Elysium Healthcare Limited

Victoria Gardens

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received most of their training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The long stay or rehabilitation mental health wards for working age adults worked to a recognised model of mental health rehabilitation. The acute ward had clear operational protocols that had been developed with the commissioning NHS trust. It was well led and the governance processes ensured that ward procedures ran smoothly.

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	Good 	We have reported and rated all the wards at Victoria Gardens together within this report. Please see the overall summary for an overview of our findings.

Summary of findings

Contents

Summary of this inspection

Background to Victoria Gardens

Victoria Gardens is an independent hospital for up to 40 men and women with mental health conditions. The service mainly provided rehabilitation for patients with complex mental health needs, but it had recently changed one of the wards to an acute inpatient ward.

The service has three rehabilitation wards:

- Dovecot ward – eight beds for men over 18 years old
- Roby ward – 12 beds for women, usually over 50 years old
- Sefton ward – seven beds for men over 18 years old

The service had one acute ward:

- Bluebell ward – nine beds for men over 18 years old

The service also had four self-contained flats for men as part of the rehabilitation pathway.

All patients are funded by the NHS. The acute inpatient ward was set up to provide beds for a specific NHS trust. Patients may be detained under the Mental Health Act or admitted voluntarily; most patients on the rehabilitation wards were detained under the Mental Health Act.

Victoria Gardens registered with the Care Quality Commission in February 2019. It is provided by Elysium Healthcare Limited. It is registered to provide the regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; and treatment of disease disorder or injury.

The service has a manager registered with the Care Quality Commission.

We have inspected Victoria Gardens once since registration in November 2019. It was rated as good overall, and good in all five domains: safe, effective, caring, responsive and well led.

This was an unannounced comprehensive inspection.

The main service provided by this hospital was long stay or rehabilitation mental health wards for working age adults. Where our findings on long stay or rehabilitation mental health wards for working age adults – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the long stay or rehabilitation mental health wards for working age adults service.

What people who use the service say

The feedback we received was from a small number of patients and carers, but was overwhelmingly positive. Patients and carers told us that they were involved in their care, and found staff supportive and approachable.

Patients had access to an advocacy service, and patients and carers were able to raise their concerns with managers and staff.

Summary of this inspection

Fortnightly community meetings were well attended by patients and staff. They had standing agendas, and patients made requests and suggestions, raised concerns, and were given feedback on actions from previous meetings.

How we carried out this inspection

Before the inspection visit we reviewed information that we held about the service.

During the inspection visit the inspection team:

- visited three wards, looked at the ward environment and observed how staff were caring for patients. We were unable to visit one ward due to COVID-19 restrictions.
- spoke with or received comment cards from six patients or their relatives
- spoke with the registered manager
- spoke with 18 other staff
- received comment cards from seven staff
- reviewed eight care records of patients and other care related documents including prescription charts and audits
- spoke with an advocate
- spoke with the host commissioners for the service
- attended two meetings
- 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 SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

The service should ensure that all staff are up to date with the required level of safeguarding training (Regulation 18).

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	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Good

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

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Environmental risk assessments and ligature audits had been carried out of the whole site. These identified the level of risk, and any required actions or mitigation. A monthly environmental quality walk round was carried out to identify any risk, maintenance or cleaning issues in the building.

Staff could observe patients in all parts of the wards.

The ward complied with guidance and there was no mixed sex accommodation. There were three male wards and one female ward.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. This was included in the environmental and ligature risk assessments.

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

Maintenance, cleanliness and infection control

Ward areas were clean, mostly well maintained, well furnished and fit for purpose. We observed some areas where repairs were required. This included damaged bedroom door windows, which managers told us had been reported and were waiting to be repaired.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff made sure cleaning records were up-to-date and the premises were clean. Infection prevention and control checks were carried out as part of the routine monitoring of the clinic room. This included waste management, sharps bins, personal protective equipment and hand hygiene. More frequent and targeted checks were carried out during the COVID-19 pandemic.

