Gateway Recovery Centre

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Good**
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated Gateway Recovery Centre as good because:

- Concave mirrors situated in the ceiling allowed full view of the corridors, thereby allowing staff to observe all parts of the wards. Ligature points were noted during the inspection, and the environmental risk and assessment plan showed that these points were considered and action was in place to address issues. Staff had personal alarms and all rooms had wall-mounted call buttons. The key security system used biometric readings to issue and accept keys. Outside areas were well maintained, and had exercise equipment in good repair for all four wards. Staff, including bank and agency staff, completed induction training.
- Staff completed comprehensive risk assessments and these were updated regularly. Advance statements and crisis plans were in place for patients.
- Patient care plans were comprehensive, personalised, holistic and recovery orientated. Each patient had signed to show they agreed with their care plan and had received a copy. There was evidence of patient involvement in all aspects of their care.
- Patients had good access to physical health interventions. Staff completed physical health monitoring including the use of a tracker system by a practice nurse to ensure all relevant tests were undertaken. There was a service level agreement with a local GP, and evidence of their involvement in patient care. Multi-disciplinary meetings were attended by relevant staff including the consultant psychiatrist, a qualified nurse, an occupational therapist, and other staff as required ensuring patient needs were met. Work on diabetes monitoring with patients with a history of self-harming was really good practice. There were a range of mental health disciplines employed at the service, including consultant psychiatrists, qualified nurses and support workers, occupational therapists and psychologists.
- Staff were regularly supervised and appraised, with plans for monitoring and continual improvement. Mandatory training was being completed and monitored. Staff received training in the Mental Health Act as part of their mandatory training, as well as training in the Mental Capacity Act.
- Discharge planning was evident in care records and case files, as well as being actively monitored on the hospital electronic dashboard system.
- We observed kind, caring and positive interactions between staff and patients. Patients said that staff were respectful, approachable and were clearly interested in patient well-being. Staff were knowledgeable about their patients, and this was reflected in their interaction and notes on case files. Minutes of community meetings that involved the patients were reviewed and shown to reflect the feelings and demands of patients. Patients commented favourably on the available activities. Multi-disciplinary team reviews showed participation and consideration over all aspects of care. Carers said that they had been involved in meetings with their relatives and the multi-disciplinary team, and felt that their opinions had been taken into consideration.
- Patients who were on leave did not have their beds filled in their absence, ensuring the bed was available on return. Patients had access to a range of rooms and equipment to support treatment and care.
- There was access to telephone rooms, as well as patients having their own mobile telephones. Patients had access to a range of meaningful activities for patients, available seven days per week.
- The service could make adjustments to meet the needs of patients with physical disabilities as well as mental health problems. Patients had been involved in menu choice developments and smoking cessation initiatives.
- Complaints were fully investigated, and there were a low number of complaints in the 12-months prior to inspection.
- Staff knew senior managers; both qualified staff and support workers said that senior managers and executives visited the hospital. Staff used performance indicators to gauge and improve performance by 'ward to board assurance', and these were available live on the service electronic dashboard.
- Clinical audit was being carried out with full staff involvement; the audit and assurance framework showing comprehensive auditing across the service, with indications of positive impact on the service.

Summary of findings

- Staff felt they could raise concerns without fear of victimisation, and morale was high among staff.

However, some of the care plans reviewed did contain jargon or language that might be confusing to patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Good 	Please see summary of inspection.

Summary of findings

Contents

Good

Gateway Recovery Centre

Services we looked at:
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Gateway Recovery Centre

Gateway Recovery Centre was formerly part of a partnership between a mental health trust and an independent provider. The service was taken over by Elysium Healthcare in 2017 and registered to undertake regulated activities on 1 August 2017. This was the first inspection of the service under its new registration. Prior to this registration, the service was rated as 'Good' in June 2016 after inspection of the mental health trust which provided the service at that time.

The service is a high dependency rehabilitation unit, split into two distinct areas:

- Male Autism Service for the challenging and complex needs of adults with Autism and Asperger's syndrome – 12 beds
- Assessment and rehabilitation for women with complex mental health needs and personality disorders – up to 34 beds.
- At the time of the inspection, the service had 43 patients admitted.

The overall aim at Gateway Recovery Centre is to improve the mental health and wellbeing of patients and to help them develop and maintain healthy relationships with others. The service works to reduce risk behaviours associated with mental health conditions so that patients can ultimately live successful and fulfilling lives within the community.

There are four wards:

- Ash ward – ward for women with complex mental health needs and personality disorders – 12 beds
- Beech ward - ward for women with complex mental health needs and personality disorders – 10 beds
- Cedar ward – ward for male patients with learning disabilities or autism – 12 beds
- Fir ward - ward for women with complex mental health needs and personality disorders – 12 beds.

Gateway Recovery Centre has a registered manager and a nominated individual.

The service is registered to carry out the following regulated services:

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

Our inspection team

The team that inspected the service comprised two CQC inspectors and one specialist adviser from the field of rehabilitation nursing.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we asked the following five questions of the service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

Summary of this inspection

- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- attended a presentation by the registered manager;
- toured the hospital, looked at the quality of the ward environment on all four wards, and observed how staff were caring for patients;
- spoke with twelve patients who were using the service;
- spoke with one carer and reviewed four carer emails to the CQC;
- spoke with the four ward managers for the service;
- spoke with 20 other staff members; including nurses, health care assistants, an occupational therapist, a psychologist, a social worker and a consultant psychiatrist;
- spoke with one practice development nurse;
- reviewed Mental Health Act procedures and looked at six Mental Health Act paperwork files;
- looked at 15 care and treatment records of patients, and case tracked each record;
- carried out a specific check of the medication management on all wards, including a review of eight sets of medication records;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- attended one multi-disciplinary team meeting;
- attended one morning meeting of senior staff;
- spoke with three stakeholders;
- spoke with one advocate; and
- reviewed the quality of handover reports for the service.

What people who use the service say

Patients at the service were positive about their experience whilst at Gateway Recovery Centre. Patients told us of their involvement in treatment and the way the service was helping them, as well as their involvement in other aspects of the service that made their lives better. We received a letter from a patient, outlining their journey through the service, stating how the service and staff helped in her recovery and current transition back into the community.

Carers told us verbally and by electronic mail that the treatments for their relatives at Gateway Recovery Centre had improved dramatically. A former patient on Cedar ward had successfully reintegrated into the community, a goal the carer of the patient never thought would happen. We were told by carers that patients at the service had improved a great deal since transferring to Gateway Recovery Centre.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Concave mirrors situated in the ceiling allowed full view of the corridors, thereby allowing staff to observe all parts of the wards. Ligature points were noted during the inspection, and the environmental risk and assessment plan showed that these points were considered and action was in place to address issues.
- Staff had personal alarms and all rooms had wall-mounted call buttons.
- The key security system used biometric readings to issue and accept keys.
- The outside areas were safe for patients to use, and had exercise equipment in good repair.
- The hospital furniture was well maintained and the hospital itself was very clean.
- Staffing levels were good, and followed service staffing policy.
- Induction training was available for all staff, including bank and agency, and was being completed.
- We saw risk assessments were updated and comprehensive, and advance statements and crisis plans were in place for patients.

Are services effective?

Good

We rated effective as good because:

- The care plans were comprehensive, personalised, holistic and recovery orientated. Each patient had signed to show they agreed with their care plan and had received a copy.
- There was physical health monitoring taking place including the use of a tracker system by a practice nurse to ensure all relevant tests were undertaken. Work on diabetes monitoring was commendable.
- There was evidence that staff participated actively in clinical audit.
- There was a range of mental health disciplines employed at Gateway Recovery Centre, including a consultant psychiatrist, qualified nurses and support workers, occupational therapists and psychologists. There was a service level agreement with a local GP, and evidence of their involvement in care.

