The Langford Centre

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated The Langford Centre as good because:

- There was a person-centred culture. We saw evidence of patient involvement in care planning. Patients had a comprehensive assessment in place that was individualised and person-centred with a focus on patient goals and recovery.
- Patients had access to innovative psychological therapies and activities on the ward and in the community throughout the week as part of their treatment. The service had a robust multidisciplinary team who worked well together and were fully involved in patients' care.
- Patients experienced care and treatment that was compassionate, sensitive and person-centred. Staff morale was generally high and the wards supported each other. Wards were well-led and there was clear leadership at a local level. The ward managers were visible on the wards during the day and the multidisciplinary team were available to support patients and staff.

However:

- There was a lack of learning following a serious incident where a patient in the hospital was subjected to a high number of episodes of inappropriate restraint throughout their several month admission in 2016. During our inspection five months later, we found that not all staff had been trained in restraint which meant there was a lack of learning from each incident to ensure staff were trained in appropriate restraint techniques. All of the service's mandatory training completion levels, except for that in restraint training, exceeded their completion target of 75%. In the staff team, only 68% of permanent staff and 22% agency staff who regularly worked at the service received the provider's approved restraint training. Another contributing factor to the incidents were that the ward manager was working across a number of wards, which meant that there was a lack of consistent oversight to manage staff practices. At the time of our inspection we found that the ward manager was still working across two wards.
- Patients' privacy and dignity were compromised on Pevensey ward because their physical weight and statistics were measured in the quiet lounge instead of their bedrooms.
- Assessment of patients' capacity was not always properly assessed and documented.

Summary of findings

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Good

The Langford Centre

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to The Langford Centre

The Langford Centre is run by Bramley Health.

The service provides both low secure and rehabilitation services to male and female adults with a range of mental health needs, learning disabilities and substance misuse support needs. It has 51 beds over four wards. On the days of the inspection there were 29 patients accommodated over four wards.

Daffodil ward is a 15 bed female locked rehabilitation ward for patients with complex needs. Balmoral ward is an 11 bed female locked step down ward for patients from Daffodil ward.

Pevensey ward is a 15 bed male low secure ward.

Blenheim ward is a 10 bed male learning disability locked ward.

The Langford Centre is registered to provide:

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

We have inspected The Langford Centre seven times since registration with the Care Quality Commission (CQC) in 2011. The last inspection took place on the 21 and 22 July 2015. During that inspection we found the provider had breached three of the Health and Social Care Act 2008 (Regulated Activities) Regulations (Regulation 10 Dignity and Respect, Regulation 9 Person Centre Care, and Regulation 17 Good Governance). We asked the service to take steps to address the breaches of regulation and the service responded with an action plan to do this and we reviewed these as part of this inspection. During this announced inspection we determined that the service had made improvements in these areas.

Our inspection team

Team leader: Linda Burke, Care Quality Commission (CQC) inspector.

The team that inspected the service comprised five people; one CQC inspection manager, two CQC inspectors, one Mental Health Act reviewer and a specialist advisor who was a senior mental health nurse.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients at three focus groups.

Summary of this inspection

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the registered manager and managers or acting managers for each of the wards
- spoke with 16 other staff members; including physical health specialist doctors, nurses, therapeutic care workers, the senior occupational therapist, the consultant psychologist and consultant psychiatrist
- attended and observed one multidisciplinary handover meeting
- collected feedback from eight patients using comment cards
- looked at 17 care plans and health records of patients
- looked at 50 incident forms
- carried out a specific check of the medicine management on all four wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with six patients across the four wards. We also received comment cards from eight patients. Most patients told us they found staff to be caring and supportive. They were generally positive about their experience in the hospital and felt that they received support that was appropriate to their needs. Patients felt that most staff had an understanding of their care needs and were actively involved in their care planning. Two patients told us they felt that staff did not listen to them and would like more time with the psychology team.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The provider had not ensured that a sufficient number of staff were trained in restraint. The provider filled a high number of shifts with agency staff. Of the pool of 55 agency staff who worked in this capacity, only 12 had been trained in restraint and so were able to participate in incidents of restraint. Although the provider told us that a rapid response team managed restraint, when we looked at 50 records, we found that this was not the case. The Care Quality Commission and local safeguarding team had been informed of a serious incident where a patient in the hospital was subjected to repeated incidents of inappropriate restraint throughout their seven-month admission in 2016. The provider had not responded by ensuring that staff had the capability to use restrictive interventions appropriately.
- There was a lack of learning following an incident on one ward where a patient experienced incidents of inappropriate restraint throughout their admission. An independent investigation identified that the ward manager working across a number of wards was a contributing factor as they were not available to monitor and offer guidance to staff on the ward. There was a lack of learning following these incidents and the investigation as the ward manager was still working across two wards.There were two ward manager vacancies across the four wards during our inspection.

However:

- All patients had a nurse who was allocated to them and there was enough time to ensure that patients had regular one to one time with this nurse. There was adequate medical cover day and night on the wards.
- We found evidence of good management and storage of medicines across all four wards.
- Wards completed an incident rating scale for each patient which was discussed in daily ward rounds which helped manage patient risk with regards to ward and community activities.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Patients received a range of psychological therapies recommended by the National Institute for Health and Care Excellence.
- All patients had access to physical health care from a specialist health doctor in the hospital and in the community from GPs and dentists.
- Staff were supervised monthly, appraised annually and attended weekly multidisciplinary team meetings and monthly reflective practice sessions led by a member of the psychology team.
- All patients had a physical examination on admission to the hospital and these were noted clearly in their health action plans.
- The service used the learning disability Greenlight Tool Kit to audit and improve mental health services so that they were effective in supporting patients with learning disabilities and autism.

However:

- Staff monitored patients' health with the use of national early warning system ratings. Staff had completed and scored ratings well on three out of four wards. The exceptions were that forms for four patients on Pevensey ward were not dated, fully completed or scored and one form on Balmoral ward did not list any scores.
- The wording in Section 17 leave forms gave unlimited leave for occupational therapy and hospital appointments. The responsible clinician should state any circumstances where leave should not go ahead.
- We saw examples where three out of four patients on one ward had been assessed for advance decisions, however there was a lack of evidence their capacity had been assessed prior to this. There was also a lack of evidence of any discussions having taken place amongst the multi disciplinary team to assess the patients' capacity in their absence.