Staff followed infection control policy, including handwashing. Staff had worked with the infection prevention and control team from the local authority during the COVID-19 pandemic. The local authority team had identified some areas for improvement, which had been addressed on a return visit.

Seclusion room

The seclusion room had recently been installed. It was available for use by all the wards, as it was not directly connected to a specific ward. We were unable to view the seclusion room because it was in use during our inspection.

The seclusion room allowed clear observation and two-way communication. We were told it met the recommendations of the Mental Health Act code of practice. It had a clock with date and time, a shower and toilet behind a partition wall, and controllable heating and lighting. All areas of the room were visible either directly or through mirrors and livestreaming CCTV. There was direct access to private outside space.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Each ward had its own clinic room. Staff regularly checked that it was clean, and kept records to confirm this. Staff checked, maintained, and cleaned equipment, and documented when this had been completed.

Safe staffing

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

Nursing staff

The service had vacancies for nurses and support workers, but there were enough staff on duty to keep patients safe. The service had 7.4 vacancies out of 25 nursing posts, with four nurses going through the recruitment process. There were 16 vacancies out of 67.5 support/recovery worker posts, with six staff in the process of recruitment. Vacancies were covered by staff within the service, including managers, and by bank and agency staff. Managers and staff said that staffing levels could be lower than planned, particularly at weekends, but they never went below the minimum levels, and there were always enough staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Safe staffing levels were routinely monitored both locally by the service in the daily senior management team and monthly governance meetings, and corporately by the provider. The service had a computer-based system that monitored and produced the staff rota, and supported the booking of staff where there were gaps. The ward manager could adjust staffing levels according to the needs of the patients.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients rarely had their escorted leave or activities cancelled because there were not enough staff available. The service had enough staff on each shift to carry out any physical interventions safely. This was taken account of when managers were planning staff rotas.

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

Managers supported staff who needed time off for ill health. Levels of sickness had not had a significant impact on the service. However, staffing levels had been affected by staff who were required to self-isolate during the COVID-19 pandemic, either because they or a member of their household had tested positive.

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. Two consultant psychiatrists provided medical cover in the hospital. One doctor worked full time and covered the two male rehabilitation wards, and the other worked three days per week in the female rehabilitation ward. Both consultants worked on the acute wards, with patients allocated to a specific consultant. The provision of medical staff in the unit was under review, with plans to increase provision across the service, including to the acute ward.

The provider's Elysium-wide on call doctors provided cover to the hospital out of hours.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Permanent staff had completed 88% of their mandatory training, and bank staff 73%.

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

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us that there had been some difficulties providing face to face training during the COVID-19 outbreak but alternatives had been provided, and this had now been addressed. Areas where rates were lower than expected were for annual safeguarding training, whose rates were still above 70% for levels one and three, and 50% (of four staff) for level two. Managers told us that online training had been completed, but it would not be marked as completed until the planned face to face training had also been done. The service was assured that although face to face training was preferable, the online training was sufficient until this could be completed.

Training rates for bank staff were lower. Managers told us that not all bank staff worked regularly in the service, and there was a plan to ensure all bank staff who worked in the service had completed the necessary training and had the necessary skills to work with 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 and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Long stay or rehabilitation mental health wards for working age adults

Good

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. The rehabilitation wards used the short term assessment of risk and treatability (START) tool to assess patient risk. Other risk assessments were carried out when necessary. For example, if patients were physically vulnerable a recognised tool for assessing the risk of falls, skin integrity or nutritional needs may be carried out. Psychologists used the historical clinical and risk management-20 (HCR-20) tool with patients to assess their risk of violence. Risk assessments were routinely reviewed through ongoing multidisciplinary team meetings, care programme approach meetings, and after any significant changes or incidents. The acute risk matrix had been developed for use with patients on the acute ward, and was incorporated into the electronic care records.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff could observe patients in all areas of the wards.

