Calverton Hill

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	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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 Calverton Hill as requires improvement because:

- The ward environments were not all clean, well-furnished or well maintained.
- There were not enough permanent nurses on Bestwood and Newstead Wards. Agency and bank staff were relied upon to deliver safe care.
- Staff did not always assess and manage risk or patient safety incidents well.
- Staff did not consistently carry out patient observations in line with policy.
- The service did not have robust systems to prescribe, administer, record or store medicines safely. Staff did not regularly review or record the effects of medicines on each patient's physical health.
- Staff did not always assess physical health of patients or promote good to physical healthcare.
- Staff did not always develop holistic, recovery-oriented care plans. Care plans were not written in a format that was easy to read.
- Staff did not engage in regular clinical audits to evaluate the quality of care they provided.
- Managers did not ensure that all staff received mandatory training and supervision.
- Staff did not clearly assess and record patients' capacity to make decisions in line with the Mental Capacity Act 2005.
- Staff did not always actively involve patients' families and carers in care decisions.
- Staff on Bestwood and Newstead Wards did not plan and manage discharge well.
- Some leaders did not have the skills, knowledge or experience to perform their roles, and did not have a good understanding of the service they managed.
- The governance processes did not ensure that ward procedures ran smoothly.
- Staff did not have easy access to clinical information on the electronic records systems. Multiple systems for recording information were used which led to gaps in the information available to staff.
- Staff did not always involve patients in care planning and risk assessment. Staff did not always work collaboratively with patients to understand their individual needs and support them to understand and manage their care, treatment or condition.

However:

- Staff followed good practice with respect to safeguarding.
- Staff had the skills required to develop and implement 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 provider employed enough doctors.
- Staff treated patients with compassion and kindness and respected their privacy.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement 	
Wards for people with learning disabilities or autism	Requires improvement 	

Summary of findings

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Requires improvement

Calverton Hill

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Wards for people with learning disabilities or autism.

Summary of this inspection

Background to Calverton Hill

Calverton Hill hospital is provided by Priory Healthcare Limited and registered to provide assessment or medical treatment for persons detained under the Mental Health Act, diagnostic and screening procedures and treatment of disease, disorder or injury.

The hospital offers a medium secure service for women with a learning disability on Clumber Ward. It also offers a medium secure service for men with a learning disability on Rufford Ward. This closed at the time of our inspection, so we did not inspect Rufford Ward. Clumber Ward is expected to close in February 2020. At the time of our inspection there were eight patients. The provider has given notice to NHS England that the ward is closing due to the NHS England Transforming Care programme that aims to move people with learning disabilities out of hospitals into the community.

There are two acute mental health wards for men and women on Newstead and Bestwood Wards. There are 16 beds on each ward and this service is commissioned by Nottinghamshire Healthcare NHS Foundation Trust.

There have been 13 previous inspections to Calverton Hill hospital. The latest was in June 2017 when we rated Calverton Hill as good overall and Good in all five key questions. There were no requirement notices made at this inspection. However, our Mental Health Act reviewers have visited the wards on the following dates: Bestwood Ward and Clumber Wards in June 2018, Rufford Ward in October 2016 and Newstead Ward in December 2018. They found:

- Information about how to contact the Care Quality Commission, complaints and safeguarding was not available on the wards.
- Patients said they were not informed of their rights under the Mental Health Act
- Patient meetings were not held regularly
- Medical reviews were not always completed when patients were in seclusion
- There was no evidence of advance decisions
- Patients were not always involved in care plans

There were blanket restrictions on Rufford Ward

On 8 May 2019 the Care Quality Commission restraint, seclusion and segregation thematic review team visited Clumber and Rufford Wards and found the following:

The seclusion suite where a patient was in long term segregation did not meet the requirements of the Mental Health Code of Practice for nursing patients in conditions of long-term segregation because:

- Patients had access to only a bedroom and an en-suite shower room and did not have a lounge area or an outside space.
- The bedroom was devoid of any personal possessions, toiletries, clothing or toys/games. It was not therefore as homely as possible. The patient presented a risk of self-harm, there were always two staff with her, so it was the view of the review team that these risks could have been managed in a less restrictive way.
- Patients did not have access to a bath as the bathroom was on the main ward and there were risks associated with taking her there. However, the ward manager told us that the patient enjoyed having a bath and found this relaxing and therapeutic.
- Patients had access to a small activity room – comprising of a central table (like a circular dining table) with chairs. Games and activities were piled up in the corner. It was not clear how it was safe for the patient to use this room but not safe for her to have any possessions in her bedroom. It was also not clear how often she accessed this room as it was a room used by other patients on the main ward.
- There were charts on the bedroom wall with Velcro to attach cards with different activities depicted on them. Each card had a picture and a verbal description of the activity. We asked the patient about these and she was unable to tell us what they meant or what they were for. It was the view of the review team that these charts were not meaningful to the patient or used by her.
- We saw one entry for the approved clinician review (one should take place every 24 hours). The review stated that the patient was on leave. We were unable to find other entries relating to the approved clinician 24-hour reviews or evidence of a three-monthly external review taking place.

Summary of this inspection

- No evidence of family or Independent Mental Health Advocate (IMHA) involvement in the decision to segregate the patient or Independent Mental Health Advocate involvement in the reviews of long – term segregation.

The thematic review team also reviewed the seclusion records for two patients and had the following concerns:

- Independent nursing reviews were carried out by a solitary nurse about 50% of the time (the Code of Practice requires these to be undertaken by two nurses, one of whom should not have been involved in the initial decision to seclude the patient).
- Four hourly reviews by a doctor were not taking place. The Code of Practice states that alternative medical review arrangement may be made following the first internal multidisciplinary team meeting. The first doctor's visit to the patient on long-term segregation was considered to be the first multidisciplinary team meeting. There was no record of changing the frequency of medical reviews, and no further medical reviews were documented.
- There was no evidence to show that an independent review had taken place after eight hours.
- The Independent Mental Health Advocate was not involved in any reviews or discussions of seclusion.
- One patient self-harmed whilst in seclusion causing what was described as "significant bruising". There was no evidence that she had access to a doctor outside of the long-term segregation review process.

This was fed back to the provider at the time of the thematic review and the registered manager developed an action plan to address these issues.

Our inspection team

The team that inspected the service comprised five CQC inspectors, two nurse specialist advisors, an occupational therapist specialist advisor and an expert by experience who was a family carer for a person with a learning disability.

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 always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all three wards at the hospital that were open – Clumber, Newstead and Bestwood Wards, looked at the quality of the ward environment and observed how staff were caring for patients;
- we did not visit Rufford Ward as this was due to close the day before our inspection, there was one patient there during our inspection and staff were working with commissioners to move the patient to a new placement;
- spoke with 12 patients who were using the service;
- spoke with the registered manager and managers for each of the wards;

Summary of this inspection

- spoke with 29 other staff members; including doctors, nurses, occupational therapists, cleaners, a psychologist and a social worker;
- spoke with an independent advocate;
- attended and observed two hand-over meetings and one multidisciplinary meeting;
- looked at 17 care and treatment records of patients:
- spoke with six carers
- carried out a specific check of the medicines management on each ward; and looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients on Bestwood Ward told us that the ward and bedrooms were not clean. Patients informed us there was blood on the curtains that had not been cleaned and that the television had been broken for a period of time. Patients stated that they had to ask staff to make a hot or cold drink for them as they weren't allowed to do so for themselves.

Patients on Bestwood and Newstead Wards told us that there were not enough staff on the wards, which resulted in staff being too busy to support patients. They also reported that there were agency staff who did not engage with patients. Additionally, they were not receiving regular one-to-ones due to the staffing issues. Patients on Clumber Ward said staff sometimes sat in the office and didn't talk to patients.

Patients on all wards told us that they felt safe and that the majority of staff were kind and caring.

Patients on Clumber Ward told us that staff supported them to be independent by supporting them to do their washing, making their bed and going out often to do their shopping. One patient said, "They have helped me a lot here, it's a good place, I have learnt a lot and changed for the better."

One patient's relative said communication with staff was poor and staff had not told them when their relative was involved in an incident or secluded even though they had asked for this. Another relative said that staff always informed them of incidents by phone. One relative said their relative can phone when they wanted to, and they can always contact the ward by phone. Relatives said they knew how to make a complaint although as they had no concerns they had not done so.

One patient's relative said the doctor was very welcoming, involved them in their relative's care and told them what medicines they had prescribed for their relative and why. Another relative told us that not all staff knew about their relative's needs as there seemed to be a big turnover of staff, but some staff were caring.

One relative told us that patients had a lot of unhealthy food and not much exercise.

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?

Inadequate

We rated safe as Inadequate because:

- Bestwood Ward was not clean, well-furnished or well maintained. There were some areas of Clumber Ward that were not well maintained.
- The hospital did not have a robust approach to the recruitment and retention of staff. Vacancy rates were high among nursing staff and healthcare workers on Bestwood and Newstead Wards. Agency and bank staff were relied upon to deliver safe care.
- Staff did not always assess and manage risks to patients well or do all that was reasonably practicable to reduce risks.
- There were blanket restrictions in place, for example, patients on Bestwood Ward not able to make their own drinks and searching of patients.
- Staff on Bestwood Ward were not aware of the environmental risk assessment.
- Staff did not always carry out observations on patients in line with policy and record these at the time of the observation.
- The electronic records systems used meant that staff did not have easy access to clinical information and to maintain high quality clinical records. Multiple systems for recording information were used which led to gaps in the information available to staff.
- The provider had not trained enough staff in fire safety, infection control, the Mental Health Act and the Mental Capacity Act. The provider had not trained staff in the management of patients with sepsis.
- Staff review of the effects of rapid tranquilisation medicine on each patient's physical health was inconsistent.
- Staff on Clumber Ward had not managed all patient safety incidents well.
- On Bestwood and Newstead Wards the systems to prescribe, administer, record and store medicines were not always carried out safely. Staff did not regularly review or record the effects of medicines on each patient's physical health.

However:

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

Summary of this inspection

- Staff used restraint only after attempts at de-escalation had failed.
- Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- 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 recognised incidents and reported them appropriately.
- Staff on Clumber Ward used systems and processes to safely prescribe, administer, record and store medicines. They knew about and worked towards achieving the aims of the STOMP programme (stop over-medicating people with a learning disability).

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care plans were not personalised and recovery-oriented and were not written in collaboration with patients.
- Staff did not always assess the physical health of all patients on admission. Staff did not ensure that patients had good access to physical healthcare. Staff did not effectively use recognised rating scales to assess and record severity and outcomes of patients' physical health needs.
- The service did not take part in quality improvement initiatives.
- Managers on Newstead and Bestwood Wards did not support staff with adequate supervision in line with their policy.
- Not all disciplines attended patients' multidisciplinary meetings or ward rounds.
- The provider had not trained enough staff in the Mental Health Act and Mental Capacity Act.
- Staff did not always assess and record capacity clearly for patients who might have impaired mental capacity.
- However:
- Staff provided a range of care and treatment interventions suitable for the patient group that were consistent with national guidance on best practice and supported patients to live healthier lives.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national

Summary of this inspection

guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation.
- Managers supported staff with appraisals, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- The ward teams had effective working relationships with staff from services that would provide aftercare following the patient's discharge.
- 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.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Staff did not always work collaboratively with patients to understand their individual needs and support them to understand and manage their care, treatment or condition.
- Staff did not always involve patients in care planning and risk assessment or actively seek their feedback on the quality of care provided.
- Staff did not always inform and involve families and carers appropriately.
- Care plans were not written in a format that was easy to read.

However:

- 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 ensured patients had easy access to independent advocates.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Staff did not manage discharge well on Bestwood and Newstead Wards. This resulted in a patient being discharged who had nowhere to live. Staff did not develop discharge plans on patient admission.

Summary of this inspection

- There were blanket restrictions for patients on Bestwood Ward who could not make their own drinks and snacks at any time. This was because action had not been taken to repair the hot water pipe.
- Patients on Clumber Ward told us that there was not a variety of food that met their needs and likes.

