Elysium Neurological Services (Badby) Limited

The Avalon Centre

Inspection report

The Avalon Centre
Edison Park, Hindle Way
Swindon
SN3 3RT
Tel:

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

Summary of findings

Overall summary

The Avalon Centre is a purpose-built neurological centre for men and women over the age of 18 years, who have an acquired brain injury located near the town of Swindon in Wiltshire.

We rated this service as good because:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff assessed and managed risks to patients and themselves well. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through transdisciplinary discussion and updated as needed. They involved patients and gave them access to their care planning.
- Managers ensured they had staff with the range of skills needed to provide high quality care. They supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- 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 helped patients with communication, advocacy and cultural and spiritual support.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff planned and managed discharges. They liaised well with services that would provide aftercare. Staff did not discharge patients before they were ready and ensured they did not stay longer than they needed to.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results, which were shared with the whole team.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the service they managed and were visible and approachable for patients and staff.
- Staff felt respected, supported and valued. They said the service promoted equality and diversity and provided opportunities for development and career progression. They could raise any concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. Teams had access to information they needed to manage patients effectively. They had plans to cope with unexpected events.

However:

- While there were systems and processes to safely prescribe, administer, record and store medicines and staff participated in the provider's restrictive interventions reduction programme they did not follow national guidance for the physical monitoring of patients after the administration of rapid tranquilisation.

Summary of findings

- The ward was generally safe and well equipped. However, we found ligature anchor points from the drainpipes and flexible door hooks and wooden pallets which could be used as a climbing aid to abscond. These were addressed during the inspection with all hooks removed and a garden risk assessment completed for the service. The wooden pallets had not yet been removed as staff were waiting for the return of maintenance staff to attend to the concern.
- While the service had measures in place to follow same sex accommodation, the hospital did not have a dedicated female lounge in line with Department of Health guidance on the reduction of same sex accommodation. This was addressed during the inspection.
- Most staff had completed Mental Capacity Act (MCA) training. However, staff spoken with said they were unclear about the principles of the MCA and how this affected their work with patients.
- Patient's food and fluid intake charts were incomplete. This meant that there was insufficient information to provide a clinical decision in the event of a medical review.
- While outcomes data and quality improvement opportunities and evidence-based policies and procedures were reviewed within the clinical governance framework, we were not assured how this information was shared with staff. All outcome measures were primarily focussed on individual patients and did not provide information on how well the service was performing.
- The service did not have information on display informing those patients who were informal of their rights to leave the ward freely.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to The Avalon Centre

The Avalon Centre is a purpose-built neurological centre for men and women over the age of 18 years, who have an acquired brain injury located near the town of Swindon in Wiltshire. The centre was designed to support people who have complex needs that require a neuro-behavioural rehabilitation programme. The service is registered as an independent hospital and can support people who may be detained under a section of the Mental Health Act 1983 (amended 2007). The service is made up of 18 individual en-suite bedrooms and two self-contained flats.

The service provides a person-centred programme which encompasses the physical, psychological, emotional, behavioural and social needs of each patient and aims to work closely with the person's family and carers.

The service employed the following staff so that it could provide the specialist intervention and support patients needed to meet their individual goals and outcomes. These included; a neuropsychologist, psychology assistants, psychiatrist, specialist nurses, rehabilitation assistants, social workers and therapists.

This service was registered by the Care Quality Commission (CQC) on 20 May 2020 and has not previously been inspected.

The hospital 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 service had a manager registered with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What people who use the service say

Patients told us that most staff were nice, sympathetic and attended to their needs. However, some said that staff differ in their ability but overall felt staff supported them. Patients said staff supported with family visits and overnight visits.

Family members were positive about the therapy their relatives received and were reassured by the service provided.

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 unannounced inspection visit, we reviewed information that we held about the location. During the inspection visit the inspection team:

Summary of this inspection

- Observed the interactions between staff and patients.
- Spoke with three patients and two family members/carer of patients.
- Interviewed the hospital director.
- Spoke with 15 staff members including registered nurses, consultant neuropsychologist, rehabilitation assistants and therapists.
- While having a tour of the hospital we checked the safety and cleanliness of the service.
- Observed a transdisciplinary meeting and a patient planning meeting.
- Attended two daily activities with patients.
- Reviewed eight care and treatment records.
- Checked 10 prescription charts and how staff stored and managed medicines.

Read meeting notes, service dashboard audits and procedures and other documents relating to the service.