Are services caring?

Good

We rated caring as good because:

- Staff spoke about patients in a respectful manner and demonstrated a high level of understanding of their individual needs.
- Staff throughout the hospital had a good understanding of patients' individual needs.

Summary of this inspection

- Staff verbally oriented patients onto their wards following their admission.Blenheim ward, for patients with learning disabilities, provided patients with an easy read patient guide.
- Patients were involved in the planning of their care.
- The occupational therapy team provided patients with an 'interest checklist' so they could choose activities they were interested in on the wards and in the community.
- Patients gave feedback on the care they received via patient surveys, friends and family test and the hospital's complaints procedure.

However:

- Nurses carried out weekly routine physical health checks with patients in their bedrooms, however on Pevensey ward these checks took place in the quiet lounge area.

Are services responsive?

Good

We rated responsive as good because:

- The hospital reviewed all admissions to ensure they accepted patient referrals where they could meet the patients' needs and manage their risks safely.
- Patients had access to their own bed when they returned from overnight leave from the wards.
- All wards had a full range of equipment and rooms including clinic rooms, quiet lounges, art therapy and communal television rooms to support the treatment and care of patients.
- Each ward had a quiet room and private meeting room where patients could meet visitors.
- Patients had access to their own mobile phones without cameras while on the wards when appropriately risk assessed.
- All patients had supervised access to the outside garden areas.
- Patients were allowed to personalise their bedrooms and we saw evidence of this during our tours of the wards.
- All patients had access to their bedrooms throughout the day.
- Each ward had very extensive activity schedules seven days per week.
- The hospital was adapted for patients requiring disabled access.
- The hospital provided a range of food to meet patients' dietary requirements.

Are services well-led?

Good

We rated well-led as good because:

- The provider used key performance indicators to monitor performance and quality.

Summary of this inspection

- Staff participated in a range of clinical audits to monitor the effectiveness of services provided.

However:

- All staff were aware of the whistleblowing policy and process.
- There was good morale amongst the staff group and all staff we spoke with spoke with enthusiasm and pride about the work they did.
- Staff had access to mandatory training, but not all members of staff had completed the training provided.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We reviewed the files of all detained patients across the wards and a Mental Health Act reviewer carried out a detailed Mental Health Act (MHA) review on Pevensey ward. MHA documentation was filled in correctly, was up to date and stored appropriately.

Information of the rights of patients who were detained was displayed clearly on the wards and in an easy to read format.

The wording in Section 17 leave forms gave unlimited leave for occupational therapy and hospital appointments which were authorised by the responsible clinician. The responsible clinician should state any circumstances where leave should not go ahead.

Section 132 rights forms were present on all files and rights had been given to patients monthly as per the provider's policy and the MHA Code of Practice. Staff were aware of the need to explain patients' rights to them under the MHA

Staff were aware of the need to explain patients' rights to them under the MHA. However, on Pevensey ward there was a lack of evidence in the nursing notes that patients were seen on the dates they had their rights explained to them.

The MHA office was situated in the hospital and all staff knew how to contact the officer for advice when needed. The MHA officer carried out monthly MHA paperwork audits to monitor that the MHA was being applied correctly.

Staff had access to mandatory training in the use of the MHA. At the time of our inspection, 90% of staff had completed this training. This was an increase from the 70% training completion level we noted during our inspection in July 2015. Staff we spoke with had a good understanding of the MHA and Code of Practice.

Patients had access to an Independent Mental Health Advocate (IMHA). Independent advocacy services were readily contactable and available to support patients when needed. We heard from patients that they had spoken with the IMHA in relation to complaints they had about their care. Details of the local IMHA were displayed on the wards' notice boards.

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy.

Staff had access to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. At the time of the inspection 98% of staff had completed this training which was an increase from the 92% completion level we noted during our inspection in July 2015.

Formal capacity assessments in relation to consent to treatment took place. However, the assessments assessed patients' competence to consent rather than their capacity to consent to treatment. Gillick Competence requires that competence is assessed for people who are aged under 16, while the patient group in his hospital were over all over 18 years of age. This meant that patients' competence was assessed and not capacity in accordance with the four stage test required by the Mental Capacity Act Code of Practice 2005.

Where patients were not detained under the Mental Health Act, their capacity to consent to medicine and to stay in the hospital as an informal patient had been assessed. However, there was no evidence that patients were properly assessed as having capacity to manage their finances. We saw that one patient was deemed to have capacity but they also had appointees or family members managing their finances for them. In two files we reviewed, we saw that both patients had been assessed for capacity to manage their finances. However, for the first patient an assessment meeting had not been

Detailed findings from this inspection

recorded to demonstrate the assessment had taken place with them. For the second patient, a ward round meeting included an assessment of their capacity, however the patient had refused to attend this, so was not present. This meant there a lack of evidence that the patients were seen or present when the capacity assessments were carried out and that discussions to assess patients' capacity in their absence took place among the multi disciplinary team.

There was a lack of evidence that three out of four patients were assessed for capacity when advance decisions were completed for them. An example of this was that in the advance decisions we viewed, patients were asked whether they consented to electroconvulsive therapy. However, there was a lack of evidence that patients were assessed for their capacity to make that decision and that discussions to assess patients' capacity in their absence took place among the multi disciplinary team.

One patient was subject to Deprivation of Liberty Safeguards authorisation. We saw evidence of staff supporting the patient to make decisions about their care and evidence of best interest decisions being made to help agree actions regarding their care and treatment.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Requires improvement

Safe and clean environment

- Pevensey and Daffodil wards were laid out in 'T' shapes which meant that these wards had no blind spots. Staff were placed strategically throughout the ward to ensure all areas were monitored during shifts. Blenheim and Balmoral wards had blind spots due to the ward layouts, however these were mitigated by the use of closed circuit television, mirrors, and continual staff presence throughout the wards.
- Each ward had a ligature risk assessment. However the assessments for Daffodil, Pevensey and Blenheim wards were incomplete as they did not detail how identified ligature points were mitigated. The ligature risk assessment for Balmoral ward did not list all ligature points located on the ward. We raised this with the registered manager who provided updated and comprehensive ward ligature risk assessments following our inspection. During our inspection, ward ligature risk assessments were not available in nurses' stations which meant that there was a risk that staff on shift, including agency staff, were not aware or reminded of the location of ligature points on the wards.
- All wards were single sex which meant the provider complied with the Department of Health eliminating mixed sex accommodation guidance.
- The clinic rooms on all four wards were well equipped and all emergency medicines were in date and checked weekly by the pharmacist and ward managers. There were procedures in place to regularly check all clinical equipment and we saw evidence that these checks were routinely carried out. All clinic rooms were clean but appeared cluttered due to their small size.
- There were no seclusion rooms on any of the wards in the hospital. The Langford Centre reported no incidents of seclusion or long term segregation between 1 March 2016 and 31 August 2016
- All ward areas were clean and well furnished. Wards were cleaned from Monday to Friday by domestic staff and ward staff carried out essential cleaning during weekends. The hospital did not have a cleaning checklist to indicate when and which areas were cleaned.
- The Langford Centre was awarded a food hygiene rating of 5 (Very Good) by Rother District Council on 6 June 2016. However, we noted that patients' food items in the kitchen fridge on Pevensey ward were incorrectly stored. For example, some food items were not sealed and some food items had 'opened on' dates recorded (to ensure they were disposed of at the correct time) and some did not.
- Staff carried out procedural and environmental security checks each morning and evening on all wards to identify any damage on the wards which was a potential safety hazard. The checks monitored aspects such as floors being free of slip hazards, checking for items on the ward which could be used as a ligature, and checking under chairs for anything which could harm patients such as pens and lighters.
- All staff carried personal alarms. During our inspection we observed staff activating alarms in emergency situations and colleagues responded with support very quickly.

Long stay/rehabilitation mental health wards for working age adults

Good

Safe staffing

- The provider estimated the number and grade of nurses to cover each shift across all wards to ensure safety for patients and staff by accounting for observation levels required for each patient.
- The total number of whole time equivalent substantive staff for the hospital was 76 as at October 2016. The total number of staff leaving in the previous twelve months was 30 whole time equivalent staff. The staff turnover in that the year prior to October 2016 was 39%. Recruitment of staff was listed on the provider's risk register.
- During our inspection, ward managers told us there were eight qualified nursing and eight therapeutic care worker vacancies across the hospital. The registered manager told us they were recruiting to these posts. On the first day of our inspection we were informed that the ward manager for Daffodil ward was leaving that day and the ward manager vacancy for Pevensey ward was covered by an interim manager. We were informed that recruitment was underway. This meant that two out of four wards did not have a permanent ward manager. An independent investigation was commissioned by the provider found that a contributing factor to an incidences involving inappropriate restraint on a patient during their several months admission in 2016 was that the ward manager worked across a number of wards. This meant they were unable to monitor and offer focussed guidance to staff on the ward. During our inspection, the ward manager was working across two wards which meant there was a lack of learning and improvement in practice following the incidents during the patient's admission.
- Staff received appropriate mandatory training in 20 areas including adult and children's safeguarding, autism awareness, Mental Health Act and Mental Capacity Act training. Information provided to us by the provider in December 2016 noted training compliance levels across all topics exceeded their 75% training completion target rate except for restrictive physical intervention (RPI) which was at 68%. The provider told us that training was scheduled for those who had not received RPI training.
- However, the provider had not ensured that a sufficient number of staff were trained in restraint. The provider filled a high number of shifts with agency staff. Of the pool of 55 agency staff who worked in this capacity, only 12 had been trained in restraint and so were able to participate in incidents of restraint. Although the provider told us that a rapid response team managed restraint, when we looked at 50 records, we found that there was a lack of evidence to demonstrate this. The Care Quality Commission and local safeguarding team had been informed of a serious incident where a patient in the hospital was subjected to repeated incidents of inappropriate restraint throughout their seven-month admission in 2016. The provider had not responded to these incidents during this time by ensuring that staff had the capability to use restrictive interventions appropriately.
- Figures given to us by the provider for the period 01 June 2016 to 31 August 2016 showed that 1,739 shifts were filled by bank or agency staff to cover sickness, absence or vacancies. There were five occasions when 'bank' or agency staff could not be obtained to cover shifts. The provider used a pool of 55 members of agency staff who worked when required across all wards.
- There was high use of agency and bank staff on all wards. Ward managers adjusted staffing levels daily to ensure safety on the wards. We observed evidence of ward managers requesting additional agency support when patient observation levels increased due to clinical need. For example, during periods when patients were at increased risk of harming themselves or others. Ward managers always requested staff, wherever possible, who were familiar with the wards. When agency staff were new to the hospital, ward managers requested staff profiles to review their nursing experience to ensure professional matches to the nursing duties required. However, three members of staff told us that they experienced challenges with the high use of agency staff. These challenges included when agency staff were unfamiliar with the wards or patients and when there were language differences which led to communication issues. We also found that, at the time of inspection, only 12 out of the pool of 55 agency staff used by the provider when required were trained in restraint which meant very few could assist in the event of such an incident.
- All patients had a nurse who was allocated to them and there was enough time to ensure that patients had regular one to one time with this nurse. All patients had an allocated care team including primary nurse;

associate nurse and therapeutic care worker. Ward managers and other staff members told us that ward activities and ward leave was never cancelled due to staff shortages.

- There was adequate medical cover day and night on the wards. Medical staff told us that there were adequate doctors available over a 24-hour period, seven days each week who were available to respond quickly on the ward in an emergency.

Assessing and managing risk to patients and staff

- There were 84 incidents of restraint involving 15 different patients during the period 01 March 2016 to 31 August 2016 on Daffodil, Pevensey and Blenheim wards (Balmoral ward was not opened until October 2016). The majority of incidents occurred on Daffodil ward with 56 incidents taking place involving seven different patients. According to information provided by the service, none of these incidents involved prone restraint resulting in the use of rapid tranquilisation. However, on reviewing 50 incidents reports during the same period, we found that rapid tranquilisation following restraint was used on two occasions.
- Staff had access to training in the use of physical restraint, which was called restrictive physical intervention (RPI). At the time of inspection 68% of staff were trained in RPI. All staff we spoke with told us that they used de-escalation interventions before physical restraint, was used as a last resort. During the period of the inspection we viewed 50 incidents reports for a patient from the period February 2016 to December 2016. We found that the forms were not always complete and did not clearly state if restraint had been used or not. The description of the incident in 11 cases outlined volatile behaviour/ physical aggression towards staff and others, but did not clearly state how this was managed by staff. The incident reports recorded the actual use of restraint on seven occasions, and on only two of these occasions a restraint form was used to record what had happened during the restraint. In a further five incident reports it recorded the use of other types of restraint, such as 'primary holds', the staff releasing the patients grip on another patient and staff escorting the patient to their room 'through tough resistance'; however these were not recorded as restraint.
- The service used a pool of 55 agency staff and only 12 of these were trained in RPI. This could put patients and staff at risk where they had not been appropriately trained. The registered manager told us that the remaining agency staff would attend the next available restraint training sessions provided by the hospital.
- Staff risk assessed patients using the short term assessment of risk and treatability (START) tool. This meant that a comprehensive and dynamic evaluation of risk was carried out throughout each patient's admission. Staff assessed risk factors such as self-harm, violence, self-neglect, suicide, victimisation and substance use. However, we did not see evidence of a risk assessment for one patient who refused to engage in treatment for a terminal physical health condition and a number of chronic health conditions.
- Wards had procedures for conducting patient observation. Patient observation levels were agreed by the ward teams at the beginning of each shift. Ward staff also adapted individual patient observation levels throughout each shift in the event of an incident, which indicated an increased risk of harm for any patient. We observed staff completing observation monitoring on each ward where they noted the frequency and type of patient observation, for example, if a patient was observed by two staff within eyesight and how frequently.
- We observed one multidisciplinary staff handover meeting where staff discussed patients' individual risks and patients presenting with immediate issues of concern such as self-harm. During the meeting, following discussion about a patient at increased risk of self-harm, staff agreed to increase observation levels for that patient to mitigate risks they presented to themselves.
- Crisis plans and advance decisions were discussed and developed for patients in ward rounds. For example, staff told us that male staff were not permitted to restrain a female patient if this was an advance decision made by the patient.
- Patient risk was also discussed in monthly patient safety committee meetings which were attended by the multi-disciplinary team including a local police liaison officer. Minutes from the April 2016 meeting noted that safeguarding risks, allegations of intimidation and aggression between patients were discussed to highlight and agree actions to mitigate all risks identified.
- We found that blanket restrictions across the four wards, were justified and clear notices were in place for

patients explaining why these restrictions were in place. For example, patients were not permitted to hold cigarette lighters on them whilst on the wards and they were securely stored. Staff told us this was because of the risk of inappropriate use, which could endanger the lives of patients and staff.

- Patients were not permitted to use mobile phones with cameras on the wards. However, they were permitted to use phones without cameras following appropriate risk assessment. Staff told us that camera phones were prohibited due to misuse by some patients on the wards. Ward phones were also available for patients to use in private. Patients had keys to their rooms which contained lockable storage, if this was risk assessed as appropriate.
- The provider had a system for managing safeguarding issues. Safeguarding concerns were reviewed and discussed in handovers and multidisciplinary team meetings. Staff had access to mandatory safeguarding training. Training completion levels for December 2016 indicated that 99% and 96% of staff completed adult and children's safeguarding respectively. Staff we spoke with had an understanding of safeguarding issues and their responsibilities in relation to identifying and reporting allegations of abuse. Staff told us of the steps they would take in reporting allegations to the safeguarding lead within the service and felt confident in contacting them for advice when required. We reviewed a matrix, developed by the provider, which tracked the involvement of the police with any relevant safeguarding on the wards.
- One agency staff member we spoke with told us that agency staff received an induction into the provider's safeguarding policy and procedure when they joined the wards.
- The provider submitted 12 safeguarding concerns to the CQC in the 12 months prior to 17 October 2016.
- We found evidence of appropriate management and storage of medicines across all four wards. For example, we saw that medicines were stored securely on the ward. Temperature records of the ward medicine fridges and clinic rooms were monitored daily, which meant medicines were stored in conditions recommended by the manufacturers. The charge nurse and pharmacist carried out medicine reconciliation for each patient when they were admitted to the wards. The pharmacist carried out weekly medicine checks on each ward which were also reviewed by the ward managers.

Track record on safety

- According to data provided by the service, there were two records of serious incidents between November 2015 and June 2016. One incident involved a fire in the laundry room and another related to a set of missing ward keys and alarm in the reception area.
- In the 50 incident reports we reviewed across all four wards, we saw evidence of instances of patient assaults on staff which had been recorded.
- Staff we spoke with told us about improvements in practice following incidents. For example, the ward manager on Blenheim ward told us that their team attend monthly reflective practice sessions to review their work and ensure they were working within their competence levels following an incident on the ward where they cared for a patient with very complex needs.

Reporting incidents and learning from when things go wrong

- Staff told us that shared learning across the service took place with regards to serious incidents by emails and in staff meetings. However, we did not see evidence of learning following a high number of incidents on one ward involving inappropriate restraint on a patient. There was a lack of learning following these incidents. An independent investigation commissioned by the provider found that one contributing factor was that the ward manager had responsibilities of working across more than one ward which led to a lack of guidance for staff. At the time of our inspection, the ward manager was still employed to work across two wards.
- Staff we spoke with knew how to recognise and the process for reporting incidents, for example, incidents relating to violence, trips, falls, and patient self-harm. Ward managers told us that all incidents were reviewed and discussed amongst the multidisciplinary team. The incident reporting system ensured that senior managers within the service were alerted to incidents in a timely manner and monitored the investigation and responses to incidents. We reviewed 50 incident forms and saw how ward managers reviewed the information and processed in an appropriate and timely manner. Incident forms contained a section for ward managers to complete regarding lessons learned and findings from staff debriefings and these were completed on the incident forms we reviewed. We were informed that

Long stay/rehabilitation mental health wards for working age adults

Good

action to ensure adequate staff were on Balmoral ward at all times following a patient incident was carried out. However, as highlighted earlier in the report, the records of incidents did not clearly state the interventions or restraint used to support patients, and improvements were needed in this area.

