St Andrew's Healthcare

St Andrew's Healthcare - Mens Service

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as requires improvement because:

Following our inspection we took urgent action because of immediate concerns we had about the safety of patients on the learning disability and autism wards. Conditions were placed on the provider's registration that included the following requirements; that the provider must not admit any new patients without permission from the CQC; that wards must be staffed with the required numbers of suitably skilled staff to meet patients' needs; that staff undertaking patient observations must do so in line with the provider's policy; that staff must receive required training for their role and that audits of incident reporting are completed. The provider is required to provide CQC with an update relating to these issues on a fortnightly basis.

Whilst the CQC acknowledge the impact of the COVID-19 pandemic on staffing across the health and social care sector, we had identified staffing issues at this location at our previous inspection. Our assessment process for rating services requires previous breaches to be considered.

- Senior managers and staff on the learning disability and autism wards did not always treat patients with compassion and kindness and did not always support, inform and involve families or carers. Staff at the learning disability and autism wards were unable to define a closed culture or describe how they ensured patients were protected from the risks associated with a closed culture developing. Staff on the learning disability wards and forensic wards did not always treat patients in seclusion with dignity and respect.
- The psychiatric intensive care ward, forensic wards and learning disability and autism wards did not always have enough nursing and support staff to keep patients safe and the wards were regularly short staffed. Patients regularly had their escorted leave, therapies or activities cancelled or cut short because of staff shortages.
- Staff did not manage risks to patients and themselves well. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. This happened on the psychiatric intensive care ward, forensic wards and learning disability and autism wards. Staff did not always know what incidents to report and how to report them at the forensic wards, long stay rehabilitation wards and learning disability and autism wards. Staff were not always updating patient risk assessments and care plans at the forensic wards, long stay rehabilitation wards and learning disability and autism wards. Staff did not always ensure patients' physical healthcare needs were met at the forensic wards and learning disability and autism wards. Staff were not always following systems and processes when administering, recording and storing medicines on the learning disability and autism wards. Not all ward areas at the long stay rehabilitation service and learning disability and autism service were safe, clean and well maintained.
- Seclusion rooms did not meet all the guidance in the Mental Health Act Code of Practice on the forensic wards, long stay rehabilitation wards and learning disability and autism wards. When a patient was placed in seclusion, staff did not always follow best practice guidelines on the forensic wards and learning disability and autism wards. When a patient was placed in long term segregation, staff on the forensic wards and learning disability and autism wards did not always follow best practice guidelines in the Mental Health Act Code of Practice.
- Managers did not ensure all staff had the right skills, qualifications and experience to meet the needs of the patients in their care on the forensic wards and learning disability and autism wards. Staff did not always provide a range of care and treatment suitable for the patients in the long stay rehabilitation wards and learning disability and autism wards. The service had not fully responded to the needs of patients with autism at the learning disability and autism service.

Summary of findings

- Leadership and governance arrangements across all core services had not addressed previous issues or ensured concerns were identified and acted on. The provider's data was not always accurate. Not all leaders had a good understanding of the services they managed. Not all staff felt respected, supported and valued by senior managers. Not all staff felt they could raise concerns without fear of retribution from senior managers. Senior managers are managers above ward manager level.

However:

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another service. As a result, discharge was rarely delayed for other than clinical reasons.
- The provider had a care awards initiative to celebrate success and improve the quality of care across services. Staff engaged in local and national quality improvement activities. The provider reported involvement in various research projects.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	Our rating of this service stayed the same. We rated it as requires improvement because: • Staff had not recognised or reported one safeguarding incident and we were not assured staff knew when to escalate incidents such as financial issues. • Only 54% of registered nurses completed immediate life support training. This posed a risk to patients who require immediate medical attention. Across the service five out twelve nurse call alarms were either not working or damaged. • Staff were not always completing patient's observation records accurately. CQC reported on this at our earlier inspection. Staff did not always receive breaks between observing patients. • Five of eighteen care plans we reviewed were incomplete and staff had not followed up on the progress notes. Staff had not followed physical healthcare plans of two patients. We found similar issues at our inspection in March 2018. None of the care plans had clearly recorded consent to treatment. • Seclusion rooms on all wards met most but not all guidance in the Mental Health Act Code of Practice. There was no exit plan for a patient in long term segregation on one of the wards. Staff did not always keep clear records or follow best practice guidelines when patients were in long term segregation or seclusion. We reported on similar issues at our inspection in March 2018. • Staff did not always protect the privacy and dignity of a patient in prolonged seclusion. • Processes for recording staff supervision were not robust. We reported on similar issues at our earlier inspection.

Summary of findings

- The service did not have enough nursing or support staff to keep patients safe and ensure all patients care needs were met all the time. CQC reported on this at our inspection in March 2018.
- Senior leaders were not always visible on the wards. Two managers told us they did not feel supported by senior leaders on matters such as staffing levels and recording supervision. These managers told us they felt senior managers did not fully appreciate the pressures faced by staff on the wards and their focus was on different priorities for the service.
- Governance systems and processes were not always robust. We were not assured managers would recognise and identify all potential risk issues.

However:

- All wards were clean, well equipped, well furnished, well maintained and fit for purpose. Cleaning records were complete and up to date.
- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.
- Staff involved patients in care planning and risk assessment. They ensured that patients had easy access to independent advocates. Staff informed and involved families and carers appropriately.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Summary of findings

We rated this service as requires improvement because it was not safe, effective, caring or well led.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

- Staff had not completed discharge plans for all patients. Patients were not always aware of their specific goals for discharge.
- Clinic rooms were not adequately equipped to meet patient need. Two of the three wards did not have access to emergency resuscitation equipment on the ward. All three wards did not have oxygen signs on the clinic room door.
- Staff had not labelled all opened food items in the fridge, which was identified as an action from the last inspection in March 2018.
- Staff did not always report safety or safeguarding incidents. These incidents had not been reviewed effectively and patient care needs had not been updated.
- The providers compliance with safeguarding level three training on two of the three wards was low at 60% and 63%.
- Managers allocated therapy staff to frontline shift work due to staffing shortages which impacted on the delivery of therapies to patients.
- Patients leave was affected by and planned around staffing levels and not around patient choice. We found therapy sessions had been cut short or cancelled due to staffing levels.
- The seclusion rooms consisted of blind spots that the staff were not aware of increasing the risk of patients harming themselves without staff knowing when using the facilities. We found blind spots in the garden that the staff were not aware of.
- Staff did not always learn lessons from incidents and follow processes put into place after incidents.

However:

- Staff monitored and supported patients' physical health.
- Staff treated patients with compassion and kindness. They respected patients' privacy and

Summary of findings

dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

- All ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

We rated this service as requires improvement because it was not safe, effective or well led.

Wards for people with learning disabilities or autism

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- Senior managers and staff did not always treat patients with compassion and kindness. Staff did not always support, inform and involve families or carers. Staff were unable to define a closed culture. Staff kept a patient in seclusion for longer than required.
- The service did not have enough nursing and support staff to keep patients safe and the wards were regularly short staffed. Patients regularly had their escorted leave, therapies or activities cancelled or cut short because of staff shortages.
- Staff did not manage risks to patients and themselves well. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. Staff did not always act to prevent or reduce risks despite knowing any risks for each patient. Staff did not always know what incidents to report and how to report them. Staff were not always updating patient risk assessments and care plans. Staff did not always ensure patients' physical healthcare needs were met. Staff were not

Summary of findings

always following systems and processes when administering, recording and storing medicines. Not all ward areas were safe, clean and well maintained.

- Seclusion rooms did not meet all of the guidance in the Mental Health Act Code of Practice. When a patient was placed in seclusion, staff did not always follow best practice guidelines. When a patient was placed in long term segregation, staff did not always follow best practice guidelines in the Mental Health Act Code of Practice.
- Managers did not ensure all staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Staff did not always provide a range of care and treatment suitable for the patients in the service.
- The service had not fully responded to the needs of patients with autism in the ward environment. The design, layout, and furnishings of the ward did not always support patients' treatment. Senior managers and staff were sometimes dismissive of complaints from patients with autism. Not all patients could make hot drinks and snacks at any time.
- Leadership and governance arrangements had not addressed previous issues or ensured concerns were identified and acted on. The provider's data was not always accurate. Leaders did not always have a good understanding of the services they managed. Not all staff felt respected, supported and valued by senior managers. Not all staff felt they could raise any concerns without fear of retribution from senior managers. Senior managers are managers above ward manager level.

However:

- The provider evidenced sharing of national safety alerts and action taken to ensure wards acted as required.
- Staff completed comprehensive mental health and physical health assessments of each patient either on admission or soon after.

Summary of findings

- Staff received and kept up-to-date with training on the Mental Health Act and Mental Capacity Act.
- We observed staff treating patients with respect, kindness and dignity and responding to their needs during the site visit.
- Staff engaged in local and national quality improvement activities. The provider reported involvement in various research projects

We rated this service as inadequate because it was not safe, effective, caring, responsive or well led.

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

Requires Improvement

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

- The ward was regularly short staffed because managers moved staff to other wards to cover shortfalls.
- Staff undertook patient observations for long periods of time without a break. This impacted on staff well-being, morale and patient care. Observations were not completed in line with policy and guidelines by the National Institute for Health and Care Excellence.
- We were not assured staff knew the individual risks for patients which meant they might not be able to identify a deterioration in patients mental health, which may put staff and patients at risk.
- The manager did not share lessons learned with the whole team when things went wrong. Improvements were not always identified or shared within the team.
- The leadership, governance and culture for the ward did not always support the delivery of high-quality person-centred care. Staff did not always raise concerns as they felt they were not always taken seriously, appropriately supported, or treated with respect when they did.
- Not all leaders had the necessary experience, knowledge, capacity, capability or integrity to lead effectively.
- Staff did not understand how their role contributed to achieving the service strategy.

Summary of findings

- Staff did not always feel respected, supported or valued.

However:

- The ward environments were clean. Staff minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by comprehensive patient assessments. The ward had access to the full range of specialists required to meet the needs of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity. Patients' comments were overwhelmingly positive. A patient told us the staff aided their management of anxiety and reduced incidents.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The provider had a care awards initiative to celebrate success and improve the quality of care across services.

We rated this service as requires improvement because it was not safe or well led.

Summary of findings

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Summary of this inspection

Background to St Andrew's Healthcare - Mens Service

St Andrew's Healthcare Men's location has been registered with the CQC since 11 April 2011. The service has a registered manager and a controlled drugs accountable officer.

This location consists of four core services: acute wards for adults of working age and psychiatric intensive care units; long stay/rehabilitation mental health wards for working age adults; forensic/inpatient secure wards; wards for people with learning disabilities or autism.

St Andrew's Healthcare Men's location 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.

This location has been inspected ten times. The most recent inspection in July 2019 was a focused inspection of one ward, which subsequently closed.

The last comprehensive inspection of this location was in March 2018. The location was rated as requires improvement overall; requires improvement for safe, good for effective, good for caring, requires improvement for responsive and requires improvement for well led. We issued requirement notices for breaches of the following regulations:

- Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 210 Safe care and treatment.
- Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 210 Good governance.

We found that the provider addressed some, but not all of the issues from the last inspection. The issues that remain are identified later in this report.

The following services and wards were visited on this inspection:

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

- Heygate ward, a psychiatric intensive care unit with 10 beds.

Forensic inpatient/secure wards:

- Robinson ward, a medium secure ward with 17 beds.
- Fairbairn ward is a 15 bed ward in purpose-built medium secure service which manages Deaf or hearing impaired (profound, severe, partial or hard of hearing) patients' with complex mental illness in a culturally sensitive environment.
- Prichard ward, a medium secure ward with 15 beds.
- Rose ward, Rose ward, a medium secure ward with 17 beds for people with an acquired brain injury.
- Cranford ward, a medium secure ward with 17 beds for older males.

Long stay / rehabilitation wards for working age adults:

- Berkeley Lodge which provides support for up to six male patients in a locked rehabilitation environment.

Summary of this inspection

- Spencer North (previously Church ward) ward which provides support for up to 10 male patients in a low secure environment.
- Spencer South (previously Fenwick ward) ward which provides support for up to 13 male patients in a low secure environment.

Wards for people with learning disabilities or autism:

- Marsh ward (previously Mackaness ward), a 10 bed medium secure service for men with autistic spectrum conditions.
- Meadow ward (previously Mackaness ward), a 10 bed medium secure service for men with autistic spectrum conditions.
- Fern ward (previously Upper and Lower Harlestone wards), a 10 bed low secure service for men with autistic spectrum conditions.
- Acorn ward, a 10 bed low secure service for men with autistic spectrum conditions.
- Sunley ward (previously Naseby ward), a 15 bed low secure service for men with autistic spectrum conditions.
- Hawkins ward, a 15 bed medium secure service for men with learning disabilities.

What people who use the service say

We spoke with 43 patients.

At the psychiatric intensive care unit, we spoke with three patients. Patients' comments were overwhelmingly positive. A patient told us the staff aided their management of anxiety and reduced incidents.

At the forensic service we spoke with 17 patients. Patients had mixed views about the service. While 14 patients agreed the facilities available to them at St Andrews were excellent, ten patients said the food was not good and seven patients commented that mealtimes were rushed as staff tried to rush them to eat so they could clear away and get back to the ward. All patients we spoke with commented on the shortage of staff and gave examples of how this impacted on them including; having to wait to be escorted off the ward for non-planned activities; having ward activities cancelled or changed due to lack of staff or staff being sent to other wards. Two patients said they did not like having to use e-cigarettes on Prichard ward rather than their own vapes; and two other patients said they did not like having only three snacks a day particularly when they felt they had not had time to finish their meals.

At the long stay / rehabilitation wards for working age adults we spoke with three patients. All patients told us staffing levels affected their section 17 leave and staff planned it to fit around staffing levels. Patients liked the food and reported good relationships with staff.

At the wards for people with learning disability or autism we spoke with 20 patients. Nine patients shared positive feedback about staff, describing them as caring and hard working. Five patients told us they did not feel safe (four of these were Hawkins ward patients). Five patients told us staff were disrespectful and sometimes rude. Three patients on Hawkins ward told us staff did not stop bullying from other patients. Two patients on a low secure ward told us they felt like they were in prison. Two patients told us they were not treated well. Two patients told us that night staff speak in their own language and two patients told us that night staff have been asleep, including when on patient observations.