Areas for improvement

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with Regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 legal requirements.

- The service must ensure that staff follow national 11 guidance regarding the monitoring of patients after the use of rapid tranquilisation.

1.

Action the service SHOULD take to improve:

- The service should have processes in place to oversee staffs' understanding and application of the Mental Capacity Act.
- The service should ensure staff understand the restraint process when using "clinical holds."
- The service should ensure patient preferences are being considered and recorded when attending to personal care and the use of lap belts.
- The service should ensure that it has processes to review and analyse the accurate completion of food and fluid charts.
- The service should consider having processes to ensure outcomes data and quality improvement information is shared with staff.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Requires Improvement

Safe and clean environment

Safety of the ward layout

The ward was generally safe, clean, well equipped, well furnished, well maintained and fit for purpose. However, we found some areas had not been identified as a risk.

Staff completed and updated risk assessments of the ward areas to remove or reduce any risks identified. However, during the inspection we saw flexible coat hooks on bathroom doors which were not included in the ligature risk assessment. A ligature is an item that can be used for tying or binding something tightly. These hooks were described by the manufacturer as anti-ligature but on checking them we found they were able to sustain excessive weight from a tied knot. This was discussed with the manager who arranged for all the coat hooks to be removed.

Patients had access to outside space. However, there was no environmental risk assessment completed for the garden. We saw ligature anchor points from the drainpipes and wooden pallets were placed against the fence that patients could use as a climbing aid to abscond. This was brought to the manager's attention during the inspection of 15 June 2021. On our return visit on 18 June 2021 the garden had been added onto the environmental risk assessment for the site. The wooden pallets had not yet been removed as staff were waiting for the return of maintenance staff to attend to the concern.

The service generally followed mixed sex accommodation guidance. However, they did not have a designated female only lounge in line with the Department of Health's guidance on eliminating mixed-sex accommodation. This was brought to the manager's attention who immediately addressed our concerns and allocated a female lounge within the ward.

The ward layout did not allow staff to observe all parts of the ward. However, during the inspection, we saw staff continuously monitoring all areas of the ward to ensure patients were safe.

Staff had access to alarms and patients could use the nurse call system to obtain support.

Long stay or rehabilitation mental health wards for working age adults

Good

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. We observed the patient's bedroom areas to be clean and had good furnishings which were well-maintained.

Cleaning records were up to date and demonstrated that areas were cleaned regularly. Housekeeping staff were aware that cleaning strategies had been enhanced due to the Covid-19 pandemic and had changed their practice accordingly.

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 is a law that requires employers to control substances that are hazardous to health. COSHH is a set of regulations put in place to protect workers from ill health when working with specific substances and materials. The ward had a folder which provided staff with information such as risk assessments and/or control of exposure. All cleaning items were locked away when not in use and not left unattended. However, there was no stock check of the products used which meant there was a risk of stock being mislaid and unaccounted for. Housekeeping staff told us they had recognised this as a concern and were in the process of introducing stock checks and audits.

Staff followed the services infection control policy. There were clear protocols in place in relation to containing the spread of Covid-19 in relation to wearing of personal protective equipment. Figures seen for 1 June 2021 showed that 92% of clinical staff and 100% of support staff had completed their infection control training.

Clinic rooms and equipment

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

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.

Staffing levels were in line with the agreed acuity and staff we spoke with felt they had enough one-to-one time with the patients to support their individual needs, facilitate activities and ensure they had relevant breaks. Patients had regular one- to-one sessions with their named nurse and escorted leave and community recovery programmes were rarely cancelled.

The staffing establishment was 10 on days and seven on nights with two nurses per shift. The shifts also included health care professionals such as dietitians, occupational therapist, a social worker and physiotherapists. The roster showed that almost every shift was filled and very rarely did the service run with one staff short.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff said they could adjust qualified nurse and rehabilitation assistant staffing levels according to the observation needs of the patients. This ensured that the service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

The service used low rates of bank and agency nurses. The clinical director ensured all bank and agency staff had a full induction and understood the service before starting their shift. Senior leaders acknowledged that this was an expanding service, and so they maintained a close review of recruitment. There were processes in place to encourage recruitment which included for example; bonuses and relocation allowances.

Medical staff

The service had enough daytime and night-time medical cover. The service had a full-time consultant neuropsychologist who was supported by psychologist assistants in the day to day running of the service.

