

Elysium Healthcare (St Mary's) Limited

St Mary's Hospital

Inspection report

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

Ratings

Overall rating for this location

Good 

Are services safe?

Requires Improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The ward environments were safe and clean. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff developed and implemented good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Staff had not completed the necessary training required to carry out their roles.
- The hospital used a high amount of agency staff and this meant that staff and patients were sometimes not confident in their ability to carry out their roles effectively.
- Staff did not always have access to regular management supervision.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for people with acquired brain injury	Good	



Summary of findings

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Summary of this inspection

Background to St Mary's Hospital

St Mary's Hospital provides inpatient care for men aged 18 years and older. The service was in the process of reconfiguring the wards, but at the time of our inspection it had 65 beds over 5 wards.

These wards are:

- Cavendish ward – 17-bed ward for men with an acquired brain injury. This includes 4 self-contained flats.
- Leo ward – 12-bed assessment, treatment and rehabilitation ward for autistic men.
- Hopkins ward (part of Leo ward) – 2 bed assessment and treatment ward for autistic men.
- Adams ward – 12-bed medium secure ward for men with an acquired brain injury including up to 4 beds for deaf patients.
- Dalston ward – 18-bed low secure ward for men with an acquired brain injury.
- Eve ward – 4-bed acute mental health ward, used by a local NHS acute trust.

We carried out this comprehensive inspection to ensure that the service was compliant against a warning notice that we issued as part of a previous inspection in July 2022 and previous requirement notices that had been issued. At this inspection we found that the service had carried out the necessary work to meet the requirements of the warning notice issued in July 2022 and previous requirement notices.

This is the 7th time we have inspected St Mary's Hospital since it was registered by the Elysium Healthcare group in August 2018. We previously carried out a comprehensive inspection in June/July 2021, a focused inspection in October 2021 and a focused inspection in July 2022 because of concerns about the service.

The service is registered to provide the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983; and
- treatment of disease, disorder or injury.

The service has a registered manager.

What people who use the service say

Patients said that staff were very good, supported them in their treatment journey and encouraged them to take part in range of therapies and activities. Patients said that staff made themselves available to support them when necessary. They said that the environment was clean, well furnished, and well equipped.

Patients said that the food could be improved and that they noticed a high number of temporary staff being used at the hospital which meant they didn't know all their staff well.

Families and carers said that staff were caring and considerate and that they were polite to them if they attended the hospital. They said that staff encouraged patients to keep in touch with them and involve them in their treatment journey.

One carer said that they were not satisfied with the assessment and treatment that their family member had received.

Summary of this inspection

How we carried out this inspection

The inspection team was made up of 4 inspectors, 1 specialist advisor and an expert by experience. Before the inspection visit, we reviewed information that we held about the location. During the inspection visit, the inspection team:

- Visited all the wards and looked at the quality of the environment
- observed how staff were caring for clients using the Short Observational Framework for Inspections
- observed 2 handover meetings, several ward-based activities, and other operational meetings
- spoke with 7 patients who were admitted to the wards
- spoke with 4 carers of patients who were admitted to the wards
- spoke with members of the senior management team including the registered manager and the consultant psychiatrist
- spoke with 21 other staff members including registered nurses, healthcare support workers and therapists
- looked at 14 care and treatment records, and
- looked at a range of policies, procedures and other documents relating to the running of the wards.

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

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **MUST** take to improve:

- The service must ensure that staff take part in the necessary mandatory training to enable them to carry out their roles safely and effectively. (Reg 18 Staffing)
- The service must ensure that they minimise the use of agency staff use so that they can provide patients with a more consistent team of staff. (Reg 18 Staffing)

Action the service **SHOULD** take to improve:

- The service should ensure that they continue to implement their plans to improve the monitoring of health conditions such as epilepsy.
- The service should ensure that all staff receive a level of supervision that meets their needs.
- The service should ensure that patient specific PRN protocols are easily available to those staff that are making decisions about prescribing, such as registered nurses.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Services for people with acquired brain injury

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

Are Services for people with acquired brain injury safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

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

Safety of the ward layout

We carried out a detailed tour of each ward area and we found that staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Each day on each ward a member of staff was allocated to check that all ward areas were safe and there were detailed up to date risk assessments available to all staff which included a map of where each potential ligature points had been highlighted.

