ward managers had been recruited for the wards and managers met regularly with their teams to discuss performance and risk. However, the full impact of these changes was not yet clear.

We observed that the structure, content and documentation of meetings, including handover and multidisciplinary reviews had improved.

Leads within the service told us that they were clearer about their roles and responsibilities and they had regular opportunities to meet, discuss and learn from the performance of the service.

The service held regular clinical governance meetings and issues were escalated to the regional meetings.

However, there remained a lack of governance processes to ensure complaints were responded to, investigated, and lessons learned.

There had been repeated incident relating to patient's medicines. Lessons learned and action plans implemented following these incidents had not led to sustained improvement.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service did not routinely use outcomes measures and assessment tools identified in the service specification and there was a lack of governance processes to monitor how clinically effective the hospital was.

Management of risk, issues and performance

The identification and management of risk, issues and performance did not always lead to improvements or action plans.

The service had a risk register in place which mostly matched risk issues identified by staff and leaders. The highest risks for the service included COVID-19, fire and recruitment. However, the 'existing controls in place' were not all up to date.

The COVID-19 risk register item did not include reference to the impact on patient wellbeing and recovery and therefore no mitigation had been identified. The risk register focused on infection prevention and control measures and had not been updated in response to the most recent infection outbreak.

The fire risk assessment for the service was out of date and had not been reviewed within the specific time and following environmental changes to one of the fire exits.

Managers had completed ligature and environmental audits for each ward. However, staff were unsure on the processes to manage some identified risks, and an item identified as requiring removal had not been removed in the 12 months since it was identified.

Prior to the new hospital director starting in March 2022, managers did not complete timely or comprehensive investigations and action plans in response to incidents, complaints and audit outcomes. There had been a recent improvement in this, and managers shared lessons learned and outcomes with the team.

A process to review the quality of care records and physical health monitoring had only been introduced in February 2022. Managers had informed staff of the issues identified but a comprehensive action plan to improve quality had not been developed.

Information management

Managers collected and analysed data about outcomes and performance.

The hospital director had access to information to support them with their management role. The service used systems to collect data that managers could easily access and use to monitor performance of their service against other similar service types.

Staff had access to the equipment and information technology they needed to do their work. The service used electronic records and the system was password protected.

Learning, continuous improvement and innovation

Staff were not engaged in any local and national quality improvement activities.

Managers had developed a comprehensive site improvement plan in response to the last CQC inspection and outcomes from serious incidents. Staff were engaged with the action plan and felt that improvements were progressing well.

The service had previously initiated the Royal College of Psychiatrists rehabilitation accreditation process (AIMS). However, managers paused the process as the service did not yet meet the necessary requirements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Environmental risk assessments were not up to date and staff did not understand and implement processes identified to mitigate risk. Staff were not using personal alarms and pagers to maintain the safety or themselves and others, and ensure they could call for assistance from other staff during an emergency. Medicines were not managed safely.

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 The service did not have an effective reducing restrictive practice programme embedded, and restrictive interventions were not always proportionate, individually assessed and any negative impact on patients reduced as far as possible. Governance processes did not ensure clinical effectiveness of the service was monitored. Timely action was not always taken to address areas identified for improvement or in response to concerns raised.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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 Staff did not develop comprehensive and person-centred recovery and discharge care plans. Staff were not aware of, or working towards the service specification and chosen model for recovery and rehabilitation.