Patients were registered with a local GP who attended the service each week. Staff told us the service had effective out of hours arrangements during which a doctor could attend the ward in an emergency.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The overall compliance for mandatory training modules as at 1 June 2021 was 86%. The clinical director informed us that this was showing below the compliance level as it included staff who had not yet completed their induction training.

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

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

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. While staff participated in the provider's restrictive interventions reduction programme, they did not always meet best practice standards for the monitoring of rapid tranquilisation after administration.

Assessment of patient risk

Staff completed risk assessments for each patient on admission/arrival and ensured that the service did not admit patients unless their needs could be safely met.

We attended a daily transdisciplinary team meeting and observed staff discussing recent risk incidents and the actions taken to ensure they were suitable. We saw these were appropriately documented and followed up.

Shift changes and handovers included all necessary key information to keep patients safe.

Management of patient risk

Long stay or rehabilitation mental health wards for working age adults

Good

Staff identified and responded to any changes in risks to, or posed by, patients. Some patients had behaviours which challenged the service and could be verbally aggressive when they were anxious. This was recognised for all new patients who received one to one support for at least the first 48 hours on the unit. Risks were reviewed and observations adjusted after that time.

Both permanent and agency staff knew about individual risks specific to each patient and acted accordingly to prevent or reduce risks. For example, they showed their knowledge of each patient within their care which included: risks due to difficulty with communication, memory and problem solving.

Staff completed training in prevention and management of violence and aggression. This included safe restraint techniques. Training records seen as of 1 June 2021 showed that 85% of staff had completed both their breakaway and conflict resolution techniques. Staff used de-escalation techniques when patients were distressed. Examples included talking with patients about what interested them, such as their family.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low and /or reducing.

While staff participated in the provider's restrictive interventions reduction programme, they did not always meet best practice standards for the monitoring of rapid tranquilisation after administration.

Staff did not follow the National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We reviewed two episodes of rapid tranquilisation being given. According to NICE guidance; Violent and aggressive behaviours in people with mental health problems, Quality standard [QS154], people given rapid tranquilisation need to be monitored at least every hour until there are no further concerns about their physical status. It is recommended that; side effects, blood pressure, pulse, temperature, respiratory rate, level of hydration and level of consciousness should be monitored every 15 minutes for one hour after intramuscular (IM) rapid tranquilisation medicines is administered. We found no documented evidence of physical observation recorded in the records reviewed to support this.

Staff said they 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 patients or others safe. However, we found that 11 of the 38 (29%) incidents reported "clinical holds" in May 2021 which had not been recognised as restraint. This meant that we were not assured of staff's understanding of restraint.

We observed that eight of the 38 incidents (21%) identified clinical holds linked to personal care. Most of the patient records demonstrated staff following the legal framework regarding capacity and best interest process and how best to support patients. While patient records seen identified they consented to the care and treatment received as part of their rehabilitation programme to regain their independence there was no evidence within the records of processes to adapt to the patient's preference. Nursing staff confirmed they carried out "clinical holds" for those patients who declined personal care after three requests in line with the service's protocol. We requested to see a copy of the guidance regarding the carrying out of clinical holds after three requests, but this was not available to us. We found no reasoning evidenced in the care notes for this procedure although we saw mental capacity assessments reflecting the decision-making process. This meant that patients may be subjected to personal care without a clear rationale for this.

Long stay or rehabilitation mental health wards for working age adults

Good

We did not see a specific mental capacity assessment or best interest decision-making process, or consent when the patient had capacity to consent to the use of lap-belts. A lap belt is intended to provide safe and adequate support to hold the body in a seat to prevent them from sliding or falling out. We saw a documented discussion of the risk should a patient refuse to wear their lap belt and the need for safety and supported interventions to manage the risk. The outcome recorded the guidance for staff to follow which included prompting a patient first and followed by hands on therapeutic restraint by four staff and the fastening of the lap belt. We requested three staff to provide us with evidence of patient consent or a capacity assessment for their use which they were unable to locate. This meant we were not assured of the risk being discussed with the patients or of a risk management/care plan in place.

Staff informed us that they often carried out "clinical holds" for those patients who declined to remove their dentures at night. The practice of removing dentures overnight reduces the risk of inflammation, infection, and illness. It was difficult to assess the concerns relating to dentures as none of the eight records showed evidence of personal care plans relating to the removal of dentures. Staff informed us the removal was in line with the speech and language therapist's guidance but confirmed they had not made a re-referral to the therapist for their intervention/review or a discussion with the patient to identify their choice on how to manage the situation. The consultant neuropsychologist confirmed they were aware of the concerns around the removal of dentures and were looking at ways to manage this.