Staff could observe patients in all parts of the wards, this included the use of mirrors for blind spots. If patients were assessed as a higher risk then additional staff could be assigned so that they could be observed using parts of the ward that that were out of the way.

The ward complied with guidance and there was no mixed sex accommodation. The hospital only accepted male patients.

Staff had easy access to alarms and patients had easy access to nurse call systems. We observed examples where staff responded quickly to support other staff if it was required.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. We looked at a sample of completed records on each of the wards.

Staff followed infection control policy, including handwashing. At the time of this inspection the hospital was taking measures to reduce the spread of infection. There were effective systems in place such as regular hand sanitiser dispensers, clean masks and posters for staff and patients to help them remember to follow good practice guidance.

Services for people with acquired brain injury

Seclusion room

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. They were clean and well maintained and when not in use were kept to a standard that would allow for their immediate use.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment. There was a clear process in place to ensure these were carried out on a routine basis.

Safe staffing

The service had nursing and support staff vacancies. They had high rates of agency staff use including staff who may not always be fully confident in meeting the needs of patients. Not all staff had completed all the necessary basic training to carry out their roles. However, the service had enough medical staff.

Nursing staff

The service had nursing and support staff vacancies. It was clear that if the needs of patients changed that additional staff could be called upon at short notice to enable enhanced observations to be carried out. Staff and patients told us that they felt safe on the wards. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

The service had a small number of nurse and support worker vacancies across all of the wards. The management team told us about several different ways that they were trying to recruit new staff, for example by hosting local recruitment events and working with local training providers to increase awareness of their recruitment opportunities.

The service had high rates of bank and agency nurses and support workers across the wards. This ranged from between 10-50%. 2 of the wards had a high number of patients that required varying numbers of staff to support them, depending on their current needs. This meant that at times the wards would need to considerably increase the number of staff and therefore the use of bank and agency staff increased. However, managers limited their use of bank and agency staff and requested staff familiar with the service, where possible.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We spoke to several agency staff and they knew patients well and were able to clearly explain how they would be expected to support people that they worked with. We also looked at all the agency staff profiles which showed that they had undertaken suitable training to work on the wards.

The service had high turnover rates which had increased slightly from the previous year. Overall turnover was currently 36.4%.

Levels of sickness remained about the same over the last year, it was an average of 6.5% per month.

Patients had regular one to one sessions with their named nurse. We saw evidence that patients had regular input into the development of their care plans, which included the use of language that they could easily relate to.

Services for people with acquired brain injury

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Data showed that a small number of escorted leaves were cancelled because of staffing shortages but an alternative option was always offered, for example a different activity or escorted leave later or the next day.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. We observed 2 handovers which were detailed and gave all staff the opportunity to be fully updated on the current status of all patients and what new and current risks were. Handover documents were clearly documented so that those staff not in attendance could read them when they arrived.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was an on-call rota and staff told us there was a timely response if they needed advice from a doctor at any time of the day or night and that doctors were able to attend at night in good time if they were required.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with the majority of mandatory training. However, only 42% of staff that required it had completed training to work with people with a learning disability or who were autistic, 69% of staff had completed training in epilepsy awareness and only 47% of staff had completed training on how to work with and understand positive behaviour plans.

Assessing and managing risk to patients and staff

We looked at 13 care records. Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills and experience to develop and implement effective plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incidents. They used the short-term assessment of risk and treatability and the historical risk 20 tools to document each patient's assessment of risk. We saw continuous reviews of these assessments throughout each patients care record.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. They used several different mechanisms to carry out this function. For example, well documented handovers were carried out between each shift where we saw evidence of current and new risks being discussed with all staff. We observed a daily meeting during which ward managers and the majority of the MDT came together to discuss newly reported incidents and how these might be responded to. We also spoke to staff and they were all able to give us detailed explanations of each patients risks and how they were expected to manage them.

Services for people with acquired brain injury

Staff identified and responded to any changes in risks to, or posed by, patients. There was clear evidence that incidents were reported and responded to and where needed that risk management plans were updated as a result, this included where risks increased but also where risk decreased and a less restrictive approach could be applied.

Staff followed procedures to minimise risks where they could not easily observe patients. We examined the observation charts of patients and found that staff were correctly following and documenting the prescribed observations, and these included sufficient detail to show that meaningful interventions were being undertaken where they were needed.