- Wards completed an incident rating scale for each patient which was discussed in daily ward rounds. Staff recorded patients' weekly incidents regarding their levels of aggression, risk of self-neglect, substance misuse, and risk of suicide. Nursing staff used the ratings to influence patients' entitlement to leave to ensure their safety in the community, for example in relation to their risk of self-harm.
- Staff were offered debrief support in a group or individually after serious incidents occurred. Monthly reflective practice sessions led by a member of the psychology team took place on each ward to enable staff to discuss any incidents that had occurred.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had a duty of candour policy. Staff we spoke with were familiar with the policy and understood that they had a duty to be open and transparent with patients in relation to their care and treatment and the need to apologise when things went wrong. We saw evidence that the registered manager communicated the content of a safeguarding alert to a relative regarding concerns about the care and treatment of their family member. The registered manager also communicated with the relative to keep them updated on investigation findings to ensure the process was transparent.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- All information regarding patients' care was recorded securely in both paper and electronic formats.
- We reviewed care and treatment records for 17 patients across all four wards. Staff completed comprehensive assessments, including a person centred plan and a health action plan, for all patients following admission to the hospital. These detailed their physical and mental health history, treatment needs and allergies.
- Care plans described how patients wanted to be spoken to, their mental health history and diagnosis, listed their interests and detailed situations or behaviours which may lead them to become distressed and how they wished to be supported by staff.
- All patients had a physical examination on admission to the hospital and these were noted clearly in their health action plans. Nurses developed physical health care plans where a patient's health condition may deteriorate and become acute requiring specialist treatment. For example we saw a health care plans for conditions such as cancer and chronic respiratory conditions. These care plans included details for emergency admissions to local specialist hospital teams. The physical health care plans outlined steps to be taken to ensure patients' health needs were met. However, health care plans were not developed for ongoing health conditions, for example incontinence.
- The specialist health doctor held weekly health clinics to provide diabetic care education to patients where relevant. The clinic also offered time for patients to see the doctor to address less urgent health concerns such as knee pain and to discuss queries regarding nicotine replacement therapy. More urgent health concerns were addressed daily on the wards, such as infections following incidents of self-harm. The doctor introduced a process where they had prescribed antibiotics on the wards for patients who required them. This meant that patients did not have to attend accident and emergency or GP appointments unnecessarily which often caused patients distress and sometimes led to unattended appointments.
- Staff monitored patients' health with the use of national early warning system ratings. Forms were generally completed fully on three out of four wards and noted patients' blood pressure and heart rate, but the forms we reviewed for four patients on Pevensey ward were not dated, fully completed or scored and one on Balmoral ward had not scores listed. This meant that the system did not alert staff on this ward to the

increasing health needs of particular patients. For example, one patient on Balmoral ward had a very high blood pressure reading, but this was not scored to indicate on the warning system that this was a concern requiring further investigation and monitoring. We brought this to the attention of the registered manager and the specialist physical health doctor at the time.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence (NICE) guidance following rapid tranquilisation. For example, we saw evidence of appropriate monitoring of patients' physical health following administration of rapid tranquilisation medicine. Consultants told us that they followed prescribing guidelines for the administration of medicine for patients with schizophrenia.
- Patients received a range of psychological therapies recommended by NICE including art therapy, cognitive and dialectical behaviour therapies both in individual and group settings. Patients, following appropriate risk assessments, also had access to the local NHS-led recovery college which offered groups to support professionals and patients to understand mental and physical health conditions, wellbeing, build self-confidence and return to work/study.
- Doctors carried out electro cardiogram tests for all patients on admission. This enabled the doctor to identify any issues with patients' heart health. All patients had access to physical health care from a specialist health doctor in the hospital and in the community from GPs, dentists and in the local accident and emergency department. Hospital doctors made referrals for patients to access specialist treatment, for example neurology, via the local GP. During our inspection we observed staff escorting patients to community health appointments and requesting the specialist health doctor for antibiotics for a patient for wound care.
- Staff monitored nutrition and hydration needs of patients when a need was identified. We saw evidence of this on one ward where a patient with specific physical health needs who required support to eat had their meal times organised so they ate appropriate amounts of food for necessary weight gain. Nursing staff monitored patients' weight weekly and recorded this to indicate their body mass index which indicated if there was a need for varying diets and exercise.
- All wards used health of the nation outcome scales to indicate if patients' health and wellbeing improved during their admission to the wards.
- All clinical staff took part in clinical audits including safety thermometer audits. The safety thermometer audits enabled staff to measure patients at risk of harm and those who are free from harm during ward shifts. The ward managers undertook monthly case note audits to highlight any omissions in patients' paperwork. Any action plans developed by ward managers to improve practice were presented to the weekly multidisciplinary team meetings for action. Clinical staff carried out monthly audits to review care plan approach paperwork, consent to treatment paperwork and to ensure that patients' rights were communicated to them regularly in line with Mental Health Act guidance.

Skilled staff to deliver care

- A full range of experienced and qualified health professionals including speech and language therapists, consultant psychologist and psychiatrist, specialist health doctor, learning disability consultant, occupational therapist, occupational therapy assistants, nurses, therapeutic care workers and a social worker provided input into the wards.
- The agency staff we spoke with told us they were trained in delivering personal care to patients and in lifting and manual handling.
- All staff including agency and bank staff received appropriate induction before working on the wards.
- Staff were supervised monthly, appraised annually and attended weekly multidisciplinary team meetings and monthly reflective practice sessions led by a member of the psychology team.
- Specialist training including in-house emotional unstable personality disorder training, positive support management and challenging behaviour training was available to staff. The provider's training manager was responsible for sourcing training for staff and delivered some training to staff as appropriate.

Multidisciplinary and inter-agency team work

- The wards held weekly multidisciplinary (MDT) team meetings to review patient risks, new referrals, incidents, and medicine needs. We attended one MDT meeting and observed positive interactions between all staff disciplines. Staff discussed current risks presented by a

number of patients and how observation levels were adapted to mitigate those risks. Staff also discussed medicine prescribed to patients and reviewed use of 'as necessary' medicine. Specialist staff allocation was discussed so that all ward teams knew where they would be throughout the day.

- The senior occupational therapist attended a local outcomes recovery group with local care providers to share best practice in care delivery within secure services.
- Community mental health team co-ordinators maintained good contact with the service particularly with regard to discussing transferring patients to new placements. However, we heard that there were delays in moving a number of patients to more appropriate placements due to lack of appropriate placements in other hospitals.
- Each ward had shift handovers twice a day. This was when staff gathered to discuss required patient observation levels, staffing levels for the ward, ward or occupational activities which patients were due to attend, and to review patient risk levels.
- The wards had very strong working relationships with external teams such as adult social services and the local GP who cared for patients during their admission to the hospital. During our inspection, we observed a telephone call from a member of the local care co-ordination team and a ward manager to review the care a patient was receiving. The occupational therapy team had good working links with local GP-based health trainers who provided advice for patients on diet and life coaching, with the local disability football league and the local college who attended the wards to provide literacy and numeracy education for patients.

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

- We reviewed the files of all detained patients across the wards and a Mental Health Act reviewer carried out a detailed Mental Health Act (MHA) review on Pevensey ward. MHA documentation was filled in correctly, was up to date and stored appropriately.
- Information of the rights of patients who were detained was displayed clearly on the wards and in an easy to read format.
- The wording in Section 17 leave forms gave unlimited leave for occupational therapy and hospital appointments which were authorised by the responsible clinician. The responsible clinician did not record circumstances where leave should not take place.
- Section 132 rights forms were present on all files and rights had been given to patients monthly as per the provider's policy and the MHA Code of Practice. Staff were aware of the need to explain patients' rights to them under the MHA.
- Staff were aware of the need to explain patients' rights to them under the MHA. However, on Pevensey ward there was a lack of evidence in the nursing notes that patients were seen on the dates they had their rights explained to them.
- The MHA office was situated in the hospital and all staff knew how to contact the officer for advice when needed. The MHA officer carried out monthly MHA paperwork audits to monitor that the MHA was being applied correctly.
- Staff had access to mandatory training in the use of the MHA. At the time of our inspection, 90% of staff had completed this training. This was an increase from the 70% training completion level we noted during our inspection in July 2015. Staff we spoke with had a good understanding of the MHA and Code of Practice.
- Patients had access to an Independent Mental Health Advocate (IMHA). Independent advocacy services were readily contactable and available to support patients when needed. We heard from patients that they had spoken with the IMHA in relation to complaints they had about their care. Details of the local IMHA were displayed on the wards' notice boards.

Good practice in applying the Mental Capacity Act

- There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policy.
- Staff had access to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. At the time of the inspection 98% of staff had completed this training which was an increase from the 92% completion level we noted during our inspection in July 2015.
- Formal capacity assessments in relation to consent to treatment took place. However, the assessments assessed patients' competence to consent rather than their capacity to consent to treatment. Gillick Competence requires that competence is assessed for

people who are aged under 16, while the patient group in his hospital were over all over 18 years of age. This meant that patients' competence was assessed and not capacity in accordance with the four stage test required by the Mental Capacity Act 2005.

- Where patients were not detained under the Mental Health Act their capacity to consent to medicine and to stay in the hospital as an informal patient had been assessed. However, there was no evidence that patients were properly assessed as having capacity to manage their finances. We saw that one patient was deemed to have capacity but they also had appointees or family members managing their finances for them. In two files we reviewed, we saw that both patients had been assessed for capacity to manage their finances. However, for the first patient an assessment meeting had not been recorded to demonstrate the assessment had taken place with them. For the second patient, a ward round meeting included an assessment of their capacity, however the patient had refused to attend this, so was not present. This meant there lack of evidence that the patients were seen or present when the capacity assessments were carried out and that any discussions had taken place amongst the multi disciplinary team to assess the patients' capacity in their absence.
- There was no evidence that patients were assessed for capacity when advance decisions were completed for them. An example of this was that in the advance directives we viewed, patients were asked whether they consented to electroconvulsive therapy. However, there was a lack of evidence that the patients were assessed for their capacity to make that decision and that any discussions had taken place amongst the multi disciplinary team to assess the patients' capacity in their absence.
- One patient was subject to Deprivation of Liberty and Safeguards authorisation. We saw evidence of staff supporting the patient to make decisions about their care and evidence of best interest decisions being made to help agree actions regarding their care and treatment.

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

Good

Kindness, dignity, respect and support

- When staff spoke with us about patients and during the multidisciplinary meeting, we observed, they discussed them in a respectful manner and demonstrated a high level of understanding of their individual needs. Staff appeared interested and engaged in providing high quality care to patients. We observed staff interacting with patients in a positive, caring and compassionate way and they responded promptly to requests for assistance whilst promoting patients' dignity.
- Nurses carried out weekly routine physical health checks with patients in their bedrooms. However, on Pevensey ward these checks took place in the quiet lounge area despite the forms stating that physical health checks should be made in the patients' bedrooms. This did not protect patients' privacy and dignity during these health checks. We spoke with the interim ward manager was not aware of why this practice took place despite the forms stating checks were to be conducted in patients' rooms and agreed to review this practice.
- Staff throughout the hospital had a good understanding of patients' individual needs. We observed this in the multidisciplinary team meeting we attended and from individual discussions with staff. Staff had good knowledge on how to de-escalate situations and worked as a team to promote safe ward environments. We observed staff using verbal de-escalation with patients during our inspection when a small number of patients became distressed on the wards at times.
- An NHS Friends & Family Test was undertaken in July 2016. This test involves asking patients a number of questions including "How likely are you to recommend this service to friends or family?" Thirty-three per cent of participants responded positively, that they were either "likely" or "extremely likely" to recommend the service. One commented that "staff were considerate and helpful". Twenty per cent responded that they were "neither likely nor unlikely to recommend" with 40% responding "unlikely" and 7% "extremely unlikely".
- The service carried out a patient survey in July 2016. The survey looked into the following six categories with sub-questions: Environment, Care, Medication, Food &

Long stay/rehabilitation mental health wards for working age adults

Good

Drink, Ward Rounds & Care Plan Approach meetings, and Activities & Community Access. Answers consisted of very happy, ok or unhappy. The one area for improvement noted was "Food & Drink". An action plan was introduced which included recruiting a dietician who reviewed the catering department including reviewing menus, portion sizes, calorie count, meal variety and made recommendations based on their findings.

The involvement of people in the care they receive

- Staff verbally oriented patients onto their wards following their admission. Blenheim ward, for patients with learning disabilities, provided patients with an easy read patient guide. This contained information about their entitlement to leave from the ward, storing their valuables, banned items such as alcohol and what they could expect in terms of care during their admission to the ward. Balmoral ward had a welcome pack for patients and offered bedrooms on the quieter side of the ward where possible as one side of the ward faced a busy main road. Pevensey ward also had a welcome booklet for patients. The manager for Daffodil ward told us they did not have a patient welcome booklet, however patients were given a tour of the ward, introduced to staff and explained their rights on admission.
- Patients were involved in the planning of their care and attended community meetings to discuss their ward environment, care plan approach meetings and ward round meetings to discuss their care and discharge plans, and patients' forums. Patients were supported by their advocacy representative in meetings, where requested by the patient, to discuss their care and treatment. The occupational therapy team provided patients with an 'interest checklist' so they could choose activities they were interested in on the wards and in the community, such as bicycle maintenance. The checklist was monitored by the occupational therapy team to ensure that activities chosen by patients remained relevant or needed to change.
- Staff encouraged patients to attend daily ward planning meetings to discuss their daily activity schedules and weekly community meetings to discuss their views on the wards and air any complaints which were appropriate to raise in that forum.
- All patients had access to advocacy in the form of the independent mental capacity advocate, the independent mental health advocate and the patient forums. Details of these were displayed on the wards' notice boards.
- Patients gave feedback on the care they received via patient surveys, friends and family test and the hospital's complaints procedure. We saw evidence of complaints from patients, which were dealt with, within a 20 day period, in accordance with the hospitals' complaints policy. We saw evidence recorded in the minutes from the April 2016 patient safety committee meeting where staff discussed a complaint received in the previous month.
- The provider actively encouraged patients to be involved in decisions about the service. For example, patients on Daffodil ward had requested to and were allowed to paint the skirting boards in their rooms in colours of their choice to help personalise their rooms.

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

Good

Access and discharge

- The average bed occupancy of wards for 12 months prior to March 2016 was Pevensey – 50%, Blenheim – 78%, Daffodil – 73%. Balmoral ward was opened on 3 October 2016 and had 42% occupancy at the time of our inspection. Bed occupancy levels are the rate of available bed capacity. It indicates the percentage of beds occupied by patients.The average length of stay for patients discharged in the 12 months prior to August 2016 were: Pevensey ward: 353 days, Daffodil ward: 2196 days, Blenheim ward: 818. There were no figures for Balmoral ward as it had newly opened in October 2016.
- Beds were available to people who were referred from across the country.
- The hospital reviewed all admissions to ensure they accepted patient referrals where they could meet the patient's needs and manage their risks safely. For example, patients with violent and aggressive behaviour who would put staff and patients at risk.

Long stay/rehabilitation mental health wards for working age adults

Good

- Patients had access to their own bed when they returned from overnight leave from the wards.
- Patients were discharged at a time of day which suited them. This was agreed following discussion with patients to see what would work best for them. There were discharge plans on all of the patient treatment records we reviewed. These included goals patients agreed to achieve to prepare them for discharge, for example increasing independent living skills such as cooking.
- There were two delayed discharges on both Blenheim and Pevensey wards in the twelve months prior to March 2016. Delayed discharges occurred when appropriate placements elsewhere were unavailable. The hospital worked closely with their care co-ordinator to find an appropriate placement for a patient on the ward who needed specialist care in an older person's service. The ward offered increased observation to meet this patient's needs while a placement was sought.

The facilities promote recovery, comfort, dignity and confidentiality

- All wards had a full range of equipment and rooms including clinic rooms, quiet lounges, art therapy and communal television rooms to support the treatment and care of patients.
- Each ward had a quiet room and private meeting room where patients could meet visitors.
- Patients had access to their own mobile phones without cameras while on the wards when appropriately risk assessed. Private ward phones were available for patients to make calls. However, the private rooms containing ward phones on Daffodil and Blenheim wards were sparsely furnished and appeared unwelcoming.
- All patients had supervised access to the outside garden areas. There was also an outside smoking area available for patients wishing to smoke. The ward managers told us the hospital will be a smoking-free area from January 2017 and they were preparing patients who smoked for this by introducing smoking cessation sessions using nicotine replacement patches.
- Patients told us the food quality was good and that they were happy with the variety, quality and portion size. Food was prepared in the main kitchen on the ground floor of the hospital and brought to the ward on heated trolleys. Patients chose their meals from a menu once a week, however they could change their minds on the day by speaking with a member of staff in the morning planning meetings. Patients were offered food to meet their dietary and cultural needs if requested, for example, kosher and vegetarian meals.
- On all wards, we observed that patients had supervised access to hot and cold drinks, and snacks to manage associated risks which were managed by staff on the wards. Patients were permitted to keep drinks and snacks in their bedrooms if this was risk assessed as appropriate.
- Patients were allowed to personalise their bedrooms and we saw evidence of this during our tours of the wards. We heard that patients on Daffodil wards painted the skirting boards in their room in a colour of their choice.
- All patients had access to their bedrooms throughout the day. The access was risk assessed daily to ensure that patients were safe when accessing their rooms and in possession of their own door keys.
- Each ward had very extensive activity schedules seven days per week which were developed by the occupational therapist and supported by two occupational therapy assistants. The activity schedule was displayed on the wards' notice boards. Activities included drama, art, and knitting. The therapist also worked with patients to develop individual activity schedules to reflect their personal preference which sometimes took place in the community to ensure patients had access to additional resources to meet their needs, for example football, DJ-ing, and bicycle maintenance. One patient showed us their week's activity/therapy plan which included a range of therapeutic activities.
- Volunteering opportunities were available for patients in the community and we were informed that some patients volunteered on a local animal sanctuary.

Meeting the needs of all people who use the service

- The hospital was adapted for patients requiring disabled access. For example, wards were accessible using lifts and there were emergency evacuation chairs on stairs to support patients to evacuate the building if they were unable to use the stairs.
- Staff had access to interpreters and to information in a range of languages on the hospital computers if required for patients.
- Information about treatment, local services, patients' rights and how to complain were displayed on the

Long stay/rehabilitation mental health wards for working age adults

Good

wards' notice boards. Information for patients on the Blenheim ward for patients with learning disabilities was available in easy read format to meet their communication needs.
- The hospital provided a range of food to meet patients' dietary requirements and menus were developed by the hospital nutritionist to ensure patients' nutritional needs were met.
- Patients were supported to access spiritual support in the community if requested.