However:

- The design, layout, and furnishings of the ward supported patients' treatment and privacy. 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 service met the needs of all patients who used the service including those with a protected characteristic. Staff helped patients with cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Some leaders did not have the skills, knowledge or experience to perform their roles, and did not have a good understanding of the service they managed.
- Staff did not have opportunities to contribute to the service strategy.
- There was a negative culture on Bestwood and Newstead Wards surrounding supervision and its function.
- Our findings from other key questions demonstrated that governance processes did not operate effectively at ward level and risk was not managed well.
- Ward teams did not always have access to the information they needed to provide safe and effective care.
- Staff did not engage actively in local and national quality improvement activities.

However:

- Most leaders were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Leaders managed performance well.

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.

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

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice during induction and this was updated with e- learning. However, at the time of our inspection, only 68% of eligible staff working on Clumber Ward had received this training. However, 83% of staff on Bestwood and Newstead Wards had completed this. There was information on different sections under the Mental Health Act in the staff room on Newstead Ward. This had been placed there to support staff, particularly those that had moved from the secure services and may not have a vast knowledge of different sections relating to acute services.

Staff requested an opinion from a second opinion appointed doctor (SOAD) when they needed to, and patient records showed they had visited.

The Mental Health Act administrator had recently left the hospital. The provider had recruited another and in the interim an administrator from another hospital provided advice.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Patients had easy access to information about independent mental health advocacy. Staff referred patients who lacked capacity to the advocacy service. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time. This included their right to an independent mental health act advocate.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of Justice. Patients records showed that staff had assessed the patients mental state before going on leave to ensure the patients' and staff safety.

The service displayed a notice to tell informal patients that they could leave the ward freely. This was displayed on both sides of the door on Newstead Ward. There was a sign displayed on Bestwood Ward but at the time of inspection, this was not visible as it had been removed by patients.

Care plans included information about section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment. Ward managers told us that a referral was made to the community mental health team for patients on admission.

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

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training during their induction in the Mental Capacity Act. However, at the time of our inspection only 67% of eligible staff working on Clumber Ward had received this training. However, 89% of eligible staff on Bestwood and Newstead Wards had received this training. The social worker showed us flashcards they had produced to help improve staff understanding of the Mental Capacity Act.

Detailed findings from this inspection

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies. There was one deprivation of liberty safeguards application made on Newstead Ward in the last 12 months to protect people without capacity to make decisions about their own care.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff knew how to access and where to get accurate advice.

On Clumber Ward, patient records did not show that staff always supported patients to make decisions on their care for themselves. Staff did not always assess and record capacity clearly for patients who might have impaired mental capacity. For example, staff had recorded in one patient's record that the patient lacked capacity to consent to taking their medicines. However, it was not clear how staff had reached that decision. Staff told us they did not feel confident to assess a patient's capacity in deciding whether they should use sun cream. This had resulted in the patient being sun burnt. There were gaps in patient's consent to treatment in nine of the 15 prescription charts on Newstead Ward.

Staff understood that each patient's capacity should be assessed on each decision. It was not clear if the service monitored how well it followed to the Mental Capacity Act and if they acted when they needed to make changes to improve.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Notes

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Inadequate

Safe and clean environment

Bestwood Ward was not clean, well-furnished or well maintained.

Staff did not regularly carry out risk assessments of the care environment. Both wards did not have environmental risk assessments in place. The health and safety lead had not been at work for a significant period of time to complete the assessments. There was a site wide environmental risk assessment, but this did not contain specific details of Bestwood and Newstead's ward environment. The registered manager told us there is a health and safety file on each ward that contained risk and environmental assessments that were reviewed in August 2019. They said the support services manager was reviewing these at the time of inspection and reissued these to the wards shortly afterwards. However, at the time of inspection, staff on the wards were unaware of these.

Cleaning records were not robust and there was no evidence that wards were cleaned regularly. There were gaps in the dates of cleaning records. It was not clear to see that the wards had been cleaned daily or that all the specific tasks that were required to be carried out at a set frequency were complete. A number of patients that were spoken with on Bestwood Ward stated that the ward was dirty and not cleaned regularly.We observed that Bestwood Ward was dirty at the time of our inspection.

There was antibacterial gel available for staff to use, however there was not any available to patients.

Clinic rooms were well equipped with suitable handwashing facilities and the necessary equipment to carry out physical observations. Resuscitation equipment and emergency drugs were accessible, and staff checked these regularly. However, during our inspection on 2 October, the emergency bag on Bestwood Ward had not been checked since 21 September 2019 and was therefore four days overdue.

Staff maintained equipment, but it was not clean. The clinic room on Bestwood Ward was visibly dirty with dust on the weighing scales and underneath the examination couch.

Access to both wards was controlled and doors were locked. There were books for visitors to sign in and out to ensure that the service knew the number of people on each ward.

The ward layout allowed staff to observe most areas of the ward. The provider had installed closed circuit television cameras and mirrors to reduce blind spots in communal areas and mitigate any risks.

The provider had installed a number of anti-ligature fixtures and fittings where possible. There were identified ligature anchor points which were detailed on the ligature audits for each ward. The risks were mitigated adequately by staff observations and healthcare workers presence in communal areas. There were ligature cutters on both wards that were easily accessible to all staff.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

The wards complied with guidance on eliminating mixed-sex accommodation. Both acute wards met the CQC's guidance and the Mental Health Act code of practice where male and female sleeping areas are segregated with access to their own toilet facilities.

Staff had easy access to personal alarms and radios and patients had access to a nurse call system via a button in their bedrooms.

The communal area on Newstead Ward was clean and well furnished. However, on Bestwood Ward the communal area was messy with laundry on the floor and some items of furniture were torn and stained.

Safe staffing

Vacancy rates were high among nursing staff and healthcare workers with heavy reliance on agency and bank staff to deliver safe care. However, there were enough staff and the service ensured that staff received the basic training to keep patients safe from avoidable harm.

The hospital had developed a tool to indicate the core number of staff on each shift on each ward, depending upon the number of patients that were admitted to the ward. At the time of inspection, this was two nurses and four healthcare workers with additional staff supporting depending upon the level of clinical observations.

Staff reported that there were staff shortages and that several agency staff were used, particularly at the weekend. Staff had raised concerns to managers that the weekend period presented with high risk due to a higher use of agency staff at weekends who did not know individual patients. The acute service required a staffing establishment of 22 whole time equivalent nurses and 48 healthcare workers across both wards. As of 22 September 2019, there were 16 whole time equivalent (72%) vacancies for nurses and 15.8 whole time equivalent (33%) vacancies for healthcare workers.The provider was in the process of closing the secure service on the site and told us that some vacancies would be filled by staff from that service.

Managers could adjust staffing levels daily to take account of case mix. When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. Additionally, there was a site coordinator for each shift that was responsible for covering shifts that were short staffed.

They reviewed the staff numbers and skill mix on each ward and moved staff across wards to ensure that there were safe staffing levels across the hospital site. The provider employed enough doctors.

There were not enough permanent staff to safely staff the wards and the provider used agency and bank staff to cover vacant shifts. On Bestwood Ward there were 329 shifts covered by agency staff in the three-month period of 24 June 2019 to 22 September 2019 and 106 shifts covered by bank staff. On Newstead Ward there were 311 shifts covered by agency staff in the same period and 132 shifts covered by bank staff. In this period there were 24 shifts on Bestwood Ward and 26 shifts on Newstead Ward that were not filled by bank or agency staff. This meant there were not enough staff to cover the shifts.

The staff turnover rate for Bestwood Ward at the time of inspection was 2.1% and 2.7% for Newstead Ward. The sickness rate for the 12 months prior to our inspection was 2.3%.

A qualified nurse was not always present in communal areas of the ward at all times. There were not always two nurses on shift due to vacancies, which meant that the nurse that was on shift was carrying out nurse in charge duties such as medicines and could not be present in the communal area. However, there were healthcare workers in communal areas.

Due to staffing levels, it was not always possible for patients to have regular one-to-one time with their named nurse. Some staff stated that they did not have time to do so with the other tasks that needed to be completed. The ward manager on Bestwood Ward was not confident that one to ones were being carried out and care plan audits demonstrated that one to ones were not routinely carried out on a regular basis.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. Informal patients were able to leave the ward at free will and detained patients were individually risk assessed for leave. Ward activities were carried out by the occupational therapy and wellbeing teams and so staffing did not affect the activities that patients could take part in.

There were enough staff to carry out physical interventions safely. There was an alarm system in place for staff to call upon staff from the current ward or other wards across site to help support during physical interventions. Newstead

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Ward had a de-escalation room that was equipped with bean bag type furniture that allowed patients to be restrained safely. Staff on the ward stated that they did not use physical interventions very often. Staff on Bestwood Ward used more physical interventions due to the challenging nature of the patient group but felt that they had support to do so.

There was medical cover day and night and a doctor could attend the ward in an emergency. However, the on-call system worked on a week on, week off basis. Newstead Ward relied on the on-call doctor to cover both the day and night for that week as there was currently no speciality doctor for the ward.

Staff had completed and were up to date with their mandatory training, including bank staff but not agency staff. The compliance for statutory and mandatory training across the hospital at September 2019 was 93%. Managers monitored staff compliance and sent alerts when trained needed to be updated.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients well or do all that was reasonably practicable to mitigate risk.

We looked at 12 care records of patients. All of these demonstrated that staff completed a risk assessment for each patient upon admission. Staff used a Priory Group risk assessment screening tool (RAST) and reviewed and updated risk assessments weekly at ward round and after every incident, apart from on one record. A safeguarding concern had been raised about a patient and the risk assessment had not been updated to reflect this.

Staff were aware and dealt with any specific risk issues such as pressure ulcers and falls. Falls assessments were carried out if required in collaboration with the occupational therapist.

Staff did not do all that was reasonably practicable to mitigate risks to patients. On Bestwood Ward, restricted items such as razors and aerosols were stored in lockers in a cupboard that was locked. Staff members should sign the item out on a locker sheet, inform the staff carrying out observations, update care notes and ensure the item is signed back in. The process was not being followed. On Newstead Ward, staff told us that such items were stored in drawers in the office and there were no cupboards or lockers for restricted items. There was not a log of these items and they were not signed out or back in by staff. On both wards there had been incidents where patients had obtained razors and processes had not been followed to ensure the items had been put back, resulting in deliberate self-harm occurring.

Staff did not always follow good policies and procedures for the use of observations. Staff on Newstead Ward were reminded in a staff meeting not to fill in patient observations in advance, and to personally hand over to the next member of staff taking over the observation and sign off. During the inspection a staff member was observed completing their observations in the nursing office before going on their break and did not personally hand over to the next staff member but left the observation books in the office. Additionally, a bank staff member left their observation record to attend to another patient during an incident the week before our inspection. The staff member was immediately suspended from duty and immediately following this incident, support and debrief was offered to the patients involved. The incident was reported on the incident reporting system, to the local authority safeguarding team and to CQC. The provider undertook an investigation which resulted in a disciplinary hearing at which the staff member was dismissed.

There were blanket restrictions in place on Bestwood Ward. Patients bags, and property was routinely searched when returning from leave, but not their clothing. This had led to patients having items which risked their safety and welfare. At the time of inspection, patients were unable to make themselves hot drinks and had to ask staff to make them a drink. There were no snacks available for patients, such as fruit, as this was kept in the main kitchen, which patients did not have access to due to damage to the pipes. Cutlery and crockery were counted in and out at mealtimes discreetly, and staff told us this was due to patients self-harming.

Staff did their best to adhere to best practice in implementing a smoke free policy. Patients were able to smoke in a designated area of the site. However, during the inspection, patients were observed smoking by the main reception area and close to the entrance of Bestwood Ward. There were cigarettes ends scattered around the entrance of Bestwood Ward. There were reminders to patients seen in community meeting minutes to smoke in designated areas and not by the wards or reception.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Informal patients on Newstead Ward could leave at will and told us they could leave the ward. There was a sign displayed on both sides of the ward entrance door. The sign on Bestwood Ward had been removed by a patient and had not been put back and the front door was locked at all times.