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

Use of restrictive interventions

Levels of restrictive interventions were about the same across the last 12 months. The hospital gathered large amounts of data about the numbers of restrictive interventions that were carried out, the majority of them were low level interventions such as guiding a patient towards a different area of the ward. The hospital also explained that they had several patients that required restrictive interventions on a very regular basis due to their complex needs. The hospital was seeking alternative placements for a number of these people.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. This included bank and agency staff. There was an expectation that an agency staff deployed to work on the wards would have taken part in training that met the same standards of the full time staff, this meant all staff would be trained to use the same techniques.

We examined incident reports and CCTV and this enabled us to see that staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

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

Staff followed NICE guidance when using rapid tranquilisation. The use of rapid tranquilisation had halved over a period of 6 months, there were 30 episodes over the last 6 months. Staff carried out the necessary observations following the use of rapid tranquilisation; however, these observations were not always documented in a way that made them easy to find.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We examined 2 episodes of seclusion and both showed that the necessary steps had been taken to ensure that seclusion was proportional and that it was reviewed on a regular basis.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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

The majority of staff were up-to-date with their safeguarding training, 90% had completed a refresher in the last year.

Services for people with acquired brain injury

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. All staff that we spoke to had a good understanding of what to look for when working with people. They also had a clear understanding of how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were several different sources of support available to all staff which included a nurse in charge, ward manager, named safeguarding leads and the hospital registered manager.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records, there was a combination of paper based and electronic records.

Patient notes were comprehensive, and all staff could access them easily. The majority of the patient's records were stored on an electronic system which all staff could access. Important details such as risks and strategies to manage risks were made available on paper so that they could be easily accessed for staff that did not have regular access to the electronic system.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients did move between wards during their treatment journey and staff could access the electronic record easily when this happened which ensured a smooth transfer of information.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines but they were not always used effectively. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. The relevant legal authorities for treatment were in place. Upon admission to the ward a review of medicines currently prescribed took place and every Thursday a Multi Disciplinary Team (MDT) meeting was held which included discussions around people's medicines.

There were a small number of administrative errors, but the provider was already aware of these and was taking steps to rectify them. We found gaps in one patient's epilepsy monitoring, this meant that the hospital could not clearly and easily inform a clinician about the person's recent seizure history. Although on this occasion this had not led to any harm, we had previously asked the hospital to take action to improve this system, this improvement process was still being undertaken.

We also found that patients had specific protocols to help staff to decide which PRN medication could be administered, however, these protocols were not easily available and therefore not all staff making this decision could benefit from the guidance. PRN medication is medication which should be administered when required.

Staff stored and managed all medicines and prescribing documents safely.

Services for people with acquired brain injury

A pharmacist attended once a week to review medicines administration records and order any medicines that were needed. If a medicine was required out of hours, a policy was in place to obtain the medicine. Staff were able to tell us how to obtain medicines out of hours if needed.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Rapid tranquilisation (intramuscular injections for the management of severe agitation and aggression) was only used as a last resort. An audit conducted by staff in December 2022 outlined that monitoring hadn't been completed as per policy. This process was currently under review and we saw evidence that monitoring had taken place after rapid tranquilisation, but it was not recorded correctly.

The service was achieving the aims of STOMP (Stop Over Medicating People with a learning disability). Examples were seen where this had been completed effectively and psychotropic medicines had been stopped or reduced successfully.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Health action plans were completed for people when admitted to the service. These were reviewed every 6 months. Evidence was seen of different healthcare professionals attending the service for physical health needs.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. All of the staff we spoke with could describe what types of incidents they were expected to report and knew how to do so. The hospital used an electronic reporting system which meant that they could be easily tracked and linked to a patient record if required.

Staff raised concerns and reported incidents and near misses in line with provider policy. We saw evidence that each incident that was reported was checked to ensure that it was completed properly and where necessary that further instruction was given to correct errors and ensure that staff learned from any mistakes that they made.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if, and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff told us that senior managers at the hospital came to support them if there was a serious incident, to ensure that staff were supported and that serious incidents were dealt correctly. Staff said that this was helpful to them.