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. Training records as of 1 June 2021 showed that 67% had received level one, 100% of staff had received level two and 74% of staff had received level three safeguarding adults and children's training.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect an adult at risk from abuse.

When there were incidents between patients, staff appropriately reported into multi-agency safeguarding systems which included the local authority and the police. Patients told us they felt safe in the service.

The senior team took part in serious case reviews. We attended a transdisciplinary team meeting and observed staff discussing concerns and making the appropriate changes based on the outcomes.

Staff access to essential information

Staff had access to clinical information, and there was an effective process in maintaining high quality clinical records – whether paper-based or electronic.

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

Long stay or rehabilitation mental health wards for working age adults

Good

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date, complete and securely stored.

Care plans reflected how to manage a patient if they became distressed or displayed behaviours that were challenging. Staff could explain what the interventions were for the patients they cared for.

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

We saw the service's dashboard for May 2021 which checked the quality of record keeping and compliance with practice standards. Areas reviewed included; care and risk plans, consent to treatment and clinical notes completed by nursing staff, social workers, therapists and psychologists. The dashboard did not identify any issues or concerns.

Medicines management

The service used systems and processes to safely prescribe, record and store medicines. Staff regularly reviewed the effect of medicines on each patient's mental and physical health. However, we found concerns regarding the monitoring of rapid tranquilisation.

We reviewed 10 patient prescription charts and eight physical health records and found these were recorded in accordance with the National Institute for Health and Care Excellence (NICE) guidance. The service used systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and their effects on each patient's mental and physical health.

The clinic room was well organised and tidy, all the equipment required was available and new.

The service commissioned a pharmacy company to supply medicines and make checks of practice. This including a scheduled visit by a pharmacist to review prescription charts and medicines storage. The service had a process to ensure medicines were stored correctly and safe to use. They monitored the fridge and room temperature where medicines were stored. Controlled medicines were stored and managed appropriately.

We reviewed a sample of medicines in the stock cupboard and found all were in date. Where appropriate all medicines corresponded with the guidance within the Mental Health Act. There was no excessive usage of "pro re nata" (PRN) or when required medicines. The service managed time specific medicines well for example, diabetes medicines were given at set times. We found no omissions or prescription errors within the records seen.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure patient's behaviour were not controlled by excessive and inappropriate use of medicines.

Track record on safety

Long stay or rehabilitation mental health wards for working age adults

Good

The service had a good track record on safety.

Since the registration of the service in May 2020, we reviewed the serious incidents reported to the Strategic Executive Information System (STEIS). There had been two reported serious incidents which had been fully investigated with lessons learnt shared with staff.

Reporting incidents and learning from when things go wrong

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

Staff raised concerns and reported incidents in line with the provider policy.

Staff reported incidents well but on review of the incidents report for May 2021 we found they did not always recognise restraint within some incidents.

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

Managers debriefed and supported staff after any serious incident.

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

Staff received feedback from investigation of incidents, both internal and external to the service. We noted that incident recordings were discussed at every handover for the last 24 hours and every Monday included the whole weekend. There was a fortnightly learning meeting where an overview of incidents was discussed looking for themes and trends.

There was evidence that changes had been made as a result of feedback such as protected time for medicines administration and good access to information technology to ensure staff could update patient records in a timely manner.

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

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly and updated as needed. Care plans reflected patients' assessed needs.

Long stay or rehabilitation mental health wards for working age adults

Good

On admission, therapists assessed each patient's strengths and areas for development and completed care plans for the clinical staff to follow. For example, psychologists evaluated the patient's cognitive functioning and developed plans to improve the patient's orientation, attention and planning processes. We saw staff supporting a patient living with diabetes and we noted the care plan covered their diet, medicines and the monitoring of their blood sugar levels.

We reviewed eight patient care records and found staff developed a care plan for each patient that met their mental and physical health needs. While the care plans reflected patients assessed need, they did not clearly reflect how to support a patient if they declined for example to use a lap belt or attend to their personal care needs.

Patients had their needs assessed in relation to their mobility by a physiotherapist on admission. The transdisciplinary staff team decided what type and the frequency of physical health checks each patient should have. For example, staff checked the weight and body mass index of some patients weekly where should there were concerns about them maintaining a healthy weight. Staff said that working within a transdisciplinary team setting meant there was 24-hour rehabilitation available with increased patients' opportunities to learn.