There were no seclusion facilities for either acute ward. Staff used restraint only after de-escalation had failed and used correct techniques. There were 117 episodes of restraint from 1st March 2019 to 31 August 2019 on Bestwood Ward and no episodes of restraint in the same time period for Newstead Ward. We have not previously requested this information, so it was not clear if this number showed an improving or worsening trend. Bestwood Ward had a different patient group with a number of patients with emotionally unstable personality disorder and a higher patient acuity. Staff reported the use of restraint through the incident reporting system. The provider trained staff in physical interventions, breakaway and restraint and ensured that all bank and agency staff were trained in these techniques. Staff understood and where appropriate worked with the Mental Capacity Act definition of restraint.

The wards participated in 'safe wards', utilising the techniques to reduce restrictive interventions, however this was in its infancy and not fully embedded across the hospital. The psychology and well-being team provided patients with an assessment within 48 hours of admission. Part of this assessment involved completing a 'my 5 a day', which is five things that can be done to increase well-being and patients kept this on a card.

The service used rapid tranquilisation and followed the National Institute for Health and Care Excellence (NICE) guidance when doing so. There was evidence that staff carried out physical health monitoring on patients following rapid tranquilisation, and where a patient refused, this was documented.

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 were trained in safeguarding adults and children and knew how to make a safeguarding alert and did so when appropriate. Staff knew how to identify adults and children at risk of or suffering significant harm and gave examples of indicators and the types of incidents that they would report to safeguarding, such as physical violence, financial exploitation and manipulation.

Patients were protected from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff provided an example of a transgender patient who was receiving abuse from another patient, so staff protected the patient and moved them from their bedroom to one further away, with consent and monitored them closely to ensure they felt safe and protected.

There were safe procedures for children visiting the service and staff followed them. There was a child visiting room located near the main reception area which was equipped with toys and games for children. This was risk assessed for each patient, but staff promoted child visits whilst patients were on leave.

Staff access to essential information

Staff had access to clinical information, but it was not always easy for them to maintain high quality clinical records, with multiple systems used for recording information.

The service used a combination of an electronic record system, the network shared drive and paper records. Whilst information was available for staff, this made it difficult to clearly identify where information was and to triangulate information. It also meant that information was not up to date across all three systems. A patient had an allergy alert which was recorded on their paper file but was not noted clearly on their electronic file. Managers informed the inspection team that three systems were used as the electronic record system was built for the forensic service and did not fit within the acute service. The paper file and shared drive were utilised to support this.

Medicines management

The service did not have robust systems to prescribe, administer, record or store medicines safely. Staff did not regularly review or record the effects of medicines on each patient's physical health.

Staff did not ensure that there were sufficient quantities of medicines available to ensure the safety of patients and to meet their needs. It had been highlighted by the pharmacist and doctors that there were issues with

medicines not available on the ward for staff to administer. In particular, a patient missed their prescribed medicine as it was not correctly ordered. We were not assured medicines requiring refrigeration were managed safety. For example, medicines delivered to the ward requiring refrigeration were left on rather than in the fridge, nor was the fridge or room temperature monitored. The lack of fridge and room temperature monitoring had been highlighted in previous pharmacy audits. To try and reduce this, the provider was planning to install a separate notice board in the office to detail patient medicines and stock control.

A suspected illegal substance was found on Bestwood Ward in the controlled drugs cupboard and should have been recorded in the controlled drugs book and the police notified, but this did not happen.

Staff did not consistently review the effects of medicines on patient's physical health regularly and in line with the National Institute for Health and Care Excellence guidance. When patients were prescribed a high dose of antipsychotic medicines side effect monitoring charts were not routinely used to review the effects of medicines. There were inconsistencies in the monitoring and recording of physical health observations within patient records. Where medicine care plans directed physical observations to be carried out at a certain frequency, they were not always carried out and there were omissions in recording.

Track record on safety

There had been no serious incidents reported by the service in the 12 months prior to the inspection, in the information submitted. However, during the weekend before the inspection, there were two serious incidents that took place on Bestwood Ward regarding a patient ligating on a number of occasions and a patient being asked to carry out the clinical observations of another patient.The provider reported these to the CQC as required. When things went wrong, staff apologised and gave patients honest information and suitable support.

There was also an adverse incident where an antibiotic was prescribed for a patient on a private prescription for emergency use but there was no one available to get it from the local pharmacy. This meant that the patient had to wait two days to start their treatment of antibiotics.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. The service had recently changed reporting systems and some staff said this was challenging and that there was little training provided. The new system did not work in line with the electronic patient record system to make an alert on the system, which therefore created a duplication of work for staff or meant that information was not available.

Staff reported all incidents they should report however, this was not always within 24 hours of the occurrence. This was demonstrated with a serious incident that took place on a Saturday, not being reported or a safeguarding referral made until Monday after a discussion with the consultant.

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

Staff received feedback from the investigation of incidents. Lessons learnt were distributed via a newsletter, email and through staff meetings. The provider carried out team incident reviews with all staff members involved in an incident to look at the outcome and any recommendations for future learning. These meetings could involve external bodies such as the local safeguarding team.

There was evidence that changes had been made as a result of feedback. Staff gave examples where practice had changed as a result of an incident. A patient had gone on leave when they should not have, so staff implemented an addition to the handover sheet to ensure changes in leave were documented and ensured that suspended leave was displayed on a board in the office for all staff to see.

Staff were debriefed and received support after a serious incident, through the team incident review process.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Care plans were not individualised, did not always reflect the assessed needs and were not always personalised, holistic, recovery orientated and were not written in

collaboration with patients. Staff did not always assess the physical health of all patients on admission. They developed care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.

Staff completed a comprehensive mental health assessment of the patient in a timely manner at admission. Staff developed a care plan within 48 hours of admission. However, not all sections of the care plan, particularly the keeping safe element were completed on assessment. This was highlighted through the care plan audit, for staff to ensure all sections are completed on admission.

Staff did not always assess patient's physical health needs such as bloods, electrocardiogram and general physical health observations on admission. It was not clear that all patients received an electrocardiogram or had blood taken on admission from the 12 care records looked at, with some patients receiving electrocardiograms and others not. The service also provided pregnancy tests for females and alcohol and drugs tests were available on admission.

Care plans were not personalised or holistic with clear goals for the individual patient. Care plans appeared to be copied and pasted from care plan to care plan. One patient told us that their care plan stated that they had schizophrenia when they did not. Care plans were not always updated following a change in the level of observation and there were care plans that did not match the risk assessment or observations prescribed. The provider carried out regular care plan audits and this was highlighted as a continuing theme. There was no evidence in nine of the 12 care records looked at that patients were given a copy of their care plan.

Nurses had most of the input into the four domains of the care plans; keeping safe, keeping healthy, keeping connected and keeping well. Other members of the multidisciplinary team had little input into these.

Best practice in treatment and care

Staff did not ensure that patients had good access to physical healthcare. There was not good access to physical healthcare over the weekend. There were gaps in patient's individual physical observations and staff were not completing or effectively using National Early Warning Signs 2 (NEWS 2) as a monitoring tool. Patients had access to a specialist if they required one.

Staff provided a range of care and treatment interventions suitable for the patient group that were consistent with national guidance on best practice and supported patients to live healthier lives.

The interventions were those recommended by and were delivered in line with, guidance from the National Institute for Health and Care Excellence. The provider used an approach to reinforce positive behaviours and was in the process of rolling out across the core service one-page positive behavioural support plans for patients. There were dialectical behaviour therapists available to support patients through groups and on an individual basis and a wellbeing team in place.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration.

Staff supported patients to live healthier lives. Newstead Ward had a gym that was locked, and a fitness instructor visited the ward and provided gym sessions for patients who had been individually risk assessed to use the gym. There was also a men's group in place to promote men's health and common issues to look for.

Staff used recognised rating scales to assess and record severity and outcomes, they also participated in clinical audit and benchmarking but not quality improvement initiatives.

The Health of the Nation Outcome Scale (HONOS) was completed on admission to assess and record severity and outcomes. However, it was not clear in patients notes where individual Health of the Nation Outcome Scales scores were located. One ward manager stated that the Health of the Nation Outcome Scale was not used.

Staff used technology to support patients effectively. During the inspection, a consultant transmitted the electrocardiogram reading of a patient over the telephone to the cardiology department to speed up the process of getting results.

Staff participated in clinical audit such as the Mental Health Act and ligatures but were not carrying out quality improvement initiatives.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of

skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The team included a full range of specialised required to meet the needs of patients on the ward such as occupational therapists, psychologists, dialectical behaviour therapists, speciality doctors and a wellbeing team.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Healthcare workers were supported to complete their Care Certificate if they have not already done so.

Managers provided new staff with a two-week induction, including locum nurses, followed by a ward orientation day. The staff member then acted as an extra member of staff and was not included in the required nursing numbers for three to four shifts and was allocated a buddy to work alongside.

Managers had ensured that staff were provided with supervision. The provider policy stated that supervision should take place every four weeks. The percentage of nursing staff that had received supervision from 1st August until 1st October on Bestwood Ward was 88%. The percentage of nursing staff that received supervision on Newstead Ward in the same period was 94%.

During the inspection, three supervision records were looked at. The content of the supervision was very minimal and did not include information that was individual to the staff member, such as individual staff development or personal issues. Two supervision records mentioned being late due to traffic and another one highlighted anxiety regarding the service restructure. There was no detail of reassurance or support for this staff member around their anxiety. Ward managers reported that there was a negative culture surrounding supervision and it was seen as a negative process, rather than a positive, supportive experience to improve working life.

The percentage of staff that had had an appraisal in the last 12 months on Newstead Ward was 100% and on Bestwood Ward was 90%. Psychology, social work and occupational therapy teams had all received an appraisal in the last 12 months.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge, such as providing specialist training for personality disorder and learning disabilities. However, training had not been provided for staff on sepsis.

Managers dealt with poor staff performance promptly and effectively. Managers detailed examples of dealing with poor performance and being supported by the human resources team to go through the process.

Multidisciplinary and inter-agency team work

The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. However, not all disciplines attended the multidisciplinary meetings or ward rounds.

Staff shared information about individual patients at effective handover meetings within the team. A morning meeting handover was observed during the inspection where each patient was discussed, involving members of the multidisciplinary team. Ward managers then cascaded any information to their individual wards.

The ward teams had effective working relationships, including good handovers, with other relevant teams within the organisation and external organisations. The service had good working relationships with the local authority, local mental health trust and other mental health services such as the crisis team, home treatment, psychiatric intensive care units and patient care coordinators.

Multidisciplinary meetings were held on a weekly basis for both wards. During our inspection, we observed one of these meetings and there was little input from the psychology and occupational therapy teams. The psychology team attended ward rounds for patients they were working with. However, the team had to create a balance between delivering interventions to patients with attending ward rounds. They gave priority to seeing patients and delivering sessions over two days of the week and held regular discussions with the responsible clinician who provided feedback to ward rounds.

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

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

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.

At the time of inspection, the provider had trained 83% of staff on Bestwood and Newstead Wards in the Mental Health Act. Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. There was information on different sections under the Mental Health Act in the staff room on Newstead Ward. This had been placed there to support staff, particularly those that had moved from the secure services and may not have a vast knowledge of different sections relating to acute services.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health administrators were, however, they had recently left the service and were in the process of waiting for a new administrator to start.

The provider had relevant policies and procedures that reflected the most recent guidance.

Staff had easy access to local Mental Health Act policies and procedures and to the code of practice via the intranet.

Patients had access to information about independent mental health advocacy. Advocacy services attended the wards on a weekly basis. Information about advocacy had been previously displayed on boards on the wards but this had been destroyed on a number of occasions and not replaced.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. Bestwood Ward had developed easy read rights to support patients who had communication difficulties.

Staff ensured that patients were able to take section 17 leave (permission for patients to leave hospital) when this had been granted by the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor when necessary.

Staff stored copies of patient's detention papers and associated records correctly so that they were available to all staff that needed access to them. Original copies were kept in the mental health administrative team office and copies for each patient were kept in the nursing office.