Summary of this inspection

- The multi-disciplinary meetings were attended by relevant staff including the consultant psychiatrist, a qualified nurse, a care coordinator, the occupational therapist, and other staff as required ensuring patient needs were met.
- We saw evidence of consideration of physical health aspects such as patient menu involvement and smoking cessation initiatives.
- Staff were regularly supervised and appraised.
- Mandatory training was being completed and monitored.
- Staff received training in the Mental Health Act as part of their mandatory training, as well as training in the Mental Capacity Act.

However,

- Some of the care plans reviewed included 'jargon' or language that might be confusing to a patient.

Are services caring?

Good

We rated caring as good because:

- We observed kind, caring and positive interactions between staff and patients.
- There was evidence of patient involvement in all aspects of their care.
- Patients said that staff were respectful, approachable and were interested in patient well-being.
- Staff were clearly knowledgeable about their patients, and this was reflected in their interaction and notes on case files.
- Minutes of community meetings that involved the patients were reviewed and shown to reflect the feelings and demands of patients.
- Patients commented favourably on the available activities.
- Multi-disciplinary team reviews showed participation and consideration over all aspects of care.
- Carers we spoke to said that they had been involved in meetings with their relative and the multi-disciplinary team, and felt that their opinions had been taken into consideration.

Are services responsive?

Good

We rated responsive as good because:

- Patients who were on leave did not have their beds filled in their absence, ensuring the bed was available on return.
- Patients had access to a range of rooms and equipment to support treatment and care.
- Patients had access at any time to their bedrooms.

Summary of this inspection

- There was access to telephone rooms, as well as patients having their own mobile telephones.
- Discharge planning was evident in care records and case files, as well as being actively monitored on the hospital electronic dashboard system.
- Patients had access to a wide range of meaningful activities which were available seven days per week.
- The service could make adjustments to meet the needs of patients with physical disabilities as well as mental health problems.
- Complaints were fully investigated, and there were a low number of complaints in the 12-months prior to inspection.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew senior managers; both qualified staff and support workers said that senior managers and executives visited the hospital.
- Staff used performance indicators to gauge and improve performance by 'ward to board' assurance processes. These were available live on the service electronic dashboard.
- Mandatory training figures showed that none of the training was below 75%, and that updated training and refresher training had been organised and booked for staff.
- Clinical audit was being carried out with full staff involvement; the audit and assurance framework showing comprehensive auditing across the service, with a positive impact on the service provision.
- Staff felt they could raise concerns without fear of victimisation, and morale was reported as being high among staff.
- Staff had the opportunity to receive leadership training.
- Staff from different disciplines worked effectively together and there was a high level of support from the hospital manager and senior staff.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

At the time of the inspection there were 43 patients admitted to Gateway Recovery Centre, almost all of whom were detained under the Mental Health Act. Mental Health Act documentation was checked and found to be in line with guidance and the Code of Practice. A Mental Health Act monitoring visit had been held at Ash ward in April 2018, and an action plan had been submitted to deal with findings from that review on 30 May 2018. On inspection, we found that findings from the review had been acted upon. We reviewed six Mental Health Act files, and found all paperwork to be in order.

A Mental Health Act administrator was employed at the service, and we saw that all aspects of Mental Health Act documentation was monitored by the administrator, as well as being a point of contact for any enquiries related to the Mental Health Act.

Audits on adherence to the Mental Health Act were carried out. Mental Health Act training figures showed that 82% of staff had completed the mandatory training, with dates arranged for on-going training. Staff were knowledgeable about the Mental Health Act and its application to their patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was mandatory, and figures showed that 84% of staff had undertaken the training. Staff were knowledgeable about the Mental Capacity Act and the principles, the qualified nursing staff being more knowledgeable than the support staff.

There was a policy on the Mental Capacity Act and Deprivation of Liberty safeguards. Staff assumed a patient had capacity unless evidence to the contrary was available. Capacity assessments were carried out by staff on patients on assessment at point of admission and when considering individual decisions. The assessment form was stored on the electronic system. At the time of the inspection there were no patients detained under Deprivation of Liberty safeguards. The 15 care records that were reviewed showed that capacity was being considered and recorded in patient notes. Best interest meetings would be held if required. Patients were being supported to make decisions where appropriate.

Capacity was not routinely audited at the service. However, care records did reflect consideration of capacity in an open manner, making a visual check of compliance straightforward.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Good

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

Gateway Recovery Centre was a service comprised of four wards, three wards for women and one for men. The buildings and grounds were originally designed for a secure service. The layout of the area and the airlock and key system in use reflected that design. The service is a high dependency rehabilitation unit. Patient bedrooms were en-suite throughout the service. Rooms were personalised by patients, and a check of the cleaning roster showed that bedrooms and other rooms in the service were cleaned regularly. All four wards were clean and bright in their layout, the design of the wards lending itself to reflect the overall open nature of the service. The wards were situated in a well-kept area of lawns and pathways that patients used to relax and take exercise.

The service utilised parabolic mirrors (convex) situated at blind spots in the design of the wards, allowing staff and patients to see into the minimal number of out-of-sight areas. Bedroom doors allowed for privacy for patients as well as a viewing window for staff to check patient safety. Staff were seen knocking on the door before entering a room, and patients told us that staff were always polite. Patients had access to their bedrooms during the day, and rooms could be secured at the request of a patient. The wards were very well decorated internally and externally. The colour schemes for each ward's external façade had been decided by patients for that ward. There were wall murals on each ward. On Ash ward, there was a tree mural, with a similar mural on Beech ward that had cards and comments from patients symbolising their recovery journey.

All staff wore personal alarms that were issued at the main reception area of the service, and before staff could enter the airlock system. The key system used biometric fingerprint reading to access keys from the key tracker system. Staff carried their keys carried in a small pouch on their belt and linked to a strap for access. All rooms had call buttons that could be used to alert staff.

Furniture was in good condition and was well maintained, and designed of a durable and heavy nature that would prevent the furniture being improperly used against staff or patients.

An environmental risk assessment was completed for each ward, and was held both electronically and as a paper copy in the health and safety folder for the ward. Patients did not have unsupervised access to rooms with ligature points in the wards. We found within positive behavioural support plans that patients were assessed as to their propensity to use ligature points and this was reflected in ligature risk assessments.

A ligature point is something a person intent on self-harm may use to assist in choking themselves by external pressure on the throat. Ligature risk assessments had been carried out for each ward and were audited monthly, the last being May 2018. For Ash, Birch and Fir wards, the risk of use of a ligature by patients was deemed high due to patient use of ligatures to self-harm, whilst the ligature risk on Cedar ward was not deemed high. Each en-suite bathroom on site had flush-fit taps and the bathroom doors were champhered to minimise use of the door as a

ligature point. The use of communal bathrooms was individually risk assessed for each patient. Legionella tests were regularly carried out for all wards at the service, as well as water temperature checking and cut-off valve monitoring.

In May 2018, the service employed a dietetics and nutrition service to support the catering department in implementing a food traffic light system and developing nutritional values for meals provided. Hospital food standards are mandatory for NHS trusts, but the service wanted assurance that the food quality provided was high. Over a four-week period, 198 different meals were available to patients, with limited repetition. The menus were red-amber-green colour coded to show how healthy the meal was: red was deemed the least healthy, green was the healthiest, allowing patients to choose the meal they wanted with the health information of each meal easily understood. The service provided food for staff, they could choose from the same menu as the patients. At Gateway Recovery Centre, 24-hour provision of food was available at ward level. If patients wanted food out of hours there were cereals, toast, yogurts, fruit and their personal snacks. If sandwiches were unopened and stored as per food hygiene standards, then these were also available. There were hot and cold drinks available throughout the day consisting of tea, coffee, sugar-free hot chocolate, milk, sugar-free squash and ice-cold water.

All allergen information for patients was stored in the kitchens and catering staff were notified of any service users or staff with allergies, with meals provided separately to meet their needs.

Each ward was single sex, as such Department of Health guidance regarding mixed-sex accommodation was not considered during this inspection.

Each ward had its own garden area for access by patients at any time. The areas were well tended, and had seating areas and equipment that patients could use for exercise. Cedar ward had a trampoline with a safety net for patients to use.