Staff followed the hospital's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. All patients were searched on admission to the service, though admission audits showed this wasn't always documented. The need for searches was then individually risk assessed for each patient.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Managers had carried out a closed culture risk assessment of the service. This identified situations that may indicate a low, medium or higher risk of a closed culture developing. Overall the risks were low, but where medium risks were identification mitigation, actions, or ongoing monitoring was identified. Each ward completed blanket restriction audits. This identified where there were restrictions, with a rationale and timescale to remove or review the restriction. This included free access to the kitchens, which was reviewed regularly.

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 had training in the management of violence and aggression. This included how to safely use 'hands on' restraint as a last resort, but also included how to de-escalate situations to minimise the use of restraint. In the six months up to the 31 January 2022 there had been 41 instances of physical restraint which ranged from one to 13 per month. Most restraints lasted for less than five minutes (34), and only two restraints were over 15 minutes, with none longer than an hour. All patients had positive behaviour support plans or care plans that included how staff should support them if they became agitated or distressed.

Staff followed NICE guidance when using rapid tranquilisation. In the six months up to 31 January 2022 there had been 11 uses of rapid tranquilisation, ranging from none to four each month. Staff reviewed each use in the daily senior management team meeting to ensure that the necessary observations had been carried out after the medication was given. Eight-five percent of nursing staff had completed immediate life support training, which is a requirement for monitoring patients who have received rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. In the six months up to the 31 January 2022 there had been no use of long-term segregation or seclusion. The seclusion room use was in use at the time of this inspection. The seclusion room was installed in early 2022. Staff received training in how to

complete the seclusion pack, and the skills required to safely move a patient into the seclusion room. The seclusion pack included the necessary checks and reviews in accordance with the Mental Health Act Code of Practice. This included one-to-one observation throughout the period of seclusion, monitoring of physical health observations, and reviews by ward, medical and independent staff at specified times.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. In the six months up to the 31 January 2022 there had been no use of long-term segregation.

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. Seventy-one percent of staff had completed safeguarding training at levels one and three, and 50% (of four staff) at level two. Managers told us that online training had been completed, but it would not be marked as completed until the planned face to face training had also been done. The service was assured that although face to face training was preferable, the online training was sufficient until this could be completed.

Staff knew how to recognise adults and children at risk of or suffering harm, and knew how to make a safeguarding referral and who to inform if they had concerns. The deputy manager was the safeguarding lead for the service, and had established contact with the local authority safeguarding team. Safeguarding concerns were discussed in the daily senior management team meeting, and decisions made as to whether a safeguarding referral was required, and if any further action was required. Ongoing safeguarding investigations or concerns were followed up through the daily meeting.

Staff followed clear procedures to keep children visiting the ward safe. Social workers co-ordinated any child visits. Staff told us that these could take place in the visiting room in the hospital, but family visits usually happened offsite.

Staff access to essential information

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

Patient notes were comprehensive and all staff could access them easily.

Patient records were computer-based and stored securely. Any paper records used by the service, such as seclusion records, were scanned into the electronic record after use.

Medicines management

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

Long stay or rehabilitation mental health wards for working age adults

Good

Staff followed systems and processes to prescribe and administer medicines safely. Staff and an external pharmacist carried out routine medicines audits which included prescription charts, consent to treatment under the Mental Health Act, and safe storage and management of medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients about their medicines. Medicines were discussed as part of each patient's multidisciplinary team meeting.

Staff completed medicines records accurately and kept them up-to-date. Staff stored and managed all medicines and prescribing documents safely. Staff learned from safety alerts and incidents to improve practice. Managers had identified problems with the management of medicines in the service following some serious but unrelated incidents, and a significant amount of lower level errors where medicines were missed or there were gaps on prescription charts. A medication management action plan was implemented to address the identified concerns, which included additional supervision for nursing staff, a monthly meeting to monitor and review medicines within the service, and a daily review of all prescription charts for errors or gaps in the senior management team meeting. This had been effective in reducing the number of errors, and where there were gaps or anomalies these were quickly identified and addressed.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Prescribing guidance was followed by the consultant psychiatrists. Patients receiving high dose antipsychotic therapy (medicines above specified limits) had physical observations monitored in accordance with national guidance, and this was audited by staff.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Patients on specific medicines such as lithium and clozapine require additional physical health checks. These were carried out in accordance with national guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff accessed the service's electronic incident reporting system to report incidents. This information linked into the patients' care record system. Staff reported serious incidents clearly and in line with hospital policy.