The service displayed a notice to tell informal patients that they could leave the ward freely. This was displayed on both sides of the door on Newstead Ward. There was a sign displayed on Bestwood Ward but at the time of inspection, this was not visible as it had been removed by patients.

Care plans included information about section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment. Ward managers told us that a referral was made to the community mental health team for patients on admission.

Managers and staff carried out regular audits to ensure that the Mental Health Act was being applied correctly and discussed findings and any actions.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005. However, patient's capacity to consent to treatment was not clearly recorded on Newstead Ward.

Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles. At the time of inspection, the provider had trained 89% of staff on Bestwood and Newstead Wards in the Mental Capacity Act.

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies. There was one deprivation of liberty safeguards applications made on Newstead Ward in the last 12 months to protect people without capacity to make decisions about their own care.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it via the staff intranet.

Staff could get advice from the mental health administrative team regarding the Mental Capacity Act, including the deprivation of liberty safeguards.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Staff took all practical steps to enable patients to make their own decisions. However, there were gaps in patient's consent to treatment in nine of the 15 prescription charts on Newstead ward. Therefore, it was not clear to see that staff had assessed and recorded capacity to consent.

When patients lacked capacity, staff made decisions in their best interest, recognising the importance of the persons wishes, feelings, culture and history.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Most staff treated patients with compassion and kindness and respected patients' privacy and dignity. Staff did not always work collaboratively with patients to understand their individual needs and support them to understand and manage their care, treatment or condition.

Staff attitudes and behaviours when interacting with patients showed that they were discreet and respectful but were not always responsive when providing patients with help, emotional support and advice at the time they needed it. During the inspection we observed a number of staff asking patients to wait and telling them that they would be able to help them in two minutes. Some patients also told us that staff were very busy and were not able to assist them at times.

Staff did not always support patients to understand their individual needs and manage their care, treatment or condition. Staff did not work collaboratively with patients to develop their care plans and identify their needs or goals and patients were not receiving regular one to ones. On Bestwood Ward, female patients had to ask for and be individually risk assessed for a sanitary bin to remain in their bedroom. One patient told us that they waited two days before receiving a sanitary bin. The registered manager told us that all female patients were provided with sanitary bins and these were only removed if the multidisciplinary team clinical risk assessment indicated this was necessary. However, patients told us they did not have sanitary bins.

The inspection team saw evidence of discussions with patients around their medicines and it was recorded that patients were offered a copy of their medicines leaflet. Patients had access to religious items on the ward and could request any items that they needed. There was food to cater for patients dietary and religious needs.

Patients said that staff treated them well and behaved appropriately to them. Some patients said that staff were caring but they did not always have enough time to speak with them. Other patients said some staff are caring and others aren't.

Staff said they could raise concerns about disrespectful discriminatory or abusive behaviour or attitudes towards patients through supervision or discussions with their ward manager, without fear of the consequences.

Staff maintained the confidentiality of information about patients. There were privacy screens on the computers to ensure that patients were unable to see the information through the nursing office. Patient information was also stored away from sight to ensure confidentiality.

Involvement in care

Staff did not always involve patients in care planning and risk assessment or actively seek their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Staff used the admission process to inform and orient patients to the ward and to the service. Newstead ward provided patients with a welcome pack containing relevant details. There was only one copy of this, and it contained a lot of detail and did not have any pictures to aid reading for those who were acutely unwell. Patients on Bestwood Ward stated that staff did not wear badges and so were unable to tell apart staff from patients, upon admission.

Staff did not always involve patients in care planning and risk assessment. Care plans were not personalised and did not always contain the patient's point of view. Some staff stated that due to staffing pressures, they were not always able to complete care plans and risk assessments collaboratively with patients.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Staff communicated with patients so that they understood their care and treatment. Bestwood Ward had developed easy read care plans and easy read rights to support patients with communication difficulties.

Staff involved patients when appropriate in decisions about the service through community meetings. Patients had also had the opportunity to put forward questions for interviews for psychologists.

Staff enabled patients to give feedback on the service they received. There were regular community meetings that patients could attend. Minutes from this meeting demonstrated that patients felt that they could raise issues. There were also complaints and compliments boxes located on Newstead Ward, and a complaints book on Bestwood Ward for patients to raise any concerns.

Staff ensured that patients had access to advocacy. The service used an external advocacy service and an advocate visited the ward on a weekly basis to support patients. However, some patients told us that they did not know who the advocate was, and information had been removed from boards on the ward providing the advocates details.

Staff did not always inform and involve families and carers appropriately. Staff did not always inform or involve families and carers or provide them with support when needed. One family were visiting for a period time and had not received any information about their loved one's condition, medicines or support mechanisms to support their loved one. Another family told us that there was a case of bullying and belongings stolen and staff reacted quickly to resolve the issues. Newstead ward had developed a carers information pack which gave details of how to access a carer's assessment and other useful information. However, there was only one copy of this and there was not a carers information pack available on Bestwood Ward.

There was a feedback box located at the main reception area of Calverton Hill for visitors including family and friends to provide feedback, however there was no process in place for families and carers of the acute wards to give feedback on the service they received. Most family and carers that we spoke felt they were able to talk to staff on the ward and could raise concerns.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons. However, discharge plans were not consistently used within the service.

Beds were available when needed for patients living in the 'catchment area'. Beds on both acute wards are contracted to the local mental health trust and so beds were for local residents only.

There was always a bed available when patients returned from leave.

When patients were moved or discharged, this happened at an appropriate time of day, between the hours of 9am to 5pm.

A bed was always available in a psychiatric intensive care unit (PICU) if a patient required more intensive care and this was sufficiently close for the person to maintain contact with family and friends. Highbury hospital were responsible for gatekeeping all psychiatric intensive care unit beds to ensure a smooth transition process.

In the reporting period of 1st March 2019 to 31st August 2019, there were nine delayed discharges, three on Bestwood Ward and six on Newstead Ward. Managers informed the inspection team that the delayed discharges were due to a delay in patients' social care needs being met.

Discharge plans were not in place for a number of patients and were not started on the date of admission. A patient was due to be discharged from the service the day after the inspection and there was not a discharge plan in place for the individual. The individual was homeless and would be taken to the local council upon discharge.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Staff supported patients during referrals and transfers between services. There was a visiting programme for step down services for patients so that they could visit to reduce anxiety.

The facilities promote recovery, comfort, dignity and confidentiality

The design and layout 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 a good quality, but patients could make hot drinks and snacks at any time on Bestwood Ward.

Patients had their own bedrooms with en-suite facilities. Patients were able to bring items from home to personalise their bedrooms. There were large amounts of storage in patient bedrooms with lockable facilities for patients to store their items, which was individually risk assessed for the patient to hold the key. Bestwood Ward had a storage cupboard where patient belongings could be stored. However, this was messy and disorganised.

Staff and patients had access to a range of rooms and equipment to support treatment and care. There were quiet rooms which had books, games and a television. Newstead Ward had a gym and Bestwood Ward had a room with various arts and crafts. Both of which were individually risk assessed. The occupational therapy department told us that there was a lack of dedicated therapy space for the acute service and the quiet room is often used for therapy, which was not always appropriate.

There were quiet areas on the wards and a room where patients could meet visitors. Both wards had a number of smaller quiet rooms and lounges that patients could use.

Patients could make a phone call in private. Newstead Ward had a room with a telephone which patients did not have to pay for. The room was locked at all times and patients had to ask to access the telephone as there had been some abuse of the free telephone line. Patients were individually risk assessed for mobile phones on both wards.

Patients had free access to outside space on both wards. Newstead Ward had a large grass area with a football goal.

Bestwood Ward has a courtyard area which was much smaller and not well maintained, with lots of overgrown plants and trees, and did not provide a therapeutic or relaxing space for patients.

There were dialectical behavioural therapy groups that ran three times a week for women and a psychology skills group for men with additional one to one sessions available. A living with visual experiences 'group' and a substance misuse group were also available dependant on need.

The provider employed recovery workers who worked on the wards from 7.30am to 7pm Monday to Friday and one worker worked eight hours on Saturday across the hospital. The recovery workers were part of the wellbeing team. The wellbeing programme was re- launched at the time of our inspection. This included sports and fitness sessions and staff gave patients a timetable of what activities were available each week. The wellbeing manager held a training day with senior healthcare workers the week before our inspection where they talked about activities and engagement as all need to be involved. Activities such as Thai chi, were ran on the wards by the wellbeing team. However patients told us, and records showed there were minimal activities to do on the wards at the weekend.

The provider offered a variety of food of good quality. Some patients felt that there wasn't much choice of meals at certain times of the day with jacket potatoes or salads offered as an evening meal. Patients could make hot drinks and snacks 24/7 on Newstead Ward. On Bestwood Ward, some of the drinks making equipment was broken and patients had to ask for a hot drink to be made. There was also an issue with some pipes in the kitchen area after a patient incident, so this room was now locked for patient's safety. This meant patients were unable to make snacks, and no snacks such as fruit were provided in communal areas.

Patients' engagement with the wider community

Due to the service providing care for patients with acute mental illness for a short period of time, there was little access to work and education opportunities as staff encouraged this to be utilised on leave. There was a patient who used their leave to support the community occupational therapist in areas of their role.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Staff supported patients to maintain contact with their families and carers. Families and carers were invited to attend all meetings that took place at Calverton Hill.

Staff encouraged patients to develop and maintain relations with people that mattered to them, both within the services and the wider community. Patients were supported to access local services whilst on leave.

Meeting the needs of all people who use the service

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

The service made adjustments for disabled patients. Both acute wards were located on the ground floor with wide corridors and bedroom doors.

It was not clear that patients could obtain information on treatments, local services, patient rights, how to complain etc. There were lots of information boards and spaces for leaflets on both wards, but staff stated that patients kept removing this information, so it was replaced. Ward managers said that information was available in the office if patients wished to obtain it.

The information provided was in a form accessible to the patient group. Bestwood Ward had produced easy read care plans and easy read rights to support patients with communication needs. Whilst staff had not received training in Makaton (sign language used by people with learning disabilities), there was information displaying Makaton signs around the nursing office to aid staff to communicate with a patient who sometimes used Makaton to communicate, particularly when distressed.

Information was made available in languages spoken by patients on an individual need's basis. Staff gave examples of different languages that information had been made available in such as Romanian and Hindi.

Managers ensured that staff and patients had easy access to interpreters and signers on an individual need's basis. Staff on Bestwood Ward gave an example of providing a Nepalese translator for a patient.

Patients had a choice of food to meet dietary requirements of religious and ethnic groups. Staff informed us that the kitchen keep halal food on site at all times, as there were often admissions through the night.

Staff ensured that patients had access to appropriate spiritual support. There were religious items in the nursing office for patients and a multi-faith room was available on site for patients with leave to access. There were good relationships with local faith leaders who could provide spiritual support to patients.

Listening to and learning from concerns and complaints

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

There were eight complaints on Bestwood Ward and one complaint on Newstead Ward in the 12 months prior to inspection. Of those nine complaints, two were upheld and three were partially upheld.

Patients knew how to complain or raise concerns. There were regular patient community meetings where patients could raise their concerns. The state of the furniture had been raised through the community meeting on Bestwood Ward, and the ward had ordered new furniture. There were complaints boxes that patients could place any complaints into.

When patients complained or raised concerns, they received feedback. Newstead Ward kept a complaints folder which had details of each complaint received. There was evidence of acknowledgement letters to patients to inform them that their complaint had been received. Each complaint also had a front sheet which was updated according to the progress of the investigation, giving a clear and quick oversight of each complaints progress.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Most patients said that they felt safe on the ward and able to raise concerns.

Staff received feedback on the outcome of investigation or complaints and acted on the findings.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement

Leadership

The registered manager had been in post since January 2019 and had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. All staff spoke positively about the registered manager and said they were visible in the service. Staff said the registered manager listened to them, responded quickly and got things done.

In the last few months before our inspection the director of clinical services and the director of secure services had left the hospital. The service had appointed a director of nursing who was to start working at the hospital at the end of October 2019. In the interim there was an acting director of nursing from another Priory hospital.