Staff met to discuss feedback and look at improvements to patient care. This happened in several different ways, at ward level staff had the opportunity to attend team meetings and group supervision sessions and the senior staff met daily to look at the outcome of incidents and investigations. We could also see that data was fed into a wider system of governance which gave staff the opportunity to study themes and trends. Staff also received monthly bulletins which outlined recent lessons learned, which included events that had occurred at other hospitals.

Services for people with acquired brain injury

There was evidence that changes had been made as a result of feedback. An example of this was where staff had told managers that they did not always receive adequate feedback from multi-disciplinary team meetings. Managers took this feedback on board and introduced a system which saw discussion and outcomes summarised and a brief email sent to all staff to ensure that they were kept up to date. Staff told us that this new system was helpful to them in ensuring they delivered high quality care.

We were also told about a new system where CCTV would be randomly reviewed and studied in an effort to pick out good practice and areas for improvement. Staff said that this was a positive development and that they received useful feedback as a result.

Are Services for people with acquired brain injury effective?

Good 

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan where one was required.

Staff completed a comprehensive mental health assessment of each patient on admission. We saw evidence that these assessments were thorough and well documented and enabled staff to gain a useful understanding of each patient.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. These were reviewed every 6 months. We saw evidence that healthcare professionals attended the service to support physical health needs such as dysphasia, epilepsy, sensory needs, podiatry needs and nutritional needs.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. It was clear that there was a link between assessed needs and care plans for each patient. Patients that had specific needs had a specific section of their care plan which addressed each of these needs. Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery-orientated. Care plans contained details of discharge planning where it was appropriate and there was evidence that patients had been involved in the development of care plans and in the language used to write them. They were written in a way that patients could easily understand.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Services for people with acquired brain injury

Staff provided a range of care and treatment suitable for the patients in the service. The hospital had a range of resources such as assisted daily living kitchens, a gym, quiet spaces, computer rooms, craft rooms and games rooms. There was evidence within care records that people were making good use of these resources and we observed a number of sessions and activities taking place. We also saw that people were being encouraged to make use of section 17 leave to access the community where it was appropriate and of therapeutic benefit.

Staff identified patients' physical health needs and recorded them in their care plans. For example, patients who required specific diets had clearly identified plans in their care records which included what information kitchen staff would be given to ensure that people's needs were met. Staff developed and implemented good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. We saw evidence that staff acted in accordance with guidance where these assessments indicated further action was necessary or that support should be sought.

Managers used results from audits to make improvements. Minutes from governance meetings showed that managers were having regular conversations about the results of audits that had been carried out. These included the use of section 17 leave, rapid tranquilisation and physical health monitoring. Meeting minutes also showed that the senior management team were giving consideration to their future programme of audit and what would be most beneficial.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of the patients on the ward. They included nurses, psychiatrists, psychologists, physical health specialists, dieticians, speech and language therapists, social workers, and occupational therapists.

Managers ensured staff had the right, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. However, not all staff were up to date with specialist training that they would need to carry out their role effectively. Training included learning disabilities and autistic people, positive behaviour support plans and epilepsy awareness.

Managers gave each new member of staff a full induction to the service before they started work. We spoke to several staff that had recently undertaken an induction as they were new to the hospital. They said it was detailed and thorough and gave them a good understanding of what to expect on each of the different wards and gave them time to shadow staff in the area they would be working in.

Managers supported staff through regular, constructive appraisals of their work. At the time of our visit, 94% of all staff had taken part in an appraisal in the last 12 months.

Managers supported staff through regular, constructive clinical supervision of their work. A small number of staff told us that they did not feel like they had access to regular supervision. However, data that we saw showed evidence that all staff had taken part in some form of supervision over the last 4 months.

Services for people with acquired brain injury

Managers made sure staff attended regular team meetings or gave information from those that could not attend. We saw a sample of team meeting notes for each of the wards which evidenced that team meetings were held on a regular basis, were well documented and contained a range of useful agenda items pertinent to the work of each ward.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Although some staff were not up to date with some elements of training, there was a thorough programme of training available to people and the hospital was taking steps to ensure that all staff that needed it undertook appropriate training.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We saw evidence within patients care records that meetings about their care were carried out on a regular basis. These meetings were attended by a wide range of staff and included patients and carers where they wished to attend and where patients wanted their family member or carer to attend. Some patients made the decision that they did not want their carers to be part of these meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We observed several handover meetings between changing shifts and they were detailed, well attended and gave staff the information they would need to be able to care for people safely and effectively. We also observed a daily meeting of senior staff where they discussed incidents that had occurred and possible responses that might be required.

