Elysium Healthcare Limited

Arbury Court

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- The service did not always provide safe care. The wards did not have enough nurses and support staff to safely care for patients or who knew patients well. There were many shifts that did not have the full complement of staff. The ward environments on the forensic wards were damaged in parts and required maintenance.
- Risk management of individual patients was not robust. Staff were not completing patient risk assessments in a timely manner or updating them following incidents.
- Staff were not fully trained to support the needs of all patients. Staff had not received training in learning disability and autism despite having many patients with a learning disability or who were autistic. Mandatory training compliance was low on the psychiatric intensive care unit.
- Staff were not following infection prevention and control guidance regarding use of masks and wearing nail varnish and false nails on the forensic wards.
- Staff on the forensic wards were not receiving regular supervision and did not have access to regular team meetings and updates about the service.
- Patients were not discharged promptly on the psychiatric intensive care unit when their mental health had improved. There were excessive delays for patients to return to their home areas. However the provider was working with external stakeholders and discharges were improving.
- Governance systems were ineffective in identifying areas of concern and responding promptly. Governance processes did not ensure that wards procedures ran smoothly. This included the oversight of the agency induction process, the quality of the patient risk assessments and the sickness and vacancies at ward level.

However:

- Staff minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding. The ward environments were safe and clean on the psychiatric intensive care unit.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team 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.
- 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 on the forensic wards. Staff liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

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 	Our rating of this service went down. We rated it as requires improvement because: • The service did not always provide safe care. The ward did not have enough nurses and support staff to safely care for patients. There were many shifts that did not have the full complement of staff. • Risk management of individual patients was not robust. Staff were not completing patient risk assessments in a timely manner or updating them following incidents. • Staff were not fully trained to support the needs of all patients. Mandatory training compliance was low for safeguarding children and adults and immediate life support training. Staff had not received any training in learning disability and autism. • Patients were not discharged promptly when their mental health had improved. There were excessive delays for patients to return to their home areas. However, discharge rates had improved significantly over the last 12 months. • Governance systems were ineffective in identifying areas of concern and responding promptly. However: • The ward environments were safe and clean. Staff minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding. • Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided. • The ward teams included or had access to the full range of specialists required to meet the

Summary of findings

needs of patients on the wards. 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.

Forensic inpatient or secure wards

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- The service did not provide safe care. The ward environments were damaged in parts and required maintenance. The wards did not have enough nurses and health care assistants that knew the patients well. There were unfilled shifts and a high percentage of agency staff who did not always know the patients.
- Staff were not following infection prevention and control guidance regarding use of masks and wearing nail varnish and false nails. The service failed to audit the implementation of infection, prevention and control guidance and the providers own policies.
- Staff were not receiving specialist training relevant to their role. Staff were not receiving regular supervision and did not have access to regular team meetings and updates about the service.
- The service did not have good governance processes and did not ensure that ward procedures ran smoothly. This included the oversight of the agency induction process and the sickness and vacancies at ward level.

However:

- 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

Summary of findings

assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983.
- 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 with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

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Summary of this inspection

Background to Arbury Court

Forensic and secure wards

Arbury Court is an independent hospital, part of Elysium Healthcare Limited and was registered with CQC on 21 October 2016. There was a registered manager in post and a controlled drugs accountable officer. Arbury Court is registered to provide the following regulated activities:

Treatment of disease, disorder or injury

Diagnostic and screening procedures

Assessment or medical treatment for persons detained under the Mental Health Act

The hospital has 82 beds for women aged over 18 years, with mental health needs. However, the service were caring for 25 women who had a learning disability or were autistic, in addition to their mental health needs.

All patients were detained under the Mental Health Act. Five of the six wards provided forensic or secure services, and one ward was a psychiatric intensive care unit. This will be reported on separately.

There were 44 low secure beds across three wards:

• Daresbury ward has 15 beds for female patients who need care and treatment in a longer term low secure setting.

• Hartford ward has 14 beds and was for female patients who required medium or long-term care and treatment in a low secure setting.

• Alderley ward has 15 beds and was the admission ward, for female patients who required a low secure setting. From this ward, patients could move within the service to another ward.

There were 27 medium secure beds across two wards:

• Delamere ward has12 beds.

• Oakmere ward has 15 beds.

Patients were admitted from across the United Kingdom.

The service was last inspected in November 2020, the inspection was focused of the safe key question and was not rated. The service has been inspected in July 2019, was rated as good overall and good for each key question. There were no actions from the last inspection.

The main service provided by this hospital was forensic and secure services. Where our findings on forensic and secure services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the forensic and secure services service.

Summary of this inspection

What people who use the forensic services say

We spoke with 26 patients, 14 carers and received 14 completed comments cards. We also observed part of the patient council meeting.

When we spoke to patients, they told us they were most concerned about staffing levels, with 16 patients telling us that the wards were short staffed, and this had an impact on activities, accessing leave, observations, and how safe they felt. However, three patients thought the activities were of a good quality and frequency.

Food was another area of feedback from patients, with nine patients saying the food was tasteless, unhealthy and very repetitive choices.

Five patients told us their family were involved in their ward rounds and contributed to the planning of their care.

Six patients told us the communication from the responsible clinician was poor, they were not visible on the ward, and actions agreed at ward rounds had not been completed by staff. Six patents did not feel involved in the planning of their care. Two patients had asked for support from a dietician and they were waiting for this to be arranged.

The environment was a concern raised by patients, with five patients having ants in their bedrooms. Three patients told us it took a long time for repairs to be completed on the ward. However, five patients told us the hospital was clean.

Nine patients said the staff were nice and respectful. However, three patients said staff don't wait for an answer once they have knocked prior to entering their room.

Patients told us of a couple of blanket restrictions; no sugar in their drinks and not being able to do their washing more than once a week and after 7.30pm. This was shared with the clinical manager who was going to investigate this.

Patients knew how to complain and said they felt confident in doing so.

At the patient council we observed, patients raised a concern of staff falling asleep on observations, a relative also told us that too.

Feedback from the comment's cards showed 10 were providing positive feedback, that staff were supportive, caring and resilient.

Two cards were concerned about staffing levels and the high use of bank and agency staff that patients did not have consistency of care.

Two cards included the food being nice and one with the food not being nice.

One cards included concerns about the environment.

Feedback from carers included difficulties of being able to talk to staff to get updates on their relative's progress. This included the challenges of getting through on the phone. Seven carers felt they could have better contact and updates from the service, especially from members of the multidisciplinary team. However, one carer was clear of the plans and next steps of their relative's treatment and the discharge plan.

Summary of this inspection

Seven carers were given information about the service and four were not. Seven carers felt involved in their loved one's care planning and five did not. Nine carers told us they were invited to meetings about their loved one and felt listened to. Three carers were not invited to meetings. However, carers were aware that staff had to ask permission from the patient regarding information sharing and if they declined staff could not share information.

Eleven carers told us they could visit their loved one and the option to visit in the café was a positive, more relaxed experience.

Families told us that the permanent staff that knew their relatives, were compassionate and caring. However, there were concerns regarding agency use, as this affected consistency and opportunity for activities as some agency staff had restricted activities they could support patients in.

Families told us they felt the service could improve the activities they provided for the patients, especially in relation to exercise and physical health. Five relatives were concerned about the physical health of their relatives and said the service had not been proactive in meeting the physical health needs, including referrals to other services.

Acute and PICU

Arbury Court was been registered with the Care Quality Commission on 21 October 2016.

There were 10 psychiatric intensive care beds on Primrose ward. Primrose ward had its own consultant psychiatrist, ward manager and nursing team, but was integrated within the rest of the service.

Patients were admitted from across the United Kingdom. Beds in the psychiatric intensive care unit were purchased on a case-by-case basis by individual NHS trusts and authorities.

Arbury Court was registered to provide the regulated activities:

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

Arbury Court was run by Elysium Healthcare Limited, and was registered with CQC in October 2016. Arbury Court had a registered manager.

At the last comprehensive inspection in July 2019 the service was rated good in each key question. There were no requirement notices but following shoulds:

- The provider should ensure that there is robust monitoring and auditing of the paperwork associated with the Mental Health Act.
- The provider should ensure that the implementation of investigations into incidents, such as root cause analysis, is completed effectively.
- The provider should ensure that the management of medicines is carried out correctly.
- The provider should ensure that when patients are unable or unwilling to participate in the development of positive behaviour support plans, alternative methods are used to determine the meaning behind the patient's risk behaviours.

Summary of this inspection

There was a subsequent focussed inspection in November 2020, looking at elements of the safe key question only. There were no requirement notices but following shoulds:

- The provider should ensure that their policies outline the safeguards required for all patients who are segregated.
- The service should ensure that the necessary safeguards are implemented for all patients subject to restrictive interventions.
- The provider should ensure its policies incorporate standards for the physical environment provided for all segregated patients, and how this will be monitored through governance at all levels of the organisation.
- The service should consider reviewing the culture on wards, to ensure that the potential positive and negatives aspects of familiarity are considered against the need for appropriate professional boundaries.

What people who use the PICU say

Patients told us they felt safe and that staff addressed incidents well. Patients felt some incidents made them feel anxious and that the ward was noisy at times.

Patients described staff as caring and doing their best.

Patients explained they enjoyed the activities such as arts and crafts and that the grounds were pleasant.

Patients felt that they were too far from their home areas which were in the south of England for some.

Carers reported that overall care was good and that they could see that their loved one had progressed in their treatment. However, discharge was slow to proceed. Carers felt that this hampered patients recovery.

The latest patient survey was conducted between February and April 2021. Much of the feedback was positive. However, patients did strongly advocate for a dedicated occupational therapist to be based on the ward.

Feedback from patients via comments cards was mostly positive. This included good food, feeling safe, environment being clean and suitable, the doctor being very involved in patient care and staff being friendly and caring. One patient felt the environment was shoddy.

How we carried out this inspection

Forensic services

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

During the inspection visit, the inspection team:

• visited the service

• toured the service, including all wards and observed the care being provided, including two short observation for inspection (SOFI)

• received feedback from 13 commissioners and an advocate

Summary of this inspection

• spoke with 26 patients

• spoke with 14 family members

• observed five group activities, three ward rounds and a morning handover

• spoke with 35 staff including administrators, health care assistants, nurses, consultant psychiatrist, occupational therapists and leads for different disciplines, ward managers, clinical nurse managers, lead nurse and the registered manager

• looked at 35 care and treatment records of people and 48 prescription cards and associated documentation

• looked at a range of policies, procedures and other documents relating to the running of the service including staff records.

This inspection was unannounced.

The inspection covered all key questions.

The inspection team was three CQC inspectors and four specialist advisors.

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

Acute and PICU

This was a comprehensive inspection focussing on all elements of the following key questions:

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

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

During the inspection visit, the inspection team:

- visited the service and observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with the senior nurse on shift
- spoke with three other staff members
- looked at four care and treatment records of patients
- did a specific check of all patients risk assessments
- carried out a specific check of the medicine management
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

- spoke to two carers of patients
- carried out a review of the seclusion suite
- reviewed information from patients received via comment cards

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Outstanding practice

We found the following outstanding practice:

Forensic and secure wards

- Visiting pods and a café in the grounds to enable patients to have a more relaxed visiting experience with family and friends.
- Patients could access training within the hospital. At the patient council meeting, patients talked about attending basic life support training. Plans were in place for other courses to be offered to patients.

Acute and PICU

- Patients had access to a real work scheme that allowed patients to apply and take up various positions within the hospital. Patients were paid a small wage. Opportunities included hairdressing assistant, retail assistant and domestic roles. A patient on Primrose ward was working in a catering position at the patient café as they were ready for discharge.

Areas for improvement

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

Action the service MUST take to improve:

Forensic and secure wards:

- The service must ensure that repairs to the environment are completed in a timely manner and that risks of infection control are minimised, including replacing flooring in affected areas. (Regulation 15)
- The service must ensure there is an effective governance system in place to oversee the induction and start details of bank and agency staff and meeting infection, prevention and control guidance. (Regulation 17)
- The service must ensure that staff attend relevant training to meet the needs of the patients. Including learning disability, autism and personality disorder. (Regulation 18)
- The service must ensure that staff receive regular supervision in line with the supervision policy. (Regulation 18)
- The service must ensure there is enough suitably qualified, competent, skilled and experienced staff to meet the needs of patients. (Regulation 18)

Acute and PICU:

Summary of this inspection

- The service must ensure that risk assessments are completed promptly for all patients newly admitted to the service. Risk assessments must be updated following incidents to reflect increases in risks. Reg 12 (1) (2) (a)
- The service must ensure that there are enough staff delivering safe care and treatment on each shift to meet the needs of patients. Reg 18 (1)
- The service must ensure that staff are appropriately trained. Staff must be trained in all mandatory training modules. Mandatory training must include relevant specialist training such as learning disability and autism training where necessary. Reg 18 (2)
- The service must ensure that governance processes are robust and able to identify deficits in patients risk assessment, training needs, and that policies are up to date. Reg 17 (1)

Action the service SHOULD take to improve:

Forensic and secure wards:

- The service should ensure that staff follow guidance in relation to minimising the risk of infection and following the dress code in relation to nail varnish and false nails.
- The service should ensure that risk assessments are completed for patients at admission and then reviewed following incidents.
- The service should ensure that policies and procedures are reviewed within the timescales specified.
- The service should ensure that records are updated following changes in patient's needs, especially care plans and moving and handling assessments.
- The service should ensure they review the physical health needs of patients and refer to external professionals as required.
- The service should develop a process of updating staff on changes and provide an opportunity to share ideas, particularly when coordinating team meetings is challenging.
- The service should ensure they produce information for patients about their rights in relation to the use of force by staff who worked in the service.
- The service should ensure that staff understand their role in relation to mental capacity, when a capacity assessment would be needed and where to record the assessment.
- The service should review the training content in Autism to ensure it reflects best practice guidance and legislation.
- The service should review the patient feedback regarding food choices and quality to improve this experience for patients.
- The service should review the requirements of the accessible information standard and ensure they are meeting the requirements.
- The service should develop a way of sharing learning from complaints with staff.
- The service should consider the introduction of a visual board of staff that work on the wards to assist patients who respond well to visual information.
- The service should review the arrangements for providing updates to families, including responding to phone calls.

Acute and PICU:

- The service should consider improving ways to promptly discharge patients who require less supportive environments.
- The service should consider the positive impact of designated occupational therapy input into the ward.
- The service should consider improving the quality of care plans to ensure they are personalised.

Our findings

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	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

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

Requires Improvement

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

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

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas, and removed or reduced any risks they identified. An environmental risk assessment was available for staff working on the ward.

Staff could observe patients in all parts of the wards. There were no blind spots. There were mirrors to aid staff's vision where needed.

The ward complied with guidance and there was no mixed sex accommodation. The ward was female only. All patients had en-suite bathrooms.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. A map demonstrating ligature points and the location of the ligature cutters was displayed in the ward office. Ligature risks were mitigated by the use of observation.

Staff had easy access to alarms and patients had easy access to nurse call systems. Patients could summon assistance via the nurse call alarm system. Staff had individual personal alarms. Both systems were able to show the location of the incident to support a prompt staff response.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. Ward areas were spacious and well designed. Walls were painted in subtle colours and decorated with relaxing artwork. Furniture was in a good state of repair and the cleanliness was to a good standard. Patients had access to an activity room equipped with board games and other appropriate materials.

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

Requires Improvement

Staff made sure cleaning records were up-to-date and the premises were clean. The ward was visibly clean and records indicated that cleaning was completed daily.

Staff followed infection control policy, including handwashing. We observed staff washing their hands or using sanitiser where necessary. Due to the covid 19 pandemic, staff were wearing masks and adhering to the extra infection prevention measures put in place such as opening windows for extra ventilation.

Seclusion room

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. Seclusion rooms were appropriate for patient use and well maintained. There was a television behind a screen for patient use. Each seclusion room had a specialised seclusion bed, chair, toilet and a shower. There was non-rip clothing and blankets if required due to specific patient risk. There was an anti-flooding plan in place.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency medicines that staff checked regularly. All equipment was available and checked including medicines and emergency equipment. All audits had been fully completed. However, one sharps bin had not been dated when first opened.

Staff checked, maintained, and cleaned equipment. All maintenance and cleaning checks were up to date.

Safe staffing

The service did not always have enough nursing staff to keep people safe. Not all staff had received the correct level of basic training. However, there were enough medical staff.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. The staffing establishment for the ward was eight registered nurses and 16 healthcare assistants to run effectively. There were two registered nurse vacancies and an unknown number of healthcare assistant vacancies. Shifts were therefore supplemented by bank and agency staff. We were unable to ascertain full ward vacancy figures during or after the onsite inspection.

The number of shifts that did not have a full complement of staff was high.

For example, on 4 June 2021 the ward required one registered nurse to be working alongside seven healthcare assistance. However, there was one registered nurse working alongside only four healthcare assistants. On 3 December 2021 the ward required two registered nurses to work alongside 10 healthcare assistants. However, there was only one registered nurse working with six healthcare assistants. Records state that support was provided to the ward by staff from across the hospital site.

Over the last 12 months there were 239 shifts (33%) that did not match the staffing requirement set by the service. Of the 239 shifts, 89 (37%) stated that the staffing problem had been escalated to senior and managers and other support was provider from elsewhere within the hospital. Other shifts that did not have a full establishment of staff did not state how staffing was resolved.

There were three shifts during the last six months where there was no qualified nurse:

- 5 October 2021 there was no registered nurse on shift at night.
- 19 December 2021 there was no registered nurse on shift at night.

- 21 December 2021 there was no registered nurse on shift at night.

On both 5 October 2021 and 19 December 2021, the provider safe staffing reports states that support was provided by the twilight shift or the site coordinator. However, the report does not state how staffing was resolved on 21 December 2021.

It is unclear from the safe staffing exception report how senior managers are assured that staffing is always safe. However, there were daily meetings with hospital managers to discuss and plan daily staffing needs.

Most registered nurses were skilled and experienced. There was only one preceptorship nurse employed.

The service had several vacancies for both registered nurses and health care assistants over the last 12 months.

The service had increasing rates of bank nurses. There were no agency nurses used at all. There were four bank nurses that were familiar with the ward and were allocated to the ward as much as possible.

The service had high and increasing rates of bank and agency nursing assistants. Bank and agency staff were mostly deployed at night. During April 2022 bank staff covered 21% of shifts. Agency staff covered 25% of shifts. The ward had approximately 55% of staff who were permanently based on the unit.

Managers used bank and agency staff frequently due to vacancies. Managers requested staff familiar with the service. Managers utilised bank staff as much as possible and attempted to keep staff on wards that were familiar to them. Agency staff were utilised more frequently on night shifts to minimise the impact on patient care.

Managers did not always make sure all bank and agency staff had a full induction and understood the service before starting their shift. The service was reliant on asking bank and agency staff whether they had worked within the hospital and ward before. New bank and agency staff were given an induction into the hospital and ward processes. However, there was a hospital wide problem with the collating of this information. Ward managers could not be assured that all bank and agency staff had received the appropriate inductions due to information not being stored in an accessible format.

The service had a steady turnover rate.

Managers supported staff who needed time off for ill health. There was a policy in place and a human resource department to support staff and managers regarding sickness absence and processes.

Levels of sickness were low. There was one registered nurse currently on sick leave and two healthcare assistants. There had been sporadic short -term sickness due to the covid 19 pandemic. Hospital wide sickness had been between 6 and 11% over the last three months.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Staffing establishment reviews were conducted every six months to ensure there were enough staff for each ward.

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

Requires Improvement

The ward manager could adjust staffing levels according to the needs of the patients. Ward managers calculated staffing needs daily to match the needs of the patients. Ward managers could request extra staff to cover enhanced observations or to support seclusion or long term segregation. However, there were not always enough staff available to meet all the needs of the patients. Staff told us that staff from other wards were requested to support them. However, there were not always enough staff to be shared between all the wards.

Patients had regular one to one sessions with their named nurse. Between November 2021 and May 2022 there had been 292 hours of one to one time with patients and named nurses. Patients confirmed nurses spent time with them when needed.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Data relating to activities was captured on an electronic system. There were no cancelled activities recorded in the last six months. Patients and staff confirmed that occasionally activities or leave were re-arranged due to staffing.

The service had enough staff on each shift to carry out any physical interventions safely. All shifts had at least four staff. Staff could summon support from other wards if needed via the electronic alarm system.

Staff shared key information to keep patients safe when handing over their care to others. All nursing staff attended handover meetings twice a day. Handover meetings thoroughly highlighted patients progress and any incidents.

Staff also had access to a one-page profile document for each patient. This was useful for staff when completing observations. The one-page profile contained detailed relevant information about each patient.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The service had no medical vacancies.

Managers could call locums when they needed additional medical cover. Locum cover was accessible if required.

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

Mandatory training

Staff had not completed and kept up-to-date with all of their mandatory training. Overall compliance across 21 training modules was 87%. The providers target was 90%. There were nine modules that fell below 90% which were:

- Safeguarding adults and children 52%
- Immediate life support 71%
- Fire 86%
- Information governance 81%
- Infection prevention level 1 86%
- Infection prevention level 2 71%
- Mental Health Act 81%
- Professional boundaries 81%
- Suggestions and ideas 86%

The mandatory training programme was not comprehensive and did not meet the needs of all patients and staff. No staff had received any training in learning disability and autism despite 10% of current patients on the ward having a formal diagnosis of learning disability or autism. Three new modules had been added to the mandatory training schedule which were self-harm, learning disability and autism and personality disorder. There was a plan for all staff to have completed these by January 2023.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers and staff were aware of when mandatory training was due. There was an electronic system that highlighted that a course needed to be completed.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. Not all patients had risk assessments in place. However, staff did follow best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff did not always complete risk assessments for each patient on admission / arrival. There were three patients without a risk assessment in place. We reviewed all 10 patients risk assessments.

One patient had been admitted on 23 April 2022 and had no risk assessment in place. The patient had been involved in an incident on 10 May 2022 which was not recorded on the risk assessment document. This patient had been taken to seclusion on 11 May 2022 without any risk assessment in place.

Another patient had been admitted on 10 May 2022 and had no risk assessment in place. The patient had been involved in an incident with another patient on 10 May 2022 which was not documented on the risk assessment.

Another patient was admitted on 29 April 2022 and had no risk assessment in place when reviewed. This patient was also involved in an incident on 10 May 2022 but this was not recorded on the risk assessment document.

Staff explained that risk assessments are completed within 14 days of admission and this is the reason for the delay. However, the provider's policy states they should be completed within seven days of admission. Following our feedback to the provider all risk assessments were completed to include information on:

Current formulation

Need for intervention

Risk estimates

However, one risk assessment still did not include information that they assaulted a peer recently.

We also saw other examples of risk assessments not being updated following incidents. For example:

- A patient had an incident with a peer and the risk assessment was not updated.
- A patient was involved in an incident which involved violence and aggression towards staff. The risk assessment was not updated.

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

Requires Improvement

Staff explained that incidents are not documented within any of the progress notes or risk assessments because the process is to complete an incident form first and then this form is added to the patient care records. However, there is a delay as the incident form needs to be signed at the next morning meeting. We reviewed the care record again during the following morning and no update could be found.

Staff explained that risk assessment would not be updated to reflect recent incidents of violence as historical violence risks are already documented.

Staff used a recognised risk assessment tool called the Short-Term Assessment of Risk and Treatability (START). Some patients also had forensic risk assessments called Historical, Clinical and Risk Management – 20 (HCR-20)

There were monthly audits of patients care records to check the quality of the information held about patients. Over the last six months 15 patient care records had been audited. 13 were found to have risk assessments in place and were up to date. Two patients did not have a risk assessment. The audit did not check whether the risk assessments had been updated following incidents.

There was a risk assessment audit completed in March 2022. Five out six patients had risk assessments in place. One patients audit stated the risk assessment was not completed but was in progress. It is unclear how long the patient had been on the ward. The audit did check whether the patient had been admitted for over two weeks. This had been answered “part”.

There was a pre-assessment care plan produced for each patient prior to admission. This included problem risk behaviours. However, this document was not stored within the patient’s electronic care record.

Management of patient risk

Staff did not know about all risks to each patient and were therefore unable to act to prevent or reduce risks. Not all patients had risk assessments and not all risk assessments were updated following incidents. Staff gathered information from handovers and multidisciplinary meetings.

Staff identified and responded to any changes in risks to, or posed by, patients. Following incidents staff were able to increase observations, offer one to one time or consider seclusion if necessary. However, for patients without risk assessments in place staff were unable to predict risks or act to prevent risks increasing.

Staff could observe patients in all areas. There were no blind spots in the ward. Staff were able to observe patients easily within communal areas.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. There were search policies in place for staff to follow.

Use of restrictive interventions

Levels of restrictive interventions were high. There had been 330 restraints on 30 patients over the last 12 months. Supine restraint was used on 22 occasions and prone restraint on 14 occasions. Intramuscular medicine was administered to patients whilst in prone or supine restraint on 12 occasions. Restraints were high on this ward due to the acuity of the patients. We observed staff attempting de-escalation during incidents.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff were trained in the therapeutic management on violence and aggression (TMVA) programme. TMVA was accredited by the Restraint Reduction Network. The service had a restrictive intervention working group to consider ways to reduce restrictive practice. Safety pods had been introduced to support safer and less intrusive ways to restraint patients. The service was aware of and working towards compliance with the Use of Force Act.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff described using verbal de-escalation and distraction skills to avoid incidents escalating. All staff were trained to use de-escalation skills and staff acknowledged that restraint was only used as a last resort.

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

Staff followed NICE guidance when using rapid tranquilisation. Staff had access to rapid tranquilisation monitoring forms. Staff were aware of the physical health monitoring required following the use of rapid tranquilisation and were able to describe instances of when this was utilised.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Patients in seclusion were reviewed regularly by nursing staff and multidisciplinary reviews were attended by the consultant psychiatrist. This was clearly documented within the electronic care record. Staff documented patient observations on paper notes to highlight events of note. Staff responded to the requests made by patients such as altering the room temperature. Patients confirmed that there care whilst in seclusion was good. There was an up to date seclusion policy available to staff to refer to.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. Staff understood the process for patients in long-term segregation. Patients were reviewed regularly and their care plans updated following reviews. Senior managers had oversight of patients in long-term segregation and external reviews were also carried out. Staff attempted to integrate patients back into communal ward areas when safe to do so. There was an up to date long-term segregation policy available to staff to refer to.

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. However, safeguarding training compliance was low.

Staff received training on how to recognise and report abuse, appropriate for their role. Safeguarding training was included within the staff induction programme and the mandatory training schedule. Staff were expected to complete regular updates or this training.

Staff were not all fully up-to-date with their safeguarding training. Safeguarding training compliance was only 52%. Adult and child safeguarding training, including different levels had been combined into one large module. This meant it took longer for staff to fully complete.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had received training in equality and diversity training to support their understanding.

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

Requires Improvement

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff were aware of vulnerabilities of patients. Staff knew to report and address issues such as patient to patient bullying and exploitation. Clear examples of safeguarding lessons learnt was shared via a monthly newsletter to all staff.

Staff followed clear procedures to keep children visiting the ward safe. There were procedures in place to protect child visitors. Child visits only take place in dedicated family rooms that are away from ward areas. Staff risk assess the visit in advance which may include liaison with the local authority where the child is from.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff described the safeguarding process which included alerting internal safeguarding teams and the local authority where necessary. There were 17 safeguarding incidents and five referrals made to the local authority across the hospital site in the last 12 months.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

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

Patient notes were comprehensive and all staff could access them easily. Patient notes were stored electronically. Staff had easy access to the electronic care record system.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Electronic patient records were stored on a system with password protection and other security settings.

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 mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Medicine was prescribed and reviewed by the consultant psychiatrist on a weekly basis. Medicine was administered by nurses. There was a medicine management policy for staff to follow.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. There were weekly multidisciplinary meetings to discuss each patients progress including whether medicine was improving patient's mental health and wellbeing. Patients confirmed they understood each medicine they took and that the reasons for medicine were explained to them.

Staff completed medicines records accurately and kept them up-to-date. We reviewed seven patient's prescription charts and found all entries to be accurate and up to date.

Staff stored and managed all medicines and prescribing documents safely. All medicines, including controlled medicines were stored appropriately. An external pharmacy visited the ward every two weeks to conduct a medicine audit. A weekly internal audit was also conducted by staff.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. National practice was embedded into the providers medicine management policy for staff to follow.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Excessive use of medicines was considered a part of patient's medicine review. Staff were able to report whether patients appeared over sedated and doctors could reduce medicine as needed.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff used the relevant side effect monitoring tool to assess the impact of any side effects of medicine on each patient. Staff regularly monitored patient's physical health and recorded this on the electronic system.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff were aware to report safeguarding incidents, physical and verbal abuse and many other incidents on the electronic incident reporting system. Staff described the system easy to use and were competent to use it.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff had a policy to follow and had received training in managing incidents. However, the managing incidents policy was out of date and was overdue for review since July 2021.

Staff reported serious incidents clearly and in line with trust policy. There had been 19 serious incidents across the hospital site in the last 12 months. None of the serious incidents related to Primrose ward.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff were aware of the duty of candour principle. Duty of candour was incorporated into the complaints process and other policies as necessary.

Managers debriefed and supported staff after any serious incident. Staff described having significant de-briefs following any serious incident which included the attendance of the senior management team.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers confirmed that after incidents were reported, they were investigated usually by the ward manager. There were currently no themes relating to the nature of the incidents and were generally lower level incidents such as verbal threats by patients and patient's missing belongings.

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

Requires Improvement

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback relating to investigations and lessons learnt from the ward manager and during team meetings. Lessons learnt from other wards within the hospital site was also shared. Staff received a quarterly lesson learnt bulletin.

Staff met to discuss the feedback and look at improvements to patient care. Feedback from incidents was discussed during team meetings. Staff had the opportunity to make suggestions to changes to ward procedure to ensure safer patient care.

There was evidence that changes had been made as a result of feedback. Nurses had experienced distraction whilst completing the administration of medicine. Nurses now where a medicine tabard. This may prevent staff and patients from interrupting nurses working on this task and reduce medicine errors.

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

Good

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

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Assessments were completed during the admission process. Assessments contained both historical and current information.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. All patient's physical healthcare needs were assessed during the admission process. The hospital had on onsite GP who was able to regularly review patients and was also available to them on request. Patients physical health observations were completed at regular intervals and followed up when required.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Patients had multiple care plans that highlighted their needs. Plans included social, mental and any physical care needs.

Care plans were personalised, holistic and recovery-orientated. However, plans lacked specific detail in some areas and contained vague descriptions that lacked meaning. For example, a communication care plan stated, "the ward must make reasonable adjustments to accommodate sensory impairment". However, there was no description of what the sensory impairment was or what adjustment needed to be made. Discharge plans also lacked detail and patient preferences were not noted.

Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were updated to reflect the changing needs to patients.

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

Requires Improvement

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Patients had access to psychological interventions from a team of psychologists. Although there was no psychologist assigned to the ward, the psychological team provided some group work to patients if they were able to partake. Two patients were currently receiving one to one therapy.

Patients also had access to occupational therapy services. There was no occupational therapist assigned to work into the ward multidisciplinary team. However, occupational therapy staff did provide a timetable of activities to the patients which included exercise classes and arts and craft sessions. Occupational therapy staff also visited the ward to provide adhoc occupational therapy activities dependant on current risks and needs of the patients.

Nursing care such as patient observations, risk assessment, care planning and one to one time with nurses was also provided. There was evidence of patients receiving regular one to one time with nurses.

Staff delivered care in line with best practice and national guidance. (from relevant bodies e.g. NICE) Ward policies and processes referenced national guidance such as the National Minimal Standards for Psychiatric Intensive Care Units…

Staff identified patients' physical health needs and recorded them in their care plans. Patients had physical health care plans which detailed any physical health needs and actions required to support better physical health.

Staff made sure patients had access to physical health care, including specialists as required. There was a GP who provided physical health care to all patients across the hospital. There were physical health nurses and nursing assistants. Staff ensured patients attended external health appointments which were prioritised. Patients were provided with transport and staff escorts to support any specialist appointments.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Meals, snacks and drinks were available to patients.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients were weighed regularly and measured against BMI metrics. Patients were encouraged to consider diet and exercise in their daily routines. There were symbols on menus so patients could make an informed choice regarding healthy eating. There was access to ward-based exercise classes. Outdoor walking groups and gym sessions were available for patients with authorised leave.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Health of the Nation Outcome Scores were used on admission, review and discharge to track patients progress in relation to recovery and progress.

Staff used technology to support patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. There were regular audits in relation to clinic room checks, medicines audits, care records audits and infection prevention control audits. The hospital site was in the transition of moving to a new model of care and pathway. Staff were focusing improvements on embedding the new pathway into the service.

Managers used results from audits to make improvements. Manager used results from care record audits to support clinical supervision sessions and aid staff learning.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of the patients on the ward. Ward staff included, consultant psychiatrists, nurses, healthcare assistants and social workers. Occupational therapists and psychologists were available on request. There were no occupational therapists or activities coordinators assigned to the ward specifically. There was no psychologist assigned to work specifically with the patient group. However, psychological support was provided in group and individual sessions.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff were trained in a range of modules suitable for their roles. There were gaps in some staffs training needs which included a lack of learning disability training and personality disorder training. There were plans to include this training within the mandatory training schedule within the next 12 months. Most of the qualified nursing staff were experienced. There was only one preceptor nurse working on the ward. Bank staff had access to the same training as permanent staff members. Agency staff had undergone training within their agencies which matched the providers.

Managers gave each new member of staff a full induction to the service before they started work. Staff received a thorough induction package prior to commencing work. Staff also had a local induction on the ward.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Supervision compliance for the last three months was 78%. Supervision figures had improved significantly over this time. In January only 58% of staff received supervision, in February this was 75% and in March 100% of staff had received supervision. There had been a drive from senior managers to improve clinical supervision over this timeframe.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. There were monthly team meetings for each shift to attend. Minutes were taken and emailed to all staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had opportunities within appraisals and supervision to identify any training needs. Staff reported that access to specialist training was limited. However, managers and senior nursing staff had access to leadership training. There was a new programme of training being rolled out to health care assistants. This included modules on reflective practice, person centred care, health promotion, epilepsy and diabetes. This training was due to start in August 2022.

Charge nurses had been offered management training and investigation training.

Managers did not always make sure staff received any specialist training for their role. There was a large training deficit regarding learning disability training. Although many patients had a diagnosis of learning disability or autism, very few staff had received any training in this area. A new learning disability lead nurse had been employed for the hospital. There was a plan for her to role out training to all staff.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers had access to a human resources team who could support managers through any staff performance issue. There was a policy and guidance for managers to follow.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Weekly or more frequent multidisciplinary meetings were held for each patient.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Meetings gave a thorough overview of the patient's progress, changes in risk and any recent incidents. Medicine was reviewed if required and any changes to treatment discussed with the patient.

Ward teams had effective working relationships with other teams in the organisation. Ward staff liaised well with other internal departments such as the GP service. Staff were able to request GP appointments as needed and share information.

Ward teams had effective working relationships with external teams and organisations. Ward staff had close working relationships with care coordinators and commissioners for each patient. Care coordinators were invited and attended multidisciplinary meetings and discharge meetings. Information was shared and progress and plans mutually discussed.

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. However, training compliance was below the provider target at 81%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff had access to a Mental Health Act administrator who was based on the hospital site.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff spoke highly of the Mental Health Act administrator. Staff could seek informal advice when needed.

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

Requires Improvement

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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Independent mental health advocates were provided by an outside provider. Independent mental health advocates visited each ward at least weekly to speak to patients. There were posters on a notice board regarding the advocacy service available to patients. Leaflets were available upon request. Staff routinely referred patients who lacked capacity. Patients were also offered advocacy if they required support to make a complaint.

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

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. Patient leave was prioritised by staff. There had been no cancelled section 17 leave in the last six months.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. There was evidence of SOAD reviews within patient care records.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. All detention paperwork was recorded electronically. Paper forms were scanned onto the system. Detention records were easy to locate on the electronic system.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. There were no informal patients on the ward at the time of our visit.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act administrator had systems and audits to ensure the Mental Health Act was implemented correctly. The Mental Health Act administrator was able to highlight to managers and staff if any paperwork was due to expire.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Mental Capacity Act training was incorporated into the mandatory training programme. All staff received Mental Capacity Act training suitable for their role. Compliance with Mental Capacity Act training exceeding the providers 90% target.

Staff had a good understanding of the Mental Capacity Act and the processes around assessment and best interests.

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

Requires Improvement

There were no deprivations of liberty safeguards applications made in the last 12 months. All patients were detained under the Mental Health Act.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff had access to a Mental Capacity Act and Deprivation of safeguards policy. The policy was due to be reviewed in November 2022. The policy did not include information relating to the Liberty Protection Safeguards.

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

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. There were concise capacity assessment forms which prompted staff to consider each principle and explain any reasoning and judgement. Capacity assessment forms were clearly identifiable within the electronic care system.

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.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

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

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. Staff knocked on patients' doors prior to entering and attempted to told conversations in private wherever possible.

Staff gave patients help, emotional support and advice when they needed it. Patients reported that staff were available to them if they requested support. Staff endeavoured to help patients with any practical or emotional needs.

Staff supported patients to understand and manage their own care treatment or condition. Patients were knowledgeable about their diagnosis, medicines and treatment plans. Patients had been offered copies of their care plans and were able to describe the content.

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

Requires Improvement

Staff directed patients to other services and supported them to access those services if they needed help. Staff made referrals to external agencies on behalf of patients when required. Staff supported patients to attend any appointments by arranging transports and escorting staff.

Patients said staff treated them well and behaved kindly. Patients described staff as doing their best and were very caring. Patients felt at times staff could appear patronising but recognised that this wasn't intentional and was perhaps due to inexperience.

Staff understood and respected the individual needs of each patient. Staff were able to speak in-depth about patients' needs and any current concerns. Staff spoke in a respectful manner regarding any difficulties.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff confirmed that they felt confident to raise any concerns regarding patient's welfare immediately and without any fear of retribution. Staff described processes for raising concerns via incident reporting, safeguarding reporting and during handover meetings.

Staff followed policy to keep patient information confidential. All patient information was stored securely within an electronic care system. Staff were aware of confidentiality procedures and had a policy to refer to.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients had access to a welcome booklet which described the physical ward environment and explained some restrictions and security measures in place.

Staff involved patients and gave them access to their care planning and risk assessments. Patients confirmed they had copies of their care plans. The electronic record system also highlighted that all patients had been offered copies of their care plans, although some patients had declined. Patients were able to describe their risks and understood actions staff had taken to mitigate the risks. However, we noted that care plans were not always written in patient friendly language and lacked personalisation.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Patients we spoke with understood their care and treatment and spoke about how staff spend time to explain this to them. Multidisciplinary meetings attended by patients gave a good overview of patient progress. Patients with communication difficulties had a communication care plan. However, the communication care plan was vague and lacked specific detail.

Staff involved patients in decisions about the service, when appropriate. Patients had completed surveys regarding their views on the service. Results from the survey were shared with the senior management team. The latest survey was conducted between February and April 2021. Much of the feedback was positive. However, patients did strongly advocate for a dedicated occupational therapist to be based on the ward. An action plan was developed to address any themes. Occupational therapy and activities were to be reviewed on a regular basis.

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

Requires Improvement

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients knew how to raise a complaint and felt confident to do so. Patients explained staff would support them through this process. Patients could feedback on the service via regular ward community meetings.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. There were posters regarding the advocacy service in communal areas. Advocacy service leaflets were available to patients on request. Advocates visited the ward each week to speak with patients. Staff were aware to recommend and refer patients to the advocacy service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers were aware of patient's progress and next steps on their recovery journey. Managers and staff felt that family liaison work was completed well on the ward and that their communication was consistent and of good quality.

Staff helped families to give feedback on the service. Carers were invited to provide feedback about the service via the carers survey. Families and carers could also feedback informally to staff and via the compliments and complaints process.

Staff gave carers information on how to find the carer's assessment. The service had a social work team who signposted families and carers to organisation who could provide carers assessments and other useful resources.

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

Good

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

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. However, patients sometimes stayed in hospital when they were well enough to leave. This was often outside of the hospitals control.

Bed management

Managers made sure bed occupancy did not go above 85%. Bed occupancy rates were well managed. Sitewide bed occupancy was 60%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. However, external factors sometimes meant patients were not discharged promptly. At the time of our inspection visit, there were three patients who were ready for discharge. There was a lack of suitable placements in the patient's home areas which meant there were delays in finding suitable alternative beds. There was good liaison between the ward staff and patients care team. The number of delayed discharge patients had reduced over the last 12 months.

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

Requires Improvement

The service had many out-of-area placements. Most patients were from outside the local area. The service provided psychiatric intensive care beds for patients nationally.

Managers and staff worked to make sure they did not discharge patients before they were ready. There were regular ward meetings to discuss the progress of patients and their suitability for discharge. Patients care coordinators were invited to attend meetings to discuss discharge and make suitable plans.

When patients went on leave there was always a bed available when they returned. Patients beds were not utilised in their absence.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. Patients care needs were considered when deciding if ward moves were required.

Staff did not move or discharge patients at night or very early in the morning. Discharges were planned and were at convenient times for patients.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care. The ward had access to seclusion suites for patients who required more intensive care within the ward.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Managers were aware of patients who were delayed discharges. This had been escalated to senior managers. Staff were liaising with commissioners and other professionals to seek alternative placements.

Patients sometimes had to stay in hospital when they were well enough to leave. Three patients were well enough to leave the psychiatric intensive care unit and return to their home area. However, there was little bed availability in their home area. Staff were continuing to liaise with outside professionals to progress this issue.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Discharge plans for most patients were vague and lacked specific detail. However, discharge discussions within weekly multidisciplinary meetings records were more informative. There were strong links with care managers and care coordinators who were frequently invited to meetings. Attendance was supported using technology such as video conferencing. Despite this three patients remained on the ward for many months after being ready for discharge.

Staff supported patients when they were referred or transferred between services. Patients were given information when they were referred into the service such as a booklet about the ward. Staff supported patients to understand the content and orientate them to the ward environment. When patients were due to be transferred to other services information was given to support patients to understand their plan.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

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

Each patient had their own bedroom, which they could personalise. All patients had individual bedrooms with ensuite bathrooms. Patients were encouraged to add personal touches to their rooms to promote a homely feel.

Patients had a secure place to store personal possessions. There were security lockers which patients could store valuable items.

Staff used a full range of rooms and equipment to support treatment and care. The ward was bright and spacious and decorated with calming colours. There was an activity room with access to board games. There were other rooms for private discussions.

The service had quiet areas and a room where patients could meet with visitors in private. There was a separate visitor's room where families could meet. There was a room for patients to access the telephone if needed.

Patients could make phone calls in private. Patients had access to their personal mobile phones unless this was restricted due to risks. Patients could use their mobile phone in their bedrooms for privacy. Patients had access to a landline telephone that was in a private room.

The service had an outside space that patients could access easily. Patients had access to a garden area.

Patients could not always make their own hot drinks and snacks and were sometimes dependent on staff. The kitchen was locked due to the high risk of patients. One patient was assessed as low risk and had unsupervised access to the kitchen when requested. Most patients needed to request hot drinks or snacks from staff.

The service offered a variety of good quality food. Patients had a choice of meals that patients described as good quality.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. The ward did not have a dedicated occupational therapist. However, activities were facilitated by the occupational therapy team and ward staff. Activities over the last few weeks included exercise classes and arts and crafts sessions. There was a timetable for patients to refer to. Other activities such as board games were initiated on an adhoc basis according to patient's willingness and ability to engage. Over the last six months 787 hours of patient activity was recorded on the electronic system. This included therapeutic interventions, leave, one to one time with staff and activities.

The service had access to a real work scheme. This allowed patients to apply for job roles within the hospital such as assistant hairdresser and shop assistant. One patient from Primrose ward worked within the catering team at the patient café.

Staff helped patients to stay in contact with families and carers. Families and carers were invited to meetings where appropriate. Staff kept families up to date in relation to patients progress with patients' consent.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. There were group activities for patients to engage in together. Patients were observed to have good relationships with ward staff and other staff such as occupational therapy staff and the psychology team.

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

Requires Improvement

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The ward was all ground level with no steps to support those with mobility issues. There was a disabled access bathroom.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. There were information leaflets available to patients about many aspects of their care and treatment. These were not readily available to patients and needed to be requested via a staff member.

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets could be printed in a range of different languages on request.

Managers made sure staff and patients could get help from interpreters or signers when needed. The service had access to an interpreter agency who supported patients during meetings. At the time of the inspection there were two patients whose first language was not English. There was evidence of interpreters being used appropriately.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Alternative food was available to meet specific needs of patients.

Patients had access to spiritual, religious and cultural support. Patients were supported to visit local places of worship if they were able to do so.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Patients and their families were aware of how to make a complaint. There had been two formal complaints in the last two months from patients.

The service clearly displayed information about how to raise a concern in patient areas. Complaints information was displayed within the ward area for patients to access.

Staff understood the policy on complaints and knew how to handle them. Staff spoke knowledgeable about the complaints process and understood their role.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Patients disclosed how staff are available to support them to make complaints. Staff also suggest to patients to make complaints if there is an area of their care, they are unhappy about. Managers are aware of the process to feedback to patients following the outcome of the complaint.

Managers investigated complaints and identified themes. Managers followed a process to investigate the complaint and reach an outcome. There were currently no themes relating to complaints in recent months.

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

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

Requires Improvement

Patients received feedback from managers after the investigation into their complaint. Staff treated patients fairly and professionally following the making of a complaint. There was a process for managers to feedback to patients the outcome. This was communicated verbally and in writing.

Managers shared feedback from complaints with staff and learning was used to improve the service. Themes and feedback from complaints was analysed and discussed during team meetings. Changes were considered if appropriate.

The service used compliments to learn, celebrate success and improve the quality of care. The service logged any compliments received. There was a staff member of the week who could be nominated by patients for their good work.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

Leaders had the appropriate skills for their roles. However, there were some gaps in governance that required attention. This included gaps in staff skills and knowledge around learning disability and autism and gaps within risk assessment processes.

Senior managers understood the service well and the needs to the patient group.

Senior managers visited the ward on a regular basis. Staff knew who senior managers were and what their individual roles were. Senior managers modelled a hands-on approach to help engage staff. Senior managers were visible to staff and patients as needed.

Vision and strategy

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

Staff understood that the vision of the service was to promote mental health recovery wherever possible. The providers values were kindness, integrity, teamwork and excellence.

A new strategy had been introduced which included a new model of care for patients. This demonstrated a clearer pathway for patients' journeys. The new model was:

- phase 1 assessment
- phase 2 treatment
- phase 3 integration and synthesis

The hospital was in the process of embedding the new approach onto every ward.

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

Requires Improvement

Culture

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

Most staff told us they felt supported and valued. However, morale could fluctuate depending on the acuity of patients and staffing levels. Staff told us they felt stressed when staffing was below the expected level.

Staff told us equality and diversity was promoted within their work and that training regarding this was ongoing.

Staff felt there were opportunities for career progression and additional training if desired. This included leadership training. There was a new training programme for health care assistants to complete. This was being rolled out within the next 12 months.

All staff said they felt they could raise any compliant or concern without fear of retribution.

At the last inspection there were concerns about staff not always behaving professionally around patients. We found no evidence of this during this inspection.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Systems and processes were not fully effective in identifying gaps in the risk assessment provision. There were three patients without a risk assessment in place. There were two patient incidents that were not updated on patient's risk assessments. Care record audits and other governance checks did not capture these shortfalls.

Systems were ineffective in ensuring the staff skill mix met the needs of patients. The ward regularly admitted patients with learning disability or autism needs. The service was slow to respond to this need.

There were also two policies that were overdue for review.

However, other governance processes were in place and effective in identifying issues such as low staffing levels.

The necessary board and committee meetings were in place. There was a process for information from ward level to board level if needed. Meetings were held regularly, and the appropriate assurances were sought for any issues raised.

Management of risk, issues and performance

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

Team managers had access to electronic dashboards that contained information that was useful for quality checking the service. Ward managers monitored the dashboards within their day to day work. This included, staffing levels for each shift, staff mandatory training compliance rates and staff supervision and appraisal figures.

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

Requires Improvement

There was a risk register in place that captured relevant and current service level risks. There were actions in place to mitigate these risks and timeframes for completion. Risk issues could be escalated to senior managers within a framework of quality and governance meetings. Staffing issues were a sitewide risk and were highlighted within the risk register for the service.

Information management

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

The service had systems and process in place to collate and analyse data from various sources. This included an electronic incident reporting system and data produced from audits. Ward managers and senior managers were able to use the data to look for themes and trends.

Key performance indicators were produced to measure quality and shared with commissioning bodies on a quarterly basis.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers engaged well with outside agencies. There were good links with patient's home area care teams. Managers and staff actively sought to forge links to support patients discharge home.

Learning, continuous improvement and innovation

The service was part of the National Association of Psychiatric Intensive Care Units accreditation scheme. Managers felt that aspects of the safewards intervention would be beneficial to the ward. Another priority was to embed the new pathway methodology.

Requires Improvement

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

Not all wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Environmental ligature point audit & risk assessments were completed for all wards, main areas of the hospital and grounds. These included the level of risk and recommended action.

Staff could observe patients in all parts of the wards. There were blind spots which were mitigated by mirrors.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. A leaflet had been created to help staff understand their role in reducing ligature risks and we saw the symbol for the ligature cutters on all door of the location of the cutters to assist staff to locate them promptly.

Staff had easy access to alarms and patients had easy access to nurse call systems. Nurse call buttons were in patient bedrooms and staff and visitors had portable alarms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose on Daresbury and Hartford wards. However, on Oakmere ward, a patient's bedroom has sections of the floor covering missing and peeling in parts and smelt of urine. Due to the floor covering not being intact, this meant there was porous material which would have absorbed the odour and posed a risk of infection control and would be unpleasant for the patient sleeping in that room. We reviewed the authorised environmental repairs and noted that approval for this repair had been authorised on 21 April 2022. However, at the time of the inspection this repair had not been carried out.

Requires Improvement

Forensic inpatient or secure wards

On Alderley ward, there were missing seat cushions on two chairs, staff and patients told us they had been missing for a while. They were not listed on the audit action plan or on the authorised environmental repairs. However, we were shown an invoice for five chairs ordered on 20 April 2022. The chairs had not been replaced at the time of the inspection visit. This meant that patients had limited space to sit in the quiet lounge.

Privacy screening in the bedrooms on Alderley ward were peeling off, although you couldn't see into the bedrooms from outside, you could see the peeling screen which was not welcoming. Data provided regarding repairs and refurbishments stated that bedroom and bathroom furniture would be replaced on Alderley ward. The provider explained this also included the replacement of the privacy screening.

On Delamere ward there were cubes that staff sat on mainly in corridors when competing observations. These were ripped. The provider had ordered replacement cubes on 20 April 2022.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff did not follow infection control policy, including handwashing. We saw staff with painted and long false nails. This was not following the providers dress code policy which states: "Employees should also be aware that varnished/acrylic nails/nail extensions can cause injury to patients, should the wearer be involved in a clinical incident or in the course of delivering care. Additionally, this is an infection control risk within clinical areas. These should not be worn in clinical areas." This also posed a risk of injury to patients.

We saw five occasions where staff were not wearing their face mask properly in clinical areas. Current guidance was that staff working in healthcare settings should wear a facemask. We observed staff wearing the mask under their noses on two occasions and staff pulling their face masks down below their chin on three occasions to talk to patients. This meant staff were not doing all they could to stop the spread of infection.

Infection, prevention and control audits were completed daily by the night coordinator. We reviewed the infection prevention and control audits for 2022 which should have been completed daily. We found there were 51 audits missing. Of the 83 reviewed, there were 17 days where staff were not wearing masks properly. There was no record of infection prevention control audits being competed during the day shifts. This meant the service were not reviewing the staff compliance with PPE during the day.

Seclusion rooms

There were seclusion rooms on Hartford ward, Alderley ward, Delamere ward, allowed clear observation and two-way communication. They all had a toilet, and all had access to a clock apart from the seclusion room on Alderley ward. The seclusion rooms on Delamere ward had paint peeling off and marks on the walls.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Requires Improvement

Forensic inpatient or secure wards

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. Patients and carers told us there were not enough staff on the wards. We reviewed staffing reports for four dates in April and May 2022 and found on 24 April 2022, the day shift showed two registered nurse shifts unfilled. On 25 April 2022, the day shift had two health care assistant roles unfilled. On 7 May 2022, the day shift showed one registered nurse shifts unfilled and one health care assistants unfilled. On 8 May 2022, the day shift showed three registered nurse shifts unfilled and four health care assistants unfilled. This meant there were not enough staff to ensure activities took place with patients, staff had breaks and staff followed best practice for having breaks between observations. We reviewed the allocations for Oakmere ward on 3 May 2022 which showed the registered nurse did not have a break. Review of the observations board on Oakmere ward for 12 May 2022 showed four staff doing continuous observations for 3 and 4 hours at a time. National institute for health and care excellence guidance NG10 states "Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours.

The service had vacancies for registered nurses since January 2022 and health care assistants since December 2021.

The service had high rates of bank and agency use. We reviewed the bank and agency usage per ward and found in the month prior to the inspection, Oakmere ward had just over 40% permanent staff, Hartford ward had just over 50% permanent staff, Delamere ward had approximately 30% permanent staff, Alderley ward had 40% permanent staff. However, Daresbury ward had nearly 70% permanent staff. Patients raised staffing at the patient council meeting and the Hospital Director said they were trying to attract more staff by doing recruitment days, and offering incentives. Feedback from commissioners was that incidents seemed to happen more when patients were supported by agency staff and staff that did not know them well. There was some attempt by the provider to match bank staff to specific wards. However, this was not always consistent.

Managers were trying to limit their use of bank and agency staff and had started to request staff familiar with the service. We reviewed the agency sign in sheets for May 2022. On 11 May 2022 night shift there were 14 agency staff working across the hospital, 13 of whom had worked at the hospital earlier in the month. On 11 May 2022 day shift there were 17 agency staff working across the hospital, 15 of whom had worked at the hospital earlier in the month.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift. There was no system to monitor agency and bank staff's completion of the induction. Induction checklists were stored in a variety of places across the hospital, they were not scanned onto the computer system and there was no record of the date of completion and the first shift with the hospital. Managers told us historically there was a system in place, which had been lost due to technical problems. A blank checklist was submitted following the inspection. We asked to view the completed induction checklists for the agency staff working on 12 May 2022, these could not be located during the inspection, however they were submitted following the inspection.

Managers supported staff who needed time off for ill health. Staff told us of the support provided to them.

Levels of sickness had been high in January 2022 with 12.1% and was 8.9% in March 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Staffing coordinators had oversight of this during office hours. However, in an evening and weekend this responsibility was given to one of the registered nurses on shift, staff told us, and records showed that this took the staff away from the ward and the direct care of patients.

The ward manager could adjust staffing levels according to the needs of the patients. More staff

were requested when there were increased observations.

Patients did have their escorted leave or activities cancelled, due to staffing challenges. We reviewed the incidents for the last six months where patient leave, and activities had been cancelled. We found Alderley ward had 50 hours of cancelled activity, Daresbury ward had 399 hours of cancelled activity, Delamere had 76 hours of cancelled activity, Hartford ward had 1300 hours of cancelled activity and Oakmere had 104 hours of cancelled activity. These figures include leave that has been cancelled for other various reasons such as declined due to patient refusal, declined as the patient is too unwell to engage at the time and wards needing to isolate due to covid outbreaks. However, staff and patients confirmed the primary reason in most instances was staffing issues. There was a policy in place that stated, all cancelled activities, regardless of reason, should be always re-arranged with a two week period.

Staff shared key information to keep patients safe when handing over their care to others. One page profiles were being introduced and patients were discussed at handover.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There were five consultants and a speciality doctor. However, the speciality doctor was not an approved clinician, and was part time. The consultants shared the allocation of the patients from the PICU. This also made it difficult when trying to cover for colleagues. Staff accessed the on call for the North West for support out of hours.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The April 2022 training report showed that compliance for permanent staff was 92% and for bank staff it was 79%.

The mandatory training programme or induction did not include learning disability or autism awareness and the hospital forensic wards were caring for 24 women who had a learning disability or were autistic, in addition to their mental health needs.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well, however these were not always updated following incidents and completed timely. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. The ward staff had regard to Mental Health Unit (Use of Force) Act 2018 and its guidance, however they did not always comply with the requirements.

Assessment of patient risk

Staff completed risk assessments for the majority of patients on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 35 care records. Two risk assessments on Hartford ward were not updated following incidents. One patient on Delamere ward did not have a completed risk assessment, they were

admitted to the service on 25 April 2022, the manager told us they would be completed within two weeks of admission. It was over two weeks when we reviewed the record. The risk assessment policy states that where risk assessments are not completed pre admission, they will be completed within 7 days of admission. This meant risk assessments were not current for all patients and the risk assessment policy was not being followed.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff knew about the majority of the risks to each patient and acted to prevent or reduce risks. One page profiles had been introduced to provide staff with a summarised brief document of how best to support patients and essential information staff needed to be aware of. These documents are particularly helpful for staff new to the ward. One patient on Hartford ward did not have an accurate and up to date risk assessment, recent incidents had not been included on the risk assessment or one page profile. It was not clear how staff would know how best to support an individual with a nut allergy.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff were visible in communal areas and were responsive to people's needs. Records showed staff responding to incidents.

Staff followed procedures to minimise risks where they could not easily observe patients. These included the use of mirrors.

Staff followed the providers policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Search training was included in staff induction. The search policy was dated April 2019 and should have been reviewed prior to April 2022, however this had not been completed. This meant the provider were not reviewing policies as planned.

Use of restrictive interventions

Levels of restrictive interventions were reducing. At the last comprehensive inspection in July 2019 there had been 917 episodes of restraint in the 6 months prior to the inspection. At this inspection there had been 1533 episodes of restraint over 12 months, this is an overall reduction as 6 months data would be approximately 767.

The service had a high risk items database which included items that were restricted in the ward environments, however there were examples where patients had access to items in a controlled way, for example with staff supervision and these were individually assessed.

Hartford ward' bedroom corridor was locked between the hours of 10am to 1.30pm, this was included on the wards blanket rules log. The rationale for this practice was to allow cleaning to take place due to patients trying to self harm with cleaning products and also to encourage patients to participate in activities. This was also reviewed at the patient community meetings.

Staff participated in the provider's restrictive interventions reduction programme training, which met best practice standards including the requirements of the Mental Health Unit (Use of Force) Act 2018 and its guidance. The training was accredited by the British Institute of Learning Disability. However, there was no published information for patients about their rights in relation to the use of force by staff who worked in the service.

Requires Improvement

Forensic inpatient or secure wards

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Records showed and we saw staff deescalating patients including use of distraction and making use of the outside space.

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

Staff followed NICE guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. The seclusion and segregation policy, recently updated, provided staff with guidance and expectations of their roles.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There were two patients being nursed in long term segregation. All records were compliant with the Mental Health Act and individualised long term segregation care plans were in place. One of the patients we spoke with, told us they would like to be involved in more activities and gave suggestions of activities. This was fed back to the service and an update was reviewed following the inspection that the activities had been facilitated.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Bank staff compliance was 73%. Permanent staff compliance was 80%.

Staff were kept up-to-date with their safeguarding training. A matrix was in place to identify staff who were due to expire and needed to refresh their training. Training was completed annually.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. A child visitor policy was in place with clear procedures for staff to follow.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider's safeguarding policy provided staff with guidance on their responsibilities and actions to take.

Managers took part in serious case reviews and made changes based on the outcomes. Safeguarding matters newsletters were created and shared with staff bimonthly. These included contact details for advice and guidance, updates and reminders, for example think family, culture, Use of Force Act.

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.

Requires Improvement

Forensic inpatient or secure wards

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

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date for the majority of patients. Two risk assessments had not been reviewed following incidents and one patients did not have a risk assessment completed by the service.

Medicines management

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

We reviewed 48 prescription cards.

Staff followed systems and processes to prescribe and administer medicines safely. There was an investigation underway regarding prescribing errors for two patients in relation to clozapine, the provider had informed CQC of this via a statutory notification.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Leaflets were available and patients told us they had been provided with information about their treatment.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely. Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medicine charts where required.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Guidance was included in the providers medicines policy.

Staff learned from safety alerts and incidents to improve practice. The lead consultant attended the clinical governance meetings and learning was discussed there under physical health. Ward managers attended these meetings so that information could be disseminated.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Records showed this took place.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Requires Improvement

Forensic inpatient or secure wards

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy. The managing incidents and untoward occurrences policy was dated July 2018 and should have been reviewed prior to July 2021, however this had not been completed. An updated policy had been under review during April 2022. This meant the provider was not reviewing policies as planned.

Staff reported serious incidents clearly and in line with policy. Incidents were discussed at the clinical governance meetings, with learning and actions shared with attendees.

The service had no never events on any wards.

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

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly.

Staff received feedback from investigation of incidents, both internal and external to the service. Actions and outcomes were shared at the clinical governance meetings.

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

There was evidence that changes had been made as a result of feedback. Following feedback from patients and staff that agency staff had been sleeping on observations, these were individually investigated. If found to be substantiated, staff were not allowed to continue to work at the hospital, this was shared with the agency and other hospitals within the group. We observed a member of staff that seemed to be sleeping on observations, we informed the provider and they took appropriate action.

Are Forensic inpatient or secure wards effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Hospital passports were in use for the patients, if they were attending acute hospitals to advise of their needs and how best to support them.

Requires Improvement

Forensic inpatient or secure wards

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. However, family members told us that the service was not that proactive at making referrals to external agencies for physical health needs and that they has to make the referrals.

Staff did not always develop a comprehensive care plan for each patient that met their mental and physical health needs.

Two patients that we reviewed had moving and handling needs. One patient used a variety of aids and equipment to mobilise. Although they had a moving and handling assessment in place, this was dated 15 February 2021 and had not been updated since then and did not include how staff were to support them with the equipment. The provider's manual handling policy says "A review should be carried out at least annually. If there is any significant change to a task, environment, individuals or types of load, then reassessment should be carried out as the change occurs." Staff were not following the policy.

Staff had received training in moving and handling needs with 21 out of 23 permanent staff for the ward, having completed the training. Both eLearning and face to face training was provided, which was tailored to the individual needs of patients.

Staff regularly reviewed and updated care plans when patients' needs changed. We reviewed 35 care records, all the care plans were up to date.

Care plans were mostly personalised, holistic and recovery-orientated. Of the 35 care records reviewed, 32 were personalised, 30 were holistic and 31 were recovery orientated. Patients with a learning disability had started to have communication care plans introduced however they were general guidance of how to communicate with people with a learning disability and not individualised. On Oakmere ward, one patient with a learning disability and an autistic patient did not have a communication plan in place.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff mainly delivered care in line with best practice and national guidance. However, we reviewed the allocations for Oakmere ward on 3 May 2022 which showed the registered nurse did not have a break. Review of the observations board on Oakmere ward for 12 May 2022 showed four staff doing continuous observations for 3 and 4 hours at a time. National institute for health and care excellence guidance NG10 states "Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours.

Staff identified patients' physical health needs and recorded them in their care plans.

Five relatives were concerned about the physical health of their relatives and said the service had not been proactive in meeting the physical health needs, including referrals to other services.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration.

Staff had started to help patients live healthier lives by supporting them to take part in programmes or giving advice. Zumba sessions took place on the ward and patients had access to the hospital gym. For patients with leave, they could access swimming, aqua aerobics, football and walking in the community. Healthy eating sessions took place on some wards.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. There was a psychology clinical intervention model at the service. In the first phase of assessment, risk assessments were completed, and treatment targets identified. In the second phase of treatment, a variety of psychological therapies were offered to patients including CBT(cognitive behavioural therapy), DBT (dialectal behavioural therapy), CFT (Compassion Focused Therapy) and EMDR (Eye Movement Desensitisation and Reprocessing). Commissioners said that they thought the service would benefit from providing more trauma informed care. The third phase of the model was integration and synthesis, focusing on maintaining skills and preparation for discharge.

Staff used technology to support patients. During COVID19 the use of technology enabled relatives, commissioners and other professionals to participate in meetings and reviews of patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Audits included health and safety, infection prevention control, risk assessments, care records, with actions identified.

Managers did not use results from audits to make improvements. The findings were not discussed at team meetings with staff.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers did not make sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals and managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. Including occupational therapists, psychologists, social workers and a speech and language therapist.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. This was reviewed via the agency profiles that were provided and by the recruitment process for permanent and bank staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff to develop through yearly regular, constructive appraisals of their work. A structured template was in use with the reflection of the last year, a consideration of values and the creation of measurable objectives.

Managers did not support staff through regular, constructive clinical supervision of their work. The supervision policy stated that staff should receive supervision every 4 to 6 weeks or a minimum of 10 to 12 times a year. On Alderley ward, we reviewed 11 supervision files. One staff member received three supervisions in a year. Seven staff members received two supervisions in a year. Two staff members received one supervision in a year. One staff member received four supervisions in a year. On Delamere ward, we reviewed seven staff files and found that staff had only had one supervision in the last year.

We reviewed the supervision matrix and found that on Daresbury ward 10 out of 18 staff (56%) had received regular supervision in the last quarter. On Oakmere ward 22 out of 27 staff (81%) had received regular supervision in the last quarter. On Delamere ward 7 out of 29 staff (24%) had received regular supervision in the last quarter. On Hartford ward 22 out of 24 staff (92%) had received regular supervision in the last quarter. On Alderley ward 3 out of 42 staff (7%) had received regular supervision in the last quarter. This meant staff were not receiving regular supervision, support and guidance in relation to their role.

Managers did not make sure staff attended regular team meetings or gave information from those they could not attend. We reviewed the minutes of the meetings and found that in the last six months, Daresbury and Hartford had two meetings, Delamere and Oakmere had three meetings and Alderley had five meetings. However not all staff were invited to these meetings, some were just for registered nurses, some for Health care assistants and most minutes were very brief which would make it difficult for staff who didn't attend to know what was discussed. The provider informed us that the Covid 19 pandemic prevented many meetings going ahead as staff were unable to work across wards during covid outbreaks.

Managers did not make sure staff received any specialist training for their role. The service were caring for 25 women who had a learning disability or were autistic, in addition to their mental health needs. Staff told us they had only recently been offered training in this topic. Compliance levels were 31%. We reviewed the training content for Autism and Learning Disability, this referred to challenging behaviour which is not a label used to describe people's behaviour. More recent descriptions include "people communicate through behaviours that others may perceive as challenging" the training did not refer to the Autism Act or the core capabilities framework for supporting autistic people. This meant staff would not receive training that was current and in line with best practice guidance.

Of the 25 patients who had a learning disability, 17 also had a personality disorder. There were many other patients who had a diagnosis of personality disorder. Training had been developed in the topic with 37% compliance.

Managers recognised poor performance, could identify the reasons and dealt with these. If poor performance was from agency staff, the service liaised with the agencies too.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed two multidisciplinary meetings where the patients were involved and all present contributed.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We observed a morning handover where ward managers and senior leaders shared risks, incidents and staffing challenges.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. We received feedback from 12 commissioners and an advocate. Four commissioners felt the service could be more proactive in providing updates, particularly if their patients were involved in any incidents. Two commissioners felt the service could be more trauma

informed. The use of handcuffs to transport patients to acute hospital had been a historic concern, the service had reviewed the use of these, and an investigation was underway. However, they all said the service was very caring to patients in quite a busy environment and was responsive during the admission process and provided a variety of activities and the access to paid work opportunities was viewed positively.

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

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

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Training compliance was 91%

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There were two advocates that provided support to patients. Support was available face to face or remotely.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

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

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act compliance was reviewed as part of the care record audits.

Good practice in applying the Mental Capacity Act

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

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. Training compliance was 88%

Requires Improvement

Forensic inpatient or secure wards

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. The social work department led on this and could give examples where best interest decisions were made in relation to managing finances and self neglect.

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

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

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

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. We reviewed care record audits for each ward. There was a section for how well the record complied with the Mental Capacity Act. Each audit said, "Not applicable during this review period". We found three examples of capacity assessments within the records.

Are Forensic inpatient or secure wards caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it. We saw staff responding to patients, offer emotional support and distract and divert patients who were anxious or upset into an activity they enjoyed.

Staff supported patients to understand and manage their own care treatment or condition. We observed patients were actively involved in their ward rounds.

Staff directed patients to other services and supported them to access those services if they needed help. Patients told us and records showed that activities were pursued in the community for those with appropriate leave.

Patients said staff treated them well and behaved kindly. On the whole patients gave very positive feedback about the staff. However, they said some agency staff who do not know the patients and the ward well are not that engaging and communicative.

Requires Improvement

Forensic inpatient or secure wards

We conducted two short observation frameworks for inspection. One on Alderley ward and one on Oakmere ward. On Alderley ward, we observed staff having positive interactions with patients, engaging them in activities and spending time with patients who were reserved and withdrawn. On Oakmere ward, staff were sat with patients in the communal area, talking about their hobbies and interests and progress in the service.

We reviewed the compliments for the service and found compliments had been received from carers and patients regarding the care provided.

Staff understood and respected the individual needs of each patient. Staff were accommodating of the specific needs of patients, including those with mobility needs, those who enjoyed chatting and engaging in activities and those who preferred spending time in a quiet part of the ward.

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

Staff followed policy to keep patient information confidential. Within the staff office, patient information was anonymised and there was boards that folded in to ensure information was kept confidential.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients ale received a welcome booklet which explained the ward details and what to expect.

Staff involved patients and gave them access to their care planning and risk assessments. Patients were fully involved in reviewing their needs and goals as part of their ward rounds.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Easy read documents had been created to describe the models of care, and the use of physical intervention to assist patients to understand when and why it maybe used.

Staff involved patients in decisions about the service, when appropriate. A patient council took place monthly. We observed part of a meeting. There were patient representatives from each ward. The agenda included recovery and activity, complaints, ward issues, models of care, physical health, audit and hospital update. We observed patients were able to share their views and they were listened to. Patients talked about the recruitment to being involved in the staff induction and interview process, patients had been identified and were being prepared for the role.

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings took place on the wards, patient representatives attended patient councils and we saw patients giving feedback informally on the wards. Patient surveys also took place where they were asked about topics including information given to them, understanding rights, information about their treatments, involvement, activities and food.

Staff supported patients to make advanced decisions on their care.

Requires Improvement

Forensic inpatient or secure wards

Staff made sure patients could access advocacy services. The advocate was on site during the inspection. There were two advocates that covered different wards in the hospital. Patients told us they had easy access to the advocates. Contact details for the advocacy service was on display on the wards.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always support, inform and involve families or carers. There was a family and friends information booklet in place with details of the service, what to expect and support organisations contact details for support for them.

We spoke with 14 family members. Feedback included difficulties of being able to talk to staff to get updates on their relative's progress. This included the challenges of getting through on the phone. Seven carers felt they could have better contact and updates from the service, especially from members of the multidisciplinary team. However, one carer was clear of the plans and next steps of their relative's treatment and the discharge plan.

Seven carers were given information about the service and four were not. Seven carers felt involved in their loved one's care planning and five did not. Nine carers told us they were invited to meetings about their loved one and felt listened to. Three carers were not invited to meetings. However, carers were aware that staff had to ask permission from the patient regarding information sharing and if they declined staff could not share information.

Eleven carers told us they could visit their loved one and the option to visit in the café was a positive, more relaxed experience.

Families told us that the permanent staff that knew their relatives, were compassionate and caring.

Staff helped families to give feedback on the service. Historically there had been carers events and an active group of carers meeting to discuss the service and give feedback, also involved in delivering training, however as their loved ones had been discharged from the service, the group reduced and had not been effective remotely during COVID19. However, there was a carers event planned for June 2022 with the aim of re-establishing carer involvement.

Staff gave carers information on how to find the carer's assessment. Referrals could also be made for a carer's assessment.

Are Forensic inpatient or secure wards responsive?

Good

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

Access and discharge

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

Bed management

Managers made sure bed occupancy did not go above 85%.

Requires Improvement

Forensic inpatient or secure wards

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Records showed when patients were ready for discharge. The service liaised with case managers and commissioners regarding alternative placements, we saw one patient preparing for discharge from a medium secure ward to a lower security placement during the inspection.

The service had out-of-area placements from Scotland and Wales, due to the nature of the service, some patients had to travel to access the service.

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

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. Examples included patients progressing within the hospital as their recovery progressed. There was a pathway through the hospital, with Alderley ward and Delamere wards being the admission and assessment wards.

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

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Patients did not have to stay in hospital when they were well enough to leave. Commissioners and family members said some patients were delayed discharges, due to the challenge of finding an appropriate placement to be discharged to. We reviewed the data and found there were five patients who were delayed discharges, one patient had been waiting since 2019 and the other four had been waiting since 2021. Commissioners were aware of the situation.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Feedback from commissioners was positive regarding the access and discharge process within the service.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was not always of good quality and patients could make drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw bedrooms with a variety of personalised items in them.

Patients had a secure place to store personal possessions. Locked storage was within each bedroom. For items that were restricted on the ward, patients had lockers where items were stored and accessed for them with staff supervision.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms.

The service had quiet areas and a room where patients could meet with visitors in private. There was a visitor's pod which had been created in the hospital grounds in response to COVID19, this was so well received that this has continued in use. There was also a café in the grounds where visits could take place. Families talked positively of the visiting options.

Patients could make phone calls in private. Patients had mobile phones which were individually risk assessed.

The service had an outside space that patients could access. Patients had to ask staff to access this.

Patients could make their own hot drinks and snacks and were not dependent on staff on Hartford ward, Daresbury ward, Alderley ward and Oakmere ward. However, on Delamere ward, patients could access cold drinks and required staff support to access hot drinks or snacks. This reflected the patient population and their current risks.

There was mixed feedback regarding the variety and quality of the food. Nine out of 26 patients said the food was tasteless, unhealthy and very repetitive choices.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. Paid work roles were offered within the service. These were advertised on the wards. Roles included assistant hairdresser, shop assistant and litter picker. Patients were paid a minimum wage and these opportunities provided experience and the opportunity for references.

There were animals on Daresbury ward, patients were involved in caring for them and other patients from other wards spent time with them as an activity which we observed patients enjoying.

Patients could access training within the hospital. At the patient council meeting, patients talked about attending basic life support training. More patients wanted to access basic food hygiene training as they could not cook for each other unless they had completed the training. The hospital manager said more courses were being arranged.

Staff helped patients to stay in contact with families and carers. We spoke with 14 carers, eleven carers told us they could visit their loved one and the option to visit in the café was a positive, more relaxed experience.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients were encouraged to use public transport when going out on leave and accessed community activities including swimming.

Meeting the needs of all people who use the service

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

The service were not meeting the accessible information standard for all patients with communication needs. The accessible information standard applies to people who have information or communication needs relating to a

disability, impairment or sensory loss. This includes learning disability and autism. The requirements are that they should Identify people with information or communication needs, record the needs, flag the needs on the system to alert staff, share the information with other health and social care services and then meet their needs. Patients with a learning disability had started to have communication care plans introduced however they were general guidance of how to communicate with people with a learning disability and not individualised. On Oakmere ward, one patient with a learning disability and an autistic patient did not have a communication plan in place. These plans did not meet the accessible information standard.

The service could support and make adjustments for disabled people and those with other specific needs. There were patients with physical health needs and mobility needs. Patients had the equipment they required, and wards were all on one level, which meant they were accessible for all patients.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Information was included in the welcome brochures for each ward. Information regarding how to complain and how to contact CQC was displayed on the notice boards in the wards.

The service leaflets were in English however information could be translated if required in other languages.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. Patients told us that they went to church.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Patients knew how to complain and said they felt confident in doing so. Information was included in the handbooks given at the beginning of their involvement with the service.

The service clearly displayed information about how to raise a concern in patient areas. Information was on display on the wards.

Staff understood the policy on complaints and knew how to handle them. Ward managers followed the complaints policy by recording complaints in the local informal complaints resolution log. Complaints were usually resolved locally.

Managers investigated complaints and identified themes. We reviewed the complaints logs, there was one for informal complaints which included who investigated the complaint and what the outcome was. There had been five formal complaints in the six months prior to the inspection. Three were upheld and related to loss of items, one was partially upheld in relation to staff attitude.

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Patients confirmed they had received outcomes to their complaints.

Requires Improvement

Forensic inpatient or secure wards

Managers did not share feedback from complaints with staff in team meetings. This meant staff's awareness of any learning from complaints was limited.

Are Forensic inpatient or secure wards well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

Leaders were visible in the service and approachable for patients and staff. The registered manager led the patient's council and was visible within the service. Staff told us how supportive they were.

There had been changes within the senior leadership team with the lead nurse recently starting in post.

Leaders provide clinical leadership. Daily senior handover meetings took place Monday to Friday to review incidents, staffing and any areas for escalation. We observed this meeting and found it to be effective and well led.

Leaders had the skills, knowledge and experience to perform their roles.

The organisation has a clear definition of recovery and this is shared and understood by all staff. The models of care had recently been introduced, the model was phase 1 assessment, phase 2 treatment and phase 3 integration and synthesis. We saw the stage of patient's recovery discussed at ward rounds with patients and some patients were able to tell us where they were in their recovery journey.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Vision and strategy

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

Staff know and understand the vision and values of the team and organisation and what their role is in achieving that. The providers values were kindness, teamwork, integrity and excellence.

All staff had a job description.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff Communication and Consultative Group meetings took place monthly. Minutes showed that the registered manager led them, with staff representatives from each ward.

Staff could explain how they were trying to work to deliver high quality care within the budgets available. Staff consultative reflect and reconnect sessions took place with the different staff groups to listen to their experiences and share the hospitals three main focus areas for 2022; Improve Culture, Improve Security and Improve Clinical Quality.

Culture

Staff did not feel respected, supported and valued. However, some said the service promoted equality and diversity in daily work and provided opportunities for development and career progression.

Staff did not feel respected, supported and valued. Staff told us due to the staffing challenges that shifts were very busy, challenges with allocating observations, staff having breaks and there being enough staff to respond to incidents. When agency staff were working, there were some aspects of the role that they could not do which meant other staff felt more stretched. Staff said they felt tired and burnt out. We saw and staff told us that staff got moved between wards, this could happen part way through a shift, this was disruptive for both patients and staff.

Patients raised staffing at the patient council meeting too.

Staff raised staffing and morale at the staff communication and consultative group, staff reported feeling burnt out and the salary not being competitive for the nature of the work.

The service monitored morale, job satisfaction and sense of empowerment. Staff consultative reflect and reconnect sessions took place with the different staff groups to listen to staff's experiences during COVID19. Skill mix was raised by staff as a concern and the pause on supervisions and appraisals was noted.

The service did not have a staff group that felt satisfied and had low levels of stress. Staff told us and minutes confirmed that there had been concerns about the culture of the service, with occasions where staff are not always kind to each other, respectful of each other and there is sometimes little assistance to help others.

The provider regularly recognised staff success within the service. Departmental star awards and you are awesome cards had been well received when used.

Staff were starting to feel valued and part of the organisation's future direction. Staff consultative reflect and reconnect sessions had started to take place with two departments and two wards completing the feedback process.

Staff felt positive and proud about working for the provider and their team. They were positive about the service provided and the achievement with the patients that they supported. Several staff had worked at the service for several years.

Staff appraisals included conversations about career development and how it could be supported. As of March 2022, 80% of staff had had an appraisal within the previous 12 months.

Staff had access to support for their own physical and emotional health needs. There was a counsellor employed by the service which staff could access support from. The counsellor created monthly reports for the senior team. In February 2022 they were supporting 40 staff, March 2022 38 clients and April 2022 38 clients. They worked three long days to accommodate early morning and evening appointments to support night staff.

The psychology department offered reflective practice sessions twice a month. The highest number of attendees in 2022 was seven. Staff talked of challenges of being able to access these if they were on shift and could not leave the ward due to staffing pressures.

Teams mostly worked well together and where there were difficulties managers dealt with them appropriately. Staff worked across wards to support the demands of the service. We observed staff being supportive of each other.

At the last inspection, there were concerns about the culture on the wards and the professional boundaries from staff to patients and other staff. We reviewed the professional boundaries policy and training. The policy was detailed and thorough. Staff training compliance levels were 91%. We did not observe any blurring of professional boundaries. The provider were in the process of recruiting to a regional quality and compliance lead to promote a culture of enquiry and implementation of lessons learnt, supported by quality and compliance leads in the region, further supported by compliance officers. It was anticipated that the full restructure will be implemented by October 2022.

Governance

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

Governance policies, procedures and protocols were not regularly reviewed and improved and did not include an equality impact assessment. The managing incidents and untoward occurrences policy and search policy had not been reviewed when they were due.

The service had not created information to give to patients regarding the Mental Health Units (Use of Force) Act 2018 and its guidance. However senior staff thought they were fully complaint.

Supervision was not taking place in line with the supervision policy. Particularly on Daresbury ward 10 out of 18 staff (56%) had received regular supervision in the last quarter. Delamere ward 7 out of 29 staff (24%) had received regular supervision in the last quarter. On Alderley ward 3 out of 42 staff (7%) had received regular supervision in the last quarter. This meant staff were not receiving regular supervision, support and guidance in relation to their role.

Team meetings were not taking place regularly on all wards and there was not a developed system of sharing information with staff that could not attend the meetings. Learning and themes from complaints were not discussed at team meetings.

Staff had not been able to access specialist training relevant to their role, particularly in learning disability, autism and personality disorder.

The ward environment was not maintained to a high standard on Oakmere, Alderley and Delamere wards. All of the necessary repairs had not been completed in a timely manner.

There was no process in place for the oversight of agency staff to ensure they were fully inducted into the service. Records to demonstrate the induction of agency staff were not readily available during the onsite inspection.

Requires Improvement

Forensic inpatient or secure wards

There was not a clear framework of what must be discussed at a facility, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Clinical governance meetings had a standard agenda of patient with high risk needs, physical health, patient and carer experience, clinical audit, clinical effectiveness, harm reduction, risk management, lessons learnt and complaints. There was no consistency of standard agenda items across wards, minutes showed that some were a list of actions.

Staff undertook or participated in local clinical audits. These included health and safety, infection prevention and control, risk assessment and care plans. The audits sampled the records and were sufficient to provide assurance and staff acted on the results when needed. However, the infection prevention and control audit showed recurring issues of staff not wearing masks.

Data and notifications were submitted to external bodies and internal departments as required. Key performance indicator data was submitted to commissioners prior to quarterly reviews and CQC statutory notifications were submitted by the service.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. However, four commissioners felt the service could be more proactive in providing updates, particularly if their patients were involved in any incidents.

The service had a whistle blowing policy in place. Information was on display in the airlocks regarding speaking up and there were business cards for staff to pick up with information about different ways to give feedback including email addresses for the board and speak up guardian. Also, a phone number for the staff concern line and an independent company providing the online portal.

Management of risk, issues and performance

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

There was a clear quality assurance management and performance frameworks in place that are integrated across all organisational policies and procedures. Policies included frequency for review and cross referenced to the CQC fundamental standards.

Staff maintained and had access to the risk register at service level. Staff at ward level could escalate concerns when required. Staff have the ability to submit items to the provider risk register.

Staff concerns matched those on the risk register. Staffing was on the hospital's risk register and had been since 1 March 2022. This included recruitment, retention and staff burnout. Also use of agency staff and the reduction of consistency of support for patients.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

The service monitored sickness and absence rates however, the service were unable to provide vacancies at ward level.

Information management

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

Requires Improvement

Forensic inpatient or secure wards

The service used systems to collect data from facilities and directorates that were not over-burdensome for frontline staff. There were centralised systems that collated data on the service. A software package as used for advertising vacant shifts to bank and agency staff. The incident report system could be filtered down to individual patients to review their incidents.

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 to improve the quality of care. During COVID19 the IT facilities were not able to support the demand for remote meetings and more agile ways of working. Investment had been made to the Wi-Fi and computer systems to improve this.

Information governance systems included confidentiality of patient records.

Team 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. Managers had access to a dashboard which included incidents, seclusion and physical intervention, the information could be filtered to a ward level. This meant they could review the data for their ward and explore any themes and trends. However, vacancy and sickness level was not shown at a ward level.

Staff made notifications to external bodies as needed. CQC statutory notifications were submitted by the service.

All information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins and newsletters. Hospital governance snap shots were created monthly with one page updates on progress within the service. Senior staff attended the clinical governance and operational governance meetings, information was shared with ward managers who then shared with ward staff. However, it was difficult to plan in team meetings, minutes were brief for some teams which would make it difficult for staff who weren't present to know what was discussed.

Patients and carers had opportunities to give feedback on the service they received. Patients had completed a survey and representatives attended the patient council. Historically there had been carers events and an active group of carers meeting to discuss the service and give feedback, also involved in delivering training, however as their loved ones had been discharged from the service, the group reduced and had not been effective either remotely or face to face during COVID19.

However, there was a carers event planned for June 2022 with the aim of re-establishing carer involvement.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback. Senior leaders visited the wards and welcomed feedback.

Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch. Regular meetings were held with commissioners.

Learning, continuous improvement and innovation

The organisation had started to encourage creativity and innovation to ensure up to date evidence based practice is implemented and imbedded. We saw an example of a talking mat communication system used with a patient regarding their involvement in their CPA meeting and other aspects of the meeting. This enabled the patient to contribute their views. The speech and language therapist has created communication objectives which the staff team were working through implementing. One of the actions was to have a daily communication board with who was on shift. We observed that there was no visual board for patients in relation to staffing and who worked on the ward, this would be particularly helpful for patients who responded well to visual information.

The service assessed quality and sustainability impact of changes including financial. These were discussed at the operational governance meetings. The changes in commissioning was a risk on the risk register too.

All staff have objectives focused on improvement and learning. Actions had been agreed in relation to staff completion of training in learning disability, autism, personality disorder and trauma informed care.

The service had a staff award/recognition scheme and a number of other wellbeing initiatives to support staff morale.

The service were a member of the quality network for forensic mental health services. The multidisciplinary team on Alderley ward had submitted a poster to the royal college of psychiatrist's spring conference in intellectual disability regarding their findings of delivering care to patients with a diagnosis of personality disorder and mild learning disability.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The governance processes were not robust and able to identify deficits in patients risk assessment, training needs, and policies were not up to date. The service did not have an effective governance system in place to oversee the induction and start details of bank and agency staff and ensure the service was meeting infection, prevention and control guidance.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments were not completed in a timely manner and were not updated following all incidents.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The repairs to the environment were not completed in a timely manner and there was a risk of infection due to the ward environments on Alderley, Oakmere and Delamere wards. Repairs and risks included replacing flooring in affected areas.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

There were not enough suitably qualified, competent, skilled and experienced staff to meet the needs of patients.

Staff had not completed and kept up-to-date with all of their mandatory training.

Staff did not receive specialist training in learning disability, autism and personality disorder.

Staff within the forensic and secure wards did not receive regular supervision in line with the supervision policy.