Care plans were based on the personal and recovery needs of each patient and had goals for each patient's recovery. These plans explained what nursing staff and rehabilitation staff should do to support the patient to relearn and practice their skills.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives.

The transdisciplinary staff team provided a range of care and treatment interventions suitable for the patients in the service in line with best practice and national guidance such as the National Institute of Health and Care Excellence (NICE). The staff team was led by a consultant neuropsychologist and included a range of staff such as physiotherapists, occupational therapists, speech and language therapists, psychologist assistants, social workers as well as nursing staff and rehabilitation assistants. Electronic care notes showed that therapists regularly reviewed the patient's progress and ensured they were fully supported to live healthier lives, develop their skills and become more independent.

Staff identified patients' physical health needs and recorded them in their care plans and ensured they had access to physical health care, including specialists as required. A GP provided a weekly clinic at the service. Staff could call the out of hours GP on call service when required.

A dietitian visited the service and gave advice on nutrition if a patient was not a healthy weight or had problems in relation to food and drink. The speech and language therapist also helped patients with communication skills and assessed any swallowing problems. All patients, even if there were no identifiable concerns, were routinely placed on a food and fluid chart when accessing the service. Staff informed us that currently 10 of the 15 patients had their food and fluid intake monitored. Staff completed a daily paper record which was copied on the service's electronic record system. We looked at six of the 10 food and fluid charts and found the records were incomplete. Staff did not always record accurately the dietary needs of those needing specialist care for nutrition and hydration. None of the food and fluid charts had running totals or outcome measures. They did not detail target amounts or include all the food and drinks that patients had. Staff spoken with recognised this as a problem and assured us that patients at risk of dehydration were getting adequate fluids. Patients that were at risk of dehydration were also at risk of dysphagia (dysphagia is the

medical term for swallowing difficulties). While the records identified that patients had access to dieticians and had their weight recorded regularly, we were not assured around the oversight from the nurse(s) in charge should patients not have enough food or fluids. This meant that the information was incomplete and could not accurately provide a clinical decision in the event of a concern arising.

Psychologists used recognised rating scales to monitor each patient's progress in terms of their rehabilitation and preparation for discharge. The patients' identified sets of goals were completed monthly to oversee their improvement and included in care programme approach (CPA) meeting reports.

Therapists used functional independence measures to assess the patient's ability to do everyday tasks such as self-care, cooking and domestic tasks.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of the patients. The service also had a range of therapists which included; a dietitian, occupational therapists and physiotherapists.

We reviewed six personnel files and saw details of references and disclosure and barring service checks.

The manager ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, this also included the competencies of bank and agency staff.

Registered nurses and rehabilitation assistants were supported to develop their skills and knowledge. Staff told us they had received good training and could get advice from the wider disciplinary team. The nursing and therapy team told us they were in the process of creating internal training plans to maintain staff's training and competencies.

Staff spoken with said they were supported in their role through regular constructive supervision of their work. We saw the supervision records from January to May 2021 and found that most staff had received monthly supervision.

Medical staff were supported to develop through regular constructive supervision of their work.

Registered nurses and rehabilitation assistants were supported to develop their skills and knowledge. Staff told us they had received good training and could get advice from their colleagues. Senior leaders made sure staff attended regular team meetings or gave information from those they could not attend.

The service had processes when recognising poor performance which they dealt with accordingly.

Transdisciplinary and interagency teamwork

Long stay or rehabilitation mental health wards for working age adults

Good

Staff worked together as a team for the benefit of patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early in the patient's admission to plan discharge.

The service used the transdisciplinary team (TDT) approach. This is where staff members contribute their own knowledge and expertise but come together from the beginning of the patient's journey to jointly communicate, exchange ideas and come up with solutions to problems.

We observed the TDT working collaboratively, sharing their knowledge and specialist skills and working creatively with each other to meet the overall needs of the patient.

Staff held daily transdisciplinary meetings to discuss patients and improve their care. We attended a meeting and saw staff discussing incidents from the previous day and the plans and activities for individual patients. Staff made sure they shared information about patients and any changes in their care during handover meetings. This ensured that staff had the most up to date information about patients and any changes in their care.

The team had effective working relationships with other relevant teams within the organisation as well as services outside the organisation.

