Active Pathways Limited

The Hamptons

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 well-led?	Requires Improvement

Summary of findings

Overall summary

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

- There was no emergency medicines stored in the service. This did not meet the requirements of the guidance which stated they should have a minimum of adrenaline.
- Staff were not receiving autism and learning disability training which is now a requirement of the Health and Care Act 2022.
- Registered staff were not receiving immediate life support training which is a requirement of Resuscitation Council UK.
- The service had commissioned MAYBO as an accredited provider for Bild Association of Certified Training, which complies with the Restraint Reduction Network Training Standards. However, this should have been introduced in April 2021 and there was only 60% compliance at the inspection, meaning there was not enough trained staff to ensure staff could respond to incidents.
- Staff records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed five staff files and there were gaps in three of the records.
- There was no oversight of the induction of agency staff. There were five agency induction checklists missing for agency staff that worked in the two weeks prior to the inspection.

However:

- Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Medicines were managed safely.
- Records showed regular supervision and appraisals took place. Appraisals included the 360 feedback from patients.
- Patients spoke positively about the service, including the improvement in the food, following a new chef starting.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to The Hamptons

The Hamptons is a High Dependency Rehabilitation Unit for men with mental health needs between the ages of 18 and 65 years old. It has 14 beds and can admit both informal and detained patients. At the time of the inspection, all patients were detained under the Mental Health Act. There were 13 patients in the service.

The Hamptons has been registered with CQC since 3 February 2011. The service is registered to provide the regulated activities;

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

There were two registered managers in post, one of whom had progressed within the organisation and the day to day management of the service was overseen by the other registered manager. This registered manager was also the registered manager of another service in the same site. One of the registered managers was also the controlled drugs accountable officer.

There have been six previous inspections of The Hamptons. The most recent was in November 2017, the service was rated as outstanding overall with safe, effective and responsive rated good and caring and well led rated outstanding.

What people who use the service say

We spoke with six patients and four carers.

Patients told us it was the best service they had been to, better than previous placements. They saw their consultant regularly and had access to the advocate who they found helpful. Patients told us they had one to one time with their named nurse. All patients we spoke with knew what their discharge plan was. Some patients enjoyed the group outings, cooking opportunities including the breakfast group and enjoyed the opportunity to do work around the service as part of therapeutic earnings, for example clearing the garden.

However, patients said there wasn't that many activities that appealed to them. Cleanliness of the kitchen was also an area discussed by patients, especially cutlery and crockery being dirty on occasion. They told us they didn't see the managers very often as they were based at the service next door.

Food had been an issue in the past however, a new chef had recently started, and patients said the food was a lot better now.

All the carers we spoke with were positive about the service, especially in relation to the previous placements their loved ones had been in. Carers were given information about the service, invited to meetings and sent minutes if they could not attend. Carers were pleased with the variety of multidisciplinary team members that their loved one had access to, to aid their recovery.

How we carried out this inspection

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

Summary of this inspection

During the inspection visit, the inspection team:

• visited the service

• toured the service, and observed the care being provided

• received feedback from commissioners and advocates

• spoke with six patients

• spoke with four family members

• observed two ward rounds

• spoke with 13 staff including support workers, nurses, consultant psychiatrist, occupational therapy staff, deputy manager and the registered manager

• looked at six care and treatment records of people and 13 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 the safe and well led key questions.

The inspection team was a CQC inspector and a specialist advisor.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that they follow the Resuscitation Council UK requirements in relation to emergency medicines. (Regulation 12 (2) (g))
- The service must ensure that registered nursing staff receive Immediate Life Support training (Regulation 18 (2) (a))

Summary of this inspection

- The service must ensure that all staff including bank and agency staff have an induction into the service. (Regulation 18 (2) (a))
- The service must ensure there are enough staff trained in the provider's chosen physical intervention approach on each shift to ensure there are staff who can safely respond to incidents at the service. (Regulation 18 (2) (a))
- The service must ensure that staff attend training in learning disability and autism to meet the needs of patients and meet the requirements of the Health and Care Act 2022. (Regulation 18 (2) (a))
- The service must ensure that it meets the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 17 (1) (2) (d))

Action the service SHOULD take to improve:

- The service should ensure that the kitchen and its contents are clean and fit for use.
- The registered manager and deputy manager should spend more time at the service to enable feedback from staff and patients.
- The service should ensure that staff follow the dress code policy.
- The service should continue to improve the staff experience and morale at the service.
- The service should review how they engage and seek feedback from patients, including providing the opportunity for them to give feedback to senior staff.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe	Requires Improvement
Well-led	Requires Improvement

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

Requires Improvement

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

Safe and clean care environments

All wards were safe, mostly clean and 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. The environmental risk assessment was last completed in November 2021 and identified the environment being for rehabilitation and the items in patient's rooms reflected this. However there remained three bedrooms with anti-ligature features to accommodate patients who required this. Weekly environmental audits were completed by the maintenance department.

Staff could observe patients in all parts of the wards.

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.

Staff had easy access to alarms and patients had easy access to nurse call systems. Alarms were given to the inspection team in addition to the staff team. All rooms had nurse call systems in place to summon assistance.

Maintenance, cleanliness and infection control

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

Patients told us and we saw that in the kitchen there was a dustpan and brush that was dirty. There was crockery and cutlery that was dirty. There was no system of oversight regarding this. All people who had access to the kitchen were responsible for washing items. This meant cutlery and crockery that patients ate with may be dirty and was a risk of cross infection.

Staff made sure cleaning records were up-to-date and the premises were mostly clean. We reviewed the cleaning records and found that the kitchen had three monthly deep cleans. However, the kitchen was not included in the daily cleaning schedule. This meant the kitchen was not receiving a regular clean.

Staff mostly followed infection control policy, including handwashing. There was hand sanitiser throughout the building and staff wore masks. We saw a couple of staff with nail varnish and jewellery on including bracelets. This did not adhere to the dress code policy which states "Jewellery should be kept to a minimum (bracelets, long or looped earrings and dangling necklaces are not to be worn on duty)."

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment that staff checked regularly. However, there was no emergency medicines stored in the service. This did not meet the requirements of the guidance which stated they should have a minimum of adrenaline; Quality standards: Mental health inpatient care equipment and drug lists, Resuscitation Council UK. The providers medicine management policy version five states, "A nurse may, without a doctor's prescription administer adrenaline via an Epi pen where the nurse feels the service-users reaction is severe and may develop into a life-threatening situation." However, the service did not have any adrenaline. Staff including managers advised they did not have emergency medicines. This meant if there was a medical emergency, staff would not have the necessary medicines to administer. The use of emergency medicines was not included in the basic life support (BLS) and automated external defibrillator (AED) policy. This meant staff were not being given guidance that followed Resuscitation Council UK guidance.

Staff checked, maintained, and cleaned equipment.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe.

The service had increasing vacancy rates for support workers, the vacancy rate was at 25% at the time of the inspection. The service had appointed a recruitment specialist to assist with reducing the vacancy rates at the service.

The service had increasing rates of bank and agency staff. The agency use for July 2022 was 30% and the bank use was 16%.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift. We reviewed the agency staff use for the week commencing 15 August 2022 and found that 13 agency staff had worked at the service that week. Five of these staff did not have a completed induction checklist in their file, this meant that we were not assured that staff had been inducted into the service and that they had the necessary information to support patients effectively. This did not meet the providers human resources operations manual which says, "Completed agency induction checklists must be given to the allocated administrator and should be filed with each agency profile sheet."

The service had low turnover rates with 3% for support workers for July 2022.

Managers supported staff who needed time off for ill health.

Levels of sickness were high with 21% (4 people) for June 2022 and 16% (3 people) for July 2022.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

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

Patients had regular one- to-one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service did not have enough staff on each shift to carry out any physical interventions safely.

The service had commissioned MAYBO as an accredited provider for Bild Association of Certified Training, which complied with the Restraint Reduction Network Training Standards. However, this should have been introduced in April 2021 and at the time of the inspection, there was 60% compliance for permanent staff, with staff starting to attend the courses from 2022. The delivery of this training had been impacted by COVID19. On the day shift of 23 August 2022, there was no staff at The Hamptons which were MAYBO trained, the deputy manager was, and the registered manager was however, they were not based in the building all day. There was three staff trained in the service next door which the registered manager said would have responded if needed. There was no oversight of this or the process for response and no one in the building to initially respond that was trained. Agency staff profiles did not include any training in relation to physical intervention. The training matrix showed that no bank staff had completed MAYBO training. This meant there was not enough suitably trained staff to respond to the needs of patients who may require physical interventions.

We reviewed the handover information and found that it was all handwritten for every shift, there was no prepopulated information. There was no space for risk that staff needed to be aware of. The handover covered presentation, medication, incidents, leave, physical health, visitors and meetings.

This meant if staff were new to the service they may not know the necessary information about the patients they were supporting.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was one consultant for the service who worked at the service for a day and a half per week and they were on call for the service. If they were unavailable, cover was arranged.

Mandatory training

Staff had mostly completed and kept up-to-date with their mandatory training. The service's target for mandatory training compliance was 80%. Courses that were under 80% were;

- Information governance 71%
- PREVENT and radicalisation 71%
- Fire Marshall 78%
- Mental health awareness 61%
- MAYBO, physical intervention 60%
- Safeguarding children 67%

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers monitored mandatory training and were in the process of booking further training courses to enable more staff to attend.

The service were in the process of starting to offer Autism and learning disability training, at the time of the inspection no staff had completed this. This was a requirement of the Health and Care Act 2022 from 1 July 2022.

The mandatory training programme did not include immediate life support training which is a requirement for registered nurses, the Resuscitation Council UK's Quality Standards: Mental health inpatient care states "Resuscitation Council UK's Immediate Life Support (ILS) course is recommended as a minimum standard for staff who deliver or are involved in rapid tranquilisation, physical restraint and seclusion." This meant staff did not have all of the required training for their role.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint 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 and complied with requirements.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed the Salford tool for the assessment of risk for each patient. We reviewed six care records and found that they were up to date.

Management of patient risk

Regular staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could observe patients in all areas.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff could explain the search process, which primarily took place when patients returned from leave.

Use of restrictive interventions

Levels of restrictive interventions were low. Patients were assessed to have access to the kitchen and their own room key.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards including the requirements of the Mental Health Unit (Use of Force) Act 2018 and its guidance. This included a leaflet for patients regarding the use of force and what to expect and who the responsible person was. The MAYBO training was an accredited provider for Bild Association of Certified Training, which complied with the Restraint Reduction Network Training Standards.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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. There had been three incidents of physical intervention from June 2021 to May 2022.

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

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. Safeguarding adults' compliance was 87%, however safeguarding children was 67%.

Staff kept up-to-date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were aware who their safeguarding lead was and gave examples of safeguarding concerns in relation to patient's vulnerability to others and giving away their belongings.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

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. Records were mainly paper, apart from the incident reporting process. This meant they were available for staff in the nurse's office. Physical health information was stored in a separate file.

In one of the six records reviewed, the patients' positive behaviour support plan was not current and did not reflect their presentation at the time of the inspection.

Records were stored securely. They were locked in the nurse's office.

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.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

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.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. We reviewed all 13 prescription cards and found that they included allergies and capacity to consent to treatment authorisations were in 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.

Staff knew what incidents to report and how to report them. There was an incident reporting policy in place.

The service had no never events.

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. Records showed de briefs took place. Huddle meetings took place where the shift was reviewed. The review included allocations and workload, any incidents which had occurred and what had gone well. This provided staff with an opportunity to reflect on their shift.

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

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents and lessons learned were a standard agenda item at the team meetings.

Staff met to discuss the feedback and look at improvements to patient care. Weekly risk meetings took place with the full multidisciplinary team and incidents and each patient was discussed.

There was evidence that changes had been made as a result of feedback. This included the documentation and searching of patients that had gone absent without leave.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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 sometimes visible in the service and approachable for patients and staff.

Leaders provided clinical leadership. Managers and seniors were registered nurses who had progressed within the service, and had experience of supporting patients. There was evidence of leaders also covering some clinical shifts.

Leaders had the skills, knowledge and experience to perform their roles. Managers could access the required information and explain the rationale for decision making.

The organisation has a clear definition of recovery and this is shared and understood by all staff. The service used the recovery star to assist in this process, records showed staff and patients were involved in this progress. We saw this was reviewed at patient's reviews.

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

Leaders were sometimes visible in the service and approachable for patients and staff. Staff and patients told us that the registered manager and deputy manager were primarily based at the service next door. However, they did visit on occasion. This had been introduced partly due to COVID19 where they tried to avoid cross infection. The clinical lead and team leader were based at the service. This meant staff and patients did not have regular access to the deputy manager and registered manager.

Vision and strategy

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

Staff knew and understood the vision and values of the team and organisation and what their role was in achieving that. The vision was; "That each service user and each member of staff is entitled to and will have, their own individual and unique pathway designed by them with the support of the organisation to get from their current situation to their desired situation.

Each service user is supported to be an expert in their own mental health and each member of staff is supported to be an expert in their own development, with everyone's voice heard, respected and acted upon. Quality of our care, Safety of our people and Passion for recovery."

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Minutes confirmed that team meetings had taken place in February, March, April and June 2022. Agenda items included a six-month review of service objectives, where individual objectives were discussed as a team.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Culture

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

Most staff felt respected, supported and valued. Some staff told us they felt micromanaged and that senior staff made issue of minor things. There had been an anonymous team satisfaction survey which took place in December 2021, with a 96% response rate. Results showed that 54% of staff felt involved in upcoming development work for the service, felt recognised and appreciated for the work they did, felt like their ideas were implemented and felt there was good communication within the service. Feedback themes were of poor staff morale, communication, staff not being consistent and not working as part of a team. Staff felt pay, annual leave and recognition could be improved, and night staff did not feel they were treated the same as day staff. An action plan was in place, with the majority of actions in progress.

The provider recognised staff success within the service. Step up and stand out awards were given to staff members that had been nominated by colleagues.

Most staff felt valued and part of the organisation's future direction. With 54% of staff saying they felt valued and involved and 46% of staff saying they did not feel valued and involved.

Staff felt positive and proud about working for the provider and their team. With 75% of staff saying they would recommend the service to a friend as a good place to work.

Staff appraisals included conversations about career development and how it could be supported. The appraisal policy statement included, "To highlight the potential that each individual has to develop within his or her current position or into another."

Staff had access to support for their own physical and emotional health needs through an occupational health service. Records showed staff had access to this.

The service monitored morale, job satisfaction and sense of empowerment via the staff survey.

Staff reported that the provider promoted equality and diversity in its day to day work, for example they were involved in a Pride event. However, staff did not feel the service provided opportunities for career progression, particularly for support workers.

Teams worked well across the neighbouring service, staff worked across services and there were resources that supported both services, for examples the occupational therapy provision, psychology provision and maintenance support and they had the same senior leaders. However, staff and patients felt that senior staff spent more time at the neighbouring service as they were based there. The team survey action plan had an action to "Increase management presence on The Hamptons", this meant managers were aware of this and had actions to address this.

Governance

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The provider's governance framework ensured that the provider was complying with the Mental Health Units (Use of Force) Act 2018 and its guidance.

Governance policies, procedures and protocols were regularly reviewed and improved and included an equality impact assessment. These included the date created and the date reviewed.

There was 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. There was a standard agenda for team meetings which included team issues, governance, champions model updates, CQC, safeguarding, incidents and lessons learnt, complaints and compliments and things to celebrate.

Staff had implemented some recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Senior meeting minutes and health and safety meeting minutes showed that some action has been in progress for over a year and had not been achieved, they were constantly re actioned. This included a fire induction with a member of staff that was actioned in September 2021 and had not been achieved by May 2022. Also, an audit of consent to treatment documentation that had been actioned in November 2021 had not been achieved by May 2022. This meant there was not an effective system to ensure that actions were completed.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. There was an audit calendar in place which included monthly files audits, supervision and appraisal audits too. The appraisal audit showed that staff received annual appraisals. The supervision policy stated staff should receive supervision six times per year, the audit and our review of records showed this was taking place.

Data and notifications were submitted to external bodies and internal departments as required. This included the statutory notifications to CQC.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. We saw staff from other organisations including commissioning organisations attending the reviews for patients. Feedback from commissioners and advocates was that they felt involved and updated about the service, with good communication regarding individual patients.

Staff records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed five staff files and there was missing information in three of the files. Two staff files did not have a full work history including gaps in their employment history. Two staff files did not include evidence of induction. Another staff record did not include proof of qualification and registration. This person had started in a qualified role without the service verifying these. This meant there had not been an effective process of oversight. However, we saw that a HR audit had just been completed which highlighted gaps in records and the staff were following up on the missing items. The qualifications, registration and work history for one staff member were brought in on the second day of inspection.

For agency staff there was not an effective system to ensure they had received an induction, or when or if they had previously worked at the service. Staff either had to work through the agency invoices or rely on staff telling them if they had worked at the service before. This meant they may have staff working at the service that had not been inducted into the service and may not know how best to support patients and have the essential information to keep themselves and patients safe.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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 were integrated across all organisational policies and procedures. Governance, operational and health and safety meetings took place with senior staff for both the Preston services, this meant they could ensure consistency and compare experiences.

Staff maintained and had access to the risk register at facility or directorate level. Staff at facility level could escalate concerns when required. The registered manager had oversight of the risk register and they had weekly discussions with the assistant director to review and escalate any issues.

Staff have the ability to submit items to the provider risk register. Records confirmed these were reviewed at the Health and Safety meetings.

Staff concerns matched those on the risk register. Including workforce, substance misuse and illness of patients.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. COVID19 and extreme heat were included in the risk register.

The service monitors sickness and absence rates. The service had a key performance indicator dashboard with quarterly data for review by managers.

Information management

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

The service used systems to collect data from facilities and directorates that were not over-burdensome for frontline staff. The mental health services data submission was completed by an external team and they gathered the data from existing systems within the service.

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. However, all patient records were paper. This meant only one person could access them at any one time and some records were disorganised with a variety of information filed at the front of the file. This meant finding the required information was more difficult.

Information governance systems included confidentiality of patient records. Registered nurses had individual logins to the computer system.

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. Key performance indicators were recorded and measured. Managers also had access to the multidisciplinary review notes where feedback was given from all members of the multidisciplinary team.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. Information was easy to read and process. Risks were discussed at the health and safety meetings and key performance indicators were discussed at the operations meeting.

Staff made notifications to external bodies as needed. Including CQC statutory notifications.

Some information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it. There was no consistency with where certain documents were stored, for example the allocations records, one staff member could not tell us where another staff member stored previous allocation records, the registered manager was not aware of where they were stored either. This meant not all information was available from previous shifts.

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.

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 team meetings for staff and the community meetings for patients.

Patients and carers had opportunities to give feedback on the service. Forms for complaints, comments and compliments were in the service for patients to complete and patients told us about these. Five complaints had been submitted in the previous six months, one had been upheld and one partially upheld. However, the weekly community meetings had the same content discussed and there were low numbers of attendance. Suggestions that were made were not always implemented, as actions were not recorded, for example on 7 July 2022 a request was made to change the day of fishing, to enable a patient who worked to be able to attend. At the next weeks' meeting there was no mention of this. This meant patients requests were not being actioned and this may be why there was low attendance.

There had been an annual food survey completed in March 2022, with the majority of feedback being positive, an action plan was created and was being progressed by the new chef.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback. We saw senior leaders attending the team meetings on occasion, however no evidence of them meeting with patients.

At the last inspection, patients were involved in the champions groups, based around CQC's five key questions, however this had been put on hold due to COVID19. An action plan had been created for the safe, caring and well led. These were due to start in August 2022, however they had not started at the time of the inspection.

Directorate leaders engaged with external stakeholders – such as commissioners. Feedback was that the service was approachable and responsive to requests. They were also proactive with discharge planning.

Learning, continuous improvement and innovation

The organisation encourages creativity and innovation to ensure up to date evidence based practice is implemented and imbedded. The service had been awarded the investors in people accreditation for staff support at gold level. However, they were not involved in any clinical accreditation.

All staff had objectives focused on improvement and learning. This was both within their supervisions and appraisals.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had a staff award/recognition schemes called the step up and stand out awards.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not receiving Autism and learning disability training which is now a requirement of the Health and Care Act 2022, they were in the process of sending emails to staff to complete the eLearning. The service had commissioned MAYBO as an accredited provider for Bild Association of Certified Training, which complies with the Restraint Reduction Network Training Standards. However, this should have been introduced in April 2021 and there was only 60% compliance at the inspection, with staff starting to attend the courses from 2022. On the day shift of 23 August 2022 there was no staff at The Hamptons which were MAYBO trained, the deputy manager was, and the registered manager was however they were not based in the building all day. There was three staff trained in the service next door which the Registered Manager said would have responded if needed. There was no oversight of this or the process for response and no one in the building to initially respond that was trained. The mandatory training programme did not include immediate life support training which is a requirement for registered nurses, the Resuscitation Council UK's Quality Standards: Mental health inpatient care states "Resuscitation Council UK's Immediate Life Support (ILS) course is recommended as a minimum standard for staff who deliver or are involved in rapid tranquilisation, physical restraint and seclusion."

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was no emergency medicines stored in the service. This did not meet the requirements of the Resuscitation Council UK guidance which stated they should have a minimum of adrenaline; Quality standards: Mental health inpatient care equipment and drug lists | Resuscitation Council UK.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Staff records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed five staff files and there were gaps in three of the records. One did not have a full work history and induction. One did not have a full work history and evidence of qualifications and registration. Following this being raised on 23 August 2022, the qualifications and registration were received on 24 August 2022. The service had allowed the OT to start in post without proof of qualification or registration. One record did not included an induction. Agency induction checklists, there were five missing for agency staff that had worked in the week commencing 15 August 2022 and 23 August 2022.