Ward managers met weekly and the registered manager attended these meetings. Ward managers said these meetings were useful and they were involved in discussions about the service development.

Staff spoke positively of their ward managers. However, we found that ward managers did not have the skills, knowledge or experience to perform their roles and did not have a good understanding of the service they managed but were visible and approachable for patients and staff.

Leaders were visible in the service and approachable for patients and staff. Both ward managers had offices that were on the ward. The ward manager on Bestwood Ward had their office located in a bedroom corridor and both promoted an open-door policy.

Leadership development opportunities were available with charge nurses recently completing a leadership and management course. Ward managers had also been supported to complete a moving into management leadership and development level 5 course. The provider was also arranging for nurses to complete their non-medical prescriber training and hoped to include this in nurse training in the future to support nurses who were completing their preceptorship.

A healthcare worker had also been supported to complete a National Vocational Qualification level three in health and social care.

Staff told us they did not know who the managers above the registered manager were and they had not seen them visit the wards.

Vision and strategy

Staff did not have opportunity to feed into the service strategy. However, staff knew and understood the providers visions and values and how they were applied in the work of their team.

Staff did not feel as though they had the opportunity to contribute to discussions about the strategy of the service, especially where it was changing. The service had transformed from providing medium secure wards, to acute wards. Staff were not consulted about the change to the service design or able to feed into or shape the future of the service. Staff felt that information was given when discussions had been had and the plans already made and felt excluded from those discussions.

The provider's senior leadership team had successfully communicated the providers vision and values to the frontline staff in the service. The visions and values of Priory were printed on staff lanyards.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression and they felt able to raise concerns without fear of retribution. However, there was a negative culture surrounding supervision and its function.

During the inspection, staff said that they felt respected, supported and valued. Most staff felt positive and proud about working for the provider and their team. However, some members of staff raised concerns about the future of the hospital and their anxieties about the upcoming changes to the hospital service.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Staff knew how to use the whistleblowing process and felt able to raise concerns without fear of retribution. There was a dedicated whistleblowing telephone line for staff.

Managers dealt with poor staff performance when needed. A ward manager gave details of going through the disciplinary process due to a staff members high level of sickness, utilising human resources as support through the process. Human resources staff had also provided support to send letters of concern to employees.

Teams worked well together and where there were difficulties, mangers dealt with them appropriately. The team on Newstead Ward had only been in place since the opening of the ward in May 2019, and new staff members were moving across from the secure service. The manager was working on creating team cohesion through staff meetings.

Staff appraisals included conversations about career development and how it could be supported. Appraisals included information pathways on training for promotion which was clear and specific. This ensured that there were discussions around how staff could develop in their role in preparation for the next role in their career pathway. Managers reported that there was a negative culture surrounding supervision. Staff saw it as a negative process and a not an opportunity to provide support and improve their working life.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. A ward manager gave an example of supporting an agency member of staff who became mentally unwell and supporting them through returning to work.

The services staff sickness and absences were similar to the provider target.

Staff had access to support for this own physical and emotional health needs through an occupational health service. Staff reported feeling supported by the provider through personal issues such as injury, redundancy and allegations. There was a telephone counselling service in place to support staff and the service offered face to face support if required.

The provider recognised staff success within the service. There are awards where staff are nominated in line with priory values and staff that don't win, still receive a certificate as an acknowledgement of being nominated.

Governance

Our findings from other key questions demonstrated that governance processes did not operate effectively at ward level and performance and risk was not managed well.

There was a clear framework of what must be discussed at a ward, team and directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Meetings had a clear agenda and information was shared through newsletters and emails. However, governance systems were not operating effectively to enable managers to have clear oversight on the wards. Staff were recording patient information in three different places, which was burdensome for staff and meant information was not recorded properly. There were errors with staff ordering and recording medicines which resulted in patients waiting for medicines. Cleaning records were not robust and ward areas appeared dirty. Staff were not receiving adequate supervision on a regular basis. Restricted items were not stored or managed well, resulting in patients engaging in deliberate self-harm. Audits were not sufficient to provide assurance and staff did not always act on the results and actions when needed. There was evidence that actions were not always followed through, with the same issues highlighted on a number of occasions, such as the room and fridge temperatures of clinic rooms, omissions in signatures when administering medicines and issues with ordering stock.

Bestwood Ward had implemented a desktop display unit to present the meetings of minutes such as clinical governance, staff and patient and important information and updates. This enabled quick access to information. There were also plans to display patients 'my 5 a day plans' in the same way when they had been completed for each patient.

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

Management of risk, issues and performance

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Ward managers submitted risks to the risk register and these were discussed through clinical governance meetings. Staff were able to escalate concerns to the ward manager to take to clinical governance meetings. Staff concerns, matched those on the risk register, such as the removal of secure services and staffing.

The service had contingency plans in place for adverse weather, fire etc., which were held at the hospitals main reception and managed and supported by the site coordinator.

Where cost improvements were taking place, they did not compromise patient care.

Information management

Ward teams did not always have access to the information they needed to provide safe and effective care.

The service used systems to collect data from wards and directorates, however this was over burdensome for frontline staff as there were three systems in place for recording patient records and information.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped improve the quality of care.

Information governance systems included confidentiality of patient records.

Managers had access to information to support them with their management role. This included information on the performance of the service and patient care, but not staffing. Staff were not receiving supervision adequate supervision on a regular basis, so managers did not have access to staff needs. Ward managers met with other managers within the local mental health trust on a monthly basis to provide updates and share best practice across the services.

Staff information was in an accessible format, and was timely, accurate and identified areas for improvement. Information was communicated to staff through staff meetings, handover and via email. Patient information was not in an accessible format, was not timely and was not always accurate, due to information being recorded across three systems.

The provider made notifications to external bodies such as the local authority, safeguarding and the Care Quality Commission.

Engagement

Staff, patients and carers had access to up to date information about the work of the provider and the services they used. There were Priory wide newsletters that were sent out on a regular basis. Information from clinical governance meetings was fed down into staff meetings and community meetings to inform staff and patients of any changes.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients could provide feedback via community meetings. There was a box located in the main reception area of Calverton Hill where carers could provide their feedback on the service.

Managers and staff had access to feedback from patients, carers and staff and used it to make improvements. Staff members chaired community meetings and fed the information back to ward managers. On Bestwood Ward, patients had complained about the furniture on the ward being worn and torn, which was fed back to management who had ordered new furniture for the ward.

Patients and carers were not routinely involved in decision-making about changes to the service.

Patients and staff could meet with members of the providers senior leadership team to give feedback. There were regular 'You Say' forums for staff to make suggestions and provide feedback on the service. The registered manager held regular drop in sessions for nurses and healthcare workers to raise any concerns that they have and to have face to face contact with staff. The drop-in session was held at breakfast time to capture both the night and day staff. Staff fed back that they felt it was very useful, supportive and that the registered manager was very approachable and friendly.

Directorate leaders engaged with external stakeholders, such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

Staff did not engage actively in local and national quality improvement activities.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Staff were not provided with the time and support to consider opportunities for improvements and innovation and this led to changes.

Staff had opportunities to undertake research based activity and the dialectal behaviour therapist was completing research papers on reinforcing positive behaviours and dialectal behaviour therapy. They had presented this at conferences. The psychology team were also taking forward the positive behaviour support five a day and writing up the development and outcomes associated with the 'Making Sense' group, based on the Power Threat Meaning Framework (BPS; 2018).

Innovations were taking place in the service. For example, the psychology team were finalists for the award for 'excellence in risk assessment and management' by the Association of Psychological Therapies (APT). The team won the award for excellence in Dialectical Behaviour Therapy management by the Association of Psychological Therapies in 2018 and 2019.

Staff were not using quality improvement methods at the time of inspection.

Staff did not participate in national audits relevant to acute service and learned from them.

The acute wards were not participating in any accreditation schemes relevant to the service.

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

Clumber Ward was safe and clean. However, there were some areas of the ward that were not well maintained. For example, some patients had ripped up parts of the flooring around the ward and this had not been replaced. The ward manager told us they had reported this to the maintenance team. We observed the temperature in Clumber Ward was cold and one patient got a blanket from their bedroom to help keep them warm. Managers told us that repairs had been carried out to the boiler and heating system and acted immediately to rectify this. Patients told us they felt safe on the ward.

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff told us the quality manager completed walk rounds every month which identified any environmental risks and the provider acted to reduce these. The ward security representative completed the ligature audit and ligature risks were reduced.

Staff could observe patients in all parts of the ward. Mirrors were fitted where there had been blind spots to reduce these.

Clumber Ward only admitted female patients so complied with guidance for same sex accommodation.

Staff knew about any potential ligature anchor points on Clumber Ward and reduced the risks to keep patients safe.

Staff had access to alarms. Staff told us that when they pulled their alarm, they usually got a response from other staff around the hospital. However, they said that sometimes alarms had sounded when not needed so they used the radio to alert staff in an emergency to make sure all staff responded. There were enough alarms available and all members of the inspection team were offered alarms during the inspection.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including hand washing. Staff spoken with were aware of which mops to use when cleaning and we saw a poster to remind staff of this.

There were two seclusion rooms which allowed clear observation and two-way communication. We looked in the seclusion room that was not in use and saw there was a toilet and shower and a clock that could be seen from inside the room. There were several marks of nail varnish on the floor. Staff told us that a patient had secreted the nail varnish in their bra and maintenance staff had tried to clean the floor, but this had not removed it. Staff told us that maintenance staff had removed the blind spot mirror as there was a water leak in the room. We saw that staff outside the seclusion room would still be able to view the patient in all areas of the room and there were no blind spots. There was a room near to the seclusion area which was used to help patients calm down to avoid seclusion being used. There were ‘safety pods’ in the room. These are specially designed bean bags that provide a more therapeutic way of carrying out restraint which help the person to feel more secure and stop them hurting themselves. There was also, a sofa in the room and a large picture on the wall.

Requires improvement

Wards for people with learning disabilities or autism

At the time of our inspection there were two patients on long term segregation. We saw that both patients had access to a toilet, shower and outside space.

The clinic room on Clumber Ward was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic room was clean, tidy and well organised. Records showed that staff checked, maintained, and cleaned equipment.

Safe staffing

There were eight patients on Clumber Ward at the time of our inspection. The ward had enough nursing and medical staff, who knew the patients. The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The medical staff on the ward worked there permanently. Doctors contributed to the out of hours rota cover which provided cover to four hospitals in the locality and meant a doctor could attend within 10 to 15 minutes. Managers could call locums when they needed additional medical cover. Patients attended local hospitals accident and emergency departments for medical emergencies. The medical staff told us they were up to date with their intermediate life support training.

The ward had enough nursing and support staff to keep patients safe. The ward manager said the staffing establishment was two registered nurses and 11 health care workers as one patient needed four members of staff to support them and another patient needed two members of staff. Ward managers completed staff rotas and gave to administrative staff responsible for allocations who filled any vacancies with permanent staff working overtime, bank and then agency.

Clumber Ward had three registered nurse vacancies and six healthcare worker vacancies at the time of our inspection. This was reducing as patients were being discharged from the ward.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The ward had reducing rates of bank and agency nurses due to the closure of Rufford Ward, some staff had transferred to Clumber Ward. The provider mostly used bank staff or permanent staff worked overtime. Agency staff used were mainly registered nurses who were employed for long term cover and so knew the patients. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Agency and bank staff had an induction before working on the wards.

The ward had reducing staff turnover rates. In September 2019, the turnover of registered nurses was 2.8% and healthcare workers was 5.2%. Levels of staff sickness were low and reducing. In August 2019 the sickness rate on Clumber Ward was 1%. Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare workers according to the needs of the patients and requested extra staff when needed. Staff said the registered manager always supported the need for extra staff. Staff said there was always a registered nurse available in the ward area for advice and support.