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

Long stay or rehabilitation mental health wards for working age adults

Good

There was evidence that changes had been made as a result of feedback. Following several incidents involving medicines, the service reviewed how medicines were managed and provided additional supervision for staff and monitoring of processes and prescription charts.

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

Good

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

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Occupational therapy staff assessed each patient on the rehabilitation wards and developed a collaborative timetable with patients. Psychology staff carried out a detailed initial assessment of patients on the rehabilitation wards for up to 12 weeks after admission, and ongoing assessment and work continued after this. Patients on the acute ward had a shorter assessment, but still had access to activities and groups.

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

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. These were recovery orientated, and included positive behavioural support, crisis and contingency plans, and discharge planning.

Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were personalised, holistic and recovery-orientated. Care plans were changed and developed as patients progressed through their recovery pathway. They reflected the views of patients, and their families and carers where appropriate.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance. This included positive behavioural support plans, and recovery plans developed with occupational therapy and psychology for patients on the rehabilitation wards. The occupational therapy team supported patients to develop their daily living skills, and the psychology team provided a range of therapies depending on the individual needs of each patient. Medicines were prescribed and their effects monitored in accordance with national guidance, including from the National Institute for Health and Care Excellence (NICE).

Long stay or rehabilitation mental health wards for working age adults

Good

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.

Patients on the rehabilitation wards were registered with a local GP, who visited the hospital every other week. Patients on the acute ward usually remained registered with their own GP, due to their relatively short admission to the hospital. The service had a practice nurse who led on and provided physical health care. A weekly wellbeing clinic was provided, led by the practice nurse, and attended by the GP on alternate weeks. Patients had their physical observations monitored (such as blood pressure) using a standard tool (national early warning score (NEWS)). The frequency of physical observation monitoring was individual to each patient, and was routinely audited. Blood tests and electrocardiograms were also carried out onsite. Patients on the rehabilitation wards had a six-monthly health check by the practice nurse, and an annual health check by the GP.

Patients had access to other healthcare services when required such as dentists, opticians, physiotherapists, podiatrists and tissue viability nurses. Where possible, staff encouraged patients to use these services in the community, but health professionals also visited the hospital.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Staff completed the malnutrition universal screening tool (MUST) with patients when necessary, and referred them for further assessment and treatment if required. Patients had their weight monitored through the weekly wellbeing clinic.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients had access to healthy eating and smoking cessation advice and programmes. The therapy and activity programme included walking groups, gym sessions and classes, and swimming.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Occupational therapy and psychology staff used a broad range of rating scales and outcome measures to inform patient care, which included the model of human occupation screening tool. Tools were also used by nursing and medical staff which included the health of the nation outcome scales and the Liverpool University neuroleptic side effect rating scale.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the patients on the ward. This included occupational therapy, psychology and social work teams.

The service had one qualified occupational therapist, four occupational therapy assistants and two occupational therapy activity co-ordinators. The team worked across the hospital, including the acute ward. The qualified occupational therapist was due to go on an extended period of absence, and the service were in the process of covering this post.

The service had a forensic psychologist who managed the team, a cognitive behaviour therapist/psychotherapist/ trainee counselling psychologist and an assistant psychologist. Patients on the acute ward could be referred to

psychology if necessary. Patients were on the acute ward for a relatively short period of time so prolonged psychological interventions would not be possible. The psychology team worked directly with patients, and provided training and reflective support and supervision to staff. This included staff from the rehabilitation and acute wards. Five non-psychology team staff were group work facilitators and supported elements of cognitive behavioural therapy/ dialectical behaviour therapy for patients. The occupational therapy assistants delivered a dialectical behaviour skills group.

