Glenhurst Lodge

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

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

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

However:

- Due to staff absence, fire safety checks had not been completed for two weeks.
- The provider's ligature risk assessment identified that a staff member was always required to be supervising the communal areas of the wards For a brief time on the day of our inspection, not all communal areas were being supervised by staff.

Summary of findings

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Good

Glenhurst Lodge

Services we looked at
Long stay or rehabilitation mental health wards for working-age adults;

Summary of this inspection

Background to Glenhurst Lodge

Glenhurst Lodge is part of the Bramley Health group of services and is registered to provide the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- accommodation for persons who require nursing or personal care
- treatment of disease, disorder or injury
- diagnostic and screening procedures.

Glenhurst Lodge is a high dependency rehabilitation unit with two gender specific locked wards for working age adults. Davenport ward has 11 beds for men and Sandown ward has 11 beds for women. During our inspection, the hospital was providing care and treatment to 10 men and six women. There is a registered manager at the hospital.

We have inspected Glenhurst Lodge nine times since it was registered in 2011. Our last comprehensive inspection was in August 2017 where we rated all domains as good. This gave the hospital a rating of good overall.

Our inspection team

The team that inspected the hospital comprised of four CQC inspectors, a specialist advisor who was a registered nurse and an expert by experience.

Why we carried out this inspection

We inspected this hospital 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 both wards at the hospital, looked at the quality of the ward environment, clinic areas and observed how staff were caring for patients
- spoke with seven patients who were using the hospital
- spoke with the registered manager and nurse in charge of each of the wards
- spoke with 15 other staff members; including doctors, nurses, occupational therapist, psychology staff, support workers, Mental Health Act administrator and the ward administrator
- attended and observed two handover/ multidisciplinary meetings
- attended and observed a care planning meeting
- attended and observed the patients' morning Rise and Shine group
- attended and observed a psychology group
- looked at 11 care and treatment records of patients

Summary of this inspection

- carried out a specific check of the medicines management, including looking at 12 prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the hospital.

What people who use the service say

Feedback from patients was generally very positive. Patients told us staff were supportive and there was always someone available. They were happy with how involved they were in their care and treatment, having options discussed with them throughout the process.

Staff made sure patients knew how to access advocacy and how to complain if they wished to. Patients told us the food was very good and there was plenty to do each day. Two patients said the communication styles of some staff made them seem bossy and directive.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The hospital had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the hospital 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. Local authority safeguarding professionals visited regularly to offer confidential support to patients, staff and management.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The hospital 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.
- The wards had a good track record on safety. The hospital managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Due to staff absence, weekly fire safety checks had not been completed for two weeks. Managers should ensure contingencies are in place that ensure all audits are completed when the designated person is not at work.

Summary of this inspection

- The provider's ligature risk assessment identified that a staff member was always required to be supervising the communal areas of the wards. For a brief time on the day of our inspection, not all communal areas were being supervised by staff. Managers should ensure mitigation actions are carried out at all times.

Are services effective?

Good

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes, and worked effectively as a multi-disciplinary team to ensure the results were understood in a holistic context.
- Ward teams included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. Where agency staff were used, this was on a locum basis to provide continuity and agency workers received induction, training and supervision.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with staff from services that would provide aftercare following the patient's discharge. and engaged with them early in the patient's admission to plan discharge.
- The hospital operated a bespoke psychology graduate programme. This was a new initiative implemented by the organisation and involved psychology graduates working on

Summary of this inspection

the wards, supported by the psychology department. The aim of this programme was to enhance clinical skills on the wards as well as promote learning and development for psychology graduates.

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

Are services caring?

Good

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

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

Are services responsive?

Good

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, discharge was rarely delayed for other than a clinical reason or reasons outside the hospital's control.
- The design, layout, and furnishings of the ward/hospital 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.
- Most patients were self-catering or working towards being so. They received a generous food budget and support to cook their food. Where patients were not self-catering, the food was of a good quality and patients could make hot drinks and snacks at any time.

Summary of this inspection

- The wards met the needs of all patients who used the hospital – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff supported patients to access the local community and educational opportunities. Staff went the extra mile to ensure important relationships were maintained and that patients remained in contact with family and friends. For example, we were told about was a patient who wished to attend a very significant family event a long distance away from the hospital, but needed permission from the Ministry of Justice, special transport and three staff members to accompany them. Staff went to considerable lengths to secure all necessary permissions and provided the staffing and transport to enable the patient to attend this event.
- The hospital 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?

Good

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the hospital 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.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Leaders and staff actively and openly engaged with patients and staff.
- Managers and staff displayed a culture of learning and continuous improvement.

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.

The hospital had an appropriate Mental Health Act policy which staff were aware of. The hospital provided training in the Mental Health Act. Ninety per cent of staff had been trained in the Mental Health Act which met the hospital's target.

The service had a Mental Health Act administrator who monitored the service's compliance with the Act and undertook audits. Records relating to patients' detention under the Act was in order and appropriately maintained. The hospital ensured that appropriate advocacy was available to patients where needed.

Patients told us they had their rights explained to them in a way they could understand and that this was reviewed regularly. Patients also told us they had their treatment explained to them, and were consulted about medicines, including discussions about options and side effects. During our inspection we saw staff discussing where to access information leaflets about patients' rights in a patient's first language.

There were 16 patients in the hospital at the time of our inspection, all but one were detained. Systems were in place to ensure informal patients knew they could leave, and signs were displayed on doors.

Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital had an appropriate Mental Capacity Act policy which staff were aware of. The hospital provided training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Ninety-two per cent of staff had attended the Mental Capacity Act/Deprivation of Liberty Safeguards training which met the hospital's target.

During our inspection we saw staff discussing capacity and consent in relation to someone's physical health. Staff carried out capacity assessments and ensured they were appropriately recorded.

All patients at the hospital were either detained or consented to be there, therefore no patients were subject to DoLS.

The hospital ensured that appropriate advocacy was available to patients where needed.

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

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

The hospital was clean and well maintained at the time of our inspection. The hospital employed a maintenance person full time, and used a range of outside contractors for specialist tasks or general tasks when the maintenance person was not working. The hospital also employed a full time cleaner.

Each ward had communal spaces including a lounge with a games and social area, as well as a separate area with a television and comfortable seating. Each ward also had a quiet room with the patient telephone which doubled up as a multi-faith room, a large kitchen for preparing meals and a smaller one for making drinks. Each ward had a well-equipped clinic room with emergency equipment.

Wards were gender specific, so the hospital was fully compliant with guidelines around mixed-sex accommodation. Each patient had their own bedroom with en-suite bathroom, which was clean and furnished comfortably. Patients could personalise their bedrooms as they wished. Each bedroom had a patient call alarm.

Systems were in place to ensure cleaning was undertaken regularly and any environmental issues identified and rectified promptly. Staff carried out a range of health and safety, fire and environmental checks daily, weekly and monthly. An environmental risk register was maintained by the maintenance person, who reviewed and updated it weekly with the registered manager. Any identified issues were discussed in the daily multidisciplinary handover meetings, and actions agreed. At the time of our inspection, the maintenance person had been away for two weeks and the weekly fire safety check, a task allocated to them, had not been completed.

A security lead was assigned to each ward every shift. The security lead was responsible for overall security of the ward, including managing daily allocation of keys, testing and allocation of personal alarms, and environmental safety. A fire warden, who had received appropriate fire warden training, was also assigned to each ward for each shift.

Ligature risk assessments were undertaken quarterly to identify ligature anchor points. A ligature anchor point is something which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. We looked at the most recent risk assessment which was completed in December 2019 and saw that risks were identified, and mitigation put in place. One of the mitigation factors was that a staff member should be supervising the communal areas of the wards at all times. However, for a brief time on the day of our inspection, not all communal areas were being supervised by staff.

Safe staffing

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

The hospital had enough skilled staff to meet the needs of patients. Managers employed a safer staffing model to

assess the needs of the patient group on each ward and the hospital. Additional staff were added for any individual or one-to-one support, or escorted visits and outings. Staff reviewed this daily to ensure it met the current needs of patients and submitted reports each day to the director of nursing. The registered manager had the authority to increase staffing numbers or mix if necessary. Staff were supported out of hours by an on-call team that comprised of a doctor, a nurse and a director at all times.

The multidisciplinary team included a part-time consultant, a full-time specialty doctor, nurses, a psychology team including a psychologist, graduate psychologists and psychology assistants, an occupational therapist and support workers. In addition, the hospital employed a full-time maintenance person, a full-time cleaner, a Mental Health Act administrator and a part-time administrator. There was a vacancy for a clinical lead to act as deputy to the registered manager. The hospital was recruiting for this position.

There was an organisation-wide training programme. Each new staff member completed a full induction, then ongoing mandatory training. Subjects included Mental Health Act awareness, Mental Capacity Act and Deprivation of Liberty Safeguards, prevention and management of violence and aggression (PMVA), safeguarding, health and safety, infection control, information governance, moving and handling, equality and diversity, food hygiene and fire awareness.

Additional specialist training was available. Recent courses included epilepsy awareness, life support, phlebotomy, personal search training and boundaries. Three staff members were booked to attend training to enable them to run mindfulness sessions, as the previous facilitator had left the organisation. The hospital planned to resume regular sessions for staff and patients as soon as they had staff qualified to do so. Staff told us the training was easily available, of an excellent standard and equipped them to do their jobs.

The hospital met its own targets for training at the time of our inspection with completion of all subjects over 90%. Training compliance levels were available to managers on the hospital's electronic dashboard. The organisation's compliance team submitted a report every week, which was discussed at service and corporate clinical governance meetings. Additionally, a training committee met quarterly to discuss and review training needs across the organisation.

Agency nurses were used for most qualified nurse shifts, however a recruitment programme was in place. The hospital had employed long-term locum nurses to ensure continuity and safety, and most had been working in the hospital for a long time. Agency workers were fully integrated into the staff team. Agency nurses underwent the same induction as directly employed staff, and were given ongoing training and supervision. Agency staff attended multidisciplinary and staff meetings as part of the team.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Referrals were reviewed by the multidisciplinary team to assess whether the patient's needs could be met. Patients accepted by the multidisciplinary team had their referrals reviewed by the senior management team. An appropriate member of staff was assigned by the registered manager to undertake an initial assessment. The outcome of the assessment was discussed again by the multidisciplinary team which then started to make arrangements for admission.

Following the initial screening assessment by a member of staff on admission, an assessment of key areas was undertaken by members of the team during a care planning meeting. Patients discussed their situation, their needs and preferences, and their goals. Each professional in the team discussed with the patient how to work towards each goal and what their input would be. This initial meeting covered a wide range of areas including, but not limited to, mental health, medicines, offending history and risks, physical health, family and informal support, substance use and life skills.

Long stay or rehabilitation mental health wards for working age adults

Good

Relevant members of the multidisciplinary team undertook more in-depth risk assessments relevant to their area of input. Staff used a range of recognised risk assessment tools. For example the occupational therapists used the Model of Human Occupation Screening Tool (MOHOST) to assess life skills. The psychologist team would use the Brief Psychiatric Rating Scale (BPRS), a rating scale which a used to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behaviour, and the Brief Symptom Inventory (BSI) which evaluates psychological distress and psychiatric disorders. Nursing staff used a range of physical health monitoring tools such as Malnutrition Universal Screening Tool (MUST) to help identify adults, who were malnourished, at risk of malnutrition or required support with weight management. The doctor used The Glasgow Antipsychotic Side-effect Scale (GASS) which is used to monitor the side effects of antipsychotic medicines. Relevant staff members updated risk assessments as needed, but quarterly as a minimum.

Each patient had a positive behaviour support plan, which enabled them to explore their triggers and identify how they would like staff to support them in a crisis. This might include some one-to-one time with staff, therapy, listening to music or time alone. Verbal de-escalation would be attempted prior to any kind of physical intervention taking place.

When restraint was used, staff followed the organisation's policies. A restraint form, a de-brief form and body map were completed for incidents involving restraining of patients, and the incident would be reflected on by staff in various meetings. Debriefs were offered to both staff and patients following any episode of restraint. If a staff member sustained an injury, they would be offered medical assistance and support to follow criminal proceedings if they wished. There had been one instance of restraint in the service in the past year, when rapid tranquilisation was used.

Staff attended training in Prevention and Management of Violence and Aggression (PMVA), breakaway, de-escalation techniques and security. Incidents were managed safely for everyone involved and restraint was only used as a last resort. The PMVA programme was designed to reduce the use of physical restraint and focus on de-escalation and proactive interventions.

The organisation had a 'reducing restrictive practice' steering group which met quarterly. Monthly clinical governance meetings analysed all restraints to assess whether anything could have been done differently or whether lessons could be learned.

The multidisciplinary team met daily to discuss each patient, including any new or ongoing risks. The team worked effectively together to agree the best course of action. Agreed actions were logged and updated daily until completion. We saw evidence of appropriate and holistic discussions taking place, which considered a range of factors relating to each patient. These included safeguarding concerns, incidents such as aggression, changes in presentation, physical health issues such as changes to pre-existing conditions and keeping a note of appointments, and capacity and advocacy issues.

Each staff member carried a personal safety alarm which was tested before each shift. A safety lead was assigned to each ward for each shift, and was responsible for managing risks on the wards that day. Patients assessed as presenting a risk to staff or patient safety were allocated additional dedicated staff to ensure safe care and treatment was delivered, until the risk reduced.

Staff carried out room searches when necessary, and a policy and process was in place to facilitate this. Patients told us they had this explained to them on admission and that staff spoke to them about undertaking any search. The hospital had a list of prohibited items, but did not apply other blanket restrictions.

Safeguarding

Staff understood how to protect patients from abuse and the hospital 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. Local authority safeguarding professionals visited regularly to offer confidential support to patients, staff and management.

The hospital had a clear safeguarding policy which staff understood. All staff had safeguarding training as part of their induction and then regular updates. At the time of the inspection, 96% of staff had attended safeguarding training, which exceeded the organisation's target. Staff

understood how to spot any safeguarding concerns and they knew how to report them. Safeguarding concerns were logged on the company system and monitored by managers on the hospital's information dashboard.

The hospital had two safeguarding champions who had undergone a higher level of training and were available to advise staff on safeguarding matters. Safeguarding was discussed in supervision, team meetings and the daily multidisciplinary handover meetings. Weekly reflective practice sessions were used to discuss safeguarding issues and review whether lessons could be learned. These were shared with staff via minutes and in team meetings.

Safeguarding was discussed in the local monthly clinical governance meetings, and information escalated to the corporate clinical governance meetings and board meetings. Any outcomes or reflections were shared with the local staff team via the same route. The organisation had an overall safeguarding lead, who met regularly with safeguarding champions across the organisation to discuss activity, and share experience and learning.

The organisation's compliance team audited the safeguarding activity weekly and provided a report to managers about progress, highlighting any outstanding actions. This information fed into the quality and compliance report submitted to the board of directors each month.

Staff worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing. Staff had a good relationship with local authority safeguarding teams. A local authority safeguarding coordinator held monthly safeguarding drop-in clinics at the hospital . These were open to patients, staff, carers and anyone else wishing to discuss anything of a safeguarding nature. Safeguarding was an agenda item on the hospital's regular meetings with the commissioners, and in regular liaison meetings with the police.

Staff access to essential information

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

Information needed to deliver care, such as care plans and risk assessments, was in paper files and stored in secure filing cabinets in the locked staff office. Electronic copies of care plans and risk assessments were stored on the hospital's shared drive and each staff member had password-protected access.

We viewed 11 patient care records during our inspection and found all documentation to be of a high standard, fully completed, holistic and regularly reviewed.

All policies, procedures and other organisation documents were stored on a shared drive which staff had password protected access to. Information posters around key policies were on the walls in nurses offices, admin offices and staff rooms.

Regular audits of clinical records were carried out, and outcomes shared at staff meetings and clinical governance meetings. Where audits highlighted any individual practice issue, these were addressed during supervisions.

Medicines management

The hospital 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.

The hospital followed National Institute for Health and Care Excellence (NICE) best practice guidelines around the management of medicines. A full range of policies were in place. Managers received notifications of any medicines alerts and circulated these to ward staff promptly.

Each ward had a clinic room where medicines were stored. Clinic rooms were small but clean and well equipped. All medicines were appropriately stored, including in securely locked cupboards or locked fridges where required. Controlled drugs were monitored using a controlled drugs log. Each time controlled drugs were administered this was signed for by two staff.

On admission to the hospital, patients had a medicines assessment with the specialty doctor, and all prescribed medicines were reviewed. Capacity checks were undertaken by the doctor where necessary. Patients were involved in their medicines regimes, and side effects were discussed. Any patient who might require rapid tranquilisation had an individual rapid tranquilisation protocol, and any patient prescribed PRN (as required) medicines had an individual PRN protocol.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff encouraged patients to be self-medicating. Occupational therapy staff undertook risk assessments and supported patients, via a care plan, to manage their own medicines. At the time of our inspection, several patients were managing their own medicines, and others had care plans working towards this as a goal.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. The specialty doctor ran weekly physical health clinics, so patients could discuss any side effects or concerns about their physical health, and any known conditions could be reviewed.

The hospital had a service level agreement with a pharmacy service and had a dedicated pharmacist to undertake audits and provide support. The pharmacy service provided medicines and medical equipment. They carried out weekly audits of medicine cards, medicines and clinic rooms. A full quarterly medicines management audit was completed. A report and any required actions were provided to the hospital following each audit, and managers liaised with the pharmacist to ensure actions were completed. Staff told us the pharmacist was very supportive and responsive at all times, providing advice and assistance if needed.

Track record on safety

The wards had a good track record on safety. The hospital managed patient safety incidents well.

During the 12-month period prior to the inspection, no significant safety incidents were reported. A number of low-level incidents were reported, most frequently incidents of aggression, self-harm, and patients taking prohibited items into the hospital . These were managed appropriately according to the hospital's incident management policy and protocols.

Reporting incidents and learning from when things go wrong

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

The hospital had a clear incident policy and protocol which staff were aware of. Staff understood when to report incidents and how to report them. Incidents were logged on the company system and monitored by managers on the hospital's information dashboard.

A clear escalation process was in place. Incidents were reported in the first instance to the nurse in charge of the ward at the time of the incident. The nurse then escalated to the registered manager or the on-call manager. All incidents were also reported to the director of nursing and the patient's doctor, and recorded on the organisation's incident record forms and clinical daily notes. Police and commissioners were informed as necessary. The hospital had an effective duty of candour policy which staff were aware of. We saw examples of where this had been put into practice.

Incidents were investigated by the registered manager or another designated staff member. The investigation might result in a range of actions, including updates to a patient's care plan or risk assessment, or extra training and support for staff. All incident forms were signed off by an appropriate manager on completion.

Incidents were discussed in team meetings and the daily multidisciplinary handover meetings. Weekly reflective practice sessions were used to discuss incidents and review whether lessons could be learned. These were shared with staff via minutes and in team meetings. This fed into the multidisciplinary handover meetings. We were informed of several examples of lessons being learned and practice changing as a result of incident investigation. An example of this is the physical health clinic which is now run on a weekly basis by the specialty doctor. This followed an incident investigation which showed that the hospital needed to be more vigilant around patients' physical health.

Incidents were discussed in the local monthly clinical governance meetings and information was escalated to the corporate clinical governance meetings and board meetings. Any outcomes or reflection was fed back to the local staff teams via the same route.

The company's compliance team audited incidents weekly and provided a report to managers about progress,

Long stay or rehabilitation mental health wards for working age adults

Good

highlighting any outstanding actions. This information fed into the quality and compliance report submitted to the board of directors each month. Any organisational learning fed back into services via this route.

A quarterly comprehensive audit was undertaken and consisted of a spot check of incident forms. The most recent showed that, in the main, incident forms were appropriately and fully completed, although some gaps remained. For example; the dates of post incident review and post incident observation level were missing in a few cases.

Staff worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing. Incidents were an agenda item on the hospital's regular meetings with commissioners and in regular liaison meetings with the police.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

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

On admission, patients attended a care planning meeting with the multidisciplinary team to discuss their situation, history and goals. During this meeting, the patient and professionals agreed a holistic approach to work towards the patient's goals, and arrangements were made for each member of the multidisciplinary team to work with the patient to develop a care plan.

Each patient was discussed in the daily multidisciplinary handover meetings and their progress with goals was reviewed. Any agreed actions were noted and assigned to the most appropriate professional, then reviewed each day until complete.

The specialty doctor held a weekly clinic which patients could attend to review any side effects they were experiencing.

During our inspection we reviewed 11 care records. All were fully and appropriately completed, detailed and personalised, with clear evidence of patient involvement. All reviews were completed in a timely manner, either quarterly or more often if needed. Patients were offered a copy of their support plan and assessments, and each patient was offered a folder to keep their documents in.

Family, friends and carers were involved in a patient's care and treatment where the patient wished for them to be and appropriate consent had been given. We saw evidence of staff involving patients' families and saw examples of where patients had not consented and this was respected by staff.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Staff ensured that patients had good access to had good access to physical healthcare and supported patients to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

The staff team comprised of people from a wide range of disciplines. This included a consultant, a specialty doctor, nurses, psychology staff, occupational therapists and a Mental Health Act administrator. The multidisciplinary team worked effectively together to ensure each patient received the most appropriate care and reviewed this regularly.

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and

meaningful occupation. We observed a psychology group, which was very inclusive and effective. Patients were very positive about the impact of the psychology team on their recovery.

Staff used a range of recognised assessment and outcomes measurement tools. For example; the Model of Human Occupation Screening Tool (MOHOST) was used by occupational therapists to assess life skills. The Brief Psychiatric Rating Scale (BPRS), a rating scale used to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behaviour, and the Brief Symptom Inventory (BSI) which evaluates psychological distress and psychiatric disorders, were both used by the psychology team.

Nursing and medical staff used a range of physical health monitoring tools. The Malnutrition Universal Screening Tool (MUST) was used to help identify adults who were malnourished, at risk of malnutrition or required support with weight management. The Modified Early Warning Score (MEWS) was used to identify patients at risk of clinical deterioration and who may require a higher level of care. Staff used the World Health Organisation Disability Assessment Schedule (WHODAS) as a generic assessment tool for measuring health and disability across cultures. The doctor used The Glasgow Antipsychotic Side-effect Scale (GASS) to monitor the side effects of antipsychotic medicines. Staff also used Historical Clinical Risk Management-20 (HCR20) or the Short-Term Assessment of Risk and Treatability (START) to assess and manage risk of violence where necessary.

Occupational therapy staff also used the Health of the Nation Outcomes Scales (HoNOS), which measures behaviour, impairment, symptoms and social functioning, to measure outcomes relating to the health and social functioning of people with severe mental illness.

Staff undertook full physical health assessments for each patient. They identified patients' physical health needs and each patient had a physical health action plan. Patients were provided with the opportunity to have annual checks with a dentist, optician and chiropodist. The specialty doctor carried out an annual physical health audit, the most recent was in August 2019.

Each patient's physical health was discussed at the daily multidisciplinary meeting and any actions noted and reviewed until complete. The specialty doctor ran weekly physical health clinics which were used to monitor patients. Patients could also drop in if they had any concerns about their physical health or any side effects. Patients were referred to specialists, such as speech and language specialists, where needed and were supported to attend appointments.

The hospital followed NICE best practice guidelines. A full range of policies were in place, and were in line with best practice guidance. The organisation had a policy in place to review and implement new NICE guidelines. On receipt of an alert advising about new and proposed NICE guidance, the NICE coordinator uploaded it to the organisation's database. This was reviewed by the clinical committee, who decided whether the guidance applied to the organisation's services.

There were leaflets and posters visible in communal areas of the wards, with information about healthy eating, smoking cessation, diabetes management, complaints, infection control and ward safety.

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, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. Where agency staff were used, this was on a locum basis to provide continuity and agency workers received induction, training and supervision.

The organisation had a comprehensive training programme. Staff were given a full induction, with mandatory sessions. Some examples were safeguarding, Mental Health Act and Mental Capacity Act awareness, health and safety, fire safety, food hygiene, information governance, and prevention and management of violence and aggression (PMVA). As part of a service level agreement, a local pharmacist provided training in managing medicines.

All staff received regular supervision and an annual appraisal from managers. Where staff required clinical or professional supervision this was provided by an appropriate professional. Managers identified the learning

needs of staff through supervision and appraisals, and when patients had specific needs, specialist training would be arranged. Recent examples of specialist training provided are epilepsy awareness, life support, phlebotomy, personal search training and boundaries.

Staff with specific lead or champion roles were provided with the appropriate level of training. For example, the safeguarding leads had received level four safeguarding training. Fire wardens had attended the appropriate fire warden training.

Staff attended weekly reflective practice sessions. Regular mindfulness sessions were held until the facilitator left the organisation. Three more people were being trained to resume these. A bi-monthly staff forum, facilitated by someone external to the hospital, was held, and the registered manager held a weekly drop-in clinic, so staff had the opportunity to discuss anything they wanted.

Agency staff were fully integrated into the staff team and were provided with training, supervision and support. Agency staff also had access to team meetings, reflective practice sessions and mindfulness.

The hospital operated a psychology graduate programme. This was a new initiative implemented by the organisation due to the large volume of applicants received for their psychology assistant vacancies. The programme involved psychology graduates working on the wards, supported by the psychology department, gaining experience working with patients with a range of mental health conditions. The aim of this programme was to enhance clinical skills on the wards as well as promote learning and development for psychology graduates.

The quality and compliance team monitored levels of training compliance and advised managers when updates were needed. They also carried out regular audits and provided weekly reports. Training figures and compliance levels were discussed at local and corporate clinical governance meetings. A training committee group met quarterly to discuss compliance and training needs across the organisation.

Poor staff performance was addressed promptly and effectively. Senior managers and the human resources team provided support to managers in staff performance issues.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.

The hospital had range of professionals in the multidisciplinary team, including a part-time consultant, a full-time specialty doctor, nurses, a psychology team including psychologist, graduate psychologists and psychology assistants, an occupational therapist and support workers.

The team met each morning to discuss each patient's progress, risks and care and treatment needs, and to agree or review any actions. These meetings were conducted in a professional, structured way, and were very effective in ensuring that the staff team retained oversight of each patient and knew what their individual input should be at any time. We saw staff from all disciplines discussing and considering a holistic range of options for each patient, ensuring the most effective approach was taken for them.

The hospital had effective protocols in place for the shared care of people who used their services. Staff had relationships with a wide range of other agencies and professionals. These included commissioners, care-coordinators, GP surgeries, the local authority, the police and the local pharmacy. The registered manager encouraged communication, transparency and liaison with appropriate stakeholders.

Discharge planning began when patients had their initial assessment. Short-term and long-term goals were discussed, and treatment was set up to achieve what patients identified as their long-term goal. This included where and how they wanted to live and what work and educational aspirations they had.

Adherence to the MHA and the MHA Code of Practice

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

Long stay or rehabilitation mental health wards for working age adults

Good

The hospital had an appropriate Mental Health Act policy which staff were aware of. The hospital provided training in the Mental Health Act. Ninety per cent of staff had been trained in the Mental Health Act which met the hospital's target.

The service had a Mental Health Act administrator who monitored the service's compliance with the Act and undertook audits. Records relating to patients' detention under the Act was in order and appropriately maintained. The hospital ensured that appropriate advocacy was available to patients where needed.

Patients told us they had their rights explained to them in a way they could understand and that this was reviewed regularly. Patients also told us they had their treatment explained to them, and were consulted about medicines, including discussions about options and side effects. During our inspection we saw staff discussing where to access information leaflets about patients' rights in a patient's first language.

Patients with Section 17 leave entitlement were able to take their leave appropriately, and this was properly assessed and managed.

Good practice in applying the MCA

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

The hospital had an appropriate Mental Capacity Act policy which staff were aware of. The hospital provided training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Ninety-two per cent of staff had attended the Mental Capacity Act/Deprivation of Liberty Safeguards training which met the hospital's target.

During our inspection we saw staff discussing capacity and consent in relation to someone's physical health. Staff carried out capacity assessments and ensured they were appropriately recorded.

All patients at the hospital were either detained or consented to be there, therefore no patients were subject to Deprivation of Liberty Safeguards.

The hospital ensured that appropriate advocacy was available to patients where needed.

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

Good

Kindness, privacy, dignity, respect, compassion and support

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

On arrival at the hospital, new patients were given a booklet of information about the hospital. Staff showed them around to help orient them, introduce them to other patients and staff and help with any advice or questions. Each patient had their own en-suite room, which was available to them at all times and for which they held a key.

Patient feedback about staff was mostly very positive, with patients telling us they found staff kind, responsive and supportive. However, two patients told us they found the communication styles of a couple of staff members a little authoritative and that they came across as bossy and directive rather than supportive. During our inspection we saw many staff interacting with patients respectfully, kindly and appropriately. We also saw evidence of the authoritative approach some patients had told us they found difficult. We observed staff providing responsive, practical and emotional support.

Patients had regular one-to-one time with staff and were allocated more if they needed it or were at risk of a crisis. Private spaces were available for confidential discussions and phone calls.

Staff across disciplines worked together effectively to provide holistic care and treatment. They supported patients to understand and manage their treatment and recovery. Staff signposted or referred patients to other services when appropriate and supported them to access those services.

Staff recognised the importance of maintaining support networks in the community and they were very strong in supporting people to do this. We were told of a number of

examples, by patients and staff, of where staff had gone the extra mile to support patients to maintain relationships that were important to them. One example we were told about was a patient who wished to attend a very significant family event a long distance away from the hospital. The patient needed permission from the Ministry of Justice, special transport and three staff members to accompany them. Staff went to considerable lengths to secure all necessary permissions and provided the staffing and transport to enable the patient to attend this event, which was very important to them. This had a significant positive impact on the patient.

Clear confidentiality policies were in place that were understood and adhered to by staff. Staff maintained the confidentiality of information about patients.

Involvement in care

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

All risk and needs assessments, and resulting care plans, were conducted and completed with the full input of the individual. Patients told us they felt very involved and in control of the treatment process. Patients confirmed they received copies of their care plans, and were given a folder to keep all their documents in. Patients were asked in advance, as part of care planning, what they would like to happen and what they would like staff to do in a crisis.

The hospital sought patient feedback in a variety of ways. Weekly patient forums were held, and agenda items included environment/maintenance, food, activities, comments/concerns and upcoming recruitment interviews. Comment cards were available in communal areas, and a twice-yearly patient survey was carried out. Patients had one-to-one time with staff where they could feedback or raise concerns.

Patients had the option to attend daily morning 'rise and shine' meetings. These were run by the occupational therapist and gave patients a platform to raise anything they were concerned about or wanted to discuss. Patients discussed their plans for the day, what they would like to do with any leave they had allocated to them that day, what groups or activities were going on and what they wished to participate in. We observed a rise and shine group, and found it to be inclusive and effective. Minutes were taken of these meeting so that patients who did not attend could see the details of the meetings later if they wished.

Changes were made as a result of patient feedback. Changes to menus were made after patients complained about the food. Patients were given dedicated time slots on ward round as they did not want to wait around. Following suggestions of more ward outings, trips were arranged to museums, boat trips and to the zoo.

Patients were involved in staff recruitment and participated in interviews as part of the panel.

Patients had access to independent mental health and mental capacity advocates. Patients confirmed they knew how to access advocacy and that staff had discussed this with them. Posters were in communal areas on wards advising patients of their right to advocacy and how to access it.

Staff gained consent from patients to involve families and carers. We saw evidence that where consent was given, carers and families were involved. A carers forum was held every two months, and an annual carers survey was carried out.

A friends and family test was carried out quarterly, with questionnaires sent to patients, families, friends, carers and representatives. The most recent showed that 87% of respondents said they would be extremely likely or likely to recommend the hospital.

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

Good

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare

and were assertive in managing the discharge care pathway. As a result, discharge was rarely delayed for other than a clinical reason or reasons outside the hospital's control.

Average length of stay for the hospital was 428 days for the female ward and 959 days for the male ward.

Beds were always available for patients returning from leave.

Referrals came from a number of clinical commissioning groups. A multidisciplinary team reviewed referrals and made joint decisions about whether a patient was appropriate for an initial assessment. The team then considered each assessment to decide whether they could offer a placement.

Discharge planning began during initial assessments and care planning meetings. Patients would start to identify goals, and treatment and support would be tailored towards them. Goals were usually around housing, education, employment and family, but could be whatever the patient wished.

The hospital liaised with patients' funders, care coordinators and local community mental health teams when appropriate to plan for the patients' discharges.

Staff told us about two delayed discharges, both due to funding arrangements for appropriate clinical placements elsewhere, or lack of availability of suitable alternative placement. We saw staff actively attempting to speed up the process with regular contact with patients' funders and escalating issues where necessary.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward/ service 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.

All patients had their own single en-suite bedroom which they could personalise. The hospital had one ward for males and one for females, and was therefore compliant with guidelines around same-sex accommodation.

All bedrooms had a small lockable space where patients could keep their valuables. Patients could access their bedroom during the day. Patients were given their own bedroom key in line with their individual risk assessment.

Most patients were self-catering, following a risk assessment to ensure this was appropriate and safe. Each patient received a generous food budget and either did their own shopping or gave a list to staff to do it for them. Self-catering patients had their own lockable cupboard for food and each had their own shelf in the fridge, which was kept locked and staff held the key. The decision to lock the fridges was taken in consultation with patients, following some issues of food going missing from the fridge.

Any patient not self-catering had food cooked for them by staff, or cooked for themselves under staff supervision. Patients sometimes chose to cook for other patients, which was supported by staff.

Each ward had a well-equipped clinic room. These were not large enough to accommodate a couch or bed to enable staff to conduct all physical examinations on patients, and therefore these were conducted in patients' bedrooms where required.

Each ward had a fixed telephone for patient use which was in a private room so patients could have confidential calls. Subject to their risk assessment, patients could have their own mobile phones on the ward. Internet access was available to patient subject to a risk assessment, as part of their care plan.

The hospital had its own small enclosed garden.

The hospital had a range of rooms for meetings, therapy sessions, relaxation and activities.

The hospital had a dedicated room for patients to meet with visitors. However, as there was only one for the hospital, patients were advised to plan visits to avoid double bookings. Where necessary, meeting rooms could be used for visits when the family room was already in use.

The hospital was committed to ensuring patients' dignity was protected and undertook an annual 'dignity in care' audit. All staff were required to attend equality and diversity training. At the time of our inspection, 96% of staff had attended the training, which exceeded the organisation's target.

Patients' engagement with the wider community

Long stay or rehabilitation mental health wards for working age adults

Good

Staff supported patients to access the local community and educational opportunities. Staff went the extra mile to ensure important relationships were maintained and that patients remained in contact with family and friends.

Staff supported patients to maintain contact with their families and carers and encouraged patients to develop and maintain relationships with people that mattered to them. We saw evidence that staff had gone the extra mile to arrange an important outing for a patient on several occasions.

Patients who were well enough had the opportunity to undertake tasks, such as gardening, at the hospital, for which they were paid in vouchers from the shop of their choice.

Staff supported patients to participate in activities outside of the unit. Staff took patients on regular outings to community venues and places of interest, such as the zoo, museums and the theatre. Staff took patients out for daily walks, and to attend local amenities and go to the shops.

The hospital had agreed with the local church that patients could spend time in the church garden. The hospital provided an ashtray in agreement with the church so that patients could smoke. Staff were making links with a local charity shop so that patients could volunteer. One patient wished to undertake a college course and staff were looking into how this could be funded. Other patients told us they had attended college or had been offered the opportunity to do so.

Meeting the needs of all people who use the service

The wards 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 hospital had information leaflets available for patients regarding their treatment and available services. Although information leaflets were not routinely available in other languages, staff would source these as needed on an individual basis. There were display boards around the wards explaining patients' rights, advocacy services, complaints process and treatment. Information about how to contact the Care Quality Commission was available on notice boards in both wards and in the visitors room.

The hospital had an equality and diversity policy, which was part of the staff induction, and no referral was turned down because of any diversity-related factor.

The hallways were wide enough for wheelchair users and the hospital had a lift which people with mobility needs could use.

Generally, patients' feedback about the food was very positive, and any diet was catered for, including vegetarian and vegan diets, and those required for religious or medical grounds.

Patients were involved in debriefs after events to gain their views and received feedback on the outcomes of any investigations into incident and complaints.

Patients from the LGBTQ+ community were supported. We observed staff talking respectfully about a patient who had experienced some confusion around their sexuality, and discussed offering psychological support if it was required to help the patient resolve their feelings.

Staff supported patients to follow whatever faith they chose, and each ward had a multi faith room.

Staff could access interpreters and signers if needed. Staff also used pictorial aids where appropriate.

Listening to and learning from concerns and complaints

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

A clear complaints policy and process was in place, which staff understood and were familiar with. The hospital reported that in the 12 months prior to our inspection, ten complaints were received, nine of which were upheld. Records showed that complaints were appropriately managed and recorded.

Patients were given information about how to make a complaint as part of their assessment, and there were information leaflets in the hallway and posters on the walls in wards and the visitors room. Patients told us they knew how to make a complaint and how to access advocacy. Complaint records showed that advocates have been used to help with making complaints

Long stay or rehabilitation mental health wards for working age adults

Good

Complaints were discussed in team meetings, the daily multidisciplinary handover meetings and in local monthly clinical governance meetings. Information escalated to the corporate clinical governance meetings and board meetings as appropriate. Any lessons learned were disseminated back to the local staff teams via the same route.

The compliance team audited complaints and compliments weekly and provided a report to managers about progress, highlighting any outstanding actions. This information fed into the quality and compliance report submitted to the board of directors each month. Any organisation led learning was fed back into services via this route.

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

Good

Leadership

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

Leaders had the skills, knowledge and experience to perform their roles. The registered manager was quite new to the hospital, but was recognised by staff and the corporate team as having had a positive impact. Staff reported that managers were approachable and supportive, and that Glenhurst Lodge was a good place to work.

Leaders were visible in the hospital, and approachable for patients and supportive to staff. Senior staff were visible throughout the organisation and visited the hospital regularly.

The leadership team comprised of a range of professionals, including nurses and doctors. There were always a range of managers available to provide support and advice, including out of hours when a manager, a nurse and a doctor were on call.

An effective meetings structure was in place, with monthly senior leadership meetings, managers meetings and hospital staff meetings ensuring that information, developments and learning was cascaded through the organisation appropriately.

Vision and strategy

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

Staff knew and understood the vision and values of the team and organisation and what their role was in achieving that. This was reflected in the way care and treatment was delivered.

Staff had the opportunity to contribute to discussions about the strategy for their hospital, especially where the hospital was changing. Team meetings and staff events focused on the organisation's values.

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. They felt able to raise concerns without fear of retribution.

Staff told us they were happy in their roles, and felt respected, valued and supported, by colleagues and management. The culture of the organisation and the hospital was open, and staff felt confident to raise concerns if they needed to. Staff supervision and appraisal processes were effective, and included conversations about career development and how it could be supported.

Staff had access to support for their own physical and emotional health needs through occupational health. Three staff members were booked onto mindfulness courses, so they could hold regular sessions for staff and patients, as the previous facilitator had recently left the hospital. Support was available to staff via an external service, providing practical and therapeutic help.

Regular staff meetings and events were held. A recent staff day was focused on different cultures, and staff were encouraged to cook something with cultural relevance to them for colleagues to try.

Long stay or rehabilitation mental health wards for working age adults

Good

The organisation undertook an annual National Workforce Race Equality Standard audit. The most recent showed that 53% of staff in the organisation were from black or minority ethnic groups.

Staff we spoke with told us they understood the whistle blowing policy, and that they were confident they could raise concerns without fear of the consequences.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level.

The hospital used a range of key performance indicators to monitor the hospital and measure outcomes. Some of these were set by the organisation and others by the commissioning authority. Regular review meetings were held with commissioners.

Hospital staff also undertook a range of regular clinical and non-clinical audits to ensure processes were being properly followed, and the outcomes of these discussed at various meetings. A service level agreement was in place with a local pharmacy and they carried out weekly audits of medicines cards, medicines and clinic rooms and a full quarterly medicines management audit.

The organisation employed a quality and compliance team who undertook weekly dashboard monitoring of a range of items. These included safeguarding numbers, incident and restraint numbers, staffing figures and vacancies, staff supervision and appraisals, and training. They also undertook regular hospital wide audits and provided staff with a report about their findings. The registered manager was required to provide an action plan which was monitored by the quality and compliance team. In addition, peer reviews were undertaken by staff from other services, and findings reported to the registered manager.

There was a clear structure of senior management, management and team meetings. The structure was designed to ensure that essential information, such as learning from incidents and complaints, recruitment, staff training, and safeguarding was cascaded throughout the hospital and the organisation, and used to improve service provision.

Management of risk, issues and performance

Our findings from the other key questions demonstrated that performance and risk were managed well.

Staff maintained a local risk register which was regularly reviewed. Each risk had its own action plan. Items on the hospital risk register fed into the overall organisational risk register and was discussed and local, corporate and board meetings.

Information management

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

Staff had access to enough equipment and information technology needed to do their work. Information needed to deliver care was stored in paper files, stored in secure filing cabinets in the locked staff room. Electronic copies of careplan and risk assessment information were stored on the hospital's shared drive and each staff member had password protected access.

Information governance systems included measures to ensure the confidentiality of patient records was maintained. All staff were required to attend information governance training regularly. At the time of our inspection, 92% of staff had attended the training which met the organisation's target.

Hospital managers had developed effective joint-working arrangements with other professionals and stakeholders, including commissioners, the police, care co-ordinators and safeguarding teams. Staff shared information with external bodies as appropriate.

Engagement

Leaders and staff actively and openly engaged with patients and staff.

Staff that we spoke to were positive about their jobs and working at the hospital. Staff had access to up-to-date information about the work of the organisation through meeting minutes and notices in staff areas.

Managers and staff held a range of regular meetings, including staff meetings, patient meetings and carer meetings where they engaged openly. In addition, staff, patient and carer surveys were carried out regularly, and the outcomes used to learn and make improvements.

Long stay or rehabilitation mental health wards for working age adults

Good

Learning, continuous improvement and innovation

Managers and staff displayed a culture of learning and continuous improvement.

The hospital had a clear framework for learning from safeguardings, incidents and complaints, and for ensuring that learning cascaded throughout the hospital and the organisation. During our inspection, we saw examples of where practice had changed as a result of learning. Each service within the organisation was peer audited, providing an additional opportunity for services to learn from each other.

The hospital was in the process of introducing electronic prescribing. The electronic prescribing system had inbuilt safety features. These included checks which would make both prescribing and administration errors less likely, highlight missed doses and provide a complete audit trail. The system also tracked timings of PRN (as required) medicines and provided nurses with all cautionary and advisory labels at the point of recording administration. Secure access was available to doctors out of hours and enabled changes to be made remotely in real time.

The hospital operated a bespoke psychology graduate programme. This was a new initiative implemented by the organisation due to the large volume of applicants received for their psychology assistant vacancies. The programme involved psychology graduates working on the wards, supported by the psychology department. The aim of this programme was to enhance clinical skills on the wards as well as promote learning and development for psychology graduates.

Outstanding practice and areas for improvement

Outstanding practice

The hospital operated a bespoke psychology graduate programme. This was a new initiative implemented by the organisation due to the large volume of applicants received for their psychology assistant vacancies. The programme involved psychology graduates working on the wards, supported by the psychology department. The aim of this programme was to enhance clinical skills on the wards as well as promote learning and development for psychology graduates.

We were told of a number of examples, by patients and staff, of where staff had gone the extra mile to support patients to maintain relationships that were important to them. One example we were told about was a patient who wished to attend a very significant family event a long distance away from the hospital, but needed permission from the Ministry of Justice, special transport and three staff members to accompany them. Staff went to considerable lengths to secure all necessary permissions and provided the staffing and transport to enable the patient to attend this event, which was very important to them. This had a significant positive impact on the patient.

Areas for improvement

Action the provider SHOULD take to improve

Managers should ensure contingencies are in place that ensure all audits are completed when the designated person is not at work.

Managers should ensure mitigation actions detailed in risk assessments are carried out at all times.