Ward teams had effective working relationships with external teams and organisations. These included local safeguarding teams and social work staff and local specialist services that came in to the hospital to provide services where needed.

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

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

Staff received, and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All staff received training in this area during their induction and 84% of staff had taken part in refresher training since their induction. Staff that we spoke to had a good understanding of the mental health act and how it impacted on their work with patients.

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

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

Services for people with acquired brain injury

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the advocacy service. We saw posters explaining who these staff were and when they would be available or how to contact them. We spoke to several advocates and they told us they attended the wards on a regular basis.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and with the Ministry of Justice where it was necessary. There was a small amount of section 17 leave cancelled as a result of short staffing but patients were always offered an explanation and an alternative option for the leave to be rearranged.

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

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

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Good practice in applying the Mental Capacity Act

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

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of the five guiding principles. 82% of staff had taken part in refresher training. Staff we spoke to could give a good explanation of how the Mental Capacity Act impacted on their work with patients.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

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

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

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Are Services for people with acquired brain injury caring?

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

Services for people with acquired brain injury

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. We carried out several observations of care being delivered including at mealtimes, during activities and whilst patients were socialising and relaxing in communal areas. Staff showed a good understanding of each of the patients they were caring for and there was a good rapport between staff and patients across all the wards. We observed staff working hard to meet the needs of the patients.

Staff gave patients help, emotional support and advice when they needed it. It was clear to us that patients felt they could approach staff for support when they needed it. We saw several interactions between staff and patients that showed staffs ability to offer an appropriate level of input to support patients if they were distressed or upset. There was also evidence within care records that staff and patients were given the opportunity to chat and receive support where it was required.

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

We spoke to 7 patients during this inspection and they all said staff treated them well and behaved kindly. They said that staff were kind and caring and that they had helped them to recover from their illnesses, develop new interests, and take part in activities.

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

Staff followed policy to keep patient information confidential.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments and they supported patients to understand and manage their own care treatment or condition. There was evidence that care plans and risk assessments were formulated with patients, we saw written input from patients that wanted to provide it and care plans were written in a language that patients could easily understand.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. There were several patients who had a hearing impairment. The hospital employed staff that could use British Sign Language and they also used several external interpreters to support patients during activities and therapeutic interventions. The hospital also employed an advocate who could use sign language. We also saw that the hospital made use of pictures and signs to communicate with some patients and that there were many easy read visual displays around communal areas of the wards.

Services for people with acquired brain injury

Staff involved patients in decisions about the service, when appropriate. Staff facilitated community meetings which gave patients the opportunity to discuss and give feedback about their ward and the facilities at the hospital. We observed one of these sessions during the inspection and found it to be a positive atmosphere and pitched at the right level.

Patients could give feedback on the service and their treatment and staff supported them to do this. We saw a detailed log of complaints, some of which were from patients, which contained details of each investigation, any outcomes and actions identified where appropriate. For example, staff made changes to the way they managed stock of medications because of feedback that they had received from patients.

Staff made sure patients could access advocacy services. We saw posters explaining who these staff were and when they would be available or how to contact them. We spoke to several advocates and they told us they attended the wards on a regular basis.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. There was evidence within care records that carers and families of patients were involved if patients wanted them to be. They were invited to take part in meetings about the patients care and treatment and were kept up to date on progress and incidents if they occurred.

Staff helped families to give feedback on the service. Carers that we spoke to said they knew how to give feedback to the hospital if they wanted to.

Are Services for people with acquired brain injury responsive?

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

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. However, because of the complexities of some of the patients there were some delayed discharges. The hospital was making efforts to find appropriate placements for those that needed them.

The service had several out-of-area placements. Because of the type of specialist services that were provided at the hospital, they received referrals from across the country.

Managers and staff worked to make sure they did not discharge patients before they were ready.

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

Services for people with acquired brain injury

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient.

Discharge and transfers of care

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients had discharge plans identified and there was evidence that staff were supporting people to work towards the next phase of their treatment journey.

Staff supported patients when they were referred or transferred between services. The hospital was in the process of transferring several patients to alternative placements and we saw evidence of detailed transition plans that had been set out and implemented.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

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

Patients had a secure place to store personal possessions. All the wards had a designated area which contained a separate space to store each patients' personal belongings.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. These included a well-equipped and staffed gym, music equipment, craft rooms, pool tables, one to one rooms, TV and games rooms, kitchen areas and easily accessible outside spaces.

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

Patients could make phone calls in private. Patients that did not have access to their own mobile phone could make use of the wards telephone to make private calls when they wanted to.

Patients could make their own hot drinks and snacks whenever they wanted, on some wards this had to be supported by staff because of the complex nature of some of the patients and the related risks.

The service offered a variety of good quality food. However, some patients said the quality of the food could be improved.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients to access them where it was appropriate.

Staff helped patients to stay in contact with families and carers. This was detailed within care plans and families and carers that we spoke to said that staff helped patients to keep in touch with them if they wanted to.

Services for people with acquired brain injury

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

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospital had several lifts which could be used to access wards on upper floors. Once accessed, all ward areas were on the same level and therefore easy to navigate for anyone with impaired mobility. The hospital made good use of interpreters and staff could use British Sign Language to support patients that required it.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There were displays around the hospital to support patients to better understand their options for further support, good nutrition and how they might complain if they needed to.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. For example, we saw clearly documented instructions for those patients that required their food to be softened and it was clear that staff were following these instructions. We also saw evidence of the hospital receiving feedback about the quality and choice of food and that they responded positively to this feedback by altering the menu.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. We saw a detailed log of complaints that had been investigated and actioned and there were details around the hospital to advise people of the process if they wished to complain, this included in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. For example, they had received feedback about how details from multi-disciplinary meetings could be shared better and implemented a system to improve this aspect of peoples work.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning was a theme that we saw discussed at several different meetings. These included team meetings, daily hospital wide meetings, governance meetings and patient community meetings.

Services for people with acquired brain injury

Are Services for people with acquired brain injury well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

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

The Leadership team included a hospital director who was supported by a clinical director and head of nursing alongside heads of departments for various other disciplines. The senior management team were passionate about the work they did and displayed a good understanding of the work they were carrying out.

Senior leaders were supported by a team of ward managers who managed the day-to-day operations of each ward. Leaders were visible across the hospital and staff reported feeling supported by their managers.

Vision and strategy

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

Staff that had been through a recent induction told us about how their training prepared them well for the different functions that each of the wards served. Staff had a good understanding of what each of the wards was set up to achieve, for example to ready people for the next stage of their recovery.

The hospital displayed their vision and values in areas that people could view them and staff knew about them when we spoke to them.

Culture

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

The majority of the staff that we spoke to said that there was an improved culture at the hospital, they said that the management team had taken steps to improve communication, to improve systems to safeguard people and to support them to carry out their roles.

Staff told us that there were opportunities to progress within the hospital or the provider.

Staff felt able to raise concerns without fear of retribution, they felt that they would be listened to. Staff knew how to use the whistle-blowing process.

Governance

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

Services for people with acquired brain injury

Although we issued one requirement notice in relation to staff training, the hospital had improved governance processes considerably since the last inspection. Managers were aware of the issues we raised and already had plans in place to make necessary improvements.

Although some audit processes had yet to be properly embedded, there was evidence that managers and staff were working to ensure that this happened and enhance the good work they had done so far. It was clear from meeting notes and from other inspection activities that clinical effectiveness was being monitored and discussed and that feedback and learning was shared with staff via team meetings, staff bulletins and ward-based handovers.

Management of risk, issues and performance

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

Staff maintained and had access to a hospital wide risk register.

Information management

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

The management team were able to collect and process data that was submitted by staff working on wards. For example, data gathered from incident reports and local audits that had been carried out. Managers used this data to inform changes and improvements across the hospital.

Staff made notifications to external bodies as needed, including CQC notifications and safeguarding referrals.

Engagement

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

Managers were working alongside local bodies to assess the future of several of the wards at the hospital, this included the consideration of a change to service type to ensure that the wards met the current needs of the community in which it was located.

Commissioning bodies had carried out several quality visits over the last 6 months which provided positive feedback on the care and treatment that the hospital was delivering.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Treatment of disease, disorder or injury	-