Patients had regular one to one session with their named nurse. However, one patient said this was less at weekends. Patients rarely had their escorted leave, or activities cancelled. Staff told us there was some patients leave cancelled a few months ago due to staffing but this had now improved due to Rufford Ward closing. Activity workers were extra to the nursing staff on the ward which reduced the cancellation of activities.

The service had enough staff on each shift to carry out any physical interventions safely. However, one staff member told us there had been times when they had pulled their alarm and there were not enough staff to respond. Another staff member said that staffing levels varied as staff cancelled or there was short notice sickness. They said patients often pushed boundaries when short staffed which led to an escalation in behaviours which could challenge. On the first day of our inspection there were less staff on the ward after 3pm and patients noticed this also. We observed that the noise level on the ward increased and some patients became unsettled. Managers told us this was due to staff taking breaks and psychology and occupational therapy staff were not on the ward at that time.

Staff shared key information to keep patients safe when handing over their care to others.

Staff had not completed and kept up-to-date with all of their mandatory training. At the time of inspection 94% of staff had completed basic life support with defibrillator

(includes choking) training, 81%of staff had completed training in restraint and 79% introduction to health and safety. However, training was below the expected level of 75% for fire safety 66%, 64% in infection control, 68% in the Mental Health Act and 67% in the Mental Capacity Act. The provider did not train staff in the management of patients with sepsis.

Assessing and managing risk to patients and staff

Patients told us they felt safe on the ward. Staff assessed and managed risks to patients. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We looked at five patients records which contained a HCR20 (historical clinical risk management assessment of violence risk). These were comprehensive, reviewed and updated in the patient's multidisciplinary team meetings and after incidents. Records also included a short-term assessment of risk and treatability (START) assessment which staff said was updated at least every three months and following any incidents.

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff followed the providers **o**bservation and engagement policy. The provider trained staff on the policy. Each patient's observation levels were reviewed daily and at each patient's multidisciplinary team meeting. Staff handed over each patient risks between shifts and recorded this on the handover sheet. Staff followed procedures to minimise risks where they could not easily observe patients. We observed that staff knew where each patient was and moved when needed to maintain observation, for example, when patients went to their bedrooms, staff followed discreetly.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The provider told us there had been a reduction of 54% in the use of seclusion in Clumber and Rufford Wards. Patient meeting minutes we looked at showed patients discussed reducing restrictive restrictions and blanket restrictions, for example, individuals making their own drinks.

There was an incident reported to us in August 2019 where staff used handcuffs to move a patient to the seclusion room. The training for the staff member who applied the handcuffs was out of date. When managers were informed of this incident, they referred it to the local authority safeguarding team immediately. A section 42 enquiry was being investigated at the time of our inspection. Managers suspended staff immediately. The registered manager recognised that the incident had not been well managed.

Staff made every attempt to avoid using restraint by using de-escalation techniques. Staff restrained patients only when these failed and when necessary to keep the patient or others safe. Staff said the training they received in restraint included de-escalation and they tried to use the least restrictive option when managing patients. The provider used an approach to reinforce positive behaviours. The psychologist developed patient's positive behaviour support plans with the patient and staff. This considered the triggers for the patients' behaviour and coping strategies. They developed wellbeing cards for patients to help them remember what worked well for them to manage their own behaviours. One patient said they used the calming suite when needed and not the seclusion room.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Medicine records we looked at showed that staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. All staff we spoke with told us that seclusion was used as a last resort.

Staff followed best practice, including guidance in the Mental Capacity Act code of practice, if a patient was put in long-term segregation. Records clearly showed the reasons and risks for the two patients who needed to be in long term segregation to reduce the risk of harm to the patient, other patients and staff. One patient was in the seclusion room, but the amount of time was reduced each day with the seclusion room door open for four to six hours daily and the patient had access to outside space. One patient's records showed that staff had discussed the long-term segregation of the patient with their commissioner who stated that it was not in the patient's best interests to return to the ward. They were looking at alternative placements for the patient. Records showed that nursing and doctors reviews were completed as needed.

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

of patients' bedrooms if they had concerns. They searched patients on return to the ward if they had gone out on leave outside the secure perimeter. There was also a randomiser button at the entrance to the secure wards which selected random patients and visitors to search. One staff member was unclear of the search policy.

The provider told us that during August 2019 there were 32 incidents involving two patients where rapid tranquilisation was given by staff. The provider told us there had been a rise in patients self-harming behaviours which they thought contributed to a rise in the use of rapid tranquilisation. On 11 of these occasions staff had not recorded they had taken physical observations, which could impact on patient's safety. Managers noticed this when reviewing these incidents and sent an email to the nurses to rectify this on each occasion.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had monthly meetings with the local authority safeguarding teams. Managers completed safeguarding investigations with staff from the local authority safeguarding teams when needed.

The provider trained staff on how to recognise and report abuse, and they knew how to apply it. There was a change to the safeguarding training as the provider employed a social worker who was the safeguarding lead. However, when Clumber Ward closes there will not be a social worker employed at the hospital, as they were not commissioned to cover the acute mental health wards. The provider had trained ward managers as safeguarding leads and reissued the safeguarding procedures to all staff to prepare for this. At the time of our inspection, 87% of staff on Clumber Ward had completed training in safeguarding children and 84% had completed safeguarding adults training.

Staff followed clear procedures to keep children visiting the hospital safe. Children could not visit the ward but there was a children's visiting room in the visitor's suite away from the ward. We saw that this was safe for children to use, was colourful and included toys and books for children to use during the visit.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff made safeguarding referrals when patients were cared for in long term seclusion. There were two patients on Clumber Ward in long term segregation at the time of our inspection. Staff had reported this to us and the local authority safeguarding team.

Staff access to essential information

Staff had access to clinical information, but it was not easy for them to access all the records they needed about each patient. The provider used two electronic record systems from the previous provider and their own system. This meant that Priory electronic records were not pre-loaded and had to be uploaded to the system and saved on the share drive. The system was slow, and it took a long time to load each page. Staff printed off paper care plans for patients who presented with higher risks. There could only be one system on the server at a time and the hospital was awaiting a changeover to one electronic records system to reduce this risk. The registered manager had escalated the risk of this to the providers information technology department. Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health. They knew about and worked towards achieving the aims of STOMP (Stop Over-Medicating People with a learning disability).

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The visiting pharmacist checked stock weekly. The ward manager also audited medicine systems monthly. The hospital medical advisory committee met monthly to scrutinise and manage the actions arising.

Staff recorded any allergies the patient had on their medicine record. Staff had not recorded the date of birth for one patient on their medicine record.

We saw that the clinic room was clean and tidy. There was an examination couch in the clinic room. There was also a separate physical health room which staff said was used more often than the clinic room.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Patients medicines were in date and staff disposed of these when needed. Registered nurses checked and recorded the stock stored in the controlled drug cabinet. Staff checked the

temperatures of the medicines fridge daily to make sure medicines were stored safely. However, the pharmacist recorded three days in September 2019 where staff had failed to do this. Staff checked the medicines in the emergency bag weekly and recorded this.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Records showed that the multidisciplinary team reviewed each patient use of as required medicines during the patient's meeting. The pharmacist also audited this during their visits.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Staff recorded these on the pharmacist's side effects chart to monitor the effects of the medicines on the patient's health and wellbeing. The provider had trained staff in the use of clozipine and how this could affect patient's physical health, so staff knew how to monitor patients who were prescribed this medicine. However, there was an incident reported to us that showed staff had not followed one patient's prescription for clozipine medicine. This meant that it was not increased slowly which could have impacted on the patient's physical health.

Patients told us they were starting to administer their own medicines with staff support. Staff risk assessed each patient as to how able they were to do this and what support staff would need to give.

Track record on safety

The service reported to us six serious incidents on Clumber Ward that occurred between September 2018 and 24 September 2019. These included inappropriate use of restraint, patients threatening to assault staff, medicines not given as prescribed and an incident where staff used handcuffs to move a patient to the seclusion room. These incidents were investigated under the providers serious incident protocol by a manager from another Priory hospital and when appropriate in liaison with the local authority safeguarding team.

Reporting incidents and learning from when things go wrong

The ward did not manage all patient safety incidents well. For example, staff did not manage an incident reported to us in August 2019 where they used handcuffs to move a patient to the seclusion room.

Staff raised concerns and reported incidents and near misses in line with the providers policy.

Staff knew what incidents to report and how to report them. However, there was a new electronic incident reporting system used and staff had not received training in how to use this. Staff said the system did not work with the electronic patient records system. It did not alert on the patient records that there had been an incident. This resulted in duplication of work and meant that information about the patient and the incident was not easily available to all staff.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff said they informed patients immediately if something went wrong and gave a written apology following an incident.

Managers debriefed and supported staff after any serious incident. Staff said they had a debrief after incidents they had been involved in which psychologists led.

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

Staff received feedback from investigation of incidents, both internal and external to the service. Staff said there was information about lessons learnt in the providers newsletter to make them aware of these. They received feedback through emails, the providers intranet, clinical governance meetings and team incident reviews. These were reviewed by the ward manager or clinical team manager and some were externally reviewed with the local authority safeguarding team. The registered manager planned to do a separate newsletter about lesson learned.

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

There was evidence that changes had been made because of feedback. For example, they had learnt from incidents where patients had swallowed batteries from

thermometers. They now used thermometers that did not need batteries and there were no batteries on the ward to reduce this risk. Staff said they had received feedback following an incident of choking in another Priory hospital.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We looked at the care and treatment records of five patients on Clumber Ward. Staff assessed the physical and mental health of all patients on admission. Patients have not been admitted to Clumber Ward since December 2018 due to the planned closure of the ward. All admissions were planned, and staff had information about the patients' needs before admission. Staff completed a mental health assessment of each patient either on admission or soon after. On admission staff assessed the patients' needs and developed a care plan within 72 hours.

The format of care plans on the electronic system included the areas to assess for keeping safe, making contact, mental health, physical care and communication. This meant that care plans were not personalised as they had to fit into the format of the electronic records system. It was difficult to find information about the patient's individual needs. However, we saw that managers were trying to address this. The minutes of the staff meeting in August 2019 said that care plan evaluations need to be more comprehensive and include patient involvement.

Staff reviewed patients care plans regularly through multidisciplinary discussion and updated as needed. Care plans stated the future placements for the patient, but they were not goal or future oriented.

Records showed that staff assessed patient's physical health needs soon after admission and reviewed these during the patients stay on the ward. For example, one care plan detailed the action staff needed to take if the patient had an epileptic seizure.

Positive behaviour support plans were present, were clear and specific to the individual patient. They identified triggers for the patient's behaviour and ways to prevent the patient from behaving in a way that challenged the service. Staff regularly reviewed and updated positive behaviour support plans when patients' needs changed. There were staff who were positive behaviour support champions on the ward to assist staff in following these plans.

Best practice in treatment and care

Staff provided some treatment and care for patients based on national guidance and best practice. Where appropriate patient's physical health care plans included reference to National Institute for Health and Care Excellence guidelines CG137 epilepsy and referred to epilepsy organisation guidance for staff to follow. Care plans also referred to National Institute for Health and Care Excellence guidance NG10 on managing violence and aggression. However, staff spoken with were not clear on any specific guidance on learning disability or personality disorder that they followed.

Patients had access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Patients went to groups led by the psychologists called 'I can feel good' and said this was useful. This was dialectal behaviour therapy which was adapted to meet the needs of people with learning disabilities. The provider trained recovery workers in dialectal behaviour therapy so they had the skills to assist the psychologist with these groups. Patients also had access to a healthy sexuality group which records showed they attended regularly. Patients had care plans on how to support them to meet their sexual needs.

Occupational therapists completed sensory screening tools to help patients develop their sensory needs. The provider had fitted 'sound clouds' to the ward ceiling to help reduce the noise and echo. This assisted patients in reducing their sensory overload, which can increase their anxiety and agitation. Staff used weighted blankets with patients who would benefit from this. Weighted blankets use deep touch pressure stimulation to reduce stress and anxiety. However, the ward had no sensory room and limited sensory equipment provided.