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. Training records seen as of 1 June 2021 showed that 93% had completed their Mental Health Act Code of Practice training. Staff knew who their Mental Health Act administrator was and could access them for support and advice on implementing and understanding the Act and its Code of Practice.

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

Patients were informed and had access to information about independent mental health advocacy.

The reading of section 132 rights (the duty of managers to give information to detained patients) was monitored weekly and patient records showed that staff explained to patients their rights under the Mental Health Act. We observed mental capacity assessments completed within the records had been reviewed.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of Justice. We observed the section 17 leave documentation was no longer kept within the MHA files but saved on the electronic records to ensure all leave was stored together and easily accessible in one place.

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

Long stay or rehabilitation mental health wards for working age adults

Good

Staff said they informed those patients who were informal of their rights to leave the ward freely. We observed that the service did not have posters on display informing them of this right. This was brought to the attention of the registered manager who said that they would attend to the shortfall.

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

Staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. We saw evidence of this on the service's dashboard.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. However, not all staff we spoke with understood how the Mental Capacity Act 2005 affected on their work with patients. While staff assessed and recorded capacity clearly for patients who might have impaired mental capacity, staff did not always record their decision-making correctly.

Training records seen as of 1 June 2021 showed that 92% of staff had completed their Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. However, staff spoken with said they were unclear about the principles of the MCA and how to apply the principles when supporting patients. Staff said they were unclear regarding patient's status and capacity to consent. While staff had completed their training, they were often reliant on others to understand the principles due to not dealing with the MCA regularly. This meant that we could not be assured that the service had processes/oversight in place to ensure staff's continual knowledge and understanding of the MCA.

Staff could access the MCA and DoLS policies on the service's electronic system.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and checked the progress of these applications. The Mental Health Act administrator offered support to staff with the completion of the Deprivation of Liberty Safeguards (DoLS) paperwork as needed.

Staff worked with patients to promote their understanding, for example they understood that information may have to be repeated because patients had memory problems. Family members said staff explained care and treatment to their relative in a way they could understand.

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.

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

Good

Kindness, privacy, dignity, respect, compassion and support

Long stay or rehabilitation mental health wards for working age adults

Good

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

Staff were discreet, respectful, and responsive when caring for patients. They gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition and directed them to other services for support if they needed help.

Patients said staff treated them well and behaved kindly and understood and respected their individual needs.

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

Staff followed policy to keep patient information confidential.

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Staff involved patients in decisions about the service, when appropriate. We attended a daily planning meeting with patients and staff. This provided patients with the opportunity to give feedback on the service and what activities they wished to participate in. Areas discussed included; outside leave, laundry and participation in group activities. However, it was unclear how the voice of those patients who did not attend would be heard as there was no feedback from those that did not attend. Staff said they discussed patient's wishes regularly but this was not reflected in the meeting attended.

Staff supported patients to make decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Family members spoken with said they had been allocated a case worker and they had regular feedback on their relative.

The family members spoken with knew of their relative's care plans and had been provided with a copy of their relative's report prior to a CPA meeting.

Long stay or rehabilitation mental health wards for working age adults

Good

Family members spoken with said that they only had praise for staff and that they were happy with the service provided.

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

Good

Access and discharge

Discharge and delayed transfer of care

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

The service had secured and facilitated comprehensive packages of care for the discharge of patients. This enabled them to be discharged from the in-patient services to regular housing with care packages in place to meet their needs.

Managers regularly reviewed length of stay for patients to ensure discharge protocols were met in line with the services policies. The clinical director confirmed they had facilitated the discharge of three patients since opening in May 2020. The service's discharge dashboard looked at information from each patient's care review together with a proposed discharge date. This was reviewed monthly to monitor the patient's progress and potential discharge.

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

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

Of the eight patient's care record seen all had allocated discharge dates. Discharge plans were linked with outcome goals. However, this was not reflected in the discharge plans seen which meant that we could not be assured of the process to interlink the patient's goal with discharge planning.

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. When clinically appropriate, staff supported patients to self-cater.

The food was of good quality, staff encouraged and supported patients to self-cater whenever possible and all patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise and was a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. There was a room where patients could meet with visitors in private. Patients could also make phone calls in private.

The service had an outside space that patients could access easily.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients' engagement with the wider community

Staff supported patients to maintain contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Each patient was given a therapeutic timetable based on their individual needs. Examples included; daily exercise, self-directed social skills and time to think and talk.

