Plans4Rehab Limited

Elizabeth House

Inspection report

Perth Avenue
Leicester
LE3 6QR
Tel: 01165071840
www.elizabethhousehospital.co.uk

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

Ratings

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

Summary of findings

Overall summary

This was the first inspection of this service. We rated it as requires improvement because:

- The ligature risk assessment was held electronically. Numerous staff had not seen this. There was no information on the wards to indicate high risk areas.
- Not all agency staff profiles detailed mandatory training received and so we could not be assured that all agency staff were appropriately trained.
- The service did not have an employed occupational therapist. We were concerned that patients were not receiving meaningful and therapeutic activities.
- Staff lacked knowledge around the Mental Capacity Act despite having received training. Records of capacity were not consistently detailed.
- Not all care plans were personalised and lacked individual goals, aims and interventions.
- Not all patients had been involved in their care planning.
- Some staff had difficulty accessing and navigating the electronic records system.
- Patients could not have access to fresh air as and when they wanted. Most windows across the hospital could not be opened.
- Governance processes needed to be strengthened to ensure ongoing monitoring of the quality of the service.

However:

- The ward environments were safe and clean. The wards had enough nurses and doctors. They minimised the use of restrictive practices and managed medicines safely.
- Staff developed a range of care plans which were updated regularly.
- Managers ensured staff received training, supervision and appraisals. The ward staff worked well together as a multidisciplinary team and with those outside of the hospital who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Elizabeth House

Elizabeth House is an acute inpatient mental health hospital, offering assessment and treatment for adult men and women who are experiencing an acute episode of mental illness and require hospital admission. Patients may be informal or detained under the Mental Health Act (1983).

The hospital can accommodate up to 30 patients over 3 wards, set over 3 floors:

- King Ward offers 15 acute beds for males
- Castle ward offers 10 beds for females
- Swithland ward offers 5 beds, which can accommodate either males or females, dependent upon the greater need through referrals received.

The service was registered with the Care Quality Commission in February 2023 and opened to admissions in March 2023. The service had not previously been inspected.

The hospital is registered to provide the following Regulated Activities:

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

There is a registered manager in place.

What people who use the service say

We spoke with 7 patients who were using the service and received feedback from a carer of a patient using the service.

Six of the 7 patients felt safe at the hospital. One patient reported being unsettled by some other patients being noisy on occasions.

All patients told us staff were polite and kind and treated them well.

All patients said they had privacy and staff always knocked on their bedroom doors before entering.

One patient said they felt it was more like a hotel and would like to learn more coping strategies so they could manage their mental health.

All patients reported there was a variety of activities. Examples given included smoothie making; listening to music; various quiz's; board games and walks.

Three of the 7 patients we spoke with had been involved in their care planning.

All patients said that staff managed aggressive incidents well, taking time to speak with patients who were upset.

One patient told us that their relative could not visit due to the distance, and they did not know if a video call could be facilitated and was unsure how to do this.

Summary of this inspection

The carer we received feedback from said that the staff were very polite and welcoming. They said the hospital was clean and the housekeeping staff were friendly. They did share some concerns. They felt there was a lack of activities with patients having to manage their own time and feeling bored. They reported there was a lack of communication of progress. They also reported that despite the multi-disciplinary team agreeing to extended visiting times due to travel, this had not been accommodated, resulting in visits being 'cut short'.

How we carried out this inspection

This inspection was undertaken to rate the service, as it had not been inspected since registering with the Care Quality Commission in February 2023.

The inspection team included 2 CQC inspectors, 1 specialist nurse advisor and 1 expert by experience. The inspection team kept the operations manager informed of progress throughout the inspection.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the service provider.

During the inspection visit, the inspection team:

- undertook a tour of the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 7 patients currently in the service
- received feedback from 1 carer of a patient at the service
- reviewed 3 patient observation records
- reviewed the hospital ligature risk assessments and mitigation
- observed a morning meeting
- observed a staff led activity
- reviewed 9 care records
- spoke with 15 different staff members to include nurses; ward managers; support workers; patient safety officers; a consultant; psychologist; activity staff; administration staff; support service manager and the hospital director
- reviewed management of medicines across both wards
- looked at a range of policies, procedures and other documents relating to the running of the service

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Summary of this inspection

Areas for improvement

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

Action the service MUST take to improve:

- The provider must ensure that all staff have access to the ward ligature risk assessments and blind spot audits and are aware of high risk areas.
- The provider must ensure all mitigations recorded on the ligature risk assessment are adhered too.
- The provider must ensure records are kept and regularly updated for all agency staff to reflect mandatory training undertaken, levels of training and dates undertaken.
- The provider must ensure all staff are aware of patient risk assessments and know how to safely manage these risks.
- The provider must ensure all clinical staff have access to patient records, and they have received appropriate training in navigating the electronic system.
- The provider must ensure that care plans are personalised and reflect patient views and involvement.
- The provider must ensure patients are offered meaningful, therapeutic activities by skilled staff.
- The provider must ensure staff undertake and record all patient observations in real time as prescribed.
- The provider must ensure all clinical staff are able to articulate the principles of the Mental Capacity Act and recognise how this applies to day to day practice.
- The provider must ensure capacity is clearly assessed, in accordance with the Mental Capacity Act, and recorded in detail.
- The provider must ensure that patients have regular access to fresh air, in line with individual preferences.