The service had a full and part time social worker, and a social work assistant. The rehabilitation wards had a dedicated social worker. Patients on the acute ward were not routinely seen by the social work team, but patients could be referred to them if support was needed.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Eighty-four percent of staff had a current appraisal. Managers told us that most of the staff who had not had an appraisal were new staff who were not yet due an appraisal, or were currently away from work.

Managers supported staff through regular, constructive clinical supervision of their work. Staff received managerial and/ or clinical supervision from the provider, and some staff had external clinical supervision. The psychology team provided reflective practice sessions for staff. Seventy-three percent of all staff were up to date with supervision, which had reduced from 85% in December 2021 and 92% in November 2021. Most staff groups were at 100%, except for occupational therapy at 80% and nursing and healthcare workers at 63%. Managers told us that they had a new system for recording supervision and appraisal, which did not always show accurate information. Other contributory factors included the impact of the national rise in COVID-19 during December 2021/January 2022, when staff had prioritised other aspects of the service.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings had a standard agenda that included new initiatives, concerns, security issues, case studies, reflection and debriefs following incidents, least restrictive practice, and staff recognition.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Most staff had received training in trauma informed care. Staff had completed training in positive behaviour support, group work skills, reflective practice, and dialectical behaviour therapy skills. The psychology team had a programme of training for staff. Staff had specific training in the use of the assessment tools they used in their role. Staff had received specific training on the safe use of seclusion following the installation of the seclusion room.

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

Multi-disciplinary and interagency team work

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

Long stay or rehabilitation mental health wards for working age adults

Good

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Patients on the rehabilitation wards had a multidisciplinary team meeting or ward round every four weeks where their needs and care was reviewed. Patients on the rehabilitation wards had a care programme approach meeting three months after admission, and then every six months. This is where a patient's ongoing care, discharge planning and aftercare is discussed, and community staff and families (with the patient's permission) are strongly encouraged to be involved. Patients on the acute ward had a multidisciplinary team meeting more regularly, typically each week, as they were on the ward for a short period of time. Patients attended the multidisciplinary team meetings and care programme meetings (unless they chose not to) and families, community staff, and advocacy were invited. Staff from the multidisciplinary team at the hospital also attended or provided information for the meeting.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handover meetings were held between shifts, and a daily senior management team meeting was held each day to discuss ongoing monitoring and any incidents within the service.

Ward teams had effective working relationships with other teams in the organisation. Staff from all disciplines were positive about their roles, and how they worked together. The daily senior management team meeting was attended by all disciplines.

Ward teams had effective working relationships with external teams and organisations. This included with the GP, other local physical health services, and community mental health teams and commissioners for individual patients. The acute ward was for patients from one NHS trust, and staff had regular contact with the trust regarding the admission, progress and discharge of these patients.

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. Ninety percent of staff had completed training on the Mental Health Act Code of Practice.

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.

Staff knew who their Mental Health Act administrators were and when to ask them for support. They actively monitored the implementation of the Mental Health Act, and prompted staff to ensure that patients' rights were upheld. For example to ensure that patients had their rights under the Act explained to them, that detention paperwork was completed correctly so that detention was lawful, that consent for medication was reviewed when required, and that appeals were carried out when necessary.

Patients had access to information about independent mental health advocacy. Patients had regular access to a general advocate, who visited the service regularly and approached all patients. Patients were referred if they needed to see an independent mental health advocate.

Long stay or rehabilitation mental health wards for working age adults

Good

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. Managers told us that leave had been limited during the COVID-19 pandemic due to national restrictions, but they had facilitated leave as much as possible. Patients and staff told us that leave was sometimes cancelled due to their not being enough staff, but this didn't happen often.

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. Original papers were stored securely, and scanned into the electronic care record system where they were readily accessible by staff.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Most patients were detained under the Mental Health Act. Patients on the acute ward may be detained under the Mental Health Act, or admitted informally.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. This was incorporated into each patient's care plans, and was part of the care programme approach (standard process for planning discharge and ongoing care). Patients on the rehabilitation wards had a care programme approach meeting three months after admission and then every six months. Patients on the acute ward may have a care programme approach meeting at Victoria Gardens, but they were only within the service for a short period of time so this would usually be co-ordinated by the NHS trust.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. These were reviewed through the governance process, and in local management meetings.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Eighty-eight percent of staff had completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Best interest meetings had been taken with

Long stay or rehabilitation mental health wards for working age adults

Good

regards to patient's financial situation, accommodation or physical health. They involved the consultant psychiatrist, social worker and where available family members and/or advocate. During the COVID-19 pandemic patients were encouraged to be vaccinated against the virus. Easy-read information about the vaccine was provided for patients. A best interest meeting was held for patients who were assessed as not having the capacity to make the decision for themselves. However, even if it was agreed that COVID-19 vaccination was in a patient's best interest, the service decided not to forcibly give the injection if a patient refused it.

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.

Patients said staff treated them well and behaved kindly. We received feedback from a small number of patients, but this was overwhelmingly positive. Patients told us that they were involved in their care, and found staff supportive and approachable.

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Staff supported patients to understand and manage their own care, treatment or condition. Staff understood and respected the individual needs of each patient. The interactions we observed between staff and patients, and in discussions between staff about patients, were positive, friendly and respectful.

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

Staff followed policy to keep patient information confidential. Staff had secure access to the computer-based care records.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff involved patients and gave them access to their care planning and risk assessments. Staff made sure patients understood their care and treatment. Staff supported patients to make decisions about their care.

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Good

Staff involved patients in decisions about the service, when appropriate. Patients and staff attended community meetings on the wards every week. These were usually well attended, and had a standard agenda. Patients were able to raise issues on the ward, and although these could be repeated at several meetings, outstanding issues were kept on the agenda until they had been resolved. Patient representatives and managers from all the wards attended patients' council meetings. These were usually monthly, but there had been difficulties in holding inter-ward meetings when COVID-19 restrictions were in place. During this time staff had visited each ward and asked patients for feedback. The meetings had a standard agenda, and again some issues were repeated over several meetings. This included issues such as repair of equipment such as pool tables and bedroom-door windows, and requests for an additional television. Changes that had been made included the introduction of a regular fitness class and changes to the menu.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff made sure patients could access advocacy services. Patient had access to a general advocate, and an independent Mental Health Act advocacy service. The general advocate visited the service twice a week and approached all patients to offer support. The advocate provided support for patients, raised issues with staff and managers, and attended multidisciplinary team and care programme approach meetings. Patients and staff were aware of the advocacy service. Patients had to contact the independent mental health advocacy service directly if they needed their support.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Social workers were the main point of contact for families and carers, and supported them to keep in touch with their relatives. Where appropriate they arranged visits, though this had been limited during the COVID-19 pandemic.

The social work team sent out regular newsletters to families and carers that included information about what was happening within the service. Staff had written to families during the COVID-19 pandemic, informing them of what was happening in the service and how this impacted on patients and themselves. For example, if there were restrictions on visits, and what action was taken with regards to self-isolating, testing and wearing of masks.

Staff helped families to give feedback on the service. Families and carers had told staff that sometimes the phone wasn't answered when they tried to ring the service. In response managers extended the opening hours of reception, and gave families the names and direct phone number of the social worker team.

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

Good

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

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to.

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. Male patients could move through the rehabilitation wards as they progressed through their recovery pathway. This may include moving between the two male wards, or going into one of the independent flats.

The acute ward admitted patients from an NHS trust, when they required more acute beds. These patients may have been on an acute ward within the trust prior to admission to Victoria Gardens. Patients on the acute ward may return to a ward within the NHS trust, or be discharged directly into the community.

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

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The service opened in 2019 and the average length of stay was 12-18 months. The women's ward had patients on a slower rehabilitation pathway, so patients may be there for longer.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff worked effectively with other agencies to meet people's needs and support their discharge. This included established links with welfare rights advice, housing providers, colleges, charities, and community mental health teams.

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 ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite 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, and could lock their bedrooms.

Staff used a full range of rooms and equipment to support treatment and care. This included two kitchens for patients to cook, an onsite gym, an arts and crafts room and materials, and musical equipment for patients to use. There were quiet areas, interview rooms and group rooms on each of the wards, and within the wider hospital.

The service had quiet areas and a room where patients could meet with visitors in private. Patients and their visitors used the visitors' room in the hospital, but many patients went outside the hospital to meet with their family and friends.

Patients could make phone calls in private. Most patients had their own mobile phone. Each ward had a telephone booth for patient use.

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Good

The service had an outside space that patients could access. The service had gardens and courtyards for patients. These were shared between wards, including the male and female wards, so access was limited to specific times during the day and was supervised by staff. Many patients had leave outside the building.

Patients could make their own hot drinks and snacks and were not dependent on staff. Each ward had its own kitchen, which was usually open to patients. Staff sometimes locked or limited access to the kitchens but this was risk assessed and regularly reviewed.

The service offered a variety of good quality food. Food was cooked onsite and served on the wards. The service had two kitchens for patients, where they were supported to make their own food as part of their recovery pathway. The four independent flats each had kitchen areas.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Staff provided a mixture of individual and group activities, both inside and outside the service. Occupational therapy staff carried out individual assessments of patients to find out their interests and recovery goals. Patients asked for and suggested activities during weekly community meetings.

Patients could access 'real work' within the service, where they went through an interview process and were paid for working within the service. Patients also had access to courses at the local college and voluntary work. This has been limited during the COVID-19 pandemic.

Staff supported patients with independent living and vocational skills groups, in addition to a range of activities including horticulture, music, and creative groups, and visiting the local library and walking in the local area. Patients suggested activities for the monthly trips to places of interest, such as Knowsley Safari Park, Conway Castle and the Lake District. Sporting activities were provided onsite and outside the hospital, and included training sessions in the gym, golf, archery, fishing and five-a-side football.

Staff helped patients to stay in contact with families and carers. Most patients had their own mobile phone, and were able to keep in touch with their friends and relatives. Patients were supported to see their relatives, either through external visits or by relatives visiting 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.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Two of the wards had a wheelchair accessible bedroom. The corridors were wide enough for wheelchair access, and there was a lift between floors.

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Good

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Information was displayed on noticeboards around the service, and provided to patients by staff and the advocacy service. This included information about how to give feedback (comments and complaints), contacting the advocacy service, events and the therapeutic timetable, and staff information.

Managers made sure staff and patients could get help from interpreters or signers when needed. Patients usually spoke English fluently, but staff told us they could access interpreters if required. Most admissions were planned, and staff told us arrangements could be made in advance. Some staff were able to communicate with patients who were deaf using basic British Sign Language.

The service had information leaflets available in languages spoken by the patients and local community. Again, most patients were fluent in English, but staff told us that information leaflets in other languages could be sourced if required.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Food was cooked onsite, and individual needs and preferences were catered for. Special diets could be bought in, or prepared and cooked onsite.

Patients had access to spiritual, religious and cultural support. Patients could use the multifaith room in the hospital, and were supported to attend religious venues (such as churches or mosques) if they wished. The social work team could provide staff with "what you need to know" leaflets, that summarised key information about common religions.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The service had received five formal patient/carer complaints in the year leading up to this inspection. Of these one was partially upheld, two were upheld and two were ongoing. There were no overriding themes from these complaints. Managers said that low level complaints were often around smoking or vaping, and they were working with patients and carers to address these issues. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were discussed in the morning senior management team meeting, and through local and corporate governance meetings. This also included feedback from patients in the community meetings and patients' council meetings that was used to make changes to the service. This primarily focused on activities and the environment.

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

Good

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

Long stay or rehabilitation mental health wards for working age adults

Good

Leadership

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

There had been a change in the management structure over the last six months. The current registered manager was also working at another Elysium service, and spent time at both sites. There were deputy and ward managers on both sites, so that there was always a manager available. Staff were very positive about the leadership team and their managers, and found them supportive. Patients and staff knew who the managers were.

Managers had access to training through the organisation, and to support from senior managers and peers. The provider had a corporate structure which gave managers information and support through computer-based systems for staffing, human resources and finance.

Vision and strategy

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

The providers stated values were kindness, integrity, teamwork and excellence. Staff had a clear understanding of the aims of rehabilitation and recovery for patients in the service. The acute ward had clear operational protocols that had been developed with the commissioning NHS trust.

Culture

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

Staff gave positive feedback about the other staff they worked with and the culture within the organisation. Staff found this very supportive and patient focused. Staff said they worked well with other professions in the service, and there was no 'us and them' between them. Staff said they felt valued in their role. They said there had been positive changes in the service over the last year. Staff said they felt able to speak out, and that managers were approachable.

The last staff survey was carried out in October 2021. The feedback for Victoria Gardens was broadly similar to the rest of Elysium. Where there were areas for improvement, with scores in the middle rather than the lower part of the range, this was about listening to staff views, keeping well informed, being able to influence the service, induction and fair promotion. Managers said there had been a lot of changes in the service since the survey had been carried out.

Governance

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

This was demonstrated by the findings throughout this report.

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Good

The provider had had an established governance framework that described how information fed into each service from local to board level. This had recently been reviewed and a new governance framework was implemented in January 2022. This emphasised information starting at a local level and feeding up to corporate level. Gathering and reviewing of information had also been separated into clinical and operational parts. Managers were positive about the change, but acknowledged that they were still getting used to the new way of working.

Both the old and new governance processes showed that information was shared between local and corporate level, and ways of working were monitored and action taken as a result. Managers met at Victoria Gardens each week day morning to review all new or concerning information. This included any incidents, complaints or safeguarding, any use of restrictive interventions (including use of restraint, observations, rapid tranquilisation or seclusion), audits and monitoring (such as physical healthcare checks and prescription charts), and any other events (such as COVID-19 cases, external reviews and maintenance). Relevant information from these and other audits and meetings was fed into the monthly local governance meeting. Under the new structure the local governance meeting happened the week before the regional governance meeting, which was followed by the corporate governance meeting.

Management of risk, issues and performance

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

Managers maintained a risk register at local level, which fed into the corporate risk register. This included expected risks. Maintaining staffing levels, particularly during the COVID-19 pandemic, were a concern on both the local and corporate registers.

Managers had key performance indicators that they reported on for the service. They completed a monthly quality audit that was reviewed locally and corporately. There were no signification issues with the performance of the service.

The provider had processes for managing health and safety within the building. Routine testing was carried out of all equipment and utilities including for fire, water, electricity and gas. All records were up to date, and there were no significant concerns identified.

Information management

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

Staff had access to the electronic care records system, which they found easy to navigate. The electronic incident database linked with the care records system. Staff could review detailed information about incidents with regards to general themes, or specific patients. This information was used in the local and corporate governance meetings.

Managers used various electronic systems to support their management of staffing rotas, human resources and finance. Staff had access to information on the provider's intranet and the shared drive. A new information technology system had been implemented the week before the inspection and staff were experiencing some temporary delays in extracting information. This had not affected patient care records or incident records.

Engagement

Long stay or rehabilitation mental health wards for working age adults

Good

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Managers met with and provided information for the commissioners of the service, and responded to any queries or concerns raised. The acute ward was commissioned by an NHS trust, which managers had worked with to agree the care they would provide to meet the needs of patients. Staff had links with the local authority, community mental health teams, the police and benefits advice agencies.

Learning, continuous improvement and innovation

The service had an ongoing quality improvement plan. This had areas for improvement that had been identified from a range of areas including from clinical governance and staff meetings, audits, incidents and complaints. Ongoing progress was recorded against open actions, and completed actions demonstrated where improvements had successfully been made.