Staff helped patients to stay in contact with families and carers.

Meeting the needs of all people who use the service.

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

The service could support and adjust for disabled people and those with communication or other specific needs.

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

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

Staff said they could request information leaflets to be available in languages spoken by the patients and local community.

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

Patients had access to spiritual, religious and cultural support.

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.

It was not clear how patients were given information on how to complain or raise concerns. We did not see evidence of a complaint's poster on display. Patients spoken with said they were unclear on how to make a complaint but said they could get support from staff if needed. There was an introductory booklet in the reception area which covered complaints but not all patients had access to this. We spoke with two carers who confirmed they knew of the complaints process and said they had confidence in contacting staff at the service should they wish to raise a concern.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed the complaints folder and saw there had been four complaints from January to April 2021. Two of the complaints had been resolved in agreement with the complainants whilst the other two complaints remained ongoing.

The manager investigated complaints and identified themes.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers shared feedback from complaints with staff and learning was used to improve the service.

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

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed.

They could explain clearly how the teams were working to provide high quality care.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn about the service.

Leaders were visible in the service and approachable for patients and staff.

Vision and strategy

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

The leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Staff were able to clearly articulate the current model of rehabilitation being provided across the service.

Staff understood the role and purpose of the service and how it operated within the care pathway of patients with acquired brain injury.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt positive and proud about working for the service and their team. The said staff worked well together, and they could see they were achieving positive results with patients.

Managers dealt with poor staff performance when needed.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

The clinical director told us they had changed a variety of processes and systems as a result of the Covid-19 outbreak. Team meetings and face to face training ceased. Staff stated that senior leaders were supportive and provided clear guidance.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff reported that the service promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff felt able to raise concerns without fear of retribution. Staff had access to support for their own physical and emotional health needs.

Governance

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

There was a clear framework of what was discussed at ward and team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

We noted that outcome measures were primarily focussed on individual outcomes and not as a collective to see how well the service was performing. The clinical director and the neuropsychologist said they were looking to compile a service effectiveness study once more data was available due to the service having been opened for just a year and only recently filling most of their beds.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

The clinical director managed the performance of the team. They were aware of the impact of Covid-19 in reducing supervision, face to face training and team meetings but had plans in place to address this.

Management of risk, issues and performance

Teams had access to the information they needed to manage performance effectively. They had plans to cope with unexpected events.

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. Managers ensured they dealt with risks at the proper level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

The service had an up to date risk register. This explained current risks in relation to for example, staffing and the environment. Where required there were action plans to manage risk. Staffing of the service was a recognised risk and the service had implemented bonuses and relocation fees to enhance the package.

The clinical director had access to information on the performance of the service. We saw copies of the service's dashboard which reviewed all aspects of the patient's journey such as care and discharge planning and risk management. The outcomes provided assurance of the effectiveness of the service. However, we were not assured how this information was shared with staff. All staff spoken with said they were not aware of how well they were performing as a service for the benefit of the patients.

The service had plans for emergencies and had processes and procedures to manage the Covid-19 pandemic. The clinical director had introduced a system for ensuring enough personal protective equipment was always available. The service had not run out at any stage.

Long stay or rehabilitation mental health wards for working age adults

Good

The clinical director ensured staff were able to keep up to date with their e-learning. Training figures seen showed that most staff were up to date with their learning.

The clinical team reviewed reported incidents and conducted investigations where appropriate. We found staff were open and transparent in relation to incidents and acted on recommendations following investigations.

Information management

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

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had integrated and secure information systems.

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.

Information governance systems included confidentiality of patient records.

Clinical leads had access to information to support them with their management role, this included access to a dashboard on the performance of the service.

Staff made notifications to external bodies as needed.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had access to up to date information about the work of the provider and the services they used, for example, through the intranet bulletins, newsletters and emails.

Patients were invited to attend a daily planning meeting where they could give feedback on the service they received. Carers spoken with confirmed that although they had not given feedback, they could discuss any concerns they had with staff.

Directorate leaders engaged with external stakeholders such as commissioners.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Senior leaders acted to make improvements in the running of the service. They had regular meetings where learning was discussed. For example, team meeting and patient planning meetings.

Long stay or rehabilitation mental health wards for working age adults

Good

Leaders were responsive to concerns raised and performance issues and sought to learn from them to improve services.

Staff said they were given the time and opportunity to learn.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment