Partnerships in Care Limited

Priory Hospital East Midlands

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?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

The service remains in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

Priory Hospital East Midlands is in Annesley in Nottingham and is one of the hospitals of Partnership in Care Limited. It has two female wards: one specialist acute ward and one psychiatric intensive care ward. The service works with patients in achieving their goals and preparing them to move back into the community, or into other appropriate accommodation. We carried out this unannounced inspection because we received information giving us concerns about the safety and quality of the service.

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

- The ward environments were not always and clean. There was a lack of cleaning staff to ensure that the hospital was cleaned regularly.
- Staff were not able to fully observe patients in the seclusion room due to the observation area in the bathroom section of the seclusion room being used for storage.
- Staff did not adhere to infection control procedures in relation the laundry of patients and staff clothing and bedding.
- Staff did not always assess and managed risk well in relation to manage items that are deemed to be a risk for individuals. When managing risk staff did not use the correct practice when performing restrictive interventions.
- Managers did not always ensure that these staff received training, supervision, and appraisal. Staff had not received additional specialised training to support the care and treatment of patients.
- Medical staff did not follow the providers policy when admitting patients to the service, this meant that patients physical health was not complete in a timely way and medication had not been prescribed. Whilst the service had an on-call duty doctor system in place, the doctor on call was not always contactable.
- Patients were not always discharged promptly once their condition warranted this or changed.
- Staff did not always treat patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- Leadership had recently changed, and governance process and systems were still not fully embedded.

However:

- 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.
- The wards had enough nurses and doctors. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- The service managed beds well so that a bed was always available locally to a person who would benefit from admission.

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 	See summary above for more information.

Summary of findings

Contents

Summary of this inspection

Background to Priory Hospital East Midlands

Priory Hospital East Midlands is in Annesley in Nottingham and is one of the hospitals of Partnerships in Care Limited.

Priory Hospital East Midlands is registered to provide the following regulated activities:

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

• Treatment of disease, disorder, or injury.

The provider offers specialised assessment and treatment to help patients for return to either local services or alternative appropriate accommodation.

The following service and wards were visited on this inspection:

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

• Littlemore Ward, a female psychiatric intensive care unit with ten beds.

• Barton Ward, an acute admission ward for females with nine beds.

The most recent focused inspection of this location was on 30 August 2022. As this inspection was not rated the hospital was not rated. Therefore, the service is rated of inadequate in the safe and well led key questions following the inspection of May 2022. Due to these concerns and ratings the service was placed into special measures.

Following the inspection of August 2022, we served a warning notice under Regulation 12, safe care and treatment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to finding issues of concern around medicine management.

We carried out this inspection as we were notified concerns from patients about their care and treatment.

What people who use the service say

People were unhappy that there was only one washing machine available.

People told us they did not like being woken up by staff turning lights on during the night to do their checks.

People told us that the wards can be noisy when people are in distress.

One person told us that there had been confusion regarding the whereabouts of their key to their bedroom and how this had made them feel unsafe.

People told us that on Barton ward handovers happen in the dining room which means that they cannot access drinks and snacks whilst it is going on.

Summary of this inspection

People told us that they feel that the wards are not cleaned enough as there is only one cleaner.

People told us that the food is nice but due to having one meal a day at lunchtime that if they are asleep at that time, they miss it.

People told us they were not happy with the visiting area as it was small, and the coffee machine (at the time of the inspection) was broken. Visitors were traveling a distance to see them.

People told us that they feel there is enough staff on shift.

People told us staff are visible on the ward.

People told us that there are activities available.

People told us that they can go on leave and have access to the garden.

How we carried out this inspection

This was a comprehensive inspection and looked at all five key questions: safe, effective, caring, responsive and well-led.

The inspection team visited the wards on 10, 11, 18 January 2023.

During the inspection we:

Visited the service and observed how staff cared for patients.

Spoke to 9 patients:

Spoke to 1 carer:

Reviewed all medicine charts and corresponding physical health observation records.

Reviewed electronic incident reports.

Reviewed CCTV to see how staff managed incidents.

Spoke with the hospital manager and ward managers.

Reviewed training records.

Reviewed care plans of 5 patients:

Reviewed patient risk assessments.

Observed handovers of both Littlemore ward and Barton ward.

Summary of this inspection

Reviewed the quality of the hospital environment.

Reviewed a range of documents relating to the running of the hospital.

Spoke with 8 staff members including nurses, support workers, domestic staff.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that there is enough day time and night cover for medical staff and that there is a clear way to contact them if not on site. (Regulations 18(1))
- The service must ensure that all staff use the correct practice when performing restrictive interventions. (Regulations 13(4)(b))
- The service must ensure that observation areas of the seclusion suite are always clean and clear. (Regulations 17(2)(c))
- The service must that all staff understand how to consistently manage items which may present a risk to patient (Regulations 12(2)(b))
- The service must ensure that staff are trained to meet the needs of patients who have a diagnosis of personality disorder and for patients who have learning disabilities or are autistic. (Regulations 18(2)(a))

Action the service SHOULD take to improve:

- The service should ensure that a plan is put in place to fully staff the hospital cleaning staff team.
- The service should ensure that infection control is adhered to when carrying out laundry activities.
- The service should continue to work to work alongside local commissioning bodies to ensure patients are when clinically identified to be moved to a suitable location.
- The service should make sure that all emergency medicine is in date at all times.

The service should make sure that all food and drink products are labelled clearly with dates of opening and use by dates.

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	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Overall	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement

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

Requires Improvement

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

Is the service safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

All wards were not always clean. However, wards were safe, equipped, 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. We found environmental risk assessment of the hospital to cover all areas and reviewed regularly.

Staff could observe patients in all parts of the wards. The hospital had installed convex mirrors to manage blind spots identified in the service and closed-circuit television cameras were present in communal areas of all wards.

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

We found one potential ligature anchor points in the service in the seclusion room on Littlemore. As soon as we raised this action was taken by management and the assessment was updated accordingly. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We found this in the environmental risk assessments which were available for staff including hot spot maps which showed in a visual way any areas of risk. This information was in each nurse's office in the hospital.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff collected personal alarms from the hospital reception, and they were checked daily to ensure they were charged and in working order. Patients had easy access to nurse call points, including from their bedroom and bathroom areas.

Maintenance, cleanliness, and infection control

Ward areas were not always clean, well maintained, well-furnished and fit for purpose.

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

Requires Improvement

During the inspection we found that the hospital had low levels of cleaning staff available to cover all wards and the duties assigned. This meant that care staff were told to support the domestic staff in their duties. Management had considered this potential impact this would have on patients care and booked extra staff to support the domestic staff, so it did not take staff away from supporting the patients.

The majority of the hospital appeared clean and tidy and cleaning records were being completed. However, we found stains on the floor in Littlemore ward which had not been cleaned up. Staff told us that due to the shortage of domestic staff available minimum cleaning was being done. Management told us that the shortage was due to sickness levels and were looking into getting agency domestic staff to support.

Staff followed infection control policy for the majority of areas. However, in regard to the washing of patient clothes. The hospital had 3 washing machines during the time of our inspection there were only two working washing machines available for the needs of the whole hospital. We checked the laundry room and found items that were bagged up in red bags which according to the hospital policy was for soiled items under a large pile of clothing and stained underwear in a pile of other dirty washing that also included a pair of dirty wellington boots. The room was disorganised and there was no way to tell what clothes belonged to what patient. In addition, we found towels, bedding and other items mixed in with patients' dirty laundry with no separation, it was not clear if these items were dirty or clean. Management was aware of this issue and had requested a new washing machine and were awaiting its arrival at an unconfirmed date.

Staff told us that patients can have supervised access to the laundry room as part of their treatment plan.

We found that the furniture on the wards were well maintained, and improvement was seen in decoration on both wards. We found this to be an improvement to our last inspection.

Staff told us that equipment needed to keep the hospital clean were always available with no shortage or supply issues.

We found the hospital to be following government guidelines for COVID-19, this included anti-bacterial gel and mask wearing was a preference for staff and patients as was not a requirement anymore.

During the inspection, the hospital had no outbreaks of Covid-19 infection or any other infections.

Apart from the issues with the washing machine facilities we found that the maintenance teams act quickly when things were reported to them. This included fixing the entrance door to the garden from Barton ward where water was coming on to the ward due to heavy rain on the day.

Seclusion room

The hospital had one seclusion room which was on Littlemore ward and had a two-way communication which we found was working and a clock was present. We found the room to be clean.

During our first day of inspection, it was not being used. We found a potential ligature point on the intercom unit within the seclusion room where they were no anti pick sealant which meant a patient may have been able to use as a ligature point. Management had a completed ligature risk assessment which included the intercom unit as a risk but had not mentioned the lack on anti-pick which if in place would mitigate further risk. Management was made aware, and sealant was placed within the time we were on site.

Whilst we were checking the seclusion room, we found that there was clear observation into the main area of the room. However, to observe the seclusion toilet facilities we found at the time this area was full of storage.

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

Requires Improvement

Staff could not tell us how long it had been like that. Management cleared it out as when we reported it them during the inspection. We also found that this had not been brought to the managers attention and wasn't found on any audit during our inspection.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, Barton Ward clinic was overstocked with regularly used medications. This had an impact on storage of medications. The hospital had acquired a room within the grounds to become the central clinic where stock of regularly used medicines can be stored there.

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. We had concerns on staffing levels at our last inspection, but we found that the hospital has been successful in recruitment and the vacancy levels were an improving picture, Management showed examples of how recruitment has been a priority for them, holding events regularly

The service had low vacancy rates. We reviewed staffing figures during the period of our inspection and found that vacancy rates for nursing staff on Barton ward were 3.5 FTE and 3.2 FTE on Littlemore ward. The establishment rate should be at 8.2 FTE for both wards. We were told that 4 trainee nurses were in the pipeline to be nurses at the hospital due to start September 2023. When speaking to agency nurses, they told us that they were regular and had access to all information they needed. Following our last inspection this is a decrease in vacancy rate as it was 56% vacancy rate for nursing staff.

At the time of this inspection there was a vacancy level of 1.68 FTE for health care assistants with a low use of agency staff. Twelve new healthcare workers were starting shortly at the hospital with a further 17 bank health care workers. Following our last inspection this is a decrease in vacancy rate as it 77% for health care assistants.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers also made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had reducing turnover rates. Management discussed that during the recent change in management staff were leaving but that this is now reduced, and recruitment is improving.

Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. We saw evidence of this during our observations of handovers and flash meetings held daily. Ward managers and senior managers discussed and where able to make changes if needed to alter the number required.

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

Requires Improvement

Patients had regular one to one sessions with their named nurse. We observed nurses being able to spend time with patients, sitting with them and listening to them. One example was of an interaction between a patient and a nurse where actions were noted, and the nurse was prompt to fulfil what discussed and being able to give feedback to the patient.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. During our inspection we saw activities taking place and health care workers sat with patients engaging in ward-based activities. We observed patients accessing their leave with no difficulties. However, we were informed that due to sickness and holiday cover of activities were difficult, we did observe staff being given the equipment and supplies to be able to provide activities

The service had enough staff on each shift to carry out any physical interventions safely. The hospital operated an on-call system that if an alarm is activated assigned members of staff will attend to ensure both patient and staff are supported.

Staff shared key information to keep patients safe when handing over their care to others. We attended 2 shift handovers and we saw how the hospital shared appropriate information to keep patients safe.

Medical staff

The service did not always have enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The service had employed a full complement of day time medial staff. However, when reviewing admissions of patients, we reviewed a recent admission that happened during the night and found that the provider's policy had not been followed. The on-call doctor did not attend the admission within 2 hours of the patient's arrival to do physical health checks and prescribe any required medication. The patient was seen 7 hours after their admission. Patient care notes showed that the on-call doctor was called several times but did not answer. Management told us they were going to investigate what had happened as an on-call doctor should always be available for staff.

We reviewed 11 admissions over the past 3 months and found 2 admissions where patients had waited 3 hours before being seen by a doctor. One patient had not been reviewed by a doctor with 12 hours of admission and another patient waited 6 hours. The responsible clinician told us that the doctors do get to see patients in the time stated in policy but may enter data later. They told us that they will communicate to the doctors admitting patients to record the actual time of seeing the patient.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Staff had completed and kept up to date with their mandatory training. Training figures showed that mandatory training was at 87% compliance. There was no courses that fell below the achievement rate of 75%.

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

The mandatory training programme was comprehensive and met the needs of patients and staff.

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

Requires Improvement

We found that qualified staff were trained in immediate life support (ILS) which meant the hospital followed the National Institute for Health and Care Excellence guidance which recommends that any setting where restrictive interventions (rapid tranquilisation, restraint, or seclusion) are used have immediate access to staff trained in immediate life support (ILS) and to appropriate ILS medication and equipment. All other staff are trained in basic life support at an achieved rate of 80%.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed 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 completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We found staff completed 5-point risk assessment before each time patients went on leave.

The multidisciplinary team were involved in completing patient risk assessments.

Management of patient risk

Staff knew about any risks to each patient and but did not always to prevent or reduce risks in relation to ward risk items. We found that on each ward risk items were not always stored and recorded effectively to keep patients safe. On Barton ward we found risk items had been recorded as being present in a secure locker but when we checked the number of the items were different on the form making it confusing for staff to know the actual whereabouts of items. Out of the 9 lockers we checked 4 out of those had issues with the incorrect information. In one locker the itinerary form stated there was to be 5 razors in the locker but only 4 were present and no record of where the missing razor was on the ward. This was immediately investigated, and the razor had been disposed of the day of use but not been completed on the form.

On both wards we found that recording of amounts of risk items were inconsistent. We found examples of patients having hair bobbles that were a risk item to themselves, the itinerary form would state the "box/bag of bobbles" but no record of how many or how many were given to the patients. On Barton ward staff told me that the bobbles for the patient are a risk as they would attempt to self-harm with them. Management was informed and were looking at a better system of recording. They had not seen this as an issue before the inspection or seen as a priority to organise.

However, after highlighting these issues to the hospital immediate action was taken place and staff were informed on risk items and how to record them properly.

Staff identified and responded to any changes in risks to, or posed by, patients. Patient risk was discussed daily in flash meetings and during handovers with staff.

Staff could observe patients in all areas (of the wards) or staff followed procedures to minimise risks where they could not easily observe patients, this included placement of convex mirrors and using CCTV in communal areas and corridors.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. We found evidence of post incidents where a patient's room had been searched due to risk of harm. It was recorded appropriately and discussed in multi-disciplinary meeting.

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

Requires Improvement

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met national best practice standards. Senior managers and ward managers would meet monthly at "patient safety meetings." This ensured that most care and treatment was provided in the least restrictive way for patients.

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. We reviewed incident data given to us from the provider. We saw that with the information given to us incidents declined by 70% from November 2021 to November 2022. Data seen between our inspection in May 2022 and November 2022the provider recorded 741 incidents of physical interventions. The provider reported from May 2022 to November 2022, there were 23 supine (face up) and 3 prone (face down) restraints. From the date given we could see that the amount of prone and supine were dropping throughout the year.

91% of staff had been trained in restrictive intervention breakaway.

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

Evidence from the provider showed that between May 2022 and November 2022 rapid tranquilisation was used 99 times across the service. The breakdown of the month-by-month figures did show a reduction in use. For example, in May staff used rapid tranquilisation 64 times compared to November when staff used it 8 times. Following our previous inspection, we told the provider they must complete physical health checks on patients following rapid tranquilisation. We found during this inspection this was not always being completed. We looked at the past month's records for the 4 patients on Littlemore ward and found 3 occasions where physical observations were not recorded. Staff would record that a patient had declined physical observations but did not explore alternative ways to record how a patient is after rapid tranquilisation for example visual checks.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We reviewed recent seclusion records for January, and we found all paperwork to be recorded properly.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There was no record of any patient that was on long term seclusion at the time of our inspection.

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. Staff told us their responsibilities and how to report. Any safeguarding's would be discussed at handovers and flash meetings on each ward.

Staff kept up to date with their safeguarding training.

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

Staff followed clear procedures to keep children visiting the ward safe. There was a designated visitors room in the hospital for children, it had colourful murals on the wall and toys available.

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, staff knew how to make a safeguarding and worked with other agencies to protect them. Since the last inspection, the hospital had worked closely with the local safeguarding team to improve communications about safeguarding referrals. The hospital regularly attends safeguarding's meetings with the local authority, and we found management are open and transparent with information to protect the patients from harm.

Managers took part in serious case reviews and made changes based on the outcomes. Although no serious case reviews since our last inspection we saw how the working partnership with the local authority and safeguarding team have improved the practice of safeguarding the hospital have improved the detail of information being shared and how their actions have kept patients protected from harm.

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, staff confirmed this, and records were stored securely. We found that patient records were secure, and password protected However, the systems were slow due to the internet quality at the hospital, this issue was being looked at and solved by management. The hospital had also recognised that on one ward patients may have been able to see information so had implemented privacy screens on the computers in the nurse's office.

When patients transferred to a new team, there were no delays in staff accessing their records. During our inspection, a patient transferred internally, and we found that records were not delayed including medical records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. However, we did find an over stock of medicine that management were aware of and dealing with. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Following our inspection in August 2022 we issued the hospital with a warning notice regarding medicine management. During this inspection we found that the hospital had worked to improve with, and we did not see the same risks as highlighted in the previous inspection.

We were not assured that staff were in the knowledge of when the stored extra medicine was not running out of date. When brought to the attention to management we were informed that a central clinic was allocated and in process of being used but it was not ready at the time of our visit.

We found that on Littlemore the stock of emergency drug used for diabetes had expired on December 2022 and had not been disposed of. Management quickly actioned on this, and Barton ward had some stock of the drug which became available for Littlemore if they needed it whilst waiting for the new stock to arrive. We found there was 2 diabetic patients in the hospital at the time of our inspection, one of patients was on Littlemore ward.

Staff followed systems and processes to prescribe and administer medicines safely. We found no concerns over the prescription and administering of medicine.

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

Requires Improvement

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Ward rounds for patients happened weekly where this was discussed. We did observe patients asking their named nurses for advice and that being given.

Staff completed medicines records accurately and kept them up to date. Staff stored and managed all medicines and prescribing documents safely. Records were completed and stored appropriately on both wards.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. During the inspection we found 2 patients had been internally moved wards and found that they were receiving the correct medicine.

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 also reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service did not have a good track record on safety. Following the inspection in June 2022 the hospital was placed in special measures due to patient safety concerns. However, during this inspection, we did see a reduction in patient incidents.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers did not always investigate incidents and shared lessons learned with the whole team and the wider service. However, when things went wrong, staff apologised and gave patients honest information and suitable support.

During our inspection we reviewed 6 random incidents on CCTV. One of the incidents viewed involving the restraint of a patient. We reviewed the incident report and found it was not an accurate account of the incident. The form did not fully explain the situation and had not been fully reviewed by management. The incident involved a patient in distress who had required supportive holds to move from the communal area to their bedroom. Whilst the incident report explained the rationale for the supportive holds it did not record that the patient had dropped themselves to the floor whilst in supportive holds and that staff had dragged the patient across for the floor for approx. 2 meters. We were concerned that the patient could have been injured, and staff had not consider the dignity and respect of the patient. Additionally, moving a patient in this way was not in line with staffs training in restraint. We raised this with management as they had not reviewed this incident report or CCTV of the incident, they told us they would investigate the concerns raised.

However, we did find that staff knew what incidents to report and how to report them.

Staff did not always raise concerns and reported incidents and near misses in line with provider policy. Due to the incident reviewed on CCTV we are not assured that staff fully understand how to report bad practice as the practice seen was not in line with provider policy.

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events on any wards.

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

Requires Improvement

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. We saw an example of this when a patient had not received their admission to the hospital in line with the hospital policy and management went to speak with the patient and apologised for the experience.

Managers debriefed and supported staff after any serious incident. The service had well-being leads on both wards who staff could talk to if they needed to.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff met to discuss the feedback and look at improvements to patient care. This was included in handover meetings.

Is the service 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 reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

We reviewed 5 care plans during our inspection, we found them to be comprehensive and addressed both mental and physical health needs. Care plans were personalised, holistic and recovery orientated. Staff offered patients copies of their plans and recorded if they accepted them or not.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We saw evidence in the 5 we reviewed.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. However, we found examples where this was recorded as delayed by the doctors.

Staff regularly reviewed and updated care plans when patients' needs changed. We saw that care plans were updated when needed and were discussed in multi-disciplinary meetings and during patient ward round meetings.

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. This included psychological therapies and intervention as recommended in national guidance.

Staff identified patients' physical health needs and recorded them in their care plans. We saw evidence of assessments of National Early Warning Score (NEWs), a tool to check physical health deterioration. We also saw assessments of patients' nutritional health using the Malnutrition Universal Screening Tool (MUST).

Staff made sure patients had access to physical health care, including specialists as required.Patients had access to physical care coordinators and specialist doctors. Staff were able to contact on call doctors during evenings and weekends.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We found evidence of this mentioned in care plans. The hospital provided food to meet cultural needs when requested.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The hospital had a gym for patients could access, we saw evidence that this was being used and was having a positive impact on the patient using the facility.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. This included Health of the Nation Outcome Scales (HoNOS).

Staff used technology to support patients. The provider had ward computers and areas for patients to access them.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. Ward managers were involved in walk rounds and quality checks including senior management. These were then discussed in clinical governance meetings where actions were set and reviewed monthly to make improvements.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, managers did not always make sure they had staff with the range of skills needed to provide high quality care.

Managers did not always make sure staff received any specialist training for their role. When reviewing the training programme for staff we found that personality disorder training, training on how to support people with a learning disability or who have autism was not included in the training programme. We noted that the diagnosis of some patients during the time of inspection had a diagnosis of personality disorder and autism. We were not assured that staff were fully trained in best to support and work with patient who had this diagnosis. During our inspection 8 out of 9 patients on Barton Ward were diagnosed with a personality disorder and on Littlemore Ward out of the 4 patients admitted onto the ward 2 had a diagnosis of autism.

Staff told us that they had received no training on learning disabilities and autism and had a basic overview on their induction in personality disorders, but they felt that it wasn't effective. Management was looking into how to resolve this quickly by working with another priory hospital to offer in house training after we highlighted it them during the inspection.

The service had access to a full range of specialists to meet the needs of the patients on the ward. The hospital employed psychologists and occupational health therapists. However, the hospital did not employ a speech and language therapists but could access them if needed.

Managers supported staff through regular, constructive appraisals of their work. They made sure staff attended regular team meetings or gave information from those they could not attend.

Managers ensured staff had some of right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work.

Managers recognised poor performance, could identify the reasons, and dealt with these. We were given examples on recent performance issues and how management had quickly and effectively dealt with it.

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 teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

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

Ward teams had effective working relationships with external teams and organisations. The ward teams were working alongside other agencies in supporting patients waiting for discharge.

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 figures showed an 85% achieved rate.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. There was a Mental Health Act Administrator based at the hospital. Staff knew who their Mental Health Act administrator was and when to ask them for support.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw posters on advocacy and how patients could access this service. During our inspection advocacy service was visiting patients.

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.However, some patients told us that they felt this had not been done. Management explained that people's rights are always discussed at patient ward round meetings. Other patients told us that they didn't always understand their rights or things may not have been explained to them when they first arrived. Staff told us that they did repeat information for patients to help understand. In patients records we saw that staff had explained their rights as a patient.

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

Requires Improvement

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. During our inspection there were informal patients admitted and we saw them being able to leave on unescorted leave and staff followed procedures to allow this to happen.

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

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

Is the service caring?

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion, and support

Staff did not always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment, or condition.

Most staff were discreet, respectful, and responsive when caring for patients. During our inspection we observed supportive engagement by staff towards patients on both Barton Ward and Littlemore Ward. Staff were observed to make time to speak to patients, sitting with them supporting them with activities and engaging with patients in conversations. However, whilst reviewing some incidents on CCTV we saw an incident where a patient required restraint and it appeared that staff dragged the patient down a corridor during this restraint.

Staff gave patients help, emotional support and advice when they needed it. We observed examples during our inspection where this was happening. We saw how staff supported a patient who was escalating in their distress and with the staff's communication with the patient they were redirected, and the situation was managed successfully. Staff were able to tell us about situations where they had given emotional support to patients. One example was during our inspection where staff noted a patient was becoming distressed due to their upcoming discharge and this was being handover to staff so they could provide emotional reassurance to that patient.

Staff supported patients to understand and manage their own care treatment or condition. Patient told us that they did not fully understand their rights as a detained patient, when feeding this back to staff they told us that that had but will go over it with them. We found information leaflets about treatment on Barton ward. Staff told us that during ward rounds patients have their treatment explained to them and are welcomed to discuss it.

Staff directed patients to other services and supported them to access those services if they needed help.We found examples where patients had required physical health needs at the local general hospital. The provider had used secure transport for patients who require it, and patients were supported to all appointments or any stay that was required.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient. The provider had to use agency staff to cover shifts due to shortages in staffing. Patients told us that they felt unsafe with agency staff. The provider explained that they only use regular agency staff to allow continuity for the patients. However, we observed examples of how staff were using the preferred names of patients, respecting chosen pronouns, and recording their preferences in all paperwork. Staff we spoke with were able to discuss the needs of their patients they were supporting.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients. Staff told us that although they felt comfortable to discuss matters with their ward managers, they found it difficult to raise issues with senior management. Management told us how they had a developed a 'drop-in' session with the hospital director weekly to allow time for staff to discuss any issues. However, with this in place staff were not utilising this time.

Staff followed policy to keep patient information confidential. All patients' documents were stored correctly and safely. Computers within the nurse's station on Barton ward had privacy screens on them due to the position of the office and this was to prevent patients from reading the screens.

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. During our inspection, a patient was admitted onto Barton Ward during the night, and we found evidence that staff had respected the time of the admission for the patient and continued with their orientation of the ward when ready. We saw records of other assessments showing how admissions occur and checklists completed including tour of the ward and how the medical team would explain the admission and the treatment options.

Staff involved patients and gave them access to their care planning and risk assessments. When reviewing care plans, we saw how patients were welcomed to input into their care plan and receive a copy. However, we saw that patients would often decline a copy, but the multi-disciplinary staff would discuss their care planning in the patients ward rounds.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). However, patients told us that sometimes they did not understand. Managers and staff told us that they do go back to patients to explain and that it is also discussed at ward round.

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

Requires Improvement

Staff involved patients in decisions about the service, when appropriate. Patients were invited to their ward rounds where they could discuss their care and treatment.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff made sure patients could access advocacy services. During the inspection we saw that the advocate was on the wards speaking to patients that needed that support. Patients told us they were supported to access advocacy when they needed it. We found posters on the wards about the service and how to make contact.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families or carers. Patients had the right to choose whether all information is shared with their families or carers and the service supported that decision.

Staff helped families to give feedback on the service. Carer told us that the service does provide opportunities for feedback and the service are responsive at getting back to them.

Is the service 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. Patients did not have to stay in hospital when they were well enough to leave. However, some patients had to stay in hospital where assessments showed the placements were inappropriate.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. However, during our inspection we were aware of 3 patients that were inappropriately placed at the hospital and had a lengthy stay at the service. Management worked closely with the local authority, local safeguarding team and commissioning bodies to move the patients onto more suitable provision. This had not been done at the time of our inspection, but we were provided with evidence of the ongoing assessments for these patients.

The service had out-of-area placements. The beds at the service were spot purchased, this meant that patients were placed there from all areas of the country.

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

When patients went on leave there was always a bed available when they returned. During our inspection we found that 1 patient was on home leave and their room was still available on their return.

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

Requires Improvement

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. We reviewed during the inspection where a patient moved from the acute ward to the psychiatric intensive ward within the service. We found the rationale for this change was discussed at multidisciplinary level, care plans were updated, and the patients file was available for the new staff team,

Staff did not move or discharge patients at night or very early in the morning. On our review of discharges, we found the service would not discharge patients early in the morning or during the night. However, due to external circumstances not in the control of the service patients would leave early evening. We observed 1 patient being discharged during the day but due to weather warnings where they lived the service was offered an extra stay for the night until it was safe for the patient to travel safely.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends. During our inspection there was only 4 patients on the unit, there were beds available for admission.

Discharge and transfers of care

Patients did not have to stay in hospital when they were well enough to leave. We reviewed 2 months of discharge information and found that the service had discharged patients only when it was clinically appropriate.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. However, we observed that a patient was due to have a planned video call with a future placement and staff failed to remember this and the appointment was missed. The patient was issued an apology for this mistake.

During our inspection we reviewed documents that showed how the service planned and supported patients when they were referred or transferred between services.

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. However, on the acute ward we saw drinks that were for patients were not stored appropriately.

Each patient had their own bedroom, which they could personalise. Patients would have items in their bedroom following a multi-disciplinary team decision on the risk for each individual. In one bedroom a patient could not see out of their window sure to condensation. The patient told us that it has been that way since they were admitted weeks before. They also told us that they found the bed comfortable but were told they could not have any extra pillows as there was not any. The patient's toilet did not flush properly, and the bathroom had a strong an unpleasant odour. This was fed back to management and action was done immediately. The patient told us that the bedroom was a lot better after the action.

Patients had a secure place to store personal possessions. Provision was found in patient's bedrooms to store items and lockable storage if they wanted to. Risk items that were highlighted on the hospitals policy were stored in locked cupboards where staff managed the security of this.

Staff used a full range of rooms and equipment to support treatment and care. The service had therapy rooms, quiet rooms, activity rooms and a gym where patients were risk assessed to access them.

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

Requires Improvement

The service had quiet areas and a room where patients could meet with visitors in private. There was one main visitors room at the reception area with a coffee machine for visitors to use. Patients told us they felt that this space was small and at the time of our inspection the coffee machine was not working but was fixed during our time on site. If children were visiting the service had a separate room to facilitate this. The room had children's activities in it and colourful murals painted on the walls.

Patients could make phone calls in private. Although there were rooms available patients had their own mobile phones if risk assessed to have them. They were able to make phone calls on the wards or utilise the quiet areas if preferred.

The service had an outside space that patients could access easily. There was access to outside space for the patients on the acute ward but there was no easy access to outside space on Littlemore ward. The ward is on the first floor of the hospital and patients would have to walk downstairs to access it. We saw evidence that patients had escorted leave to access the grounds of the hospital and local community.

Patients could make their own hot drinks and snacks and were not dependent on staff.However, when reviewing the contents of the kitchen on Barton ward, we found that milkshake drinks had not been stored as recommended on packaging or dating when opened. This could mean that patients could be drinking a drink that could be out of date and not in the best condition.

The service offered a variety of good quality food. Patients told us that the food at the hospital was ok. However, they did find it hard that only hot food was served at breakfast and lunchtime and that the kitchen staff would finish at 4pm. This meant only sandwiches or salads could be served at teatime. Staff told us that although this was the case the patients could have toast and jacket potatoes at teatime as an option.

Patients' engagement with the wider community

Staff did not always support patients with activities outside the service, such as work, education. However, they supported family relationships and access to hospital activities

We found there was no formal arrangements were in place for education and work opportunities patients were supported to engage in meaningful activities Staff made sure patients had access to opportunities for education and work and supported patients.

Staff helped patients to stay in contact with families and carers. We observed staff support patients to use the ward phone or utilise their own mobile phones to keep in touch with friends and family.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.Staff encouraged and supported patients to utilise their section 17 leave into the community. However, the service is located away from a town centre or a village. Patients and staff told us that the service would support the use of taxis so that patients could access the community nearby.

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.

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

Requires Improvement

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. During our inspection we found that the service had accessible environments for patients. Communication needs were supported although the service did not have a speech and language therapist. We saw that information displayed was simple and in an easy to interpret language. However, we found the information leaflets for each ward due to a mistake had been printed in a confusing manner, this was rectified immediately by management.

We did not see that the service had information leaflets available in languages spoken by the patients and local community. However, 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. During our inspection we saw a patient being supported with their religious needs and on review of their care notes this was also evidenced.

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. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff would ensure that all complaints from the wards were reviewed as per policy. We saw that any complaints or concerns and compliments were discussed in handovers and any actions relating to them were also discussed.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. We found that these were discussed at monthly governance meetings.

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

Patients received feedback from managers after the investigation into their complaint. We reviewed letters sent to patients following complaints, they were clear and explained fully to the patients what was looked at and conclusions.

The service held team meetings, handovers, flash meetings were managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Requires Improvement

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

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

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.

Following our last inspection in August 2022 there had been a change in leadership at the hospital. Senior leaders in place had made some improvements to the service. For example, they highlighted the low motivation of staff and had introduced better debriefing and reflective practice for all staff. Being visible to staff was a priority and management were holding weekly drop-in sessions for staff to come and talk to them about any issues positive or negative. However, we were told by managers that whilst these drop in were in place they were not attended by staff. Staff told us that the change of management has been welcomed however they still feel low in morale. During our inspection we still found issues when recording physical health observations. At our last inspection we found that staff were not recording other ways to record side effects from rapid tranquilisation and during this inspection we found the same issue.

During our inspection executive team were present at the hospital supporting the new leadership team. Staff knew that they were present but felt no extra pressure of their presence and were able to continue as normal. Management was determined to support the staff moving forward and were trying to continue improvements in recruitment to lessen burn out for existing staff. We saw examples and practice of how managers knew their patients and would make time to go and speak to them on the ward. Their approach was kind and caring towards the patients.

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 told us during the inspection that the management team within the hospital followed the visions the hospital. However, they felt senior leaders within the organisation did not. We heard an example of a recent staff meetings where senior leaders had been present and staff left the meeting feeling targeted and de-moralised. Local management were trying to support staff to not feel this way.

Culture

Staff felt respected, supported, and valued. They told us that this was an improvement to how they have felt previously. Staff acknowledged the improvements within the hospital and how been difficult the last year had been, some still feel demotivated. Managers promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff could raise any concerns without fear. However, they did not feel listened to by senior leaders of the organisation.

Governance

Our findings from the other key questions demonstrated that governance processes were in place and improvements had been made since our last inspections.

Due to the change in leadership the improvements were not fully embedded. Therefore, we were not assured the systems and process in place for performance and risk were robust and would lead to positive changes in patient care. During the inspection we found examples such as patient risk items management, infection control, audits of seclusion rooms, incident management and reporting which showed that an emerging picture of governance that was still being embedded. None of these issues had been identified through the service's internal governance process. We do acknowledge that when we raised the concerns, we found managers did act to address them.

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

Requires Improvement

We found that the lack of effective specialised training in learning disabilities and autism or in personality disorders were not on the hospitals agenda of training even though most of their patients had a diagnosis of a personality disorder and/or a diagnosis of autism. We did not feel assured that the staff had enough knowledge to fully support and understand the patient type at the hospital.

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. We found that staff at all levels had access to information and management had meetings in place that supported this for example flash meetings, patient safety meetings, team meetings, reflective practice, clinical governance. Actions and feedback were being shared with staff on the continued improvement of the hospital.

Information management

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

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, the internet was slow, and this could cause delays in accessing information. Management told us that this was due for an upgrade sue to the hospital being involved in a trial of electronic prescribing.

Information governance systems included confidentiality of patient records. Storage of confidential material where managed well.

Staff made notifications to external bodies as needed.

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. We had received positive feedback from link workers in the local authority.

Staff, patients, and carers had access to up-to-date information about the work of the provider and the services they used – for example, “the Tuesday read,” community meetings and communication with carers.

Learning, continuous improvement and innovation

The findings form this inspection showed that the hospital has shown some improvements from our previous inspection of May 2022 and August 2022. However, systems were still not fully embedded. Managers were working with staff learning form lessons on reducing future risks.

Managers shared learning through daily risk meetings, team meetings, through weekly “the Tuesday read,” staff supervision and reflective practice. Managers had put in place drop-in sessions for staff to speak openly with leaders.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service should that all staff understand how to consistently manage items which may present a risk to patient.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure that there is enough day time and night cover for medical staff and that there is a clear way to contact them if not on site.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service should ensure that staff are trained to meet the needs of patients who have a diagnosis of personality disorder and for patients who have learning disabilities or are autistic

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service must ensure that all staff use the correct practice when performing restrictive interventions.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service should ensure that observation areas of the seclusion suite are always clean and clear.