Listening to and learning from concerns and complaints

- Patients on the wards knew how to make a complaint and we saw evidence of complaints made and how they were dealt with by ward managers in accordance with the provider's policy, for example, responding to the patient within 20 days of receipt of the complaint. Patients could raise their concerns in community meetings, patient forums, verbally and in written format. Five complaints were made in the 12 months prior to our inspection, of which one was upheld and none were forwarded to the ombudsman. Thirteen compliments were made in the 12 months prior to our inspection.
- Staff discussed complaints and learning from them in team meetings and individual supervision. We heard that improvements were made following the receipt of complaints. For example, one complaint from a patient related to unfair treatment from staff. The ward manager arranged for specialist mental health training to be delivered to staff from the consultant psychologist to support them in their care for a particular patient group

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

Good

Vision and values

- Staff we spoke with explained that they worked with patients to support the organisation's values of rehabilitation of patients back into the community and maximising their independence.
- Ward managers and their teams knew who the most senior managers were in the organisation. They told us that senior managers visited the wards to talk about development and staff support needs.

Good governance

- The provider did not have robust systems in place to record and assess ligature risks across the wards. However, this was corrected following our inspection.
- There was no system in place to ensure that Mental Capacity Act paperwork was used appropriately to assess patients' capacity to consent to treatment, to assess patients' capacity to manage their finances, to record best interest decisions for patients assessed as lacking capacity when they refused treatment. We did not see evidence in patients' nursing notes that they were seen on the dates they were assessed for capacity. We did not see evidence that any discussions had taken place amongst the multi disciplinary team to assess the patients' capacity in their absence.
- The provider used key performance indicators to monitor performance and quality through the use of audits for mental health act and medicines management.
- Ward managers did not have access to administrative support, which meant some of their time was occupied with filing, answering phones, writing correspondence, and booking agency staff. With the high use of agency staff on the wards this was a time-consuming process.
- All ward managers told us that they had enough authority to carry out their roles.
- Staff used Health of the Nation Outcome Scales (HoNOS) to monitor if patient's health and wellbeing improved during their admissions to the wards.
- The registered manager had authority to add items to the service's risk register. Use of agency staff and recruitment were on the register at the time of our inspection.
- Staff participated in a range of clinical audits to monitor the effectiveness of services provided and results were fed back to all wards to improve the quality of the service. Audits included adherence to the CQUIN (Commissioning for quality and innovation) framework. The areas covered included collaborative risk assessments, supporting carer involvement, pre-admission formulations, specialised services quality dashboards and delayed discharges from secure care.

Long stay/rehabilitation mental health wards for working age adults

Good

- Staff had access to mandatory training, but not all members of staff had completed the training provided.
- All staff received monthly supervision and annual appraisals.
- The learning from complaints, serious incidents and patient feedback was identified and actions were planned to improve the service. However, there was a lack of evidence of learning and practice development following a series of incidents involving inappropriate restraint of a patient on one ward.
- Ward managers told us they that if they had concerns these could be raised and were appropriately placed on the service's risk register.

Leadership, morale and staff engagement

- Sickness and absence rates for the wards for 12 months prior to October 2016 were Pevensey - 7%, Daffodil - 9%, and Blenheim – 5%. There were no figures for Balmoral as it was not open during that period.
- At the time of our inspection there were no harassment or bullying cases known to the provider. All staff were aware of the whistleblowing policy and process.
- All staff we spoke with spoke with enthusiasm and pride about the work they did. They told us of the good morale they experienced within their ward teams. Staff also told us that their teams were strong, they supported each other on the wards, and that they had good levels of job satisfaction.
- Staff told us they felt able to raise concerns without fear of victimisation.
- Staff described strong leadership across the wards and said that they felt respected and valued.
- The culture of the service was open and transparent with a drive for continual improvement. The service had a Duty of Candour policy. Staff that we spoke with were familiar with the policy and informed us that they were aware of their individual responsibilities to be open and transparent in respect of patients care and treatment. They also told us that they felt well supported by the managers to be open and honest.
- Staff we spoke with told us they are offered the opportunity to feedback on services to improve clinical practice, such as focussing on providing the appropriate placements for new patients and reviewing practice around medicines used for the patients with learning disabilities.

Commitment to quality improvement and innovation

- The service had established a positive working relationship with two local police liaison officers. The officers were trained in mental health and met monthly with members of staff and patients to review incidents and concerns.
- The service completed the learning disability Greenlight Tool Kit in September 2016. The Tool Kit is a tool to audit and improve mental health services so that they are effective in supporting patients with learning disabilities and autism. Following the audit, the service developed an improvement action plan which included the recruitment of a learning disabilities consultant and provision of more easy read materials on the wards for patients. During our inspection we met the interim learning disabilities consultant and reviewed a range of learning disabilities information on the learning disabilities ward.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff have up to date mandatory restraint training.
- The provider must ensure that there is detailed recording of incidents involving restraint which outlines a clear understanding of what constitutes restraint.

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Action the provider SHOULD take to improve

- The provider should ensure that ligature audit assessments are displayed in nursing stations so staff can use them as a visual prompt to help mitigate against ligature risks.
- The provider should ensure that where necessary, appropriate mental capacity assessments of patients take place, with the patient present. The assessment must be clearly recorded.
- The provider should ensure that recruitment is completed to ensure a permanent ward manager is in post for each ward and to ensure the consistency of permanent nursing staff across the wards.
- The provider should ensure that the private telephone rooms on Pevensey and Daffodil wards are decorated to appear more welcoming for patients.
- The provider should continue to ensure that all agency staff are known to wards wherever possible to ensure consistency and safety in care provision for patients.
- The provider should ensure that the hospital operates a cleaning schedule.
- The provider should ensure that patients on Pevensey ward have their physical health checks in their bedrooms to ensure privacy and dignity.
- The provider should ensure that food items are stored appropriately.
- The provider should ensure that Section 17 leave forms record circumstances where leave should not be granted.
- The provider should develop a patient welcome booklet for Daffodil ward.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing** Training completion levels for mandatory restraint training fell below the service's training completion target rate. There was high use of agency staff across the wards and low numbers were trained in the provider's approved restraint method which meant they were unable to assist in incidents requiring restraint. Following a number of incidents detailed in 50 incident reports in 2016 involving inappropriate restraint of a patient, not all staff had received training in appropriate restraint techniques. Documentation of incidents involving restraint were also not detailed to clearly describe the incidents and restraint used. This was in breach of regulation 18 (2)(a)