Action the service SHOULD take to improve:

- The service should ensure that there are adequate rooms to receive visitors of patients and flexibility in visiting times should be offered to those who are travelling a distance to see their relatives.
- The provider should ensure that clinical staff are aware of National Guidance and best practice in relation to providing acute care.
- The provider should ensure that additional seating is available in courtyards.
- The provider should consider if the hospital has adequate space to support patient's treatment, privacy and dignity.
- The service should consider if staff undertaking the ligature risk assessments have been appropriately trained to do so.
- The provider should consider if the risk register is fully reflective of hospital risks.
- The provider should consider reviewing CCTV to review and learn from incidents and or when investigating complaints.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

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

Requires Improvement

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

Is the service safe?

Requires Improvement

This was the first inspection of this service. We rated safe as requires improvement.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and took steps to reduce risks identified.

Staff could not easily observe patients in all parts of the wards. The hospital was not purpose built and had various rooms off long corridors. CCTV covered most communal areas although we observed some blind spots. Staff did not routinely use CCTV to observe activity on the ward. If senior staff needed to watch footage for any reason, they had to formally request permission through the Caldicott Guardian, in line with company policy, who would arrange viewing of the appropriate specific fottage. Staff had completed a blind spot audit. Managers had installed some mirrors to aid observation in some areas of the hospital as a result of this.

The ward complied with same sex guidance, with wards being designated to separate genders.

Not all staff knew about potential ligature anchor points. The hospital had a ligature risk assessment which was over 300 pages long and was stored electronically, meaning staff had to log into the system to locate it. Most staff we spoke with had not seen this. Nurses and support workers told us this could only be accessed by ward managers. At the time of inspection, there were no corresponding documents visible on the wards to give staff information on where the areas of higher risks were.

A nurse and a patient safety officer had completed the ligature risk assessment. We did not see any documentation which showed they had undertaken appropriate health and safety training, giving them the skills and knowledge to undertake this complex task.

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

Requires Improvement

Mitigations recorded in the risk assessment included having staff members located in certain parts of the wards. However, we observed that this did not consistently occur. Therefore, not all mitigations were adhered to, making them potentially ineffective. Ligature cutters were available across the hospital and staff told us where these were located. The allocated staff responder (to incidents) on each ward also carried ligature cutters on their person.

Staff had easy access to alarms and patients had easy access to nurse call systems and so could summon help when needed.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, and adequately furnished. Numerous items of furniture was wipeable and easy to clean.

Staff made sure cleaning records were up-to-date and the premises were cleaned regularly. We saw numerous housekeeping staff working throughout the inspection.

Staff followed infection control policy, including handwashing. Staff could easily access hand basins to wash hands and the hospital had gel dispensers available. Senior staff regularly monitored and audited infection control.

Seclusion room

The hospital had a seclusion room which had not been used since opening. The seclusion room allowed clear observation and two-way communication. We observed that the room appeared to be unfinished, not fit for purpose and did not meet the requirements of the Mental Health Act Code of Practice 2015. We saw that patients in the room could potentially harm themselves. The provider had acknowledged this and the room was confirmed as not being in use until identified issues had been addressed. There had been no seclusions in any other areas of the hospital.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff replenished items as and when necessary.

Staff checked, maintained, and regularly cleaned equipment used to monitor patients physical health.

Safe staffing

The service did not have enough substantive nursing staff. They were dependent upon agency staff to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe, as they used bank and agency staff to cover any unfilled shifts. Managers used regular bank staff, and sourced staff from 4 different agencies.

The service had a number of staff vacancies, of which recruitment was ongoing. The hospital had just created a new role for the director of clinical services, which they were recruiting into. Across the hospital, there were 4 registered mental health nurse vacancies; 5 support worker vacancies; 1 patient safety officer vacancy and 1 activity co-ordinator vacancy, which had been appointed into, start date to be confirmed. The service had 11 pre-registration nurses, who were working as support workers, while awaiting confirmation by the Nursing and Midwifery Council (NMC) that they have successfully registered and are able to work as a nurse.

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

Requires Improvement

The service used bank and agency staff to provide cover for shifts as and when needed to cover vacancies, sickness, training and other absence. The hospital had 3 bank registered mental health nurses and 7 bank support workers at time of inspection.

Between March and November 2023, managers had used bank staff to cover 90 shifts, and agency staff to cover 1061 shifts. Managers were using agency to cover the registered nurse vacancies predominantly, as well as additional staff needed for enhanced observations of patients. The percentage of shifts sourced from agency had been between 11% and 26% each month. One exception to this was in October when agency staff use was recorded as 44%. Some of the higher numbers of staff needed reflected that the hospital had opened its third ward in August 2023, so patient numbers increased. We were concerned about patients receiving inconsistent care due to the number of agency staff used.

Managers, where possible requested agency staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Induction checklists were held within agency staff profiles.

The service had experienced a total number of 28 staff leaving since the hospital opened in March. Of these, 16 were clinical, with the remainder being support service staff (administration; kitchen staff and housekeeping staff). There had been a number of reasons given, to include physical health issues; career progression; transfer to another service; a change in personal circumstances and failed probationary period. This equated, month on month to between 0% and 6%. Managers offered exit interviews to understand why staff had left.

Managers supported staff who needed time off for ill health. Staff sickness had been reported each month since the hospital opened in March 2023. The number of hours lost each month through sickness had varied, the lowest between 59 in May and the highest being 320 in December 2023. A total of 1918 hours had been lost overall due to sickness between March and December 2023. At time of inspection there were no staff off on long-term sickness. All reported sickness had been short term. Managers offered staff support and checked in regularly with them while off work and offered flexibility where appropriate with returning to work. Staff could also access psychological support through managers.

Managers accurately calculated and reviewed the number and grade of nurses and support workers for each shift. Additional staffing could be sourced as and when needed to meet patient's needs through the ward managers.

Patients had regular one to one meetings with their named nurse, which was recorded in clinical notes.

Patients rarely had their escorted leave or activities cancelled. Patients we spoke with confirmed this.

The service had enough staff on each shift to carry out any physical interventions safely. We reviewed shift allocation sheets which highlighted who the ward responders were.

Staff shared key information to keep patients safe when handing over their care to others between shifts. This included current patient risks, observations levels, general presentation and any recent concerns.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the wards quickly in an emergency.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. It included but was not limited to equality and diversity; health and safety; fire safety; safeguarding of adults and children; Mental Capacity Act and Deprivation of Liberty safeguards, Mental Health Act and basic life support.

The practice development nurse oversaw the training compliance and communicated with the ward managers to ensure the rotas reflected staff on training. The hospital director had oversight of compliance across the hospital. The compliance rate with mandatory training was over 85% in each subject.

The hospital used 4 agencies who supplied clinical staff to cover vacancies, sickness, training and absence. We identified that not all staff profiles we viewed were detailed in which mandatory courses the agency staff had completed and when. Agencies had given confirmation that the staff had received required training, but did not routinely offer information on the courses, levels completed and when. Therefore, we could not be assured that all agency staff used had the required skills, knowledge and training. Staff were trying to contact the relevant agencies to obtain this information while the inspection was in progress.

Following inspection, the provider sent us the obtained training records from the agency for the profiles viewed on site, which demonstrated these staff had received all expected mandatory training.

Assessing and managing risk to patients and staff

Staff used the least restrictions where possible when anticipating, de-escalating and managing people expressing feelings or an emotional reaction. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a provider tool, and reviewed these regularly.

Risk assessments were not always detailed. Additionally, risk management plans were not individualised and lacked detail in how to manage identified risks. We viewed 9 individual risk assessments and found significant gaps in 4 of these.

Staff had updated one risk assessment but had not recorded recent incidents of verbal aggression, as documented in clinical notes. The review lacked detail and was not comprehensive.

We saw that one patient had a care plan in place for being underweight, with a recorded nutritional screening tool risk of 4 (indicating a high risk). However, inspectors were unable to locate the tool which should have demonstrated how staff calculated this score.

One patient had recently engaged in deliberate self-harm. Staff had recorded this within their risk assessment, but offered minimal details around this or how staff should manage this risk.

We also saw that a patient was overweight and had a high body mass index (BMI). Staff had acknowledged this as a risk but there was no guidance for staff in how to support the patient to manage this risk.

Management of patient risk

Regular staff knew about main risks to each patient and acted to prevent or reduce risks. Risk assessments were completed by nurses. Some support workers we spoke with had not seen individual patient risk assessments. They had been informed of risks through the routine verbal handover.

Staff identified and responded to changes in risks to, or posed by, patients. We observed staff effectively manage an incident during inspection.

Staff did not consistently follow procedures to minimise risks where they could not easily observe patients. The ligature risk assessment and blind spot audit stated that staff would be positioned in certain areas of the wards where risks had been identified. We saw these areas unsupervised with patients present on occasions throughout the inspection on King ward.

Staff followed 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 across the hospital.

There had been 116 incidents of restraint reported between March and December 2023. Incidents of restraint had been slightly higher on the male ward (King).

Staff had not restrained anyone in the prone position (chest down). The training programme staff received for restraint did not include floor restraints, in line with best practice.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The hospital monitored restrictive interventions and reviewed these regularly.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

All staff we spoke with said they actively tried not to use any physical restraint. We observed staff managing an incident through re-direction and respectfully speaking calmly to a patient during the inspection. Staff used a 'no hands approach' which was effective.

Staff followed NICE guidance when using rapid tranquilisation. Since opening, staff had administered rapid tranquillisation on 15 occasions, 6 on King ward and 9 on Castle ward. The deputy hospital director reviewed the use of rapid tranquillisation through regular audits. We saw that some previous audits had required actions to be taken with staff, which had been completed. This was primarily around training and re-visiting national guidelines and provider protocol to ensure staff undertook physical observations consistently as expected following administration of rapid tranquillisation.

The service had not used seclusion or long-term segregation since opening.

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

Requires Improvement

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 compliance in the safeguarding of adults was 98%, and the safeguarding of children 95%. All clinical staff were trained to level 3, in line with national guidance.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The hospital director maintained regular contact with the Local Authority and was able to discuss concerns as they had arisen.

Staff followed clear procedures to keep children visiting the ward safe. The hospital had a visitors room off of the wards which had toys and books available for children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital director was the designated safeguarding lead and maintained an overview of all concerns raised.

Staff access to essential information

Staff had access to clinical information electronically. However, some staff had difficulty navigating the electronic system and could not easily locate documents related to patient care.

The electronic system was new to the service and continued to evolve. When we asked staff to assist us when looking at care records, one agency registered nurse had no access. This was reported to the ward manager who took immediate action. One regular support worker also had no access. We were unsure why this was, as they were not a new member of staff. One senior nurse was relatively new and had to ask a patient safety officer to navigate to the documents we required. This did not assure us that all staff had easy access to patient records.

Most patient records were held electronically, with some paper being used, for example to capture diet and fluid intake. Staff knew where paper records were located, and we found these to be up to date as expected.

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

Records were stored securely.

Medicines management

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

We reviewed medicines management across the hospital. Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients about their medicines during multi-disciplinary meetings.

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

Staff stored and managed all medicines and prescribing documents safely, in line with provider policy.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. This was evidenced within clinical notes.

Staff learned from safety alerts and incidents to improve practice. We saw various safety alerts visible to staff and evidence of improving practice and sharing learning related to medicines when errors had been reported.

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

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. The hospital had a lead physical healthcare nurse whose priority was to assess and monitor patients' physical health needs and offer advice to the patient and staff in how to monitor and manage different condition.

Track record on safety

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff reported incidents electronically via an incident form.

Staff raised concerns and reported incidents and near misses in line with provider policy. We sampled some incident forms and found staff had completed all sections as expected.

Staff reported serious incidents in line with policy. There had been 1 serious incident at the service relating to the death of a patient shortly following discharge. Investigations were ongoing at the time of inspection. The patient's NHS trust was undertaking this. Managers at Elizabeth house had undertaken their own internal investigation and had identified lessons learnt, which had been disseminated to staff.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw evidence of this via letters sent out by managers.

Managers had processes in place to support staff after any serious incident. Reflective practice sessions were facilitated by the psychology team on a regular basis and support was made available following a serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations if they wanted to be.

Staff received feedback from investigation of incidents, both internal and external to the service.

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

Requires Improvement

Staff met to discuss the feedback and look at improvements to patient care. Managers reviewed feedback regularly in governance meetings.

Is the service effective?

Requires Improvement

This was the first inspection of this service. We rated effective as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated regularly. Care plans mostly reflected patients' assessed needs but were not consistently personalised.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Doctors undertook the initial assessment and the physical healthcare nurse continued to assess, monitor and advise, in conjunction with the multi-disciplinary team.

Staff developed care plans for each patient which addressed their mental and physical health needs.

Of the 9 care records we viewed, 3 had some elements of personalisation, but this was not consistent. Staff had not written most care plans in the patients' voice, giving their point of view and / or preferences. Most care plans had been written by staff in the third person. We found care plans lacked individualised goals, aims and interventions. Most interventions were generic statements which staff had used across different patients. For example, to have a 1:1 time with staff; adhere to medicines or to attend the ward round. Most patient needs had been identified, but care plans did not consistently identify how staff helped the patients to manage these needs.

Best practice in treatment and care

Staff provided a range of treatment and care for patients, although could not always demonstrate during interviews knowledge of national guidance and best practice. Patients had access to physical healthcare and staff supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the patients in the service. A psychologist and psychology assistant offered relevant psychology sessions to patients either in a group or on an individual basis, dependent upon need. Psychology staff recorded if patients had declined. Due to the nature of the ward, therapies offered were mostly short term and included cognitive behavioural therapy; problem solving; coping skills and psychoeducation sessions.

Staff identified patients' physical health needs and recorded them in their care plans. We saw care plans relating to specific physical health needs, for example around diabetes.

Patients had access to physical health care, including specialists as required. Staff escorted patients to the local general hospital as and when needed for assessment of needs.

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

Requires Improvement

Staff met patients' basic dietary and hydration needs. However, we noted that patients who had been identified as at risk, due to being underweight, or overweight, had not been referred to a dietician to seek specialist support or advice.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Sessions had included healthy living and the importance of good oral health.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. This included tools to assess depression, anxiety and personality assessments.

Staff used technology to support patients. Staff recorded observations electronically via a handheld device. However, managers acknowledged that there needed to be some amendments to this programme, to ensure that staff captured observations in real time. There was a lack of oversight to ensure staff adhered to observations and recorded them to reflect this.

Managers ensured that clinical audits were undertaken, for example around medicines management, use of rapid tranquillisation and care record audits. However, the audits had failed to pick up issues with care plans we identified during inspection.

Skilled staff to deliver care

The ward teams included or had access to a range of specialists required to meet the needs of patients on the wards.

The hospital did not employ an occupational therapist. Managers had chosen to recruit 2 activity co-ordinators who undertook various recreational groups across the wards. This included smoothie making, quiz's, listening to music and going for walks. Managers had sourced an occupational therapist from another of the company's services previously when there was a specific need. However, we were unsure how frequently this had occurred. We were concerned that patients had a lack of meaningful and therapeutic activity, consisting of individualised assessments and interventions around living skills.

One patient told us that there were activities, but they would benefit more from learning some basic skills to look after their mental health. A carer told us that patients had to manage their own time and there were limited activities.

The service did not employ a social worker. They did however have a discharge co-ordinator who communicated with patients discharge teams and commissioners to co-ordinate discharge into the community or home area.

Managers made sure they had staff with a range of skills needed to provide care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for all new staff.

The service had a range of staff to meet the needs of the patients on the ward. This included doctors, nurses, psychology staff, support workers and administration staff.

Managers ensured regular staff had the right skills, qualifications and experience to meet the needs of the patients in their care. There appeared to be a lack of oversight with agency staff, regarding what training they had received and when.

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

Requires Improvement

Managers gave each new member of staff a full induction to the service before they started work. This included a local induction to the hospital, various mandatory training, being supernumerary for a 2-week period, and being allocated a buddy to support them through their probationary period, during which time they should have completed all required training and be familiar with hospital polices and processes.

All new staff were placed on probation and held regular meetings throughout their probationary period to assess how they were finding the role, to continually assess performance, and to ascertain if they had any further training or development needs. We saw that managers extended probationary periods where necessary.

Managers supported staff through regular appraisals of their work. Each staff member received their first appraisal following 12 months of service. Managers had scheduled staff appraisals for 2024.

Managers supported medical staff through regular, constructive clinical supervision of their work. All clinical staff received supervision at least 6 times throughout each 12-month period. Compliance with this was 94%. Management supervision was received as and when necessary, agreed by staff.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Meetings rotated between shifts and staff recorded minutes on the electronic system so that all staff could access them.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers completed regular training needs analysis.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to minimise any gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular, weekly multidisciplinary meetings to discuss patients and improve their care. Patients and relatives (where appropriate) were encouraged to attend these meetings.

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

Ward teams had effective working relationships with other teams in the organisation and continued to develop working relationships with external teams and organisations.

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. Staff training compliance in the Mental Health Act was 90%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The hospital had a full time Mental Health Act administrator on site. Staff knew where the administrator was located and could ask for support or advice when needed.

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

Patients had easy access to information about independent mental health advocacy. Staff had a process whereby patients who lacked capacity were automatically referred to the service. Advocacy visited the hospital regularly and was available to accompany patients in meetings, if requested.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. We viewed a sample of section 17 records and found all were in order, with related care plans for being absent without leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) as an when they needed to in order to progress treatment.

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

Informal patients knew that they could leave the ward freely and the wards displayed posters to tell them this.

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 communicated with the relevant teams to ensure appropriate care was available upon discharge.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The electronic system flagged up important dates, for example, if a patient's consent to treatment review was due, or if a detention was due to expire. This acted as a prompt to nursing staff and the wider team, thus reducing omissions in this area.

Good practice in applying the Mental Capacity Act

Not all staff we spoke with had a good understanding of the Mental Capacity Act 2005. Most staff we spoke with had difficulty in explaining what the Mental Capacity Act was and the overarching principle, despite having received the training, which was completed every 3 years. Compliance with this training was 98%. However, one regular staff member recalled having the training, but could not remember what it was about. Other staff, when asked had real difficulty in verbalising what it was about, including a registered nurse. We were concerned that the training received had been ineffective.

There was limited detail recorded in capacity assessments, and this led to some records regarding capacity appearing contradictory. For example, one patient, upon admission, was recorded as not having capacity to consent to admission. This contradicted what was recorded 2 days later in their mental health care plan, which stated they had capacity to consent to medication and treatment. The reason for the fluctuating capacity described was not clear within records.

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

Requires Improvement

In one patient's physical health care plan, staff had recorded they lacked capacity to engage in their care plan, yet staff had also recorded the patient had capacity to agree with the care plan.

We saw that during a multi-disciplinary meeting, staff had recorded concerns around potential financial exploitation relating to a patient, yet staff had not completed a capacity assessment to explore this further.

Additionally, capacity details were not as detailed as we would expect. For example, we saw that some patients first language was not English. Staff had not recorded how they were assured these patients had capacity to consent, such as understanding what they had been told, relaying this back and retaining the information.

Managers had not made any deprivations of liberty safeguards applications since opening the hospital.

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

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. The hospital employed a Mental Health Act administrator who was available Monday to Friday. Staff were aware of where they were located and had received support as and when needed.

Staff had not made any applications for a Deprivation of Liberty Safeguards, but the Mental Health Act administrator was aware of the process and how to monitor applications.

We did not feel that the service effectively monitored how and when the Mental Capacity Act was being applied in order to make changes to improve.

Is the service caring?

Good

This was the first inspection of this service. We rated it as good

Kindness, privacy, dignity, respect, compassion and support

We observed staff treat 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. We observed respectful interactions between staff and patients throughout the inspection.

Staff gave patients help, emotional support and advice when they needed it. Staff made an effort to meet with each patient on a regular 1:1 basis and recorded this.

Staff supported patients to understand and manage their own care treatment or condition. Discussions were held during multidisciplinary meetings and outside of these meetings where needed.

Staff directed patients to other services and supported them to access those services if they needed help. For example, housing advice.

Patients said staff treated them well and behaved kindly. Patients told us staff always knocked on their bedroom door before entering.

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

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in some care planning and risk assessments, although this was inconsistent. Feedback about the quality of care provided was encouraged during community meetings, and through intermittent patient satisfaction surveys. Managers ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients we spoke with confirmed this.

Staff said they involved patients and gave them access to their care planning and risk assessments. However, this was not always evident in care records. We spoke with 7 patients. One said they did not think they had been involved in care planning, and 2 said staff had written their care plan and they had been asked to sign it.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Translators could be arranged for patients who had difficulty understanding English. We observed a morning meeting where discussions were had regarding a patient who required a translator and this was booked for later that day.

Staff involved patients in some decisions about the service. For example, some patients had attended a meeting around restrictions across the hospital, where they could raise any concerns or share thoughts.

Patients could give feedback on the service and their treatment and staff supported them to do this. Managers collected feedback forms from patients, with questions around different aspects of care and treatment. Feedback posters were then displayed with details of actions taken where expected. We saw that one patient fed back that food allergies had been overlooked. In response to this, the service added a food allergies section to admission paperwork.

Involvement of families and carers

Staff informed and involved families and carers appropriately where possible, with the patients consent.

Carers could attend MDT meetings in person, or via video conferencing. We saw some patients receive visitors during the inspection.

We received feedback from one carer, who was not happy with their relatives care and treatment and had logged a complaint. The carer said that communication regarding progress had been poor. They also said that despite being told staff would be more flexible with visiting times, due to having to travel some distance, this did not occur, and described visits as ‘being cut short’.

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

Requires Improvement

Family members and carers could offer feedback about the service. We saw some had complemented staff and had given feedback about the service directly via email to senior staff.

Is the service responsive?

Requires Improvement

This was the first inspection of this service. We rated it as requires improvement.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Bed occupancy was not consistently above 85%. Upon opening, managers ensured occupancy was built up slowly. At the time of inspection occupancy was 10. The highest occupancy since opening had been in October, with 29 patients.

Managers regularly reviewed length of stay for patients. The average length of stay was 21 days.

The service had received some out of area placements, due to a lack of acute beds in other areas. Managers worked with the patients' home teams to get them transferred closer to home as beds became available within their own NHS trusts.

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

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

Patients were not moved between wards unless there were clear clinical reason, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning. Discharges were planned during the morning or early afternoon where possible.

Managers had made 5 referrals to a psychiatric intensive care unit and had not reported any significant delays with transfers. Staff had nursed patients awaiting a bed on enhanced observations if clinically justified, while awaiting transfer.

Discharge and transfers of care

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

The hospital had experienced 14 delays in discharge between March and December 2023. All of these were attributed to issues with a lack of suitable accommodation to safely discharge to. Managers worked with individual patient teams to remedy this at the earliest opportunity.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. The hospitals discharge co-ordinator worked with the multi-disciplinary team to facilitate this.

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

Facilities that promote comfort, dignity and privacy

The design 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 some quiet areas for privacy on the wards, although these were minimal. The food was reported to be of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise if they wanted.

Patients had a secure place to store personal possessions. Each patient had a locker on the ward which staff could access as and when they wanted something. Lockers were stored in a locked room.

Each ward had a quiet room, although we observed this was also used to hold psychology sessions. During the inspection, we saw one patient was reading a book in the quiet room but was asked to leave as psychology staff needed the room to see a patient. We were concerned that if the wards were fully occupied, there would be a lack of space to support patients' treatment, privacy and dignity.

The wards had minimal quiet areas where patients could meet visitors in private. There was a family room off of the wards, and a multi faith room. Where safe to do so, patients could utilise leave during visits. Managers encouraged visits to be arranged in advance to ensure suitable space was available. The hospital had set visiting times, but managers stated this could be flexible if visitors had some way to travel. Feedback received from a carer stated this had not been facilitated, as originally agreed, during visits.

Patients could make phone calls in private and had access to personal mobile telephones.

The wards had access to outside space. However, the doors were kept locked. Patients had to rely upon staff to open these and be present with patients in the courtyards, in line with hospital protocol. We were concerned that not all patients would be able to access fresh air as and when they wanted too. In addition to this, due to safety reasons, most windows across the hospital were covered in Perspex and so windows could not be opened. While the service had air conditioning and temperature control, this would not compensate for fresh air. Temperatures were controlled at reception and while these could be adjusted, controls meant that all areas had to be either heating or air conditioning, not a combination of both.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. The service had achieved a 5 star food hygiene rating.

Patients' engagement with the wider community

Staff supported patients with activities outside the service as and when needed and encouraged maintaining family relationships.

Staff helped patients to stay in contact with families and carers through calls and / or visits.

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

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The multi-disciplinary team worked together to address any issues with communication and could source translators or use visual prompt cards to aid communication. The hospital had lifts and was able to accommodate people who may need mobility aids.

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

The service had information leaflets available in languages spoken by the patients and local community which were given upon request, or if felt useful to the patients.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Menus provided by the kitchen demonstrated this. Patients were encouraged to give feedback and suggestions to the kitchen staff for consideration and action.

Patients had access to spiritual, religious and cultural support. The hospital had a multi-faith room. During our visit, we noted there was no available bible. This was brought to the attention of the staff.

The service had facilitated trips out to places of worship for individual patients who had requested this.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. There had been 15 formal complaints since opening. All of which had been managed appropriately by managers. All formal complaints had been responded to in line with hospital policy. Outcome letters had been sent to confirm if the complaint was upheld or not.

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

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with were aware of the escalation process in receipt of a complaint and knew how to acknowledge them.

Managers investigated complaints and identified themes. The main theme was around missing, or damaged patient property. Managers had reminded staff to ensure the safety and security of patient belongings, and to ensure secure lockers were offered upon admission.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. A patient had complained that night staff were noisy and disturbing sleep. Managers had addressed this and fed this back to all staff, reminding them to keep the noise levels down to promote sleep.

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

Requires Improvement

The hospital had received 19 informal complaints since opening. Several of these were around missing patient property, one was around language barriers between staff and patients, and 2 related to staff sleeping. These had all been addressed by managers and feedback given.

The service used compliments to learn, celebrate success and improve the quality of care. Managers had recorded 93 compliments received from patients, relatives and staff members.

Is the service well-led?

Requires Improvement

This was the first inspection of this service. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Senior staff were visible in the service and approachable for patients and staff.

Plans to strengthen the leadership team included the creation of a director of clinical services, which was being advertised.

Team managers we spoke with were unsure how many vacancies their wards had, what the sickness rate was, or what the staff turnover rate was. Senior leaders were able to give us this information.

The ward managers had covered the wards as and when needed to provide registered nurse cover. Ward managers were authorised to book agency staff in the events of identified gaps.

Some staff had received some training around leadership in partnership with a local organisation, which they said had been helpful.

We saw examples of staff who had worked for the company, and with support had progressed to more senior roles. For example, support workers who were promoted to patient safety officers. The service was supporting pre-registration nurses to develop skills and knowledge to become registered as a nurse.

Vision and strategy

Staff knew about the provider's vision and values. During induction, managers had successfully communicated the values of the hospital. Staff we spoke with were able to tell us the hospital aimed to provide a safe environment, for men and women in crisis. Staff placed emphasis upon being as least restrictive as possible. We saw this evidenced during inspection during the management of an incident.

Another important value held was for all patients to be treated kindly, respectfully, and support given as and when needed. It was clear that staff applied this in their daily work, through interactions observed.

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

Requires Improvement

Culture

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

All staff we spoke with were happy in their role and liked working at the service. Morale appeared to be good. It was clear that staff across the hospital worked together to offer clinical support and advice to each other as and when needed.

All staff we spoke with were respectful of patients' needs and understood they were unwell and needed ongoing care and support.

Staff were aware of who they could speak to if they had concerns about the service internally, and externally.

Teams worked well together and where there were difficulties, managers dealt with these appropriately. Expectations around performance were clear, with all new staff being on a probation period where more support was offered if needed.

Governance

Our findings from the other key questions demonstrated that governance processes did not consistently operate effectively at team level. The senior leadership team need to continue to work towards having robust systems in place to assess, manage and action risks and ongoing performance.

There were systems and processes in place to monitor the quality of the service, but this had not been fully effective in identifying and acting upon concerns. Governance processes needed to be strengthened to ensure consistent assessment and ongoing monitoring of the service, with actions being taken in a timely way to enhance patient care.

There were adequate systems in place to ensure wards were safe and clean.

There were enough nursing staff, by utilising bank and agency staff, to meet patient's needs. We were not assured all patients received meaningful and therapeutic activities.

Regular staff had received regular supervision and had upcoming annual appraisals.

The hospital had a framework in place identifying what was discussed at ward, team and service level, such as incidents and learning from complaints.

Staff participated in audits, however not all the issues we found had been identified through the audit process. There was a lack of staff knowledge around the Mental Capacity Act, which was demonstrated during interviews and in individual patient records, despite most staff having received the training. Not all care plans were personalised and demonstrated active patient involvement. Not all staff were competent or confident in navigating the electronic notes system, with some who had not received adequate training in the system.

Management of risk, issues and performance

Not all staff had access to the information they needed to provide safe and effective care. The electronic notes system was still being embedded, and changes were being requested as staff became more confident with the system and identified areas which could be improved. Not all staff had access to the ligature risk assessment or had seen it. Mitigations stated in the ligature risk assessment and blind spot audit were not consistently adhered to.

While individual patient risk assessments were in place, staff had not always updated these to reflect current risks, and risk management plans needed more detail.

We noted that the risk register had a risk identified around 'lack of compliance and information on agency staff coming into the service', as identified by managers in November 2023. This risk had been closed on 11 December 2023. Yet the matter had not been resolved when we inspected and identified gaps in training records.

The hospital risk register had issues relating to the running of the service, for example maintenance issues, or concerns around documentation. While these are clearly risks, we would have expected to see active risks affecting the hospital and function, such as the electronic notes system; agency staff being appropriately trained, ongoing vacancies, and not yet holding a CQC rating.

Information management

Staff collected analysed data about outcomes and performance.

Data was collected from wards which fed into reports presented at clinical governance meetings.

Information governance systems included confidentiality of patient records.

While team managers had access to support them in their role around day-to-day staffing, we were unclear if they had full oversight of the teams they managed.

Staff made notifications to external bodies as and when required, for example to the Local Authority, or the Care Quality Commission.

Engagement

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

Staff commissioning services were invited to attend multi-disciplinary meetings in person or via video conference.

Managers were keen to assist the local community with having accessible beds for patients who required a local bed to keep them close to home.

Staff, patients and carers had access to up-to-date information about the work of the service, through posters, bulletins and feedback during meetings and through supervision.

Learning, continuous improvement and innovation

The hospital was in its infancy, and had focused upon safe opening of the wards, staff recruitment and training, and building relationships with different NHS trusts.

As this is a new service, staff had not participated in accreditation schemes relevant to the service.

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 9 HSCA (RA) Regulations 2014 Person-centred care • The provider had not ensured all care plans were personalised and reflected patient views and involvement. • The provider had not ensured all patients were offered meaningful, therapeutic activities. • The provider had not ensured patients were able to access fresh air as and when they wanted.

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 • The provider had not ensured all staff had access to the ward ligature risk assessments and blind spot audit. • The provider had not ensured all mitigations recorded on the ligature risk assessment had been adhered to. • The provider had not ensured all staff were familiar with patients risk assessments and knew how to safely manage risks. • The provider had not ensured all patient observations had been undertaken and recorded in real time.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not ensured all staff had access to patient records, and had received appropriate training in navigating the electronic system.

This section is primarily information for the provider

Requirement notices

- The provider had not ensured team leaders had full oversight of the areas they managed.
- The provider had not ensured there were fully effective and embedded systems in place to assess, manage and action risks and ongoing performance.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • The provider had not ensured capacity had been clearly assessed and recorded, in accordance with the Mental Capacity Act.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not ensured all agency staff mandatory training was fully documented, including levels of training achieved and the date the training had been received. • The provider did not ensure all clinical staff were able to articulate the principles of the Mental Capacity Act and recognise how this applies to day to day practice.