Beech ward and Cedar ward had a seclusion room. The seclusion room on Ash ward had been decommissioned as it was never used to seclude patients, staff used this room as 'chill' room for patients to relax. The former seclusion room had air-conditioning, electric blinds, comfortable seating, and was always open for patients to use. Seclusion rooms allowed clear observations, bedding was safe. There was a two-way communication system in place, and the rooms were well ventilated with temperature controls (air conditioning) available. A clock, non-digital, was placed so patients could see, along with a board with the date visible. Both seclusion rooms had a small seating area that could be used as a low-stimulation area to either try to calm patients to avoid seclusion or to introduce patients slowly back into the ward. There was access to a small garden area for each seclusion room. We saw evidence of food and fluid charts in use in seclusion rooms, as well as review and observation procedures that matched the policy for the service.

Each ward had its own clinic room for the dispensing and administration of medication. Each clinic room had a variety of guidance displayed regarding procedures, including a rapid tranquilisation flowchart that clearly outlined administration and post-monitoring requirements. Each clinic room was clean, well maintained, with emergency equipment, weighing scales, height measuring equipment, blood pressure monitoring (both electronic and manual) and blood sugar monitoring equipment. The equipment was being regularly checked and calibrated. Emergency equipment bags were of a high standard: the interiors had been compartmentalised with clearly defined sections denoting the contents that would be used in any particular emergency. Oxygen tanks were all within date and full. Defibrillators were in the process of being checked during the inspection, as they were due for review. Drugs cupboards were checked and medication was all within date and well organised.

The service had inductions for staff both on starting with the service and with the individual wards. The induction checklist for ward staff was comprehensive and covered relevant themes. The induction also included an enhanced observation competency checklist that all staff needed to complete, understand, and sign to show they were aware of requirements at the service.

The 'safewards' model had been piloted on Beech ward and was being introduced across the service. The 'safewards' model was designed to identify and influence rates of conflict and containment on mental health wards. On Beech ward, there was an area known as "reflection corner", which used positive words posted to the wall to reinforce the philosophy of the ward. Beech ward also had a patient information wall that gave advice including

actions to take if the patient felt they were being abused, advocacy contact, how to complain, Mental Health Act information, medication information that was easy to read, and a flowchart on how to arrange a family visit. This level of information was available on all four wards.

As Cedar ward was being used to treat autistic patients, the layout of the ward was more open than the other three wards to minimise the risk of slips, trips or falls. The nurse call system was the same as on the other wards, push button operated in each room.

Safe staffing

Data provided showed substantive staffing levels for each ward between 01/03/2017 and 01/03/2018: Ash ward had 26 staff, Beech ward had 35 staff, Cedar ward had 19 staff, and Fir ward had 18 staff. The staffing numbers reflected the acuity for each ward. The service utilised a safer staffing submission form which was completed each day before 10am and 10pm. It recorded the expected staffing against the actual staffing levels. The staffing was broken down into permanent nurse/health care assistant, bank nurse/health care assistant, and agency nurse/health care assistant. Any discrepancies were immediately flagged to the Regional Director. Reviews were completed the following day and rated using a red-amber-green rating. This would indicate if the shift was staffed as expected, was less than expected but remained safe, or was less than expected and was unsafe. A narrative was supplied for all shifts that were amber or red rated. The safer staffing information was displayed in each ward area.

Staffing at the service was also reviewed each morning at a senior staff meeting, including the hospital director, consultant psychiatrists, ward managers and other senior staff. We attended a meeting and saw that a full review of the previous 24-hours was conducted, outlining and discussing incidents and actions required. Staffing was discussed and considered against current observation levels on each ward. We saw evidence that this meeting was a daily occurrence.

Sickness rates on the four wards for the period 01/03/2017 to 01/03/2018 ranged between three percent on Beech ward and 13 percent on Fir ward. The sickness rate for Fir ward at the time of the inspection was six percent, and this was due to staff on long-term sickness. There were three nursing staff vacancies on Beech ward, however two new staff had been recruited and were due to start shortly after the inspection. There were no health care assistant vacancies at the service.

The working shifts were 12 hours in length, a day shift and a night shift. Staffing was calculated using patient numbers and 'staffing ladders' which outlined minimum staffing levels. Each ward had a minimum of two trained nurses on the day shift and one trained nurse on the night shift. Health care assistant numbers were different on each ward due to acuity, and when high levels of observations were in place. The service regularly used bank and agency nurses, all of whom were required to complete an induction to the ward they were working on. On Ash ward we saw the use of a spread sheet designed to monitor which agency and bank staff had completed an induction, and were told that staff who had not had an induction would not be used. In the period 01/12/2017 to 01/03/2018 at total of 174 shifts were filled by bank staff to cover sickness, absence or vacancies, and 492 agency staff in the same period. There were no shifts left uncovered by either bank or agency staff. The use of bank and agency staff corresponded with high levels of observations on the wards.

Ward managers told us that they had the authority to bring in extra staff should they be required. During the inspection we saw that nursing staff spent most of their time in the ward area, and this requirement was confirmed by ward managers. Patient records showed that one to one time with staff was regularly taking place. Leave from the service was electronically monitored, using a system called the "Incharge Dashboard"; this showed a 'live' view of who was in the grounds of the service and who was outside the service. We were told that leave under the Mental Health Act was rarely cancelled, but it could happen if a patient required emergency medical treatment and staff were required to attend the treatment with them, limiting staff on the ward. Leave was seen to be adjusted slightly during the inspection, but not cancelled. The ward manager on Cedar ward showed how the ward diary helped staff to plan for busy days in relation to leave and appointments, ensuring staff numbers were adjusted accordingly.

We were told that there were enough staff to carry out physical interventions if necessary. There was a visible on call rota for out of hours cover that was available to staff that was updated daily. The rota followed a bronze, silver and gold manager system to identify seniority, as well as

who could be contacted from the maintenance department out of office hours. There were also the daily site coordinator details, as well as first and second tier medical contacts for contact after 1700 hrs. The system would allow for full coverage of the service after office hours had concluded.

Assessing and managing risk to patients and staff

We reviewed 15 risk assessments during the inspection. Staff used the START (short term assessment of risk and treatability) assessment tool. Risk assessments were up to date or due for review in the week of the inspection. Each risk assessment was individualised, and included a security summary that compiled key information about the patient, including key risks (for example, to staff, public, absence without leave), and factors such as known dates and anniversaries, including risk reduction strategies. Risk assessments had been signed by patients, and showed evidence of patient involvement. We saw evidence that risk assessments had been revised after incidents involving patients. Risk assessments were updated monthly.

We saw evidence of crisis plans and advance decisions for each patient reviewed. Each patient had a positive behavioural support plan that included advance decisions relating to self-harm, rapid tranquilisation and restraint. This was important on Cedar ward, as patients had an autistic diagnosis. Patients also had communication passports that had been integrated with care records. There was evidence of consideration of communication with people with profound and multiple learning disabilities, with relevant documentation and advice leaflets available.

There were relevant policies in place. The observation policy outlined the different levels of observation depending on the behaviour or need of a patient. There was a ligature risk policy related to the needs of the service and the patients being rehabilitated. Staff carried out a pat-down search of patients who had been on unescorted leave outside of the service, in line with the search policy, to ensure that nothing was brought in that could be used for self-hram, either for that patient or the safety of others. Each ward had a philosophy of care rather than a code of conduct, and this was visibly displayed on a wall in each ward. All staff who worked on the wards had completed management of violence and aggression training, as well as breakaway technique training. The service had a police liaison officer from the local police force, and the officer was invited to the service regularly to give input and assistance when required. We saw no evidence of blanket restrictions in place; the service had a group that actively worked to limit blanket restrictions, working with patients and staff to ensure consideration was given to all. Doors to and from the wards were locked, however there were signs near the doors for patients who were informally admitted to the hospital. At the time of the inspection, there was only one informal patient at the service. There was a list of banned articles that was on display in reception and a copy was kept on the wards.

Staff followed the 'No Force First' model when dealing with tense situations on the wards. Staff at the service used different distraction techniques that were evident in positive behavioural support plans, coupled with advanced decisions, to limit possible heightened tension within the service. Verbal de-escalation, distraction techniques, conflict resolution and relational security knowledge were all noted within positive behavioural support plans.

In the period 03/10/2017 to 03/04/2018, episodes of restraint across the four wards ranged in number from four to 255. The 255 restraints occurred on the most acute ward, Beech ward, and on 13 different patients. Of the 255 restraints, 11 were reported to be in the prone position, but none resulted in rapid tranquilisation. Eighty six percent of staff had received immediate life support training. Training in the management of violence and aggression at the service clearly stated that patients were not to be restrained in the prone position, however if a patient led the restraint so they went into a prone position, staff were to change the position of the patient as quickly as possible using approved techniques. The training undertaken by staff also included information regarding the risks of physical restraint, such as positional asphyxia. There had been one episode of seclusion in the period 03/10/2017 to 03/04/2018.

At the time of the inspection, mandatory training figures for the subjects studied ranged between 79% and 95%. This included basic life support (85%), immediate life support (86%), Safeguarding Adults Level 3 (84%), moving and handling (95%), and equality and diversity (91%).

The service had a safeguarding policy for both adults and children, both of which were due for review in March 2019. Safeguarding training was mandatory for all staff. The service had 16 staff trained to Safeguarding Level four. On discussion with ward managers and staff, we found that the

safeguarding policy was embedded within the service. The policies were in place to help protect patients from discrimination which might amount to abuse or cause psychological harm. Staff described how they would identify abuse by speaking with patients, watching patients interact with other patients and carers, listening to patients and questioning actions and information received. During the period 30/04/2017 and 30/04/2018, the service had raised no safeguarding alerts but had raised 24 safeguarding concerns. The hospital director led on a weekly safeguarding meeting as well as taking part in daily morning meetings that discussed safeguarding issues. Safeguarding was noted to also be a key agenda item on the monthly governance meeting. We spoke with the safeguarding lead for the local council who was involved in safeguarding meetings, and it was clear that a good relationship was maintained with the service.

There was a child visiting policy in place. Flowcharts describing the procedures for the visits of both adults and children were visible on the wards, as well as in the reception area.

All information about patients was stored electronically on a secure system. The information was available to staff when needed, including when a patient moved wards. Ward nursing stations had updated key patient information as paper copies in a file, to continue treatment should there be a problem with the electronic system.

A hospital pharmacy service supplied medication and completed clinic audits on a minimum of a monthly basis. This included the storage of medications, and to check compliance of the management of the controlled drugs on site. The pharmacy completed weekly audits reviewing prescription charts, consent to treatments, rapid tranquilisation and high dose anti-psychotic medication. After the audit had been completed, results were made available on the electronic system via the pharmacy live view website, and all ward managers, nominated deputies, responsible clinicians and members of the medicines management committee were emailed to be notified that the report was available, and for them to manage the findings. Those audits also fed into the monthly medicines management committee meeting. Medication management was a standing item on the operational and clinical governance meeting, as noted on the minutes of meetings held on 22/03/2018, 26/04/2018 and 24/05/2018. The clinical lead nurse for the service was the controlled drugs accountability officer.

Track record on safety

There had been five serious incidents at Gateway Recovery Centre between July 2017 and December 2017. The three most prevalent issues raised involved the tying of ligatures, re-opening of wounds, and restraint of patients.

Reporting incidents and learning from when things go wrong

Since August 2017, all incidents were reported onto an electronic incident reporting system. Within the shift handover document, there was a section in which staff could highlight any incidents. Any reported incident was automatically linked to a corresponding electronic patient record entry. The senior management team along with ward managers and other members of the multi-disciplinary team met at a morning meeting to discuss and review all incidents. Where a serious incident had occurred, there was a procedure in place whereby senior managers were alerted promptly. Where appropriate, the relevant CQC statutory notification form would be completed and submitted. Depending on the nature of the incident, the service could involve other stakeholders such as the police or local adult safeguarding team. In addition, senior managers on site maintained communication channels with the provider senior management team.

We saw evidence that adverse events were considered and findings from investigations were shared across the provider as well as the service. Gateway Recovery Centre had a publication that was produced and sent to all staff, “Positive Learning”. This included incidents that had happened on site, in a shortened brief, and outlined the actions that staff should take to avoid such incidents in the future. The April 2018 edition focussed on an incident where staff had used their own car to transport a patient, the importance of observations, and actions in the result of a detained patient not returning from leave.

We were told of an incident in which a patient brought a plastic bag onto the site. The plastic bag was not noticed by staff, with the result that a patient used the plastic bag to self-harm. Because of this, plastic bags were stopped from being brought on site, and the reception kept a stock

Long stay/rehabilitation mental health wards for working age adults

Good

of sturdier carrier bags for patients to use when going shopping off site. If a patient brought items back to the service in a plastic bag, the patient was asked to transfer the items to one of the sturdier plastic bags at reception for movement within the service.

If there were any immediate actions or lessons to learn a memo was prepared which was shared with staff within the hospital. In the event of a serious incident, an investigating officer was allocated. Following the completion of any investigation, reports were submitted to the monthly incident review meeting where the recommendations, actions and lessons learned were reviewed. Key lessons were put into the "Positive Learning" bulletin which was circulated to all staff. In addition to this, the information was discussed during reflective practice sessions and staff meetings, and all lessons learned were collated in a folder for future reference. In addition to the site lessons learned, the service also shared lessons that were learned from all other sites run by the provider, and ensured that this information was cascaded across the hospital via training or specific lessons learned bulletins.

Care records showed that patients had been debriefed after incidents and complaints had been investigated. The electronic patient records system had a tab that could be opened to show that a patient had been de-briefed after an incident. The service quality improvement action plan showed that patients who were to be given rapid tranquilisation were to be debriefed as well as monitored after administration, and this was audited by the service.

Duty of Candour

The service had a 'Being open and Duty of Candour' policy that was last reviewed in April 2017 and was due for review before April 2020. A copy of the Duty of Candour Policy had been distributed to all staff. We were told this had been discussed in staff meetings to ensure that staff were aware of the policy and who they should contact to discuss this further. Duty of Candour was also included in the staff induction programme for new starters. There was also a leaflet for carers on Duty of Candour.

We saw evidence of the policy being followed during an investigation into the theft of monies at the service, that was being investigated by the police. Letters and documents to patients and carers were viewed, and it was noted that the provider had reimbursed all patients for any loss incurred during the theft.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed and case tracked 15 sets of care records. They were up to date, personalised (included the views of the patient), and holistic. Positive behavioural support plans were in place. Care plans were recovery focused and were written in different 'styles', though still patient focused (for example, using the person's name, or saying "you" or occasionally "I"), but some still used jargon or unclear language. Patients told us that they had seen and received a copy of their care plan, and this was noted on the system. The electronic system allowed for a summary of key information from notes which included physical health information, the notes for the patient from the previous three months, and leave conditions. All notes showed allergy and alert notifications in red on the system, ensuring it stood out when viewing notes. Care plans on Cedar ward were completed in easy read format, and this format was also being introduced on other wards for female patients with a co-morbid diagnosis of learning disability.

Patients had several different care plans. These included care and risk management plans for mental health recovery, 'my relationships', discharge, problem behaviours and risks, and physical health. It was clear from the care plans that there had been patient involvement in the preparation of the care plans. Patients on Cedar ward had care plans that showed assessment of possible triggers for behaviour and environmental factors that could lead to a breakdown in patient care if ignored, considering autistic diagnoses.

Physical health monitoring was a key factor in treatment at the service. The service had a protocol for physical health monitoring outlining the process to be followed from admission, actions to be taken within 24 hours, within seven and 28 days, monthly, three and six monthly, and yearly. The protocol outlined who had the responsibility for each action, including nursing staff, the practice nurse, the

consultant psychiatrist and the multi-disciplinary team. There was a schedule for routine blood tests and an electro-cardiogram schedule that was broken down between all patients, patients on Clozapine, patients on lithium, diabetic patients, and patients on high dose anti-psychotic medication. The practice nurse maintained a tracker to ensure all routine tests were undertaken. The protocol also had flowcharts that dealt with specific situations, such as removal of objects from the throat, and how to deal safely and effectively with various types of self-harm. The service had an agreement with two local NHS trusts regarding rapid treatment for patients who had self-harmed, meaning the patient could avoid accident and emergency procedures and go straight to the relevant department. Care records showed adherence to the protocol. We spoke with a stakeholder from one of the NHS trusts, they told us that the agreement meant faster treatment and less patients for the accident and emergency service.

We checked on diabetes monitoring at the service. On Fir ward a system was in use that involved a patch with a wire inserted into the arm of the patient, and a small box that completed blood monitoring without the need to draw blood from the patient. Due to the levels of self-harming on female wards, the work staff and patients had done to ensure that diabetes monitoring was risk managed was commendable.

The service only accepted planned admissions, they did not accept emergency admissions. Assessments were completed within two days of referral, and the referring agency given a decision regarding admission within one week.

Clinical notes were stored electronically, the system allowing a live dashboard of information on each patient. Staff kept paper copies of documents deemed essential for on-going treatment of each patient in the event of a computer system failure, we saw that these documents were up to date and replaced as and when required.

Best practice in treatment and care

The service had medication policies that were designed to comply with the guidelines of the Royal Pharmaceutical Society and the Nursing and Midwifery Council Standards for Medicines Management. We saw that the policies were regularly updated. The clinical lead nurse was the accountable officer for the management of controlled drugs. We saw evidence that guidance from the National Institute for Health and Care Excellence was being followed, including the application of guidance relating to the treatment of personality disorder and long-term management of self-harm. The provider subscribed to the prescribing observatory for mental health, and as part of the 2018 calendar, the service was in the data collection stage for Topic 16: Rapid Tranquilisation. Medication prescriptions were checked weekly by the local pharmacy who conducted audits in relation to administration and consent to treatment paperwork. Results were available on line and discussed at the medication management committee.

We saw that the service had undertaken a National Institute for Health and Care Excellence long term management of self-harm audit, and had acted upon findings. This was notable in that three of the four wards at the service dealt with patients with histories of self-harm.

At the time of the inspection, there was a full-time psychologist, one psychotherapist, two psychology assistants and one trainee counsellor within the service. At the time of the inspection, 83% of female patients were receiving psychological treatment. This included dialectical behavioural therapy, cognitive behavioural therapy, eye movement desensitisation and reprocessing, and person-centred counselling. Some patients were receiving intensive therapy at the service, up to ten sessions of therapy a week. Representatives of the Autistic Society had attended the service in March 2018, giving face to face training to staff regarding the treatment of autism. Distance learning courses relating to autism were also available to staff. We saw that patients with epilepsy had health care plans in place that recorded and maintained treatment and risks identified.

Occupational therapy was also available at the service. There was a full-time lead occupational therapist, a senior occupational therapist who worked 30-hours a week, three full time occupational therapy assistants, and two more part-time staff due to join the service a few days after the inspection.

Patients had good access to physical healthcare, including access to specialists when needed. A new GP service had been contracted by the service, giving better access to care than the previous arrangement. We saw evidence of input from the GP service on a regular basis at the service. The practice nurse monitored all physical health aspects for

patients. Healthier living was promoted within the service, including a tailored menu outlining health food choices. Smoking was not allowed on site, however patients could use 'vaping' devices. Smoking cessation therapies were available to patients.

There was computer access available to patients. On Cedar ward, there was a room that included a computer with internet access, as well as a variety of computer gaming consoles. Patients had access to their own mobile telephones, and as such could access information and the internet using these items. Wifi internet was being fully installed across the service during the inspection.

Staff used the health of the nation outcome scale to measure outcomes. This was audited and was available on the electronic dashboard system used by the service. Audits were carried out regularly by staff at the service, and were split into patient safety audits and clinical effectiveness audits. Patient safety included ligature audit, mattress audit, infection control audit, a STOMP audit (stopping the over-medication of people with learning disability/autistic spectrum disorder) and a national early warning score audit. Clinical effectiveness included consent to treatment audit, least restrictive practice audit, local physical health monitoring audit, care plan audits, and primary nurse session audits. The green light toolkit, an effort by the government to improve mental health services for those patients with learning disability, was carried out at the service. The toolkit comprised three audits: the basic audit about things that would be easy to do; the better audit, to be considered after the basic audit, but not mandatory; and the best audit, to improve things the service finds hard to do. Gateway Recovery Centre completed the better audit, and implemented findings and improvements that were deemed necessary.

Skilled staff to deliver care

There was a multi-disciplinary team which included a consultant psychiatrist, an occupational therapist, a psychologist, a social worker, a qualified nurse, a health care assistant and the patient. As well as these team members, care coordinators, advocates, family members and commissioners regularly attended team meetings. We attended a multi-disciplinary team meeting, the meeting was professional and informative, with all relevant disciplines from the service covered by staff present.

Induction programmes were completed by all staff, and the dates and details were held both in personnel files and on an electronic recording system. The induction checklist that was maintained for each staff member was comprehensive and signed by both staff and the person taking the induction. Learning needs were identified through appraisals and supervision, with staff being able to apply for specialist training. We saw evidence of staff completing and studying in different specialist training, including search and security training, personality disorder training, autism training, and wound care training. For example, staff on Cedar ward were appropriately trained, and the ward lent itself to treating patients with learning disability or autism. Cedar ward staff had received training in communication and person-centred approaches. Ward managers had access to leadership training.

Supervision was taking place for staff, and annual appraisals were completed. Supervision was being audited. There was an action plan in place to deal with a fall in supervision rates in the period prior to the inspection, and we saw that the action plan had been effective in raising supervision rates. There were no areas within the service where appraisal or supervision rates dropped below 75%, with dates arranged to cover those who needed supervision/appraisals but had not yet received it. On Ash ward, we saw that supervision was registered, with a locked box for each nurse that contained notes from supervision, the ward was at 100%for supervision at the time of the inspection. We did not have the target figure for the trust for supervision. The responsible clinicians had been revalidated.

Managers ensured that staff had access to regular team meetings. We saw minutes from staff meetings in March and April 2018 that showed consideration of patient safety and treatment, and moving forward to the improvement of the service not just for the patients but for the staff.

We saw evidence that staff performance issues were dealt with promptly and effectively. There were staff who were suspended from the service, their situation was seen to be monitored by the service.

The provider had recently introduced a new training opportunity for senior health care assistants. The service focused on support and more integration of the staff regarding difficult patient groups, assessed and planned with regard to both learning disability and personality disorder patients.

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Good

Multi-disciplinary and inter-agency team work

Multi-disciplinary team meetings took place on each ward weekly, with each patient having a full team review every four weeks. We attended a multi-disciplinary team meeting during the inspection, and found the system used and attendance of staff to be effective. The meeting was attended by the consultant psychiatrist, an occupational therapist, a social worker, a psychotherapist, a qualified nurse, a deputy ward manager, and a health care assistant. The patient history was revisited, discussed symptomatology, the psychotherapist commented on response to therapy. Observation levels were discussed, as was risk and safeguarding. The health care assistant gave information pertaining to daily issues with the patient, leave was discussed, physical health was discussed, medication was discussed, future discharge was discussed, and police involvement with the patient. The patient was invited into the meeting and played a full and active part in the discussions. The consultant psychiatrist used a laptop computer to enter all aspects of the discussions straight on to the electronic recording system. The care coordinator had contacted the ward to apologise prior to the meeting, as they could not attend. We were told that care coordinators usually attended patient reviews.

Handover notes were effective and well considered. The template in use was comprehensive, and staff were aware of the relevant needs and requirements of patients. Electronic copies of handovers were shared with senior staff, to let staff know what had happened on the previous shift. The handovers covered mental state, diet and fluid intake, medication, observation reviews, compliance, any incidents, mental health status and risks, activities and engagement, and physical health. However, in handovers from Cedar ward and Fir ward, patients were referred to by room number and hospital numbers, not patient names. This was pointed out to the hospital director, and changes were implemented straight away. There was evidence of discharge planning for patients at Gateway Recovery Centre.

We spoke with staff from local social service groups, and were told that relationships with Gateway Recovery Centre were 'excellent'. This included the working relationship with the two NHS trusts regarding emergency access to treatment for patients of Gateway Recovery Centre, and the liaison that helped avoid use of the accident and emergency rooms at these hospitals.

Adherence to the MHA and the MHA Code of Practice

The service had associate lay hospital managers and was last visited by a Mental Health Act reviewer in April 2018, when they visited Ash ward. At that time, there were no issues with Mental Health Act documentation, and all aspects of documentation were in order. We saw evidence of Mental Health Tribunals and Managers hearings were recorded.

All staff had received training in the Mental Health Act, and this was revisited yearly. Training figures for Mental Health Act training across the service stood at 82%. Staff we spoke to had a working knowledge of the Mental Health Act, and were aware of the detention status of each patient.

Consent to treatment was adhered to, with copies of consent to treatment forms attached to medication charts. All the treatment given appeared to be given under appropriate legal authority. Consent to treatment was audited within the service.

We saw evidence that patients regularly had their rights explained to them, starting with their admission to the service. The electronic dashboard in use at the service clearly displayed that patient rights were read, then audited.

There was a Mental Health Act administrator at the service, and we saw that all aspects of Mental Health Act documentation were being monitored and audited. All staff were aware who the administrator was, and how to contact them. We saw up to date copies of the Mental Health Act Code of Practice in each nursing station at the service. There were also easy read copies of the Code of Practice available.

All paperwork reviewed was in order and stored appropriately. We reviewed six sets of Mental Health Act records relating to patients at Gateway Recovery Centre. The records we checked were well kept and up to date. Documentation was held electronically, with the original paperwork securely stored. On each ward, there was a full set of detention papers in a patient file, in case the electronic system was not working. Patients were regularly informed of their rights, which was audited. On Cedar ward, rights were explained to patients in the way most suitable for them to understand. Section17 leave forms were well

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Good

documented, with copies being given to patients. Mental Health Tribunal paperwork was apparent. Consent to treatment forms were attached to medication files, and these were also checked by the visiting pharmacist.

There was evidence that patients had access to an independent mental health advocate. An advocate visited each ward on a weekly basis. During the Mental Health Act review on Ash Ward in April 2018, the advocate was very positive about the care that staff provided to the patients. The advocate stated that the occupational therapist was very positive and proactive and had built strong links with the community. They said that the ward manager was a team player and not resistant to any suggestions and change and that the responsible clinicians took positive risks to help the patients back into the community. We spoke to an advocate about the service overall, and they were very positive about the service for detained patients. Notices on how to access the independent mental health advocate were attached to noticeboards within the patient accessible areas of the service.

Good practice in applying the MCA

Mental Capacity Act training was included in mandatory training at Gateway Recovery Centre. At the time of the inspection, 84% of staff had undergone Mental Capacity Act and Deprivation of Liberty safeguards training. An action plan was in place regarding mandatory training, to improve compliance rates. Staff we spoke to had knowledge of the Mental Capacity Act, and how to apply it.

There was a Mental Capacity Act and Deprivation of Liberty Safeguards policy in place, the policy had been reviewed in July 2017. The policy was available to all staff on the provider computer system. We were told that staff could access information relating to the Mental Capacity Act from the policy, the responsible clinician, or from a social worker.

Staff carried out capacity assessments on assessment and when considering individual decisions. The assessment form was stored on the electronic system. We saw that capacity was assumed unless otherwise indicated in care records. Capacity was noted as being discussed in multi-disciplinary team records, on consent to treatment forms, and on assessment.

At the time of the inspection, there were no patients detained under the Deprivation of Liberty safeguards. Capacity to consent forms had been completed in the six files we examined.

We saw evidence of best interest meetings in the patient care records: the Mental Health Act monitoring visit of April 2018 showed that a best interest meeting had been held for a patient on Ash ward. We were told that should a best interest meeting be required then one would be held, and an independent mental capacity advocate would be invited to attend, if agreed with the patient. During a multi-disciplinary team meeting attended during the inspection, patient and staff discussed discharge planning, with support given to make decisions where appropriate.

Capacity was not routinely audited at the service. However, care records did reflect consideration of capacity in an open manner, making a visual check for staff easy to carry out.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Patients we spoke to were complimentary not just about staff, but about the treatment they had received. There was clearly a therapeutic relationship between staff and patients. New patients would be invited to take part in orientation visits before their formal admission, to ensure they felt comfortable in the location. New patients were allocated a patient buddy on admission, to help the new patient to orient to the ward. New patients were also given a copy of the Gateway Recovery Centre patient guide booklet, containing useful information regarding the service. We saw copies of the patient guide booklet on noticeboards on the wards. On Cedar ward, easy read information was available to autistic patients, and staff had received training in communication skills to improve access for patients with learning disabilities. We saw evidence in care records that relevant information regarding likes and dislikes had been sought from families about autistic patients at the service.

Staff enabled patients to give feedback on the service they received in a variety of ways. There were five local patient representative groups in place at the time of the inspection. There was the service user council, the service user conference, the regional operational and clinical governance meeting that included patient representatives, the family and friends' forum, and finally ward patient community meetings. We saw evidence of involvement of patients in each of these groups, and active consideration of points made.

Patients had been involved in decisions about the colour scheme for the exterior walls of the buildings The patients also had the final decision on the name of the service. When the provider issued a directive that all hospitals were to become smoke free, the issue was debated in service user council and the service users were encouraged to seek the support of advocacy services to raise their concerns from site to Head Office. Service user council minutes evidenced the invitation to patients to be involved in decision making around clinical practice and decision making including the management and use of E-cigarettes, the use of agency staff at times when observations peaked and the decision to over recruit to healthcare worker posts to minimise the need for agency use, as patients reported that had an unsettling effect on their care. During refurbishment of a ward, patients directly affected by the work were consulted regarding what start and finish times for the manual labour they would prefer, and these were adhered to.

The lead occupational therapist attended the service user council and addressed any concerns around resources for activities, forthcoming events or new initiatives that were available to patients and promoted patient involvement in taking an active role in suggesting initiatives and planning events. We were told this shaped the way the occupational therapy service was delivered and the events planned throughout the year. For example, patients requested regular animal therapy sessions, so an external company visited the site on a quarterly basis with a variety of animals and reptiles for those sessions. An external arts workshop had more recently been resourced to come into the hospital and sensory sessions had been scheduled at an offsite sensory room accessible to the whole site. Some elements of the training programme were also available to patients, such as food hygiene training for those wishing to prepare and share meals. There were plans in place to expand the range of training for patients especially where there were clear benefits to their recovery journey, for example where training was applicable to their personal vocational goals and employment aspirations.

We spoke with 12 patients at the service. Patients were positive in their comments, commenting favourably about staff, food at the service, and their involvement in way their treatment was managed. Patients felt that they had choice in the way their treatment would progress. Patients said they could speak with the advocate when they needed to, or if they wanted to.

Each patient had a communication passport which identified communication needs and the best way to communicate. Speech and language therapist input also helped to manage communication needs. On Cedar ward, a large poster of the 'Communication Bill of Rights' was on display, using words and pictures to show patients what their rights were in relation choices, expression of feelings, requesting information, access to information, and other relevant aspects.

We saw evidence of advanced statements in care plans and positive behavioural support plans, outlining the way the patient would like to be treated when they were not at their best. Patients had been directly involved with the recruitment process by sitting on interview panels for all grades of staff.

The involvement of people in the care they receive

Patient community meetings were recorded in minutes, and the minutes were pinned to notice boards on each ward. The minutes were clear and easy to read.

The service held a quarterly friends and family forum, combining a joint social activity with advice and support for carers. During the forum, friends and family were consulted about the information and support they required whilst their relative was in hospital. Subsequent meeting agendas were designed around these requests. We saw minutes that included access to independent welfare rights advisors regarding benefits, information around the role of nearest relative and Section 17 leave for patients detained under the Mental Health Act. As part of the forum, friends and family were joined by patients to enjoy social activities themed by the patients. Themes included a festival experience, a Christmas market experience and a circus themed experience. The forums were predominantly held

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Good

at weekends to allow for travel and work commitments for families. At the time of the inspection, the results of a family and friends survey for 2018 was in the process of being compiled, but was not available.

We saw in patient care records that family regularly attended multi-disciplinary team meetings, and family and carers had access to the wards at any reasonable time of day. Care records for autistic patients showed family involvement during meetings with the patients. Social workers at the service were a focal point for information for patients and carers regarding carer assessments and benefit information.

Carers we spoke to were positive in their comments about the service and the effect it had on the outcomes for their relatives. We received electronic letters from carers who were very complimentary about the service, and one carer spoke of the fact their relative was now happy in the community, something they thought would never happen. A letter from a patient outlined their journey through the service, and the work done by the service on their behalf.

In March 2018, patients attended a workshop around the future design of rehabilitation services, inputting their views and ideas to the group. It was decided at that meeting that a further workshop would be facilitated to further improve care plans and the development of recovery portfolios which were owned by patients, and separate nursing guidance for the management of specific issues. Staff and patients regularly reviewed restrictive practice and the reasons these might be applied in a ward environment. This site audit ensured clinicians were mindful of the patient experience within the service and made efforts to reduce the impact of restrictions that were necessary to promote patient safety and security.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

At the time of the inspection there were 43 patients admitted to Gateway Recovery Service. The service only accepted planned admissions, there was no emergency access to the service. The average time from referral to assessment was five days. Delays in admission were down to funding from external clinical commissioning groups being agreed. At the time of the inspection, the service did not have any waiting times for admission to any of the wards. Once assessment of a potential admission had taken place, the service would advise the referrer of the decision within seven days. If accepted as suitable for the service, a bed would be offered.

Staff completed an impact assessment of each patient before admission or transfer. This would review the decision to transfer or admit, to assess possible adverse effects on a patient or the ward.

All patients who were on leave from the service were guaranteed of a bed on their return. On Cedar ward, awareness of the consideration for autistic patients to return to a familiar surrounding was also considered. We saw evidence of patients being transferred from ward to ward, with a clear pathway through the service. At the time of inspection, two patients were in the process of transition from Beech ward to Fir ward; we spoke with the patients whilst they were with other patients on Fir ward as part of the transition process.

We saw active discharge planning in care records and on the electronic dashboard system. The dashboard indicated discharge forecast date for each patient. During the multi-disciplinary meeting we attended, discharge planning was discussed for and with the patient. The average length of stay for patients discharged in the 12-month period 04 April 2017 to 03 April 2018 was broken down into ward figures. Ash ward average length of stay was 179 days. Beech ward average length of stay was 53 days. Cedar ward, the autistic and learning disability ward, had an average length of stay of 712 days. Fir ward had an average length of stay of 458 days.

The average bed occupancy rate for the six-month period 03 October 2017 to 03 April 2018 was broken down into ward figures. Ash ward bed occupancy rate stood at 82%. Beech ward bed occupancy rate stood at 86%. Cedar ward bed occupancy rate stood at 86%. Fir ward bed occupancy rate stood at 81%.

The service analysed its delayed discharges (four in total) over the period from 01 January 2016 to 03 April 2018, and found that the main cause of delayed discharge for

patients at the service was due to external care teams or commissioners identifying suitable placements for patients. We were told that discharge was discussed with the care teams routinely during care programme approach reviews, section 117 aftercare meetings and often during individual care review meetings. Staff provided regular, up to date and relevant information to external care co-ordinators with a view to assist with identifying suitable placements. At the time of the inspection, Ash ward had one patient who was delayed discharge due to difficulty finding an appropriate placement. On Cedar ward, a transitional support worker was used at point of admission and discharge, to facilitate as smooth a transition to and from the ward as possible.

The facilities promote recovery, comfort, dignity and confidentiality

Patients could access their bedrooms at any time of the day. Patients were allowed their own mobile telephones, which could include internet access. There was a landline telephone for patients who did not have their own mobile telephone, this was situated in a small personal room, although we were told it was rarely used by patients. We saw that patients had personalised their own bedrooms.

Patients had access to outdoor space on each ward. Each area was decorated with benches and seating areas, some had exercise equipment for patients to use outdoors.

Patients had access to drinks and snacks 24 hours a day. There was fruit and cold drinks on the wards, accessible to both staff and patients. Each ward had sufficient rooms to run activities and keep patients involved in a variety of activities. We saw evidence of meaningful activities taking place for each patient on each ward. Activities were available seven days a week. On Ash ward, for the week of 11 June 2018, the minimum number of hours of meaningful activity offered to a patient was 25 hours, with one patient being offered 52 hours. On Beech ward the lowest number of hours of meaningful activity offered to a patient was 32 hours, the highest being 43 hours. On Cedar ward, the lowest number of hours of meaningful activity offered to a patient was 31 hours, the highest being 46hours. On Fir ward, the lowest number of meaningful activity offered to a patient was 31 hours, the highest being 46 hours.

Over 57% of patients at the service were engaged in either education or work inside and outside of the service. Each patient had an individual engagement plan of activities that showed what was available and when, completed in agreement with the patient. Plans showed therapies, gardening activities, work placements, and other activities that were situated both on and off site. There was evidence of volunteering in the community, working with animals and at a museum.

Meeting the needs of all people who use the service

Ward activities were taking place regularly. There were weekly activity planners for the unit in general as well as individual activity planners that had been compiled with input from the patient. This included rehabilitation activities, as well as meaningful activities.

All four wards were at ground level, and the doors were wide enough to allow wheelchair access. Toilets were designed to be altered to accept disabled patients when necessary. On Ash ward we saw the use of profiling beds and bariatric beds for patients with weight problems. Beds could be fitted with handrails if required.

We saw evidence of sensory rooms in use on the wards. On Cedar ward, the sensory room was being refurbished at the time of the inspection, and an interview room had been altered as a provisional measure. On Ash ward, there was a 'chill room' that had air-conditioning and electric blinds, patients could use the room at any time to relax. The 'chill room' had formerly been the seclusion room, but due to the lack of need for a seclusion room on the ward it was deemed more prudent to use the room practically. Beech ward had three quiet rooms that patients could use to relax, and a low-stimulus area for when patients found they needed a place to calm down.

We saw easy read information leaflets on the wards. Cedar ward had a 'skilled communications wall' that gave information to patients in a manner that would make understanding rights and treatment much easier, using both pictures and words. The information technology room on Cedar ward was designed with autistic and learning disability patients in mind; patients were supported in the use of the technology available. We were told that leaflets in other languages could be procured and would be procured should the need arise. Staff could access interpreters or signers if necessary. Staff picture boards on each ward allowed easy recognition of staff members on duty.

Patients had access to a wide variety of information regarding treatments and medication could be found on

each ward. Staff had made the information accessible and easy to understand. Notices included directing patients toward advocacy, the CQC, how to complain, and bus timetables into and from the local area were printed and on display.

The choice of food was varied and menus had been compiled with input from patients. The menus were rated in red, amber and green to show which meals were considered most healthy. Food could be prepared to suit patients who ate Halal, kosher, vegan or vegetarian. We saw evidence of minister visits to the wards, and church visits were regularly arranged. On Ash ward we saw that patients were attending tea afternoons at the local church. The service had a multi-faith room near the reception area that allowed other faiths to practice. We were told that, should it be requested, an Imam or other religious representative could be arranged for a patient.

Listening to and learning from concerns and complaints

The service had received 15 complaints in the 12-month period prior to April 2018. Three of the complaints had been upheld, and none had been referred to the Parliamentary Health Service Ombudsman. The three topics of complaint identified as most prevalent related to quality of food, staffing levels, and the use of agency staff.

The service acted on complaints about food quality, involving patients in the creation of new menus that were in use at the time of the inspection, and complaints regarding food quality had stopped. Staffing levels at the service were reviewed and at the time of the inspection the service staffing levels were adequate for the service. Agency staff had been identified as a problem for many of the patients due to patient problems with unknown staff, and staff not familiar to the wards. At the time of the inspection, agency staff used by the service were all known to the service, and a comprehensive induction to the service and wards was in place.

The service had a complaints policy and procedure that was issued in August 2017 and due for review before August 2020. The policy outlined the procedure for the handling of all complaints within the service. We saw evidence that the policy was being implemented and followed.

The quality assurance clinical audit for January 2018 to June 2018 showed that, in the service user satisfaction survey, 59% of patients viewed the service at Gateway Recovery Centre as very good, but 27% said they were 'unsure' on how to make a complaint. To assist patients, the service introduced complaint books on each ward, that allowed patients to make written complaints. The books showed a full resolution process, and allowed patients to make comments on completion or during the investigation of a complaint. Information on how to make a complaint was visible on noticeboards on every ward at the service. We reviewed these books and noted that they were fair and balanced in their approach to a complaint.

Minutes from operational and clinical governance meetings showed that complaints from both staff and patients were considered and discussed. A culture of care audit was carried out for the year 2017 to 2018, and in March 2018 an action plan was formed to deal with the findings from staff at the service.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

Vision and values

The values for the service were: innovation, empowerment, collaboration, integrity and compassion. We saw posters on each ward and in the reception area extolling these values, as well as in offices throughout the main building. Staff we spoke to were aware of the values, and could comment on the values and what they meant to staff and patients. Each ward had a philosophy of care that was based on the values, and we were told that patients had taken an active role in the agreement and formulation of the philosophy for each ward.

Staff we spoke to were aware of senior management at the service and for the provider. We were told that the hospital director played an active part in all aspects of the running of the hospital, and could be contacted at any time.

Good governance

Although this was the first inspection of this service since it changed Provider in 2017, the service displayed its rating from the Care Quality Commission for the last time it had been inspected.

Performance indicators were noted on the electronic dashboard that was used by the service.

All incidents were reviewed each morning with the managers, multi-disciplinary team leads and the senior management team. We attended a morning meeting at the service. Feedback was immediately provided to frontline staff. All incident investigation reports were discussed, reviewed and actioned in a monthly incident review meeting by the hospital director, medical lead and nurse lead. There was a regular 'lessons learnt' bulletin shared. In addition, the senior management team were involved in regional community meetings that enabled the sharing of information regarding best practice up and down across the service. The dashboard showed governance aspects such as patient rights being read, ward rounds taking place, security (whether escort baseline risk assessment were taking place), data for patient incidents going back three months, room searches, a live view of who was on leave from the service, meaningful week activities, physical health monitoring, and discharge planning.

The hospital director attended a regional monthly meeting and reported on matters of concern, receiving feedback on live issues from the provider, and shared these with the senior management team who cascaded information onwards as appropriate. In addition, there was a 'hot topics' document from the service which was shared with the provider and the site risk register which was shared with regional and provider colleagues on a quarterly basis. The "Ward to Board" dashboard was discussed in the monthly governance meeting attended by the multi-disciplinary team. In addition, non-site based professionals such as the advocate and the safeguarding manager from the local council, provided different insights regarding governance. The service worked within a concept the provider called the 'golden thread, a concept for the movement of information both up and down in the service.

Minutes from the hospital operational and clinical governance meetings for March, April and May 2018 showed consideration of all aspects of governance on a standing agenda.

Audits were being regularly completed by staff, and a quality assurance clinical audit for 2018 had been completed. We reviewed the audit, and noted amongst others that care plan audits, restrictive practice audits, high dose anti-psychotic drug use audits, physical health audits, risk assessment audits and infection control audits were all being carried out regularly, and that actions were put in place to deal with any audit that showed a fall in results.

The registered manager and ward managers told us they felt that they had enough authority to do their job effectively. The ward managers told us that they felt supported by senior managers and had access to administrative support.

There was a risk register for the service, the risk analysis matrix. The risk analysis matrix had an action plan within it for managing and monitoring risk. The risks identified were discussed and reviewed each month in the governance meeting at the service. Staff could submit items to the risk register through the registered manager. We requested and reviewed policies relating to Mental Capacity Act, the Mental Health Act, complaints, medication management and administration, and safeguarding. The policies were in date and showed a service committed to improvement.

We could find no evidence that financial pressures had compromised care within the service.

Leadership, morale and staff engagement

Staff told us they felt supported by senior management. Ward managers told us they had either had leadership training or were awaiting further leadership training. The service 'culture of care' audit 2017 to 2018 gave indications on how staff felt about the service, and what actions the service would take to try to improve staff morale and engagement. The audit asked nine questions ranging from whether unacceptable behaviour is constantly tackled to whether in the previous 12 months staff had personally experienced discrimination at work from other colleagues. Results ranged from 15% disagreement that staff successes were celebrated sufficiently at the service, to 29% saying they had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. The audit outlined the way in which the service was actively working to improve the work experience for staff. Staff were happy that the service provided free meals to staff from the patient menu, giving them the opportunity to comment on the quality of food presented at the service.

Staff said that they felt respected and valued, and had admiration and respect for the management and senior staff of Gateway Recovery Centre. We were told that the relationship with senior multi-disciplinary team staff was

good, and this was witnessed during a multi-disciplinary team meeting. There were no bullying and harassment cases reported at the service at the time of the inspection. However, the data from the culture of care audit suggested that some staff felt they had been bullied or harassed. This could suggest under-reporting on the behalf of staff. The service had reacted, with an employee assistance line that was available 24 hours a day for all staff; managers had raised awareness with staff about the need for a healthy workplace; the service promoted awareness of the staff health and well-being policy; and the employment engagement lead could provide guidance and support staff as required.

We asked what senior management at the service felt were the three main strengths and weaknesses regarding leadership, morale and engagement were, and how they were acting on these findings. We were told that the three strengths were visual and open leadership from the senior management team, the clinical credibility of the multi-disciplinary team and ward managers, and a staff group that overall really loved their work and wanted to make a difference.

We were told that the three weaknesses were the continuing introduction of the new terms and conditions under the new provider and the effects of change, limited progression for senior health care assistants, and the changing and challenging nature of some of the patients with personality disorder.

The change issues were being addressed mostly through transparency and consultation with staff groups on the ground. The senior management team had negotiated a slower implementation of change against provider timelines, such as the introduction of new dress codes for staff (the provider wanted to phase out uniforms, but staff at the service felt the uniform helped them maintain an identity in the service). The service had an employment engagement lead staff member who was available for all staff to approach should they have complaints to make regarding the service or other individual staff or patients. The service also had an employee assistance telephone contact line that was available to all 24 hours a day.

Commitment to quality improvement and innovation

Cedar ward at the service was to tender application for the autism accreditation quality assurance programme from the National Autistic Society later in 2018. Representatives of the National Autistic Society had given training to the staff on Cedar Ward.

Outstanding practice and areas for improvement

Outstanding practice

The introduction of specialised equipment for the monitoring of diabetes to patients with a history of self-harm and the dedication to ensure its implementation showed strong application and consideration on the behalf of both staff and patients.

The agreement with the two local NHS trusts to bypass accident and emergency departments when a patient required specialist treatment allowed for rapid access to treatment for the patient, as well as ensuring there was no escalation in patient numbers in accident and emergency rooms.

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure that language in care plans does not include jargon or terminology that might be confusing to patients.