Staff supported patients with their physical health and encouraged them to live healthier lives. The hospital employed a physical health coordinator. All patients were

registered with the local GP who visited the hospital weekly. Patients had their annual health check with the GP as recommended for people with a learning disability. Patients visited local opticians, dentists and chiropodists.

Staff identified patients' physical health needs and recorded them in their care plans. Patients had regular blood tests and electrocardiograms.

Staff had not effectively used the National Early Warning Score outcome measure to assess patient's physical healthcare needs. The National Early Warning Score is a tool to improve the detection and response to clinical deterioration in adults. We saw that staff last assessed this for one patient in June 2019 and recording for other patients was intermittent. Staff had not always completed all the necessary checks prompted by the National Early Warning Score and did not always total a score from the checks they did make.

Staff helped patients live healthier lives by supporting them to take part in activity programmes or giving advice. Care plans included a healthy living plan which stated that staff were to encourage good food choices. The provider had employed a wellbeing manager and employed sports and fitness instructors as part of the wellbeing team at the hospital. Each patient had a fitness plan in line with their prescribed medicines and physical health needs and patients went to the gym at the hospital. Staff said that one of the quality improvements aims on Clumber Ward was helping patients to achieve a healthy weight. This included providing alternative healthy foods and following fitness plans. Staff said the hospital went sugar free in June 2019, but they found this was too restrictive for patients. Patients were limited to 14 snacks a week to help encourage them to have a healthy diet. The wellbeing manager said they were using wellness recovery action plans for staff and patients which helped patients to have a better understanding of their needs and recovery. However, we did not see these in the records we looked at.

Staff took part in clinical audits. These included the NHS safety thermometer, daily audits of emergency equipment and medicines audits.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on Clumber Ward. These included psychiatrists, occupational therapists and psychologists. There was no longer a speech and language therapist employed at the hospital. However, the previous speech and language therapist had assessed all patients and developed individual communication plans which staff followed.

Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Staff, including bank staff, said they had regular monthly supervision and a yearly appraisal. The provider told us that staff supervision rates on Clumber Ward had improved. In May 2019, 56% of staff had received supervision but this increased to 93% in September 2019. Medical staff said they had weekly group supervision.

Managers gave each new member of staff, including bank staff, a full induction to the service before they started working on the wards. Managers made sure staff attended regular team meetings or gave information from those they could not attend. All staff had opportunities for regular reflective practice sessions where they discussed incidents, management of individual patients and boundaries for patients.

Managers made sure staff, including bank and agency staff, had the right skills, qualifications and experience to meet the needs of patients. This included learning disability, autism and positive behaviour support training. The provider trained recovery workers in dialectal behaviour therapy. Staff said they had the training needed to do their job and got emails to alert when their training needed updating.

Multidisciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. These included nurses, psychologists, occupational therapists, social worker, sport & exercise therapists, recovery workers and psychiatrists. They supported each other to make sure patients had no gaps in their care. An independent pharmacist visited the ward weekly.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Each patient had a fortnightly meeting with their multidisciplinary team. Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

The ward team had effective working relationships with staff from community services identified to provide

aftercare following the patient's discharge. Staff from community services engaged with ward staff to plan patients discharge. The ward team had effective working relationships with external teams and organisations including NHS England and care coordinators. The ward team had monthly meetings with the local authority safeguarding team.

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

All patients on Clumber Ward were detained under the Mental Health Act. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice during induction and this was updated with e- learning. However, at the time of our inspection, only 68% of eligible staff working on Clumber Ward had received this training.

Consent to treatment and capacity requirements were adhered to. Staff attached copies of consent to treatment forms to medicine charts. This ensured staff administered patients' medicines under the correct legal authority. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to, and patient records showed they had visited.

The Mental Health Act administrator had recently left the hospital. The provider had recruited another and in the interim an administrator from another hospital provided advice.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Patients had easy access to information about independent mental health advocacy. Staff referred patients who lacked capacity to the advocacy service. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time. This included their right to an independent mental health act advocate.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Patients records showed that staff had assessed the patients mental state before going on leave to ensure the patients and staff safety.

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

Good practice in applying the Mental Capacity Act

Staff received training during their induction in the Mental Capacity Act. However, at the time of our inspection only 67% of eligible staff working on Clumber Ward had received this training. The social worker showed us flashcards they had produced to help improve staff understanding of the Mental Capacity Act.

There were no Deprivation of Liberty Safeguards applications made for patients from Clumber Ward in the last 12 months. There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff knew how to access and where to get accurate advice.

Patient records did not show that staff always supported patients to make decisions on their care for themselves. Staff did not always assess and record capacity clearly for patients who might have impaired mental capacity. For example, staff had recorded in one patient's record that the patient lacked capacity to consent to taking their medicine. However, it was not clear how staff had reached that decision. Staff told us they did not feel confident to assess a patient's capacity in deciding whether they should use sun cream. This had resulted in the patient being sun burnt.

Staff understood that each patient's capacity should be assessed on each 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.

It was not clear if the service monitored how well it followed to the Mental Capacity Act and if they acted when they needed to make changes to improve.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Wards for people with learning disabilities or autism

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Staff understood the individual needs of patients and supported patients to understand and manage their care. Patients said staff treated them well and behaved kindly. We observed respectful and caring interactions between staff and patients. One patient's care plan for their epilepsy showed staff how to support the patient's privacy and dignity when they had a seizure.

Staff were discreet, respectful, and responsive when caring for patients. One patient said staff were respectful and polite. However, patients told us they did not have a sanitary bin in their bedroom and said it was not nice having to bring them to staff to dispose of. Managers told us this was individually risk assessed however, we did not see this in the patients' records we looked at.

Staff gave patients help, emotional support and advice when they needed it. We observed staff spending time with patients talking about their future placements. Staff showed understanding that patients would be anxious about moving and reassured them. Staff asked patients if they wanted help to write down questions about their new placement, so they were prepared when speaking to staff from their new placement.

Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition. The previous speech and language therapist had assessed all patients. Staff used this information to help when communicating with individual patients.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. The advocate told us that some patients had complained that staff do not interact with them during observations. The advocate raised this with the registered manager, and this had improved.

Staff followed the providers policy to keep patient information confidential.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Records showed t staff had offered patients a copy of their care plan and recorded if the patient refused this. Patients had regular meetings with their named nurse and key worker when they wanted this.

Staff ensured patients had easy access to independent advocates. The advocate was at the hospital for 15 hours each week and covered all wards. The advocate met weekly with the ward manager to discuss themes of issues that patients raised with them. They said the main concern from patients on Clumber Ward was about food, but this had improved after meeting with the catering manager. The advocate attended patients care planning approach meetings if the patient requested this.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Patient records included an easy read care plan however, these included many words and few pictures. Patient meeting agendas and minutes were in a format that were easier to read.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients had a monthly meeting and minutes of these were seen. The activity worker chaired these meetings and staff from the ward did not attend. Patients discussed the ward environment, how they got on with each other, activities, celebrations and what staff could do better. They reviewed actions from previous meetings to make sure they had been completed. We saw 'You said, we did' boards on the ward with actions taken from patient meetings.

There was no information about patients making advance decisions in the records we reviewed.

Involvement of families and carers

Patients on Clumber Ward were placed from across England. The hospital social worker liaised with families and carers about visits and meetings about their relative's care. Staff informed and involved families and carers appropriately. Staff involved carers where the patient agreed to this. Records detailed which family members to contact and who and when to contact them.

Requires improvement

Wards for people with learning disabilities or autism

Staff supported, informed and involved families or carers. However, one relative told us they were not informed of incidents involving their relative. The hospital social worker gave carers information on how to find the carer's assessment.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Staff planned and managed patient discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. The provider had given notice to NHS England that Clumber Ward would close in February 2020. Rufford Ward had closed the week of our inspection. This was to meet the NHS England Transforming Care programme which is to move people with a learning disability out of hospital and into the community. Commissioners had identified placements for some patients and staff supported patients with these plans.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff talked with patients and looked at leaflets about their new placement. They were supporting one patient to pack their belongings and supporting two patients to meet with the staff from the service they would be moving to. Wherever possible, staff had supported patients to visit their new placements. One patient had a leaving party the day before our inspection and patients said this was good. Patients told us that staff talked about discharge with them and they knew the options for their future placement which would be closer to where their family lived. Patients said they felt good about moving on although anxious as it would be a change.

Staff did not move or discharge patients at night or very early in the morning. There were no delayed discharges from Clumber Ward.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite toilet and shower. Patients could personalise their bedroom and had a secure place to store their personal possessions. There were quiet areas for privacy on the ward.

The food was of good quality. Patients said there were two choices of food at lunchtime. The advocate told us that patients had raised concerns about the food with them and this had improved after they spoke with the catering staff.

Patients could have a hot drink when they wanted it. A hot water tap had recently been fitted in the dining room, this was set at a safe temperature below boiling. Some patients preferred to ask staff to make them a hot drink in the kitchen. We observed staff responding to requests immediately. Each patient had their own cup which they had chosen.

Staff used a range of rooms and equipment to support treatment and care. However, there was not a sensory room provided. There was an activity room on the ward with several games and jigsaws. Clumber Ward also had access to therapy rooms in the therapy corridor as this was in the secure part of the hospital.

The service had rooms where patients could meet with visitors in private. The visitor's suite was off the ward and patients could book these for visits from relatives and friends. There were also rooms on the ward where patients met with staff from their future placements in private

The service had considered and responded to the needs of patients with autism in the ward environment. They had fitted 'sound clouds' to the ceiling in the lounge area. Staff and patients said this had made a big difference to the noise level and echo on the ward.

There was a patient's phone room on the ward. Staff made calls from the office and then patients could take the call in private in the phone room. One patient said they used to have mobile phones which helped them to be more independent. Staff said they had to stop the use of mobiles as some patients constantly rang emergency services. One patient said staff sat in the room when they made calls, so this was not private. We saw in this patient's records that staff needed to support them when making phone calls because of the risks to their wellbeing.

The service had an outside garden which was a grassed area with seating provided and a shelter with seats. The door to the garden was locked as two staff needed to support patients when using the garden. Patients said that staff were always available to do this.

Patients' engagement with the wider community

Staff supported patients with activities outside the service including shopping and going to cafes. The provider employed recovery workers who worked on the wards from 7.30am to 7pm Monday to Friday and one worker worked eight hours on Saturday across the hospital. The recovery workers were part of the wellbeing team. The wellbeing programme was re- launched at the time of our inspection. This included sports and fitness sessions and staff gave patients a timetable of what activities were available each week. The wellbeing manager held a training day with senior healthcare workers the week before our inspection where they talked about activities and engagement as all need to be involved.

Patients on Clumber Ward could access the therapy corridor as it was in the secure part of the hospital. This included a group room, hair salon, art and hobby room, library with a computer suite, gym and sports hall. Staff told us that funding for resources and equipment was available.

Patients told us they went out often with staff to local shops and cafes. There were also events held in the hospital such as supporting the Macmillan coffee mornings.

Staff helped patients to stay in contact with families and carers. Staff supported patients to travel to their family home or at a neutral venue depending on individual patients needs and distance of travel. Patients told us that they valued this support from staff.

Meeting the needs of all people who use the service

Staff helped patients with communication, advocacy and cultural and spiritual support. All patients we spoke with knew who the advocate was and how to contact them.

The service adjusted the ward to meet the needs of patients with autism. They fitted sound clouds to the ceiling in the communal areas of the ward. Patients and staff told us this had made a big difference to the noise levels on the ward and reduced echo.

Staff made sure patients could access information on treatment, their rights and how to complain. Managers made sure staff and patients could get help from interpreters or signers when needed. Staff had access to the interpreter service, which included British Sign Language.

The service provided foods to meet patients' cultural backgrounds. Some patients told us they would like more Caribbean and Indian foods because they liked these foods. Patients said they had asked the occupational therapist and spoken with catering staff about this, but these foods were not regularly provided. We saw that vegetarian and vegan options were offered on the menus.

Patients had access to spiritual, religious and cultural support. Staff said patients could attend local churches if they wanted to and patients said staff supported them to do this. There was a multi faith room in the hospital visitor's suite which patients from Clumber Ward could access.

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. Managers investigated complaints and identified themes. The provider had appointed a clinical complaints and investigations manager. The advocate told us that the complaints manager was quick to respond to any issues they raised with them and kept them updated during complaint investigations.

Minutes of clinical governance meetings showed that managers discussed complaints, the investigations of these and any lessons learned. The minutes in August 2019 showed that patients on Clumber Ward had raised two complaints in the month via the advocate. These were about restraint and attitude of staff. These had been reported to the local authority safeguarding team and were being investigated at the time of our inspection.

Patients and relatives knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Requires improvement

Wards for people with learning disabilities or autism

Managers shared feedback from complaints with staff and learning was used to improve the service. The service used compliments to learn, celebrate success and improve the quality of care.

Are wards for people with learning disabilities or autism well-led?

Requires improvement

Leadership

The registered manager had been in post since January 2019 and had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. All staff spoke positively about the registered manager and said they were visible in the service. Staff said the registered manager listened to them, responded quickly and got things done.

Ward managers met weekly and the registered manager attended these meetings. Ward managers said these meetings were useful and they were involved in discussions about the service development.

In the last few months before our inspection the director of clinical services and the director of secure services had left the hospital. The service had appointed a director of nursing who was to start working at the hospital at the end of October 2019. In the interim there was an acting director of nursing from another Priory hospital.

Staff told us they did not know who the managers above the registered manager were and they had not seen them visit the wards.

Ward managers and managers of services had opportunities to attend leadership training and had done so.

Vision and strategy

The registered manager had a vision for what the service wanted to achieve and had developed a strategy to turn it into action, with relevant stakeholders. The vision was aligned to local plans and the wider health economy. The senior management team had successfully communicated the provider's vision and values to the frontline staff in this service. All staff were aware of the vision and values of the organisation.

However, staff who worked on Clumber Ward felt excluded from the discussion about future strategy of the hospital and service development. They told us they were informed of this rather than consulted. Minutes of the staff meeting on Rufford Ward in August 2019 showed that staff also felt excluded from discussions about the new service and during the closure period had to regularly provide staff to other wards. Staff said this impacted on their confidence to manage confrontation on the acute mental health wards.

Culture

Staff felt respected, supported and valued. Staff were positive about the registered manager and the way they supported them. However, some staff told us they did not feel respected and valued by senior managers within the organisation. They felt that they were less valued than by the previous provider. The registered manager felt well supported by their manager.

Staff told us they could raise concerns without fear of victimisation and knew how to use the whistle blowing process.

There were no bullying or harassment cases at the time of our inspection. Individual staff performance was managed. The provider acted to suspend staff when needed, fully investigate and dismiss staff when needed.

Staff said they work well as a ward team and always had reflective practice and debrief following incidents which supported them.

Staff appraisals included conversations about career development and how it could be supported.

Clumber Ward's staff sickness and absence were similar to the provider target.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The provider had recently appointed a wellbeing manager who led the wellbeing team. They said part of the team's role was about staff wellbeing. They were developing wellness recovery action plans for staff and patients which helped patients and staff to have a better understanding of their needs and recovery. They were also

introducing staff wellbeing meetings which would be informal drop in sessions. Any themes raised would be fed back confidentially to the registered manager. They were developing a gratuity board for staff in line with the safe wards model to create positivity.

Governance

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. This included checking of emergency equipment and removing any need for batteries on the wards.

Staff did not always participate in local clinical audits. Minutes of clinical governance meetings showed these were not always completed. This meant there was insufficient assurance and staff could not act on the results to make improvements when needed. The provider completed a benchmarking audit at the hospital and rated it as requires improvement.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. They worked well with the local authority safeguarding teams.

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. The registered manager had a monthly call with the senior management team which included the quality lead, regional medical director and human resources business director.

The provider had recently completed a safeguarding audit at the hospital. The quality audit and risk group had recently audited seclusion. Staff said that quality walk rounds had not been done as often as they should due to capacity. The visiting pharmacist completed weekly medicines audits. The findings of these were discussed at the monthly medical advisory meeting and monthly ward managers meetings.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. There were audit systems in place however, we found these were not always completed at ward level by nursing staff which meant there could be a disconnect between managers and what happened on the ward.

Staff had an opportunity to feedback on service development through clinical governance meetings although this was more about local services than nationally. The provider had a risk register and staff could add items to this.

The service had plans for emergencies. Staff told us they had an emergency drill at the hospital recently with the local ambulance and fire services. They set scenarios, for example, set a fire on the ward and hostage taking. They said this went well and they filmed it to use for staff training.

The provider had recently appointed a site support manager who managed the maintenance, catering and housekeeping teams within the hospital. This helped to streamline the processes for reporting issues by email and phone. The manager walked around the site each day to identify any risks to patients and staff health and safety. They had arranged for maintenance issues to be addressed that had been outstanding for several months. There were monthly quality walk arounds which focused on health and safety.

We looked at three staff recruitment records. These showed that all checks had been completed including Disclosure and Barring and right to work in the United Kingdom checks. The provider requested references which explored any previous employment gaps.

There were no examples of where financial pressures had compromised care.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff did not have access to the equipment and information technology needed to do their work. The electronic records systems were secure but not integrated. The provider used two electronic record systems from the previous provider and their own system. This meant that staff did not have clear easy access to all information about each patient, their risks and needs. The registered manager had

escalated the risk of this to the providers information technology department. Records were stored securely. Information governance systems included confidentiality of patient records.

Ward managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Staff made notifications to external bodies as needed. Staff made safeguarding referrals when needed to the local authority and sent statutory notifications to the care quality commission as required.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. The senior management team launched an engagement strategy in February 2019. This included breakfast drop in sessions with the registered manager and included day and night staff. Since February 2019 there had been a monthly newsletter to keep staff informed of developments to the service. Each ward team had a monthly valuing staff day. This started in April 2019 and gave staff an opportunity to come off the wards, which were covered by other staff. The psychologists led staff in reflective practice sessions. A member of the senior management team attended the daily morning meeting on Clumber Ward. The senior management team were involved in meetings and activities, ranging from patient fitness groups to presence at staff team meetings and leadership of clinical governance groups.The service engaged well with local and national organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients**.** They were part of the quality network for forensic mental health services. The network completed an audit of Clumber and Rufford Wards in April 2019.

Following staff and patients' meetings managers had fed back on what staff and patients had said. There were noticeboards for 'you said, we did' which showed action taken in response to the views expressed. However, patients, carers and staff on Clumber Ward were not involved in decision-making about changes to the service.

Learning, continuous improvement and innovation

All staff were committed to continually improving services but staff working on the wards did not have a good understanding of quality improvement methods. Staff did not use quality improvement methods. The providers quality improvement facilitator visited the hospital weekly but said they focussed on improving the service before developing quality improvement initiatives.

Innovations were taking place in the service. For example, the psychology team were finalists for the award for 'excellence in risk assessment and management' by the Association of Psychological Therapies (APT). The team won the award for excellence in Dialectical Behaviour Therapy management by the Association of Psychological Therapies in 2018 and 2019. They also won the trainer award at the Learning Disability and Autism awards in 2018 for their delivery of training on the adaptation of the dialectical behaviour therapy programme 'I can feel good' to use with people with a learning disability.

Outstanding practice and areas for improvement

Outstanding practice

The psychology team were finalists for the award for 'excellence in risk assessment and management' by the Association of Psychological Therapies (APT). The team won the award for excellence in Dialectical Behaviour Therapy management by the Association of Psychological Therapies in 2018 and 2019. They also won the trainer award at the Learning Disability and Autism awards in 2018 for their delivery of training on the adaptation of the dialectal behaviour therapy programme 'I can feel good' to use with people with a learning disability.

Staff used technology to support patients effectively. During the inspection, a consultant transmitted the electro cardiogram reading of a patient over the telephone to the cardiology department to speed up the process of getting results.

Areas for improvement

Action the provider MUST take to improve

We issued five requirement notices to the provider and took one enforcement action. That meant the provider had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of six legal requirements at Calverton Hill.

The provider must ensure that care plans are written collaboratively with patients and they are personalised and holistic, clearly demonstrating patient goals. (Regulation 9)

The provider must ensure that patients physical health is routinely monitored and recorded. Staff must act where needed to ensure the patients physical health needs are met and patients must have access to physical healthcare at all times. (Regulation 9)

The provider must ensure that discharge planning is started on patient admission. (Regulation 9)

The provider must ensure that all care plans are in a format that makes them easier for the patient to read and be involved in. (Regulation 9)

The provider must provide sanitary bins to all female patients.(Regulation 10)

The provider must ensure that patients' capacity to consent to treatment is recorded. (Regulation 11)

The provider must ensure that patients have access to advocacy information and know who their advocate is.(Regulation 11)

The provider must have a robust approach to the recruitment and retention of staff. (Regulation 12)

The provider must ensure that there is a robust system in place for monitoring the use of restricted items. (Regulation 12)

The provider must ensure that there are not blanket rules in place for example searching of patients or access to hot drinks. (Regulation 12)

The provider must ensure that observations are carried out in line with policy and are completed at the time of the observation. (Regulation 12)

The provider must ensure that cleaning records are completed in full and are up to date, and that all tasks are completed according to the set frequency. (Regulation 12)

The provider must ensure that there are sufficient quantities of medicines available to ensure the safety of patients and to meet their needs. (Regulation 12)

The provider must ensure that staff routinely record the fridge and room temperature of clinic rooms. (Regulation 17)

Outstanding practice and areas for improvement

The provider must ensure that where multiple systems are used to record patient information, that this is effective and all necessary information such as risks are recorded. (Regulation 17)

The provider must ensure that staff undertake clinical audits, and these contribute to making improvements where needed. (Regulation 17)

The provider must train all staff in fire safety, infection control, the Mental Health Act and the Mental Capacity Act. (Regulation 18)

Action the provider SHOULD take to improve

The provider should ensure that all staff are aware of the ward environmental risk assessments.

The provider should ensure that sensory equipment is provided to meet individual patient's needs.

The provider should train all staff in the management of patients with sepsis.

The provider should ensure that patients are offered a variety of food that meets their individual needs.

The provider should ensure that they are taking part in national audits and quality improvement and following actions from those audits.

The provider should ensure that informal patients on Bestwood Ward know that they can leave and that there is a sign in place to highlight this.

The provider should ensure that the courtyard on Bestwood Ward is well maintained and acts as a therapeutic space for patients.

The provider should consider staff wearing name badges so that patients are aware of who staff members are.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Staff had not assessed and recorded all patient's physical health observations correctly and acted where needed to ensure their physical health needs are met. Care plans were not personalised and did not reflect individual patient needs. Care plans were not always written in collaboration with patients. Some staff members told us that they did not have time to sit with patients to write their care plan. Care plans were written by the nursing team and were not collaborative with the wider multidisciplinary team. Discharge planning was not regularly started on admission and some patients did not have discharge plans in place.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff had not assessed all patient's capacity to consent to decisions about their care and treatment and had not clearly recorded this. Patients were not aware who their advocate was and how to contact them.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect All female patients did not have sanitary disposal bins in their bedrooms.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was storing patient information in multiple places. This made it difficult to clearly identify where information was and to triangulate and meant information was not up to date across all systems. Care plans and risk assessments were not always updated following an incident or change in observations. The governance at ward level was not robust. Actions from audits were not completed, supervision was not carried out regularly, patient one to ones were not happening regularly. Managers were not acting on these issues to resolve them. Staff were not completing regular clinical audits, so these did not contribute to improving the service.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of staff on Clumber Ward had not received training in fire safety, infection control, the Mental Health Act and the Mental Capacity Act.

This section is primarily information for the provider

Enforcement actions

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was not a robust system in place for monitoring the use of restricted items. There were blanket rules in place for searching patients. Patient observations were not carried out in line with policy and completed at the time of the observation. The clinic room in Bestwood Ward was dirty as were the ward areas. Cleaning records were not completed, and tasks were not completed according to the set frequency. There were not always sufficient quantities of medicines available to ensure the safety of patients and to meet their needs.