We spoke with 14 carers.

At the psychiatric intensive care unit, we spoke with two carers who gave positive feedback about the staff. They said they felt well informed and could always talk to a staff member on the telephone.

Summary of this inspection

At the forensic service we spoke with four carers. All carers were positive about the service. They felt staff were efficient and understanding and staff they had spoken with seemed to know their relative well. They all said they received information about care reviews. One carer said her relative felt very safe at the hospital and three carers felt their relatives had continued to make good progress in the last year despite COVID-19 restrictions. Three of the four carers said their relatives had benefitted from very good physical healthcare at St Andrews.

At the long stay / rehabilitation wards for working age adults we spoke with two carers. One carer told us staffing levels affected patients Section 17 leave.

At the wards for people with learning disability or autism we spoke with six carers. Four carers (Acorn ward) expressed that communication from the service was poor describing it as “awful” and “non-existent”. One carer told us that staff were “indifferent”. One carer expressed frustration at trying to work with the service to support their relative and said they had “lost faith in them” (the service). One carer told us staff do not inform them about incidents despite an Irish High Court order stipulating the family must be kept informed. One carer said they strongly dispute the provider’s claim on their website that they work alongside families and told us they are not involved in care planning even though their son has consented to this. However, the other two carers reported positive experiences of their loved one’s care on Brook and Acorn wards.

How we carried out this inspection

The inspection team visited services and wards between 6 July and 8 July 2021 on 20 and 21 July 2021 and completed further off-site inspection activity until 5 August 2021. During the inspection we:

- Visited the service and observed how staff cared for patients
- Toured the clinical environments
- Looked at the medicine management on the wards
- Spoke with 43 patients that were using the service
- Interviewed 98 staff and managers, including ward managers, clinical leads, doctors, nurses, healthcare assistants, psychologists, occupational therapists, technical instructors and social workers
- Interviewed eight senior managers and the provider’s quality improvement lead
- Spoke with 14 carers
- Observed two community meetings, one staff debrief and two handovers
- Observed six episodes of care activities
- Reviewed 62 patient care records
- Reviewed policies and procedures relevant to the running of the service.

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

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider 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:

Summary of this inspection

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

- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure lessons learned are shared with the whole team when things go wrong. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure leadership, governance and culture supports the delivery of high-quality person-centred care. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure improvements are identified and shared within the team. (Regulation 17(1) (2) (a))
- The provider must ensure staff are informed and understand how their role contributes to achieving the strategy. (Regulation 17(1) (2) (a))

Forensic inpatient/secure wards core service:

- The provider must ensure that staff protect patient's privacy and dignity when patients are in seclusion. (Regulation 10 (1))
- The provider must ensure that all nurse call alarms are working and not damaged. (Regulation 12 (1) (2) (e))
- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that all registered nurses have completed immediate life support training. (Regulation 12 (1) (2) (c))
- The provider must ensure seclusion room environments meet the Mental Health Act Code of Practice. (Regulation 12 (1) (2) (d))
- The provider must ensure patients are not secluded for longer than required. (Regulation 13 (1) (4) (b) (c) (d)
- The provider must ensure that all staff can recognise and report safeguarding incidents. (Regulation 13 (1))
- The provider must ensure that staff complete all care plans and progress notes fully, correctly and in a timely manner. That staff clearly record patients consent to treatment in the care plan and record the details of best interest meetings and decisions when applicable. (Regulation 17 (1) (2) (c))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))

Long stay / rehabilitation wards for working age adults core service:

- The provider must ensure effective discharge plans are in place for all patients. (Regulation 9 (3(b))
- The provider must ensure emergency resuscitation equipment is available on every ward. (Regulation 12 (1) (2) (e))
- The provider must ensure sharps logs are completed accurately on all wards. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure seclusion rooms do not contain blind spots and sharp edges on the viewing panes are mitigated. (Regulation 12 (2) (d))
- The provider must ensure there are oxygen signs on the clinic room door. (Regulation 12 2 (d))
- The provider must ensure all blind spots in the Spencer North and Spencer South communal areas are mitigated. (Regulation 12 2 (d))
- The provider must ensure clinic rooms are suitable and suitably equipped to meet patient needs on all wards. (Regulation 12 (2) (e))
- The provider must ensure all staff have undertaken safeguarding level three training where it is a requirement for their role. (Regulation 13 (1) (2) (3))
- The provider must ensure staff report and record all incidents appropriately, notifying external agencies when required. (Regulation 12 (1) (2) (a) (b))

- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))

Wards for people with learning disabilities or autism core service:

- The provider must ensure the service provides a range of care and treatment suitable for the patients in the service. (Regulation 9 (1) (a) (b) (c))
- The provider must ensure that staff support, inform and involve all families or carers in line with patient wishes. (Regulation 9 (1) (3) (f))
- The provider must ensure the wards respond to the needs of patients with autism in the ward environment. (Regulation 9 (1) (a) (b) (c))
- The provider must ensure staff treat patients with kindness, respect and dignity at all times, including use of appropriate language. (Regulation 10 (1))
- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure staff report and record all incidents appropriately, notifying external agencies when required. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that the environment is well maintained, safe and clean. (Regulation 12 (1) (2) (a) (b) (d))
- The provider must ensure staff complete individual risk assessments and care plans for all patients. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure the proper and safe management of medicines. (Regulation 12 (1) (2) (g)
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation and section 17 leave. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure seclusion room environments meet the Mental Health Act Code of Practice. (Regulation 12 (1) (2) (d))
- The provider must ensure staff complete and update their mandatory training. (Regulation 12 (1) (2) (c))
- The provider must ensure staff meet patient's physical healthcare needs. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure patients are not secluded for longer than required. (Regulation 13 (1) (4) (b) (c) (d)
- The provider must ensure all staff are aware of what constitutes a closed culture. (Regulation 13 (1) (2))
- The provider must ensure they respond to all patient complaints in line with policy and procedure. (Regulation 16 (1))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure their data is accurate. (Regulation 17 (1) (2) (d))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))
- The provider must ensure that staff receive the required specialist training to carry out their roles effectively. (Regulation 18 (2) (a))

Action the service SHOULD take to improve:

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

- The senior leadership team should continue to improve connections with frontline staff (Regulation 17 (1) (2) (e) (f))

Forensic inpatient/secure wards core service:

- The provider should ensure that all staff follow infection prevention and control procedures. (Regulation 12 (1) (2) (h))
- The provider should ensure that staff include all potential ligature risks on their ligature assessments and audits. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure that staff are aware of and follow the mitigation for all blind spots. (Regulation 12 (1) (2) (a) (b))

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- The provider should ensure that there is adequate medical cover on all wards. (Regulation 18 (1))
- The provider should ensure staff have access to regular team meetings and reflective practice sessions. (Regulation 18 (2) (a))
- The provider should ensure that senior managers are visible on the wards and make themselves accessible to staff and patients. (Regulation 17 (1) (2) (e) (f))
- The provider should ensure that the recording of staff supervision is robust. (Regulation 17 (1) (2) (d))

Long stay / rehabilitation wards for working age adults core service:

- The provider should mitigate all ligature risks in communal areas even if the area is not in use. (Regulation 12 (1) (2) (a) (b) (d))
- The provider should ensure auditing systems are in place to ensure all incidents are reported and actioned appropriately. (Regulation 17 (1) (2) (f))
- The provider should ensure issues raised by patients and staff are addressed in set timescales. (Regulation 17 (2 (e))
- The senior leadership team should continue to improve connections with frontline staff (Regulation 17 (1) (2) (e) (f))

Wards for people with learning disabilities or autism core service:

- The provider should ensure they meet the cultural and spiritual needs of all patients. (Regulation 9 (1) (b) (c))
- The provider should ensure that robust and effective handovers take place to ensure that information about risk and patients' care is communicated to support patient safety. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure that the service reviews the use of blanket restrictions. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure they provide outcomes to issues raised in governance meetings. (Regulation 17 (1) (2) (e) (f))
- The provider should ensure that staff feel able to raise any concerns without fear of retribution from senior managers. (Regulation 17 (1) (2) (e)
- The senior leadership team should continue to improve connections with frontline staff (Regulation 17 (1) (2) (e) (f))
- The provider should ensure staff have access to regular team meetings. (Regulation 18 (2) (a))
- The provider should ensure staff receive regular supervision. (Regulation 18 (2) (a))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Wards for people with learning disabilities or autism	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Inadequate	Inadequate
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

Requires Improvement

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Not all wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and updated risk assessments of all ward areas to highlight ligature points, however, staff had not identified exposed leads for the games console on Fairbairn ward as a potential ligature risk. The mitigation for ligature points, as stated on the risk assessment, was that all patients had individual ligature risk assessments. We looked at three patient care records on this ward and none of them had individual ligature risk assessments. A manager confirmed they did not complete these risk assessments for patients.

While staff could observe patients in all parts of the wards, we found blind spots in the courtyards on Cranford and Robinson wards that staff had not included on the environmental risk assessments. The mitigation for blind spots on the wards was that for areas which staff could not monitor by mirrors or closed circuit television cameras, staff would supervise patients in the area. We saw that staff left the doors to the courtyards open so patients could easily access areas where there were blind spots in the outside area, and there were no staff in the area to observe patients going out.

The ward complied with mixed sex guidance; all wards were male only.

Five out of twelve staff call alarms were either not working or damaged. During the inspection the team was issued with 12 call alarms. We found two that did not work which ward staff exchanged for us, and a further three had broken and staff repaired with tape.

All patients had easy access to nurse call systems that were working, either personal alarms where staff completed a risk assessment or alarm buttons in patient areas and bedrooms.

Maintenance, cleanliness and infection control

Except for some minor damage in the seclusion rooms, all ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up to date.

Most staff followed infection control precautions and sanitisers and face masks were readily available on all the wards. However, on Cranford ward not all staff were using the handwashing station or sanitiser every time they left or came onto the ward. On Cranford ward and Rose wards staff were not wiping down all shared equipment and tables in the nursing office. This meant that staff were not following all COVID-19 cleaning guidance.

Seclusion rooms

Seclusion rooms on all wards met some, but not all the guidance in the Mental Health Act Code of Practice.

Cranford ward seclusion room had two screws in the light fitting that needed securing. On Fairbairn ward the seclusion room was in long term occupation. We saw that the mattress was damaged.

On Prichard ward there was staining on the window surround and on Robinson ward there were stains around the closed circuit television camera. A second seclusion room on Robinson ward was not in use and converted into a de-escalation room. On Rose ward the viewing panel in the door was obscured by scratches this meant that line of sight was obscured. On Prichard and Rose ward seclusion rooms staff were unable to open the window blinds.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing or support staff. However, staff received basic training to keep people safe from avoidable harm.

Nursing staff

Staff, managers and patients we spoke with told us there were not enough staff on the wards to meet their needs. However, data submitted by the provider showed this service was over establishment during the period 1 April 2021 to 30 June 2021. However, managers told us the over establishment was due to staff recruited to the new Mackaness ward, due to open at the end of June 2021 currently working on Prichard ward as part of their induction process.

We spoke with 27 staff members, seven managers and 17 patients. All staff, four managers and eight patients told us there were not enough staff to meet all their needs. One staff member on Rose ward and a manager explained that safe staffing numbers were inaccurate because two staff members were currently nursing a Rose ward patient on another ward, thereby reducing the safe staffing numbers available on Rose ward by two staff, before any other absences.

On Rose ward on 7 July 2021 we noted that safe staffing levels were 11 and optimal staffing levels were 12. On this day the shift started with six staff and by 9.30 they had nine staff (this included an occupational therapy assistant acting as healthcare support workers). By lunchtime another staff member from Prichard ward appeared and the ward worked with ten staff for the remainder of the shift. The ward needed to use members of the multidisciplinary team in support

worker roles to ensure the ward met safe staffing levels. The clinical nurse lead, who was managing the ward that day in the absence of the ward manager, took on nursing duties as well as the management role. On the 8 July 2021 the ward was again short staffed by 2 people. On this occasion the inspector had to wait 15 minutes before a staff member was available to let them off the ward.

Staff and patients gave multiple examples of how staffing shortages impacted patient care. This included; disruption to patients routines, delays in responding to patient safety incidents, issues with the quality of patient records as time to write detailed notes and upload relevant documentation was not available to staff, staff ability to undertake safety checks and managers difficulties in providing effective and meaningful team meetings.

Registered nurse vacancy rates were 33% on Robinson ward; Rose 20%; Fairbairn 20% Cranford 12%, while Prichard was 7% over establishment, due to Mackaness staff temporarily working on this ward. Healthcare support worker vacancy rates were 9% on Robinson ward. While Prichard wards was 23% over establishment, Rose was 4% over establishment; Fairbairn 2% and Cranford 18% over establishment. This was due to Mackaness staff temporarily working on these wards.

Data relating to use of qualified agency staff across the directorate between 1 April 2021 and 30 June 2021, was 2%. While the use of bank staff including qualified and unqualified staff across the division was 19%.

The number of shifts filled by qualified agency staff was 2%; and unqualified agency staff was 3%. The number of shifts filled by bank qualified nurses was 9% and unqualified bank staff 22%. Less than 0.02 % of shifts were unfilled.

Staff turnover for the period 1 April 2021 to 30 June 2021 was 7% across all wards. Staff sickness for the period 1 April 2021 to 30 June 2021 was 8%.

Medical staff

Wards had enough daytime and night-time medical cover and a doctor was available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover. However, one manager told us that getting locum doctor cover was sometimes difficult for the specialist wards. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Overall mandatory training compliance for the service in June 2021 was 90% for ward staff. However, immediate life support (ILS) for registered nurses was low at 54%. This posed a risk to patients as immediate life support may be required to save a patient's life in emergency situations.

Assessing and managing risk to patients and staff

Staff did not always manage all risks to patients or themselves. However, staff did use best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Requires Improvement

Forensic inpatient or secure wards

We reviewed 17 patient care records. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff also completed a COVID-19 screening risk assessment on admission.

Management of patient risk

Most staff knew about the risks to patients and usually acted to prevent or reduce risks. Most staff could identify and respond to changes in risks to, or posed by, patients. Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Staff had not completed patients observations correctly. We sampled ten patient's observation records across the service covering three weeks prior to inspection. On Fairbairn ward for the week commencing 01 July 2021 there were two gaps in the observation records for one patient. On Robinson ward for week commencing 20 June 2021 there was one gap in the observation record for one patient. We reported on this issue at inspection in July 2019. On Robinson, Cranford and Fairbairn wards we saw that staff had been observing patients for continuous periods of up nine hours without a break. This does not meet the requirements of the National Institute for Health and Care Excellence guidance which states that staff should break between patient observations every 60 minutes to two hours. This meant that staff could become fatigued with loss of concentration and may not be aware if a patient was in danger or not.

Use of restrictive interventions

Levels of restrictive interventions remained stable.

Between 01 April 2021 to 30 June 2021 there was one use of rapid tranquilisation on a patient across all wards, on Cranford ward. Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

From June 2020 to June 2021 the number of seclusions by ward was; Prichard 27; Robinson 20; Rose 42; Fairbairn 18 and Cranford nine. Between 1 April 2021 and 30 June 2021 there were three episodes of long term segregation across all wards.

Staff did not always keep clear records or follow best practice guidelines when patients were in long term segregation or seclusion.

We reviewed seclusion paperwork of a Rose ward patient who was secluded on Fairbairn ward three times. The paperwork met some, but not all the guidance in the Mental Health Act Code of Practice. In one episode of seclusion, two medical reviews of the patient's seclusion were missing from the records. It was unclear from the patient's records when the seclusion ended. In the second episode of seclusion, the duty doctor decided to reduce the frequency of the medical reviews to twice daily, however, there was no recorded rationale for this. There were no recorded continuing medical reviews every four hours until the first multidisciplinary team review. The third record was contradictory. While a nursing review stated that the patient was awaiting transfer to an extra care facility when one became available. A ward round entry indicated that the patient had been, "relatively stable for the past two weeks whilst in seclusion" and would only move into long term segregation once there was enough staffing and an extra care suite available. For each episode of patient's seclusion, there was no evidence of an independent multidisciplinary team review after eight consecutive hours of the patient's seclusion. The patient's care plans gave no information about their privacy within the seclusion room en suite. We also noted that staff did not always fully complete food and fluid charts.

Requires Improvement

Forensic inpatient or secure wards

Long term segregation paperwork for a Rose ward patient did not identify the roles of staff involved in the decision-making process. There was a lack of therapeutic intervention to end the patient's long term segregation. Staff did not follow the patients care plan as the care plan stated the patient should have the support of two staff unless the patient requested, they leave, or the patient became threatening or hostile. However, on three separate occasions we saw that two staff were observing the patient from the nurse's office via a closed circuit television camera, with little or no direct contact. A sample of the patient's hourly observation sheets showed that at times, one member of staff only observed the patient. Over a ten-day period, staff had spent a total of ten hours face-to-face with the patient. On one date, the patient requested to go to the on-site café, however, there was a lack of staff to facilitate this. There was no evidence of the multidisciplinary team's consideration of the patient's reintegration to the ward. Two daily reviews by the responsible clinician were missing. There were no records of a periodic review by an independent senior professional. The three-month review of the patient by an external hospital was discontinued as the patient refused to speak with the doctor remotely. There was no evidence that any further attempts were made to engage with the patient.

The long term segregation paperwork for a Rose ward patient who was in long term segregation on Fairbairn ward, showed the paperwork met some, but not all the guidance in the Code of Practice. Staff had not recorded the roles of all staff involved in the decision for long term segregation. Staff were caring for the patient in the low stimulus and seclusion areas of Fairbairn ward, because there was no other suitable accommodation available. The patient had no access to secure outdoor areas. Staff had not informed the safeguarding team and the independent mental health advocate of the patient's long term segregation. We were unable to find reasons as to why this was the case. There was a lack of therapeutic intervention to end the patient's long term segregation. Whilst we noted two members of staff observed the patient within eyesight, we saw a period of two hours where only one member of staff was identified.

While we found clear rationale for the use of long term segregation for a patient on Prichard ward, we noted this would not end until commissioners identified a bespoke package of move on care. This meant the patient could remain in long term segregation indefinitely. However, there was evidence of commissioner involvement and agreement with this decision.

Staff took part in the provider's restrictive interventions reduction programme, which met best practice standards. Staff attempted 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.

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

Safeguarding

While 97% of staff had completed safeguarding adults and children levels 1 and 2 training and 84% of staff had completed level 3 safeguarding training, staff had not recognised or reported all safeguarding incidents.

25 out of 27 staff and seven managers, could explain how to protect patients from abuse. However, we found one financial safeguarding incident in patient notes on Robinson ward that staff had not recognised or reported as an incident or safeguarding concern. We raised this with the ward manager on day one of the inspection. Despite this, when we checked records at the end of our site visit (two days later) the manager had failed to report or process the safeguarding incident.

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

Staff followed clear procedures to keep children visiting the ward safe.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information, and while patient records were easy to maintain staff told us that due to short staffing on the wards, they often had little time to ensure the records were of high quality. Other staff told us they sometimes forgot to complete daily care records when managers moved them from one ward to another during a shift.

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

Staff stored records securely.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

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

Staff followed current national practice to check patients had the correct medicines.

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 that staff did not control people's behaviour by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

The provider reported the following incidents:

From 1 April 2021 to 30 June 2021 there had been 38 incidents on Cranford ward; 59 incidents on Fairbairn ward; 22 incidents on Prichard ward; 16 incidents on Robinson ward and 83 incidents on Rose ward.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers did not always share lessons learned from investigated incidents with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Requires Improvement

Forensic inpatient or secure wards

While all 27 staff we spoke with knew of the providers incident reporting policy and could give examples of some incidents and near misses to report and how to report them, we could not be assured that all staff knew when to escalate a safeguarding incident such as the financial issue reported above.

Staff understood the duty of candour. They gave examples of when they had been open and transparent and gave patients and families a full explanation when things went wrong. Staff provided an explanation to the patient affected by the actions of staff causing him to have high potassium foods.

Managers debriefed and supported staff and patients after any serious incident. The service recently introduced a new way of ensuring staff received debriefing after incidents. We saw evidence of this effectiveness where debriefs with staff increased by 21% during the three weeks before our inspection.

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

Staff received feedback from the investigation of incidents, both internal and external to the service. There was evidence that managers made change as a result of feedback such as COVID-19 relating deaths, and recent assaults on staff by patients. Staff completed recommendations such as undertaking refresher courses in de-escalation strategies.

Managers shared learning about never events with their staff. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. The service experienced eight deaths during the first wave of the COVID-19 pandemic from which lessons were learned and implemented about correct use of personal protective equipment and isolation. However, on Cranford ward staff were not always using the wash room facility or sanitiser when entering and leaving the ward.

Are Forensic inpatient or secure wards effective?

Requires Improvement

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission and produced individual personalised care plans for each patient. Five of the eighteen care plans we looked at were not complete and staff had not followed up on the progress notes.

We looked at 18 patients care plans and tracked through six patient care notes. Staff completed well formulated care plans for 13 out of 18 patients which included management plans for patients' identified risks and linked to the individuals positive behavioural support plans.

Staff did not always meet patients physical healthcare needs. Records showed that on three occasions staff had not followed a patient's specialist dietary care plan for kidney disease. Staff had given the patient food that on the third occasion caused a spike in his potassium levels leading to temporary paralysis of his limbs.

A second care plan showed a patient with a very high BMI, multiple physical health needs and a requirement for regular National Early Warning Score (NEWS) monitoring. However, the plan did not include any weight management interventions, and staff had not recorded the National Early Warning Score (NEWS) regularly between 13 June 2021 and 04 July 2021.

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, yet progress notes showed that staff did not always update care plans and implement care review changes in a timely manner.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. In most cases staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. Staff participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance such as National Institute for Health and Care Excellence.

Staff identified patients' physical health needs and recorded them in their care plans. Prichard ward introduced a cycling workshop giving patients' the opportunity to improve cycling ability and go out on their cycles when they use their grounds leave. As part of this project workshop staff encouraged patients to refurbish cycles for use in the programme.

Staff made sure patients had access to physical health care, including specialists as required.

In most cases staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. However, we found evidence of one patient who had not received foods in line with his dialysis care plan. The provider recognised this, addressed the issue with the patient and the staff caring for him provided a written apology to the patient.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes, including National Early Warning Score (NEWS), Health of the Nation Outcome Scales (HoNOS), Model of Human Occupation (MOHO) and Model of Creative Ability (MOCA).

Staff used technology to support patients, such as communication boards and language applications on smart phones and tablets.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Examples included making easy read versions of all care records to aid patients understanding, and development of a physical health passport for patients to retain as they move around and through healthcare services.

Managers used results from audits to make improvements, for example, the review of serious incidents audit to streamline the reporting process and link reports within the electronic database. A review of care records and an audit of observational records led to changes in ward recording processes.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided an induction programme for new staff including agency and locum staff.

However, the recording of supervision processes offering staff opportunities to update and further develop their skills were not robust and we were not assured of the quality of staff supervision.

The service had access to a full range of specialists to meet the needs of the patients on the ward.

Managers ensured staff had the right basic skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Appraisal compliance rates at June 2021 were 100% on all wards except Prichard at 81%. We requested supervision data from the provider twice and this was not supplied, therefore we are unable to report on their supervision rates. The processes for recording supervision notes was not robust. We could not be assured about the quality or content of supervision for qualified and unqualified nursing staff. The providers policy did not require staff to keep any records of supervision, therefore it was not clear as to how the provider was assured that supervision enabled staff to carry out the duties they were employed to perform and how the provider continually assessed staff competency and capability. Fifteen of the 17 staff and four of the seven managers we spoke with confirmed they had supervision and reflective practice but ten felt the quality of supervision was poor and they could not necessarily recall what they discussed. No one had records or proof of what they discussed with their supervisor.

Members of the multidisciplinary team had their own effective professional supervision processes.

Managers told us that while they tried to hold regular team meetings, low attendance at the meetings due to staffing pressures on the wards meant that managers had to cancel some team meetings and others were not effective or meaningful. Our review of team meeting minutes across the service confirmed this. Managers told us that to ensure staff received all relevant key information they used staff e mail and staff handovers.

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

Managers made sure staff received any specialist training for their role.

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

Requires Improvement

Forensic inpatient or secure wards

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early in the patient's admission to plan discharge.

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

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

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

Ward teams had effective working relationships with external teams and organisations.

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.

Most staff kept up to date with training with 86% completing training on the Mental Health Act and the Mental Health Act Code of Practice. Twenty four out of 27 staff we spoke with, and all managers, could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

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 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 agreed with the Responsible Clinician and, or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. There were no informal patients on the wards we visited.

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

Requires Improvement

Forensic inpatient or secure wards

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves and understood the trust policy on the Mental Capacity Act 2005. Despite this, five out of six records we looked at staff had not clearly identified the capacity assessment and we saw no evidence of best interest meetings taking place.

Most staff kept up to date with training with 86% completing Mental Capacity Act training and 24 out of 27 staff and all managers we spoke with, understood the five principles.

There were seven deprivations of liberty safeguards applications made in the last 12 months and managers knew which wards made the highest number of referrals and staff monitored them correctly.

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

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. However, staff had not clearly identified patient's capacity to consent in five out of six records we looked at. Three care plans did not have clearly identified capacity assessments, or best interest meetings, even though staff identified concerns around the patient's capacity to make informed decisions about some aspects of their health care needs.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

While there were systems in place for monitoring compliance with Mental Capacity Act processes this audit had not picked up the gaps in capacity to consent.

Are Forensic inpatient or secure wards caring?

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion and support

Staff did not recognise that they were not respecting the privacy and dignity of a patient cared for in long term segregation on Fairbairn ward.

In most cases staff were discreet, respectful, and responsive when caring for patients. However, in respect of one patient staff cared for in prolonged seclusion on Fairbairn ward, the patient had to eat their meals off the mattress, floor or their

lap. We were concerned that this compromised the patient's dignity. We noticed the closed circuit television camera monitors for the seclusion room and en suite were switched on. We asked the doctor if the closed circuit television cameras could be turned off when the patient was using the toilet and it was safe to do so. The doctor told us that this was the provider's policy and there were not enough resources to assess that situation.

Staff gave patients help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly. Staff understood and respected the individual needs of each patient.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

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

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

We spoke with 17 patients.

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

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, such as using word files, white boards, specialist electronic applications, Makaton and sign language.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions on their care. Staff made sure patients could access advocacy services.

Involvement of families and carers

We spoke with four carers.

Requires Improvement

Forensic inpatient or secure wards

All carers confirmed that staff informed, supported and involved them appropriately.

Carers commented positively about their involvement with care planning, how staff kept them informed of their relative while at the hospital and the access and support they received from the carer's hub on the hospital site.

Staff helped families to give feedback on the service. Staff gave carers information on how to find the carer's assessment.

Are Forensic inpatient or secure wards responsive?

Good

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Bed management

Data for June 2020 to June 2021 showed bed occupancy on the wards as Prichard 96%; Robinson 93%; Rose 92%; Fairbairn 99% and Cranford 70%. Managers held regular bed meetings to monitor bed occupancy and patients always had their bed available after periods of leave.

Managers monitored and reviewed length of stay for patients to ensure they did not stay longer than they needed to.

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

Staff only moved patients between wards when there were clear clinical reasons to do so, 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.

Discharge and transfers of care

The service had variable numbers of delayed discharges in the past year as follows; Prichard six; Robinson nine; Rose three; Fairbairn one and Cranford five. Managers monitored the number of delayed discharges. The only reasons for delaying discharge from the service were clinical reasons.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients during referral to the ward or transfer between services.

The service followed national standards for transfer.

Requires Improvement

Forensic inpatient or secure wards

Facilities that promote comfort, dignity and privacy

While the design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity, the seclusion room on Fairbairn, where staff nursed a patient in prolonged seclusion, did not meet all his requirements. On the wards each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality. Patients could access cold drinks and make hot drinks at any time subject to individual risk assessment, and while most wards had set snack times, staff could explain the rationale for this on grounds of overall patients' safety.

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

Patients had a secure place to store personal possessions.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

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

Patients could make their own hot drinks and snacks and were only dependent on staff to make these when their risk assessment indicated this was not safe.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients.

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

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

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 made adjustments for disabled people and those with communication needs or other specific needs.

Wards were dementia friendly and supported disabled patients.

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

The service had information leaflets available in languages spoken by the patients and local community.

Requires Improvement

Forensic inpatient or secure wards

Managers made sure staff and patients could get help from interpreters when needed.

While the service provided good quality food, that met the dietary and cultural needs of individual patients. Five out of seventeen patients we spoke with said the food was not varied enough.

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.

Patients, relatives and carers knew how to complain or raise concerns.

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

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

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

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

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

The service used compliments to learn, celebrate success and improve the quality of care.

Are Forensic inpatient or secure wards well-led?

Requires Improvement

Leadership

Senior leaders were not always visible on the wards. Two managers told us they did not feel supported by senior leaders on matters such as staffing levels and recording supervision. These managers told us they felt senior managers did not fully appreciate the pressures faced by staff on the wards and their focus was on different priorities for the service.

However, at ward level, leaders had the skills, knowledge and experience to perform their roles but sometimes felt frustrated they could not rectify issues such as staffing levels. They had a good understanding of the services they managed, were visible on wards and approachable for patients and staff.

Requires Improvement

Forensic inpatient or secure wards

Vision and strategy

Staff could describe the provider values of Compassion, Accountability, Respect and Excellence and could evidence how they applied these values in their day to day work. However, they felt frustrated and could not understand why the organisation implemented yet another re-structure to create divisions, before giving the earlier restructuring a chance to prove itself.

Culture

Staff we spoke with did not feel respected, supported or valued by senior management. They acknowledged that the organisation had become better at promoting equality and diversity in daily work and the organisation provided opportunities for development and career progression. Staff felt senior managers still did not appreciate the work staff did or the pressures they were under because of insufficient staffing numbers on the wards. Staff described this impacted upon their physical and mental health and morale was low.

We completed seven manager and clinical nurse lead interviews. While all managers and clinical nurse leads acknowledged the serious issues with staffing and supervision and we saw how managers tried to escalate these issues to senior management on several occasions, they felt this had not been effective.

Governance

Governance processes were not always robust. Managers used governance dashboards and the provider held regular governance meetings with a clear framework of what was discussed and how this was fed back to staff, yet managers were not using monitoring systems effectively. This gave rise to the issues we found in the above key questions.

Managers were not monitoring and addressing issues of blind spots in all the ward courtyards, damaged staff emergency alarms, lack of handwashing when entering and exiting Cranford ward, or cleaning of shared equipment in the nursing offices. Managers were not monitoring completion of observation records or staff breaks from observation duties, seclusion paperwork or staff's adherence to care plans for people in seclusion or long term segregation. However, the provider had improved their monitoring of seclusion practices since the previous inspection in 2018. Managers were not monitoring the recording of capacity to consent and were not always able to ensure the privacy and dignity of a patient in long term segregation on Fairbairn ward. Managers were not ensuring that all registered nurses completed immediate life support training.

We could not be assured of the quality of supervision for nurses and healthcare support workers. The providers policy did not require staff to keep any records of supervision, therefore it was not clear as to how the provider was assured that supervision enabled staff to carry out the duties they were employed to perform and how the provider continually assessed staff competency and capability. We requested supervision data from the provider twice and this was not supplied, therefore we are unable to report on their supervision rates. This meant that there was no evidence when poor performance had been addressed, what support had been given to staff as part of their welfare or what advice, support or specialist training staff received to enable them to work with patients safely. Fifteen staff interviews confirmed they had regular supervision and reflective practice, but ten staff felt the quality of supervision was poor, they could not necessarily recall what they discussed and had no records or proof of what had been discussed.

The providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data.

Requires Improvement

Forensic inpatient or secure wards

Management of risk, issues and performance

We could not be assured that all managers would recognise and identify all potential risk issues. While managers were aware of and addressed most risk issues that arose on the wards and addressed poor staff performance once they had become aware of it, due to the governance issues reported above we were not assured that all areas of risk would be identified and acted upon.

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

The provider had a directorate level risk register in place. The risk register matched the concerns of staff on the ward but had not addressed the main concern about staffing levels.

Information management

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

The provider used a dashboard system to collect data from the ward, and this was not burdensome on staff. The provider used key performance indicators to monitor the ward that included training, incidents and restraint.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

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

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

All wards were well equipped, well furnished, well maintained and fit for purpose. However, wards were not always clean or safe.

Safety of the ward layout

Staff had not identified all environmental risks and ways to mitigate them.

Staff could not observe patients on all parts of the wards. The ward gardens of Spencer North and Spencer South each had a blind spot where staff could not always clearly observe patients who accessed the far corners of the gardens. When we raised this with staff on the wards, they told us the blind spots were mitigated as staff would always accompany patients in the garden. However, during our inspection we observed multiple occasions where patients were not accompanied in the gardens by staff. Staff were not aware of these blind spots until they were raised during our inspection.

There was a potential ligature anchor point in the service that staff did not know about. Spencer South ward had a mirror in the bathroom of the accessible bedroom which had not been sealed effectively and presented a ligature risk for patients. However, this bedroom was not in use at the time of the inspection. The provider advised a review and risk assessment of the room would be carried out before a patient was admitted.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Staff did not always make sure the general cleaning records were up to date and the premises were clean. On Spencer North we observed staff had not swept the floor in the dining room after meals and there was food residue on the floor when we visited the ward on 6 July 2021. Staff told us this was because the ward cleaner was absent and ward staff were responsible for cleaning tasks that day. One patient told us the ward was usually clean. When we visited on the second day, we found Spencer North was clean.

Not all staff followed infection control policy and national COVID-19 guidelines. Staff had not completed touch point cleaning records on any wards and we did not observe any touch point cleaning during our onsite inspection. Touch point cleaning is regular cleaning of frequently touched areas and is required to be completed as part of the provider's response to the COVID-19 pandemic. When we raised this with staff on the day of the inspection, they informed us this used to be completed but was no longer necessary. This put patients and staff at an increased risk of infection from COVID-19. During the inspection, we observed seven staff from Spencer North and Spencer South not wearing face masks in accordance with national COVID-19 guidelines. For example, wearing their masks below their nose. However, all staff were bare below the elbows, hand sanitiser was available on all the wards and good hand hygiene posters were on display.

We found staff did not always follow food hygiene practices. Staff on Spencer North and Spencer South wards had not labelled opened food items in the fridge stating when they had been opened and when they should be consumed by. This continued to be a concern since our previous inspection in March 2018. This increased the risk of patients consuming food that has spoiled and not suitable for consumption.

Seclusion room

The seclusion room on Spencer South and Spencer North had toilet facilities, a visible clock and allowed two-way communication. However, when we visited, we found partial blind spots in both seclusion rooms of which the staff on the ward were not aware. These were in the toilet area in Spencer South's seclusion room and within the main area of Spencer North's seclusion room. Staff could only see a patient's legs and nothing above their waist. We also found the inside of the viewing pane had sharp edges within Spencer South's seclusion room. This increased the risk of patients harming themselves when using the seclusion facilities.

Clinic room and equipment

Spencer North and Spencer South clinic rooms were visibly clean and had enough space to prepare medication and undertake physical examinations. However, we found the clinic room in Berkeley Lodge was cramped and did not allow space for more than one person. Staff told us patient bedrooms would be used if a physical examination was required.

Staff calibrated and checked equipment weekly across all three wards to ensure physical health monitoring equipment was in good working order.

Emergency resuscitation equipment was not easily accessible on two of the three wards. Berkeley Lodge did not have emergency resuscitation equipment in the building. The nearest equipment was situated in Berkeley Close and required staff to cross a road and get through multiple locked doors. However, staff knew where to find the equipment if required. Spencer North ward did not have emergency resuscitation equipment on the ward. The nearest equipment was on Spencer South, which was in the same building but accessed through two air lock doors. Staff completed regular checks of the emergency equipment. All three wards did not have oxygen signs on the clinic room doors. The oxygen cylinder in Spencer North was not secured to the wall in the clinic room.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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 did have enough nursing and support staff to keep patients safe, but did not always have enough staff to meet patient preferences. The optimum staffing levels for Spencer North and Spencer South was two qualified nurses and four health care assistants. The optimum staffing for Berkeley Lodge was two qualified nurses and two health care assistants. The optimum staffing figure is the number of staff needed to meet people's needs. On Spencer North and Spencer South staff told us multi-disciplinary team members regularly supported ward staffing numbers to reach safe staffing levels. The safe staffing figure is the minimum number of staff needed to keep patients safe. Between 5 July 2021 and 9 July 2021, records showed that on two occasions multi-disciplinary team members needed to support the ward staffing numbers.

Patients had regular one to one sessions with their named nurse. 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 had low staff turnover rates. Berkeley Lodge had a turnover rate of 2% and Spencer North and Spencer South had a staff turnover rate of 1% over the last three months.

Levels of staff sickness across all three wards was above 10%. There was a clear rationale for this level of sickness, and it was not service related. Senior staff from the division met daily to ensure staff sickness and shortfalls in staffing would be covered and there would not be an impact on patient safety. This included managing sickness which had been high during the COVID-19 pandemic.

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

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. Staff told us they had access to an on-call doctor who covered services during out of hours.

Mandatory training

Staff completed and kept up to date with their mandatory training. All three wards had mandatory training completion rates above 94%.

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

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers told us they conducted a ward specific induction for new staff.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Assessing and managing risk to patients and staff

Staff did not always appropriately review risks to patients and themselves effectively. However, they achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly. However, we found patient risk assessments were not up to date with the most accurate information available because staff had not reported all incidents on the electronic reporting system. This meant important information relating to patient risks was not available to be considered as part of risk assessments.

Management of patient risk

Staff did not always act to prevent or reduce risks to, or posed by, patients. On Spencer South, we found staff did not always follow local policy and procedure to safely manage sharp items. We found staff did not always record when they had given sharps, including razor blades and scissors, to patients, and when they had been returned for safe keeping. We found an instance on Spencer South on 21 June 2021 where it appeared an item was missing, which was later returned, but there was no recorded evidence it was followed up to ensure there were no safety issues. This meant staff did not always have an accurate record of where sharps were located, which posed a risk for patients and staff. This was despite a recent serious incident which led to a review of sharps management.

Staff completed risk management plans for all patients. But we found incidents were not always reported and therefore risk management plans were not always updated after an incident occurred, this meant they were not always an accurate representation of what was needed to manage patient risks.

Staff followed organisational policies and procedures when they were required to search patients or their bedrooms to keep them safe from harm. Staff told us patient searches were carried out in line with the level of risk.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques. Staff had not used restraint for the previous three months across all three wards. Staff had not secluded any patients on Spencer South and Spencer North in the last three months. Staff had not used rapid tranquillisation in the last three months. Staff had not used long-term seclusion in the last three months. Staff told us there was clear guidance in place if this was needed.

Safeguarding

Not all 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, but they did not always know how to apply it.

All staff had completed level two in safeguarding adults and children. However, only 63% of staff on Spencer South completed level three safeguarding training and 60% of staff on Berkeley Lodge completed level three safeguarding training.

Spencer South staff did not always recognise safeguarding incidents and report them appropriately. The daily notes of one patient known to be a high risk of absconding included three incidents in May 2021 of temporarily leaving the location whilst on unescorted leave in the grounds. Staff had not reported these incidents on the electronic incident record or to the local authority safeguarding team.

Staff noted four safeguarding incidents in the daily notes of another patient on Spencer South between January 2021 and June 2021 which had not been reported on the electronic incident record or to the local authority safeguarding team. These incidents related to a known risk to the patient. This exposed patients and staff to a risk of harm as staff did not take opportunities to record, investigate and learn from incidents.

All staff we spoke to were able to state clearly how they would raise safeguarding concerns. Spencer North and Spencer South staff had access to a dedicated social worker, who was the local safeguarding lead for support in managing safeguarding concerns.

Staff followed clear procedures to keep children visiting the ward safe. Spencer North and Spencer South had a family visiting room with access to its own garden.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records.

Patient notes were comprehensive, and staff accessed them electronically.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medication.

Staff reviewed patients' medication regularly and provided specific advice to patients and carers about their medication. Staff told us they provided patients with easy read leaflets about their medication and encouraged them to read this before they started treatment.

Staff stored and managed medication in line with the provider's policy. However, we found prescribing documents needed to be archived as historic information was still stored with current records. One patient's medication record stated they were still on emergency medication which started in January 2021 even though this had previously been reviewed and discontinued.

There were no gaps in the administration records and staff discussed treatment plans with patients.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medication. Each patient had a ward round once a month where multi-disciplinary staff discussed and reviewed patient's medication.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance. We saw evidence of regular physical health checks on care records.

Track record on safety

The service had a variable track record on safety.

Berkeley Close staff reported four incidents in the previous three months. Spencer North staff reported 29 incidents in the last three months, although most incidents only involved verbal aggression.

Spencer South staff reported four incidents in the last three months. However, we found seven incidents in patient daily progress notes from January 2021 to June 2021 on Spencer South that staff should have reported.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well.

Staff did not always recognise incidents and report them appropriately. On Spencer South, staff did not record all incidents on their electronic incident reporting system.

When we asked to review the incident record system on Spencer South, one member of staff was unable to access the system and told us they cannot remember the last time they were required to do so.

Incidents not on the electronic reporting system were not investigated or reviewed.

We found learning from incidents was not always embedded across the service. Despite a recent serious sharps incident which led to changes across the service, we found staff did not always follow local policy and procedure to safely manage sharp items.

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

Managers offered support and debriefing to staff after any serious incident.

Staff met to discuss the feedback from incidents that were reported and look at improvements to patient care. All three wards had regular team meetings in place and the minutes were made available to all staff including those that could not attend.

Managers shared learning through lessons learnt across the organisation via emails titled 'Patient Safety Alerts'. These informed staff of incidents that have happened, what they have learnt from them and new practices which had been implemented as a result.

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

Requires Improvement

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Assessment of needs and planning of care

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

We looked at ten patient care records which were person centred. Records showed patients had a monthly ward round where all areas of care including therapy, leave, reported incidents and physical health were discussed before the patients care plan was updated. The records showed patients were involved in these monthly ward rounds and involved in their treatment plan.

Every patient record we looked at contained a positive behaviour support plan. A positive behaviour support plan is an individualised plan which is available to those who provide care and support aimed to reduce patient incidents before they occur by identifying early warning signs and de-escalation techniques. Staff involved patients in developing these plans.

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. However, patients told us they were not able to always access these facilities due to staffing levels and training.

Staff provided a range of care and treatment suitable for the patients in the service. However, we were told by staff and patients that occupational therapists were often asked to assist the nursing team which prevents them from being able to provide treatments to patients. On Spencer South we saw an example in a patient's record that the patient was currently unable to take part in his prescribed relaxation sessions due to a lack of staff. On Spencer North we saw a record of when a patients music therapy session had to be cut short by 35 minutes due to staff not being available to escort them to the session.

Staff delivered care in line with best practice and national guidance. Staff told us they had a clear model of practice and treatment pathways.

Staff identified patients' physical health needs and recorded them in their care plans. All care plans we looked at had physical health needs recorded.

Staff made sure patients had access to physical health care, including specialists as required. Staff told us they had access to an on-call doctor 24 hours a day.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. A patient on Berkeley Lodge told us staff were able to meet his specific dietary requirements as a Muslim.

We found the activity room was used as a general-purpose room in Spencer North, including for the use of daily handovers and psychological therapy sessions. Patients on Spencer South told us they could not access the on-site pool as staff did not have adequate training to assist them. Patients raised this at both the May 2021 and June 2021 community meetings, but staff had not been able to support due to lack of courses. On Spencer North gym equipment could not be used as it was not serviced. Patients raised this in May 2021 community meetings. The provider advised the external company responsible for servicing the equipment was not able to attend site due to COVID-19 restrictions.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

However, staff helped patients live healthier lives by supporting them to take part in programmes or giving advice using an Activities of Daily Living (ADL) kitchen.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff told us they used standardised tools to measure the effectiveness of interventions.

Staff used technology to support patients. Patients had access to computers and mobile phones. However, patients on Spencer North told us they could not always use the computer as there wasn't always enough staff to provide the required supervision.

Skilled staff to deliver care

The ward teams included, or had access to, the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, 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 on the ward. All wards had access to multi-disciplinary team including an occupational therapist, nurse, registered consultant and doctor.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers told us they could adjust their staff mix at daily divisional meetings to meet the patients' needs. However, when staff were moved it affected patient choice and access to activities and therapies.

Managers gave each new member of staff a full induction to the service and the ward before they started work.

Managers supported all staff through regular, constructive appraisals of their work. Staff told us they could approach management if they needed to.

Managers made sure staff attended regular team meetings or gave information from those that could not attend. All wards had regular monthly team meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they could request additional training through supervisions. However, they did not have the time to complete this during shifts but could complete in their own time and claim the time back.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge. However, we found staff did not engage with other agencies early in the patient's admission to plan discharge.

Staff held regular multi-disciplinary meetings to discuss patients and improve their care. Patients attended monthly multi-disciplinary ward rounds.

Staff did not always make sure they shared clear information about patients and any changes in their care. On Spencer South we found incidents had not been recorded and acted upon appropriately. However, staff told us each patient was discussed at handover meetings.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Ward teams had effective working relationships with external teams and organisations. Staff told us they worked well with external teams including the local authority.

Multi-disciplinary team staff did not plan discharge early in the patient's admission, which meant the patients care was not goal orientated. Five of the ten care plans we looked at did not have a discharge plan.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with, training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Over 92% of staff completed Mental Health Act training at the time of the inspection.

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. Staff told us they had access to the organisations policies through the shared area on the computer system.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. All three wards had advocacy information on display on patient notice boards.

Staff explained to each patient their rights under the Mental Health Act in a way they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. The wards had an effective electronic system in place to ensure this would be completed on time.

Patients could not always access section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of Justice. Staff and patients told us the time that patients were able to take leave and the length of time of their leave was regularly affected by staffing levels on the wards. We were told, and observed during our inspection, that patient leave was organised for the morning of each day as staffing levels would be reduced in the afternoon due to staff being redeployed elsewhere in the service. We were told the redeployment of staff occurred daily. This meant that patients had a lack of choice and control over when they were able to take their prescribed leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to and recorded this clearly on patient records.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed within the electronic care planning system.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff received and kept up to date with, training in the Mental Capacity Act and had a good understanding of at least the five principles. Over 92% of staff completed Mental Capacity Act training at the time of the inspection.

There was a policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff told us and records we looked at showed capacity assessments would be decision specific.

The service monitored through ward rounds how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

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

Good

Kindness, privacy, dignity, respect, compassion and 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 were discreet, respectful, and responsive when caring for patients. We observed staff assisting patients to make their beds as part of their daily routine.

Staff directed patients to other services and supported them to access those services if they needed help. Staff supported patients to access services in the community including opticians and dental services.

Patients said staff treated them well, were approachable and behaved kindly.

Staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff told us they could speak to ward managers or the freedom to speak up guardian if they had any concerns.

Involvement in care

Staff involved patients in care planning and risk assessments and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care planning and risk assessments. Patients told us they were involved in monthly ward rounds and we saw person centred positive behaviour support plans within all care plans we reviewed.

Staff ensured patients had access to independent advocates. We saw notice boards on all three wards with information on how to access an advocate.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients could give feedback on the service and their treatment and staff supported them to do this. All three wards had regular community meetings in place. Areas discussed included activities and the environment and section 17 leave.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Staff told us they provided patients with easy read leaflets and encouraged them to read them before they started treatment.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff told us family involvement would be dependent on the patient's wishes. Carers told us they could call the ward if they had any concerns. Family members told us they were informed of their loved one's care and treatment and received regular updates from the ward.

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

Requires Improvement

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

Access and discharge

Staff had not completed discharge plans in 50% of records reviewed. However, where records showed discharge plans were in place, staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Bed management

The low secure rehabilitation service was at 89% occupancy.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Monthly multi-disciplinary meetings reviewed length of stay and treatment plans.

The service had out-of-area placements as this was a specialist service.

Staff told us patients were moved between wards only when there were clear clinical reasons, 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.

Discharge and transfers of care

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Five out of the ten care plans we looked at did not have discharge plans in place. Patients told us they were not aware of their discharge plans and were not clear how long they would be in hospital. We looked at two of the five discharge plans in place. These were detailed and planned with multi-disciplinary teams. Staff carefully planned the discharge and worked with care managers and coordinators to make sure this went well.

Where discharge plans were in place, the only reasons for delaying discharge from the service were clinical.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom within Spencer North and Spencer South ward. On Berkeley Lodge all patients had their own bedroom but shared two toilets and bathrooms between three rooms. There were quiet areas for privacy. The food was of a good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. All patient bedrooms had been personalised with the patient's items.

Patients had a secure place to store personal possessions. Every patient had access to a locker.

The service had quiet areas and a room where patients could meet with visitors in private. The wards had access to quiet areas and rooms.

Patients on all three wards had access to phones to make phone calls in private.

The service had an outside space that patients could access easily. Berkeley Lodge had a horticultural garden that the patients maintained.

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients on all three wards had access to drinks and snacks throughout the day.

The service offered a variety of food. Patients told us they liked the food and when they did not, we saw patients making a joint complaint, supported by staff, which led to the service making changes.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients could carry out a range of activities through an an on-site centre called Workbridge including craft work, a café and garden centre. Patients also had on ward activities including horticultural sessions and bingo on Berkeley Lodge. The staff and patients on Berkeley Lodge told us they all participated in the weekly bingo session which was very popular.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff told us they had links to local businesses such as cafes and charity shops.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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 make adjustments for those with specific cultural needs. Patients had access to spiritual, religious and cultural support. On Berkeley Lodge one of the patients was assisted to attend a mosque every Friday and we saw a chaplain attending the wards during our inspection.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Notice boards on all three wards had a complaints policy on display. Patients we spoke to told us they could raise concerns if they had any.

Listening to and learning from concerns and complaints

The service did not always treat concerns and complaints seriously, investigate them and learn 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. Carers told us they could call the ward if they had any concerns.

However, patients told us that not all concerns were acted upon by the service.

Patients on Spencer South told us they could not access the on-site pool as staff did not have adequate training to assist them. Patients raised this at both the May 2021 and June 2021 community meetings, but staff had not been able to support due to lack of courses.

On Spencer North gym equipment could not be used as it was not serviced. Patients raised this in May 2021 community meetings. The provider advised the external company responsible for servicing the equipment was not able to attend site due to COVID-19 restrictions.

The service clearly displayed information about how to raise a concern in patient areas. All wards had patient information boards including an easy read complaints policy.

Staff understood the policy on complaints and knew how to handle them. Staff told how they would raise complaints and concerns. When complaints were investigated lessons learned would be shared with the whole team and the wider service. These were shared through team meetings.

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

Requires Improvement

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

Leadership

Ward managers had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed. However, not all staff we spoke to were aware of the wider leadership team, such as who the Executive team were.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Ward managers had a good understanding of the service they managed. They could explain clearly how the teams were working to provide high quality care. Ward managers were able to explain the role of the multi-disciplinary teams. However, six staff told us the executive team were not visible in the service or approachable for patients and staff.

Vision and Strategy

Staff did not know and understand the provider's vision and values and how they were applied in the work of their team.

The provider's senior leadership team had not successfully communicated the provider's vision and values to the frontline staff in this service. Some staff told us they did not know what the provider's vision and values were.

Staff had the opportunity to contribute to discussions about the strategy for their service through team meetings and divisional meetings.

Culture

Not all staff felt respected, supported and valued. However, they said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear, but these were not always addressed.

Multi-disciplinary team members allocated to frontline shift work due to staffing shortages stated they felt devalued and not appreciated.

Staff raised concerns within team meetings and divisional meetings with gym equipment in Spencer North in May 2021 and again in June and July 2021, but this had still not been addressed by the provider. However, the provider advised the external company responsible for servicing the equipment was not able to attend site due to COVID-19 restrictions.

There was not always evidence that changes had been made as a result of feedback. Staff being moved to other wards to assist was raised at team meetings, but this had not been addressed.

Staff felt able to raise concerns without fear of retribution. All the staff we spoke to knew who the freedom to speak up guardians were. We saw posters on the wards showing staff how they could contact them.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that risk was not always managed well.

Not all actions identified in the previous inspection had been addressed in Spencer North and Spencer South. Both wards had food in the fridge that staff had not labelled stating when they had been opened and when they should be consumed by even though this had been raised within the previous report. This increased the risk of patients consuming food that has spoiled and not suitable for consumption. This action had been identified in the inspection report and had not been addressed.

Spencer South had a recent serious incident involving sharps and staff continued to not complete the sharps logs effectively, meaning staff did not know how many sharps (including razors and scissors) were stored in the cupboard and how many sharps were with patients. This had not been identified by the management team as audits were not completed.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The management team did not audit daily notes to ensure all incidents were reported and risks were assessed.

The providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data.

Management of risk, issues and performance

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

All staff had access to the organisations policies and procedures through the shared drive on the computer. Staff told us updates would be emailed to them and discussed at team meetings.

Learning, continuous improvement and innovation

The service had processes to ensure lessons were learnt from incidents through team meetings and patient safety alerts. However, we found evidence that not all learning from incidents was fully embedded on the wards which increased the risk of reoccurrence.

Inadequate

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Not all wards were clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

On Fern ward there was no fire extinguisher or fire blanket in the kitchen. Inspectors alerted the ward manager who advised they would address the issue. The provider told us a fire blanket had been made available.

Staff could not always observe patients in all areas of the wards. On Hawkins ward the view from the office into the communal areas was not clear due to scratched windows. In the long term segregation area on Marsh ward staff told us about a blind spot in the bedroom area. The blind spot was where the patient's bed was located, this did not allow staff to see the patient's full body and the head area was obscured. Due the patient's sensory needs he preferred the lights to be switched off. Staff told us and showed us that it was difficult to observe the patient through the viewing panel on the door. Staff told us they would listen for breathing and noise and if they could not hear anything, they would seek advice from the nurse in charge. Staff told us the blind spot and the viewing panel were reported to senior staff including the multi-disciplinary team and the chief executive. We also identified a blind spot in the long term segregation area bedroom on Meadow ward.

The wards complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff carried these on their belt and if activated pinpointed their location. Staff called for further assistance across the site using a radio.

Maintenance, cleanliness and infection control

Inadequate

Wards for people with learning disabilities or autism

Ward areas were not always clean, well maintained, well-furnished and fit for purpose. On Fern ward cleaning records were not up to date. On Acorn ward the kitchen was not clean and we found omissions in cleaning records and no evidence of touch point cleaning for COVID-19. On Hawkins ward we found broken fixtures and fittings.

We reviewed monthly cleaning audit records provided for all wards from April 2021- June 2021 inclusive. Two wards scored below 95% (minimum pass rate). This was Berry ward in June 2021 scoring 83% and Sunley ward in May 2021 scoring 94.7%. We reviewed infection prevention and control audits from April- June 2021**.** The provider advised that Fern is the only ward with a completed infection prevention and control audit during this time. The rest of the wards are scheduled to be completed over the next year. Staff completed Fern's infection prevention and control audit in April 2021 and the ward scored an overall compliance of 91%.

Staff did not always follow infection control policy. On Sunley ward we found out of date and opened, unlabelled food in the kitchen fridge. Staff had not recorded fridge temperatures every day as required, between 09 June 2021 and 07 July 2021 we found six days missing. On Acorn ward we found expired food items in the fridge and cupboard; staff had not always completed fridge temperature checks and when they had checked there were three out of seven days when the fridge temperature was too high; staff did not always check the temperature of hot food. On Hawkins ward we identified a worn-out chair that posed an infection risk; we found the laundry room to be disorganised with piles of clothes and staff unable to describe how they managed the laundry.

Seclusion room

Not all seclusion rooms allowed clear observation and two-way communication. They all had a toilet and a clock

Seclusion rooms did not meet all the guidance in the Mental Health Act Code of Practice. We checked the seclusion room on Sunley ward. Staff were unable to operate the intercom to allow for two-way communication between staff and a patient. There was a potential ligature risk on the en suite door, however, staff told us this was low risk as a patient occupying the room was always observed by staff. There were stains on the ceiling of the seclusion room. There was a metal, combined toilet and hand-basin. The nurse manager told us that there had been no problems with this facility.

We viewed the long term segregation areas on Marsh and Meadow wards. These areas consisted of a bedroom, en suite area, lounge area and an small secure courtyard to enable the patient to get some fresh air. There was an observation area where staff were provided with seating. There was no actual access to the outside. On Meadow ward the only storage the patient had was drawers located at the bottom of the bed. There was no table therefore patients were expected to use their mattress, floor or laps. However, on Marsh ward the staff had a board that contained important information about the patient such as the correct pronouns to use and the topics of conversation the patient enjoyed engaging in. The staff had access to flasks, radio, iPod, and a drawer that had the patient's property. There was also a games console. This meant staff could easily provide the patient with items without any delays. In the lounge area there was a sofa, table, chair, a television (in a locked Perspex box) and books.

Clinic room and equipment

Clinic rooms were not all fully equipped. On Acorn ward one oxygen cylinder was less than half full and surplus oxygen cylinders were not chained to the wall. Staff did not always check equipment. Staff were not completing checks of emergency equipment on Sunley ward. However, clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly

Inadequate

Wards for people with learning disabilities or autism

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients well. Staff did not always receive basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. On Meadow ward we reviewed three incidents reporting unsafe staffing levels which took place in June 2021. Staff recorded in one incident report that "During the day the ward had to use non MAPPA trained staff on enhanced support when the patient was awake. Patients' requests were facilitated with delays or not at all". On Meadow ward we observed the nurse in charge advise Acorn ward they were unable to send staff to respond to an incident as they would be below safe numbers. On Fern ward we reviewed staffing on the provider's dashboard which showed that on 24 days between 9 June 2021 and 8 July 2021, the ward did not achieve safe staffing levels and between 9 May 2021 and 7 July 2021 (60 days) – there were 39 days (65%) that did not reach safe staffing levels. There was no mitigation to minimise risk in any of the examples where staffing fell below the required levels. Over the same period, there were no days which reached optimum staffing. Staff we spoke to said that even if optimum staffing levels were reached, staff would then be moved to support other wards. On Sunley ward we reviewed staffing from 8 June 2021 – 7 July 2021 (30 days) on the provider's dashboard which showed 22 days (73%) when staffing levels were not optimum. During this period there were three days (10%) when staffing levels fell below safe levels. The ward had the lowest number of staff on 7 July 2021, when there were seven staff (this is despite the fact that eight staff members were required to meet safe staffing and nine for optimum), we were told three staff had been redeployed to support other wards; we observed staff discussing being low on numbers and waiting for staff from another ward and one staff being sent to another ward to respond to an incident leaving the ward below safe numbers. On Hawkins ward we reviewed staffing on the provider's dashboard. This showed that in the last two months (May-July 2021) there had been 36 days when staffing was not optimum and 24 days when staffing fell below safe staffing levels. 22 staff and 11 patients told us the wards were short staffed. On Marsh ward we reviewed community meeting minutes for 23 June 2021 which stated there was no meeting the previous week as no staff were available to facilitate. At the same meeting patients raised concerns about low staffing in the afternoons and no staff being available to respond to an incident. We reviewed minutes for six meetings between April and June 2021 where staffing shortages and/or skill mix were raised as an issue on Meadow, Marsh, and Berry wards. We reviewed divisional clinical governance meetings for June 2021 which stated "patients are keen to do more activities but this is minimal due to staffing."

The vacancy rate for staff varied across wards. The provider reported a qualified vacancy rate of 30% as of July 2021. Brook reported the highest rate at 46% and Sunley the lowest at 13%. The provider reported a fill rate of 124% for unqualified staff. Meadow reported a 9% vacancy rate and Brook a 7% vacancy rate.

The service reduced its use of agency staff. The provider reported agency staff were used to cover 3% of all shifts between 1 April 2021-30 June 2021.

The service increased its use of bank staff. The provider reported bank staff were used to cover 27% of all shifts between 1 April 2021-30 June 2021.

Managers told us they tried to request 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.

The service had low turnover rates. The provider reported a turnover rate of 1.3% between 1 April 2021-30 June 2021.

Managers supported staff who needed time off for ill health. Levels of sickness were high. The provider reported a sickness rate of 10% of between 1 April 2021-30 June 2021. This was highest on Fern ward with 17% and lowest on Sunley ward with 6%.

Divisional leaders did not accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Ward managers and multi-disciplinary team members were required to cover shifts. The provider reported that multi-disciplinary team members supported 48 shifts of 182 shifts between 1 April 2021-30 June 2021 which totals 23%.

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

Staffing levels did not allow patients to have regular one to one sessions with their named nurse.

Patients regularly had their escorted leave, therapies or activities cancelled or cut short because of staff shortages. Seven patients told us they had their escorted leave or activities cancelled due to the wards being short staffed. Eleven staff told us they had to cancel patient escorted leave or cancel activities due to the wards being short staffed.

We reviewed examples in care records of patient care being impacted by staff shortages. On Meadow ward a patient access to an electronic tablet was not facilitated at the planned time due to low staffing on 2 July 2021; on Marsh ward a patient's education session was cancelled on 19 July 2021 due to staff having to cover another ward. On Marsh ward we reviewed two incidents (one December 2020 and one March 2021) where a patient was secluded in the extra care area due to there not being enough staff to safely support them (the patient was prescribed 2:1 staff observations but only one staff was available).

We reviewed 24 community meeting minutes between 1 April 2021 and 30 June 2021 and at 11 of them patients raised concerns about the impact of staff shortages on access to leave, therapies and activities.

We reviewed divisional clinical; governance meeting minutes for April 2021 which stated "As we start to reintroduce leave, we need to get the message across about the ongoing staffing issues and the difficulties we may face with getting people out on leave".

The service did not always have 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.

Medical staff

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

Not all staff completed and kept up to date with their mandatory training. The provider reported a mandatory training rate of 95% for the Men's learning disability and autism wards as of 5 July 2021. The provider reported compliance of 75% or below for the following courses and wards- Safeguarding level 3: Acorn- 67%; Hawkins- 71% and Marsh 75%. Immediate life support/identifying a deteriorating patient- Acorn- 70%; Hawkins- 71% and Marsh 75%. National Early Warning signs: Marsh- 73%. Effective record keeping: Sunley- 73%.

The mandatory training programme was comprehensive but did not meet the needs of patients and staff. Learning disability and autism training was not mandatory for these wards

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

Assessing and managing risk to patients and staff

Staff did not manage risks to patients and themselves well. Staff did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. However, staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff did not always complete risk assessments for each patient on admission and did not always review these regularly, including after any incident. On Marsh ward we reviewed a patient's records and found the risk assessments were incomplete, staff completed an initial comprehensive assessment and detailed risks including threats to kill, however these were not included in the Positive Behaviour Support or other care plans. On Fern ward we reviewed seven patient records, staff completed risk assessments for all, however only two were up to date. One patient's risk assessment was last updated in March 2021, since then 19 incidents had occurred, but staff had not updated the risk assessment. Another patient's risk assessment was updated in February 2021, 38 incidents had occurred since then including one incident requiring police intervention.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others.

Staff did not always act to prevent or reduce risks despite knowing any risks for each patient. Staff were not completing observation records in line with patients prescribed observation times or in line with provider policy.

On Hawkins ward staff were completing enhanced observations of patients for more than two hours. We reviewed four shift planners for July 2021 and found that staff were allocated to enhanced observations for more than two hours on 23 occasions. On Hawkins ward on 6 July 2021, CQC staff witnessed staff not completing observations of a patient as prescribed. We also identified that staff were allocated to enhanced observations and response duties at the same time on seven occasions on the 5 July. On Acorn ward, we observed one staff on enhanced observations for six hours during our inspection visit on 8 July 2021 and we reviewed four shift planners for July 2021. We found staff were allocated to enhanced observations for more than two hours on seven occasions. On Marsh ward, we reviewed six shift planners for

June 2021 and July 2021. We found that staff were allocated to enhanced observations for more than two hours on 36 occasions. On Meadow ward, we reviewed six shift planners for June 2021 and three for July 2021. We found that staff were allocated to enhanced observations for more than two hours on 16 occasions. We identified five occasions when staff were allocated to patient enhanced observations and other activities.

This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety.

On Sunley ward we reviewed a sexual safety incident between two patients and the investigation found that the opportunity was presented due to one of the patient's observing staff not being present as required. We identified discrepancies between two other patients' care plans and the interventions recorded in their progress notes and in other records. This included a discrepancy in the enhanced observation levels for one patient.

On Hawkins ward we reviewed records for a patient on 3:1 eyesight observations, the patient fell and sustained a cut requiring seven stitches. Staff recorded that they noticed bleeding but did not witness the fall. We reviewed the incident report and there was no mention of the patient being on enhanced observations. For the same patient we found the following recorded in clinical governance meeting minutes from January 2021 "In times of critical staffing levels, x is nursed on 2:1 in line with ward contingency plan".

On Marsh ward staff continued to, on occasions, fail to fully complete observation records.

The provider reported 47 incidents of patients self harming whilst on enhanced observations between 1 April 2021-30 June 2021. 11 of these occurred whilst patients were on arms-length observations. Marsh ward reported the most with 14 (all eyesight observations), Meadow ward reported the least with three (one arms- length and two eyesight). Enhanced observations aimed to reduce the likelihood of a patient being able to harm themselves.

A senior leader told us that staff did not always understand the reason they needed to observe a patient.

Staff were not always following the providers safety procedure for checking cutlery in and out. On Meadow ward we reviewed cutlery checking in/out forms for June 2021 and seven days were missing, many of the forms were not signed and a spoon went 'missing' on 8 June 2021 and was still missing the next day. The spoon was later found but this was not reported as an incident. On Acorn ward staff did not always complete cutlery checks and were unclear on actions to be taken when items of cutlery were missing.

Senior staff reported that staff still need to work on professional boundaries and appropriate relationships following several serious incidents involving a patient accessing contraband items.

Whilst we found no blanket restrictions in place on the wards, we identified blanket restrictions imposed on patients nursed in seclusion. On Acorn and Berry wards staff told us patients were only allowed paper or silicon plates and finger food when being nursed in seclusion. They told us no cutlery (metal or plastic) was permitted when patients were secluded. This was a blanket restriction that was not individually risk assessed.

Use of restrictive interventions

Levels of restrictive interventions were reducing. The provider reported 135 restraints between 11 April 2021-30 June 2021. Acorn reported the most with 36, followed by Hawkins with 33. Meadow reported the fewest with three. Of the 135 restraints seven were prone restraints.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

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

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

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. The provider reported four uses of rapid tranquillisation between 1 April 2021-30 June 2021. Three on Fern ward and one on Acorn.

The use of seclusion decreased. The provider reported 36 seclusion incidents between 1 April 2021-30 June 2021. Brook reported the most with ten followed by Sunley with eight.

The provider reported two incidents of long-term segregation between 1 April 2021-30 June 2021, one on Marsh ward and one on Hawkins ward.

When a patient was placed in seclusion, staff did not always follow best practice guidelines. We reviewed the records of a patient on Hawkins ward was subject to seclusion from 14 November 2021 following a violent incident where harm was caused to staff. We identified a number of issues. We noted, on the day the patient's seclusion commenced, an on-call responsible clinician, at 22:00, said the patient should remain in seclusion overnight. Further entries suggested seclusion should not be ended until the multidisciplinary team review, two days after the seclusion commenced. The patient had no exit plan from seclusion whilst they awaited transfer to a high secure hospital. The patient had periods where their interaction with staff did not meet the requirement of the code of practice for seclusion to continue, staff described the patient as 'settled' and engaging. The patient's most recent incident involving violence and aggression was recorded on 11 March 2021. The multi-disciplinary team proposed access to fresh air in a review on 1 December 2020, 16 days after seclusion commenced. The patient's positive behavioural support plan did not recognise strengths but reflected deficits such as "I am still a risk of self harm as well as aggression towards others". The seclusion care plan reflected punitive language such as "the patient must demonstrate a recognition of the seriousness of their behaviour". The patient's access to a laptop was distorted by the damaged observation panel between the ward observation office and the seclusion room, this meant they could not use the laptop. In April 2021, the multidisciplinary team felt the patient's ongoing seclusion may increase their frustration and risk of violence. The multi-disciplinary team review dated 6 July 2021 indicated that funding had been agreed to offer support in an extra care environment, however the "ward was unable to implement any special package involving extra care" which would have improved the quality of life for the patient. Staff told us the area used to nurse patients in long term segregation was not in use but reserved for potential use by another patient.

Staff did not always follow best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

We reviewed records for a patient nursed in long term segregation on Marsh ward. Staff recorded that long-term segregation would end when a bespoke placement was identified. This meant the patient could remain in long term segregation indefinitely. However, there was evidence of commissioner involvement and agreement with this decision. A care programme approach review took place on the 23 March 2021 with no record that a bespoke placement was

discussed. One approved clinician review dated 6 June 2021 lacked detail merely stating "2:1 LTS, necessary and proportionate to manage risk continue". We found gaps in the weekly multidisciplinary reviews from the 26 April 2021 to 2 July 2021. An external review was cited in the progress notes dated 26 June 2021 but we were unable to locate this. However, we found an external review dated 15 March 2021 that stated there was no clear exit strategy and that the care team needed to be clear about the care pathway. Furthermore, it recommended a review of the rationale for long term segregation, review of the patient's sensory needs, engagement in occupational therapy activities and staff to explore further if the patient had post traumatic stress disorder and offer appropriate treatment. We did not see evidence of how these recommendations were being followed. We reviewed the long term segregation care plan for this patient and it stated the patient needed to be observed due to risk to himself. We were concerned currently staff are unable to do this due to blind spots.

We reviewed records for a patient nursed in long term segregation on Sunley ward. Staff had not recorded the roles of staff involved in the decision for long term segregation. Staff attached a new positive behaviour support plan to the patient's long term segregation care plan. However, the care plan referred to a different ward, so it was unclear what was still current in this plan. We looked at a sample of the recording of the patient's hourly observations over 14 days. We noted gaps in the recordings for 64 hours during this period. We also noted the patient was observed by one member of staff as opposed to two for one hour during this period. There was no record of which staff completed the patient's observations for eight hours on one day. The criteria to allow the patient's long term segregation to end was a bespoke placement in the hospital's grounds, however, there were no updates in the patient's records about this. We were unable to find any records of a periodic review by an independent senior professional or a three-month review of the patient by an external hospital in the past six months. The provider advised that review documents were available at the time of the inspection but these were not provided as part of the draft report review process.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff mostly kept up to date with their safeguarding training. The provider reported as of June 2021 permanent staff across all wards had a compliance rate of 97% for safeguarding level one and two training and 80% for level three safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination.

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

Staff followed clear procedures to keep children visiting the ward safe. Each ward had a dedicated family visitors' room within the building which could be booked in advance so managers can ensure staff are available to attend.

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

On Sunley ward we identified two open safeguarding incidents dating back to 2018. Staff raised concerns that a member of staff had been moved to the ward following an incident of neglect on another ward. This staff member was not supposed to work unsupervised but was working alone to cover colleagues' breaks.

Staff did not make safeguarding referrals when patients were cared for in long term segregation. We found no evidence of this.

Managers did not take part in serious case reviews and make changes based on the outcomes. We found no evidence of this.

Staff access to essential information

Staff had easy access to clinical information. Staff maintained electronic high quality clinical records. However, paper copies were not always up to date.

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

The service used a combination of electronic and paper records across both wards.

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

Records were stored securely.

Medicines management

The service systems and processes to prescribe, administer, record and store medicines were not always safe. Staff regularly reviewed the effects of medicines on each patient's physical health. Not all staff knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines.

On Marsh ward staff had not signed and dated patient T2 and T3 forms and four patient's forms still had the previous ward as their address.

On Fern ward we identified issues with medication returns being signed for. The pharmacist had not signed one form on 29 June 2021 and on 31 January 2021 there was no pharmacy signature and both copies were still present for a return containing codeine, diazepam & fluoxetine. We raised this with the provider who provided immediate assurance that the medication had been returned to pharmacy. We found two boxes of expired needles, one box expired May 2021 and the other June 2021 and we identified nine days in June 2021 when staff recorded the temperature of the medicines fridge as above eight degrees with no evidence of action taken to address.

One doctor we spoke with was not familiar with STOMP (stopping over-medication of people with a learning disability, autism or both). A senior leader advised that they reported to the provider's executive committee on the service alignment to STOMP (stopping over-medication of people with a learning disability, autism or both).

On Acorn ward doctors prescribed two patients anti psychotics above the British National Formulary limits, we saw that staff completed care plans and additional health monitoring for both patients in line with guidance.

On Sunley ward we spoke with a nurse who was not aware of a spare set of medication keys. Staff had not completed the controlled drug book index. We found inaccurate records in the controlled drug book; staff recorded 102 tablets

instead of 100. Two staff were unable to describe how to escalate/investigate any controlled drug concerns and there was no evidence that controlled drugs were disposed of in line with local policy. Staff were not checking stock expiry dates and we found expired items. Staff had not recorded the temperature of the medicine fridge on 3 and 4 July 2021. Staff were not completing audits of temperature checks of the medicine fridge.

On Hawkins ward staff recorded the medicine fridge as being over eight degrees for seven continuous days from 25-31 May 2021. Staff had not recorded the fridge temperature for three days in April 2021, eight days in March 2021, six days in February 2021 and two days in January 2021. We found expired items including sterile swabs, blood collection bottles, sterile saline and blood testing kits. The weekly clinic checks did not include checking expiration dates of surplus stock.

Staff did not always review patients' medicines regularly. On Acorn ward staff had not reviewed five patients' as required medication for more than 14 days.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. All patient medication administration charts are stored on an online computer system.

Staff followed current national practice to check patients had the correct medicines.

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

Not all staff at the service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). On Fern ward medical staff were not familiar with STOMP (stopping over-medication of people with a learning disability, autism or both). However, a senior leader advised that they reported to the provider's executive committee on the service alignment to STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Clinical Excellence guidance.

Track record on safety

The provider reported the following incidents:

The provider reported 536 incidents for this service between 1 April 2021-30 June 2021. Fern reported the most with 110, Meadow reported the least with 18. The most common incident type across all wards was 'Physical aggression and violence' accounting for 222 reported incidents.

The provider evidenced sharing of national safety alerts and action taken to ensure wards acted as required.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers usually 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.

Inadequate

Wards for people with learning disabilities or autism

Staff did not know what incidents to report and how to report them. Staff did not always raise concerns and report incidents and near misses in line with provider policy.

On Acorn ward we reviewed patient progress notes, care plans and incident records from 1 January 2021 for three patients. We identified 20 incidents in progress notes that were not reported on the provider's incident reporting system. Some of the incidents which were not reported as incidents were of significant concern, including inappropriate sexual behaviour and incidents of self harm which were a known risk for the patients. One patient's positive behaviour support plan incorrectly stated the patient had not self-harmed whilst on the ward.

On Meadow ward not all identified risk incidents had been reported on the incident reporting system. Across the five patient records checked we identified 15 risk incidents that had not been reported. We also reviewed cutlery checking in/out forms for June 2021 on Meadow and identified an incident where a spoon had gone missing which was not reported as an incident.

On Marsh ward we reviewed a patient's records and found staff recorded for the most recent care review meeting "several risk issues including sexually inappropriate behaviour, racially motivated verbal abuse, threats of violence and attempted physical violence" however, staff only reported four incidents since the patient's admission three months ago. We reviewed another patient's record and identified an incident of self harm resulting in injury that staff had not reported as an incident.

The service had no never events on any wards. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

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

Managers debriefed and supported staff after any serious incident. We observed a debrief on Fern ward and staff were well supported.

Managers investigated incidents thoroughly. However, on Hawkins ward we reviewed three incident reports, one serious incident investigation was overdue and still being reviewed, the other two had no outcomes or preventative measures and one was overdue.

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

Staff met to discuss the feedback and look at improvements to patient care.

Are Wards for people with learning disabilities or autism effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Inadequate

Wards for people with learning disabilities or autism

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of patients who would benefit. They worked with patients to develop individual care and support plans, and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based. However, staff did not always involve families and carers.

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

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward and had an up-to-date hospital passport.

Staff developed a comprehensive care plan for most patients that met their mental and physical health needs.

Staff regularly reviewed and updated most care plans and positive behaviour support plans when patients' needs changed. We reviewed 31 patient records and identified two where staff had not completed or updated the patients plans. On Marsh ward staff had not completed and updated one patient's care plan and the positive behaviour support plan contained limited information. On Hawkins ward staff completed a poor-quality positive behaviour support plan for a patient, with a strength identified as the patient still being at risk of self harm.

Most care plans were personalised, holistic and strengths based.

Positive behaviour support plans were present and supported by a comprehensive assessment.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for patients based on national guidance and best practice. Staffing shortages meant that access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation was at times, limited. Staff did not always support patients with their physical health.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff did not always provide a range of care and treatment suitable for the patients in the service. Therapy staff covered more than one ward and described being stretched with one therapist advising if the wards were fully occupied, they would not be able to support all patients.

Managers were continuing to allocate therapy staff to frontline shift work due to staffing shortages which impacted on the delivery of therapies to patients. Across all wards seven patients and 11 staff raised concerns that required therapies were not always being provided.

On Fern ward multi-disciplinary team members reported being used in the numbers and receiving weekly emails telling them they have to cover shifts. We reviewed the weekly timetable, four patients had days with no activities, the maximum activity time for any one patient in one day was three hours, the majority of patients would have one x one hour activity per day. One staff told us they rarely see the multi-disciplinary team and there was no point in patients doing psychology as psychologists keep leaving and patients haven't had therapy for months which is impacting on their progress and lengthening their hospital stay.

Inadequate

Wards for people with learning disabilities or autism

On Sunley ward we reviewed a patient's progress notes for 21/01/2021 which stated "X engagement with the multi-disciplinary team has been impacted by the multi-disciplinary team being redeployed into nursing numbers". Senior staff advised therapy staff are pulled into numbers.

On Hawkins ward staff told us that multi-disciplinary staff are sometimes pulled into ward numbers.

On Acorn ward multi-disciplinary team members reported being pulled in to staffing numbers regularly, which prevented them being able to carry out therapies. This led to a backlog which at times prevented patients from receiving timely treatment. Therapy staff were asking patients to attend remote sessions due to a lack of available staff. We saw from patient records that patients were refusing these sessions. We were told by a patient this was because they didn't like the remote option.

On Marsh and Meadow wards multi-disciplinary staff told us there are lots of staffing issues limiting activities that can be offered.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg National Institute for Health and Care Excellence).

Staff understood patients positive behavioural support plans and provided the identified care and support.

Staff did not always identify patients' physical health needs and record them in their care plans. Staff did not always make sure patients had access to physical health care, including specialists as required.

On Sunley ward we reviewed a physical healthcare incident that occurred on 8 May 2021. Staff did not respond appropriately, and the patient was left all night without required interventions and was eventually taken for treatment in hospital the next day. Medical staff signed and dated a DVT/Venous thrombosis risk assessment for a patient but had not completed any details on the form.

On Hawkins ward a patient told us they have been waiting three years for a hearing test. Another patient had swollen ankles and reported this had been on-going for a few weeks, the patient had required medical intervention, but staff had not updated the patient's care plan to reflect this new physical health care need.

Staff met most patients' dietary needs and assessed those needing specialist care for nutrition and hydration. On Marsh ward staff had not fully completed patient food and fluid charts.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. However, the provider reported on BMI outcomes for June 2021 and the learning disability and autism wards (including female wards) were a considerable outlier with over 20% of patients in the extremely obese range.

The provider advised their physical health team were available for routine and urgent referrals between 08:00 and 20:00, seven days per week. Patients could access on site dentists, podiatry and GP's.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients.

Managers took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

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

The service mostly had access to a full range of specialists, however, they were not always able to meet the needs of patients on the wards due to being redeployed into frontline staffing numbers. Multi-disciplinary team members told us they were not able to perform their roles, including statutory duties under the Care Act, due to being required to cover frontline shifts. We reviewed nurse manager meeting minutes for June 2021 which stated Meadow and Marsh wards had no occupational therapist since November 2020. The provider advised that occupational therapists are in post but have been non patient facing due to long term sickness.

Managers did not make sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including non-permanent and agency staff. Managers did not make sure staff received any specialist training for their role. We were told that non-permanent staff were split into divisions across the hospital and non-permanent staff in the learning disability and autism division did not require learning disability or autism training. This meant that staff could be working with patients without the knowledge or skills in order to support patients with their required needs.

However, the provider reported a total of 541 specialist training courses had been completed by staff in the service between 1 April 2021 and 30 June 2021. Examples included the certificate in Mental Health, cyber security awareness, collaborative risk assessment, dysphagia, transgender awareness, banter in the workplace, search training, an introduction to positive behaviour support and the importance of physical activity. The provider reported 29 permanent staff across all wards completed an 'introduction to autism' course; 15 staff on Brook ward, 10 on Meadow, three on Marsh and one on Hawkins.

Managers gave each new member of staff a full induction to the service before they started work. The provider reported that all required staff completed an induction between 01 April 2021 and 30 June 2021. Senior leaders advised they were introducing a specialist learning disability and autism induction.

Managers supported staff through regular, constructive appraisals of their work. As of 24 May 2021, the overall appraisal rate for staff within this service was 100%.

We requested supervision data from the provider twice and this was not supplied, therefore we are unable to report on their supervision rates. We were advised the current compliance rate for management supervision on Meadow and Marsh ward was 100%. Marsh reported 62% for clinical supervision between April 2021 and June 2021 and Meadow reported 89%. However, there were no examples available for us to review during our site visit. On Hawkins ward we were told clinical supervision rates for past six months averaged at 44% per month, ranging from 0% to 83%.

We are unable to report on whether managers ensured staff attended regular team meetings. We requested staff meeting minutes for April 2021 to June 2021. The provider sent minutes of four meetings for Berry ward, two for Marsh two and two for Meadow two (Marsh and Meadow opened in April 2021). No minutes were provided for the other wards.

Managers tried to give staff the time and opportunity to develop their skills and knowledge. Staff told us that access to training had been impacted by the pandemic.

Managers recognised poor performance, could identify the reasons and dealt with these. The provider advised that "a capability policy and procedure is in place to support managers with managing poor performance. The majority of cases are managed informally and managers are supported by an employee relations 'manager's toolkit' where there is guidance and templates on improvement plans. A central employee relations team will support any formal cases and there is currently one on Berry ward."

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.

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

Staff did not always ensure they shared clear information about patients and any changes in their care, including during handover meetings. On Sunley ward we observed staff handing over information regarding a patient stating, "I wish I could help you guys understand this patient but he's so complicated". We observed a staff member arrive from another ward to support the ward and they stated they were unfamiliar with the ward. Staff gave a brief handover and allocated them to bedroom corridor observations.

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

Ward teams had effective 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 and could describe the Code of Practice guiding principles. Permanent staff across all wards had a compliance rate of 94% for Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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 and patients who lacked capacity were automatically referred to the service.

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

Staff did not always facilitate patients taking section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

On Sunley ward patients were allocated a day per week for section 17 leave as the ward manager advised they would be unable to facilitate in any other way due to staffing. We reviewed records for one patient who missed their leave on four out of nine weeks.

On Acorn ward we observed a ward round- one patient requested unescorted ground leave and this was denied with reason given by psychologist as "no rationale for unescorted grounds leave".

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Managers and staff made sure the service applied the Mental Health Act, in relation to detention and rights, correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Permanent staff across all wards had a compliance rate of 94% for Mental Capacity Act and Deprivation of Liberty training.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

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.

Inadequate

Wards for people with learning disabilities or autism

The service monitored how well it followed to the Mental Capacity Act and acted when they needed to make changes to improve.

Are Wards for people with learning disabilities or autism caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness. However, staff respected patients' privacy and dignity. They did not always understand the individual needs of patients but tried to support patients to understand and manage their care, treatment or condition.

Staff did not always treat patients with compassion and kindness.

On Meadow ward we found examples in one patient's care records where staff repeatedly referred to the patient as being "demanding". We reviewed ten entries in the patient's progress notes between April 2021 and July 2021 that stated the patient was "making allegations, demanding and rude".

On Sunley ward we identified use of a punitive approach in one patient's care plan- "Staff will not engage in conversation with patient in low stim. This is an opportunity for him to reflect on his behaviour. Once he has done this he can return to the ward." We overheard a staff member talking in a discriminatory manner about a patient "Yeah, it's just x playing up". One staff described "managing difficult patients", one staff described patients as "a very needy client group", one staff described the patients as "ganging up".

On Hawkins ward staff advised regarding a damaged chair observed during tour of the ward "that's what you get for giving patients their own keys". The same staff also commented that "it's a battle when you have to try and be least restrictive". One staff told us they witnessed "sharp words" from staff to patients. There was no table in the seclusion room from which the patient in seclusion could eat their meals. This meant the patient balanced their meals on their knees whilst eating. We noted the patient occupied the seclusion room since November 2020. Four patients on Hawkins ward told us that some staff (mainly night staff) were rude and sometimes spoke in a different language.

On Marsh, Acorn and Berry wards we found that closed circuit television cameras were located in the bedroom and en suite areas in the seclusion suites. The viewing screens were located in the observation corridor outside. Staff told us the screens were switched on all the time therefore patients could be seen at all times. Patients did not have bathroom privacy. This was a blanket approach that was not individually risk assessed. Privacy and dignity were not being considered on an individualised basis. Acorn ward shared their seclusion suite with a female ward which meant potentially patient privacy and confidentiality could be compromised. Staff told us they would communicate with patients via the intercom and hatch therefore if both rooms were occupied at the same time, potentially patient confidentiality could be breached. In addition to this where patients had a history of trauma it may not be appropriate for patients of the opposite gender to be nursed in these areas. This potentially could cause further trauma to the patients.

We reviewed minutes from the provider's least restrictive practice group for July 2021, where it was acknowledged that "specialist training on Autistic Spectrum Disorders could help staff understand the impact of certain behaviours and language".

Local managers and senior leaders demonstrated a lack of compassion and understanding for their patients. We reviewed nurse manager meeting minutes and divisional governance meeting minutes and found the following examples of discriminatory and disrespectful attitudes; in reference to patient complaints on Meadow ward staff stated that the patient "will inevitably complain regularly"; "Some of the patients tend to deal with stress by producing complaints and this is part of their presentation, even if they are receiving the best possible care they will still complain so it is not an issue with the service, it is a patient characteristic and is being dealt with appropriately"; "There is an Autistic Spectrum Disorder patient who regularly makes complaints, this is due to their difficulties in communication, they will go to the complaints department first before talking to staff" and "Autistic Spectrum Disorder patients and part of their presentation is to make complaints".

Most staff were discreet and respectful when caring for patients. We observed staff treating patients with respect, kindness and dignity during the site visit.

Staff were responsive to patient needs.

Staff gave patients help, emotional support and advice when they needed it.

Staff did not always use appropriate communication methods to support patients to understand and manage their own care treatment or condition. Staff identified one patient's preferred communication method, however there were no staff trained to use this method.

Staff directed patients to other services and supported them to access those services if they needed help.

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

Staff involved most patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that most patients had easy access to independent advocates.

Involvement of patients

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

Staff involved most patients in their care planning and risk assessments. However, three patients told us they were not given a copy of their care plan and three patients said they were not involved in their care plan.

On Meadow ward a patient requested to be fully involved in discussions about his care and treatment but had been told this was not possible and staff recorded "x refused to provide his requests due to wanting to be in the discussion". This patient's views were not included in his care plan and the section for family/carer involvement was also not completed despite his family being very involved. Another patient told us that they can put 'requests' in for discussion at ward round but are not allowed to be part of the discussion and are 'told' what they can have.

Inadequate

Wards for people with learning disabilities or autism

On Fern ward one patient told us they were not allowed to express their views and were told what to do.

Staff usually involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this.

We observed a community meeting on Meadow ward which was well attended by patients and staff. We reviewed further community meeting minutes which evidenced good involvement of patients.

On Acorn ward a patient told us their views are heard but it takes a long time for requests to be met.

However, we reviewed community meeting minutes for Marsh ward and there was no evidence of actions being taken in relation to concerns raised.

We reviewed 12 community meeting minutes from Brook ward between 1 April 2021 and 17 June 2021. We identified repeated issues being raised that were not resolved.

We reviewed an action plan dated May 2021 for actions agreed in the provider wide patient forum. We identified requests from patients that were not actioned for a number of months, including a query raised by a patient in January 2021 regarding a particular brand of vapes still not being responded to by May 2021. However, we saw evidence that meeting minutes and actions/initiatives were shared with nurse managers to involve patients who had not attended.

Staff made sure most patients could access advocacy services. However, on Marsh ward staff told us the advocate was only available via phone or video call.

Involvement of families and carers

Staff did not always inform and involved families and carers appropriately.

Staff did not always support, inform or involve families or carers. We spoke with six carers. Four of them (Acorn ward) expressed that communication from the service was poor describing it as “awful” and “non-existent”. One carer told us that staff were “indifferent”. One carer expressed frustration at trying to work with the service to support their relative and said they had “lost faith in them” (the service). We noted in clinical governance meeting minutes from January 2021 staff identified that the “family not happy with communication with the ward, ward are working on this.”

One carer told us staff do not inform them about incidents despite an Irish High Court order stipulating the family must be kept informed. One carer said they strongly dispute the provider’s claim on their website that they work alongside families and told us they have no involvement in care planning even though their son has consented to this.

However, the other two carers reported positive experiences of their loved one’s care on Brook and Acorn wards.

The provider reported “We also gain feedback through external peer reviews, Friends and Family Tests, Care Opinion and work closely with our PALS and Complaints team to support families and carers with any concerns or complaints they have.”

Are Wards for people with learning disabilities or autism responsive?

Inadequate

Wards for people with learning disabilities or autism

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

Staff did not always plan and manage discharge well. As a result, patients sometimes experienced excessive lengths of stay. However, staff liaised well with services that would provide aftercare.

Bed management

The provider reported an average bed occupancy rate of 84% between July 2020 and June 2021.

Managers did not regularly review the length of stay for patients to ensure they did not stay longer than they needed to. The provider reported average length of stay data for six wards for July 2020 to June 2021 (no data for Meadow, Acorn and Fern as no discharges). Lower Harlestone (now Berry, Brook and Fern wards) reported the longest average length of stay at 3719 days. Marsh reported the shortest at 509 days.

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

Patients were moved between wards only when there were clear clinical reasons, 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.

Discharge and transfers of care

The service had low numbers of delayed discharges in the past year. The provider reported five delayed discharges between July 2020 and June 2021 but no reasons for the delay were provided.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The service had not responded to the needs of patients with autism in the ward environment. The design, layout, and furnishings of the ward did not always support patients' treatment. Patients could make hot drinks and snacks at any time. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of variable quality.

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

Patients had a secure place to store personal possessions.

Staff did not have access to a full range of rooms and equipment to support treatment and care.

The service had quiet areas and had access to a room where patients could meet with visitors in private.

The service had not responded to the needs of patients with autism in the ward environment. Patients on four wards (Meadow, Marsh, Fern and Acorn) did not have access to a sensory room and there was limited sensory equipment available on Hawkins ward. On Fern ward one patient told us they are sensitive to white lights and get headaches, they have had a headache every day since being admitted to the ward in September 2020, staff agreed to change to sensory lighting but this had not been done at the time of our visit.

Patients on the one of the low secure wards (Fern) were being cared for in a medium secure environment. Two patients told us they felt like they were in prison.

Patients could make phone calls in private.

The service had outside spaces that patients could access easily.

Patients could not always make their own hot or cold drinks and snacks. Staff on Hawkins ward closed the patient drinks area citing COVID as the reason why, despite other wards having their drink areas open. Patients on Hawkins ward and Sunley ward had to ask staff for a drink.

Some patients told us the service did not always offer a variety of good quality food. Two patients told us the food was of poor quality and another said it was ok.

Patients' engagement with the wider community

Staff supported most patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients told us about their education and vocational opportunities. However, patients on the medium secure wards that recently moved to new premises reported a lack of access to facilities they previously used including light industry, arts and crafts and music.

Staff helped patients to stay in contact with families and carers. The provider reported supporting patients to stay in contact with family and friends through visits (restricted due to COVID), phone calls, video calls, written communication, care update meetings and carer events (pre COVID). The provider gave an example on Acorn ward "during the pandemic we had some imitation visits whereby a patient would get his food from Tompkins (on site café) and then spend the time on video call having his lunch as he normally would in Tompkins with his family to simulate the visit."

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

Meeting the needs of all people who use the service

The service met the needs of most 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. Staff devised communication plans for patients with communication needs. Staff used social stories and easy read versions of information to support patients.

Inadequate

Wards for people with learning disabilities or autism

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

The service could access information leaflets in multiple languages and formats to meet patients' communication needs.

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

The service did not always provide a variety of food to meet the dietary and cultural needs of individual patients. Two patients were not provided with food that met their cultural needs.

Most patients had access to spiritual, religious and cultural support. However, on Meadow ward one patient told us that their request to see an Imam more frequently had not been met. On Fern ward a patient had not been to the mosque for 26 months even though Ministry of Justice agreed to this.

Listening to and learning from concerns and complaints

The service did not always treat concerns and complaints seriously, did not always investigate them and therefore did not learn lessons from the results that could be shared with the whole team and wider service.

Patients did not always know how to complain or raise concerns, however relatives and carers did.

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

Staff did not always understand the policy on complaints and know how to handle them and managers did not investigate all complaints. We reviewed divisional clinical governance meeting minutes for June 2021 which stated "One thing staff could try is to not raise the complaints straight away and wait a day or 2 and then ask the patient if they still want to make the complaint, this has been done on Hawkins and most of the time the patients would want to retract their complaints". We were concerned about the attitude to complaints evidenced by local managers and senior leaders in divisional governance meetings which minimised and dismissed complaints from patients with autism as being part of their condition.

On Marsh ward a patient told us no-one ever asked him if he knew how to complain. On Fern ward a patient told us they complained but staff advised an in issue had to be raised five times to be investigated.

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

We requested information from the provider to include number of complaints and compliments received and number of complaints upheld, this was not provided.

Are Wards for people with learning disabilities or autism well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Inadequate

Wards for people with learning disabilities or autism

Leadership

Leaders did not always have a good understanding of the services they managed. Senior managers were not always visible in the service or approachable for patients and staff.

Not all staff and patients knew who the executive leaders were. Staff on three wards told us the executives did not visit and were not visible, staff on another three wards told us executives visit occasionally. However, we were also told that the deputy chief executive has completed shifts on two of the wards. Staff told us that the service (divisional) leaders were visible and approachable.

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 hospital's leadership team successfully communicated the provider's vision and values to the frontline staff in this service.

Culture

Not all staff felt respected, supported and valued by managers. Not all staff felt they could raise any concerns without fear of retribution from senior managers. Senior managers are managers above ward manager level.The service did not always provide opportunities for development and career progression. However, staff felt respected, supported and valued by the ward managers. staff felt they could raise any concerns without fear of retribution from the ward managers.

Across three wards (Marsh, Meadow and Fern) we asked six staff (including ward managers, clinical nurse leads, psychologists, social workers and healthcare assistants) to define a closed culture. Only one of the staff could describe what this was and how to assess the culture of their wards. Local leaders of Marsh and Meadow wards were not aware of the term 'closed cultures' despite the provider advising they conducted a closed culture review of the wards during late 2020 and early 2021 when they were Mackaness ward. We reviewed Meadow ward team meeting minutes for 30 June 2021. The minutes stated that "Staff are struggling to maintain boundaries and have appropriate therapeutic relationships with patients. The minutes also stated, "people are covering up other people's mistakes". Local leaders on Meadow ward told us staff did not have the confidence to speak up when something was wrong and there was still a culture of staff 'covering' for each other and not wanting to get colleagues in trouble.

Three staff reported feeling stressed and burnt out.

Not all staff felt respected, supported and valued by senior managers. However, staff told us they felt respected, supported and valued by ward managers.

Staff did not feel able to raise concerns without fear of retribution from senior managers but were confident to raise concerns at ward level.

Staff knew how to use the whistle-blowing process if they needed to.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

Inadequate

Wards for people with learning disabilities or autism

Leaders failed to address all concerns identified in the last inspection in relation to staffing levels, patient risk assessments, observation practices and patient's access to leave.

Although senior managers ensured there were structures, processes and systems of accountability for the performance of the service, senior managers did not appear to support staff even when these systems showed consistently staffing was an issue across the wards. We viewed monthly governance minutes from April 2021 to June 2021 which stated there were staffing issues across all wards. The same concerns were discussed each month with no outcome or solution.

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

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

The providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data. We identified discrepancies with staffing data on different systems. We reviewed minutes of divisional clinical governance meetings where ward managers raised issues that staffing data for their wards was inaccurate. Minutes from one meeting stated "Not getting an accurate picture of staffing in the mornings and evening due to the high amount of clock-ins having to be entered manually". The provider relied on data from their incident reporting system to provide an overview of acuity and concerns on wards, however, we identified that staff were not reporting all incidents on this system. We reviewed minutes from Hawkins ward clinical governance meeting in January 2021 where staff stated the dashboard recorded zero patients in seclusion when there had been three episodes of seclusion.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

Managers did not effectively manage ward performance despite using systems to identify, understand, monitor, and reduce or eliminate risks. We saw evidence in governance meeting minutes of these risks being escalated but we saw no evidence of an outcome to these.

We reviewed the risk register for the learning disability and autistic spectrum disorder division (includes female wards). The "Effects of CQC reports" was identified as a high risk with impact on reputation highlighted. "Increasing demand for enhanced support" was identified as a major risk with the impact of affecting the overall quality of patient care. Physical healthcare needs, restrictive practices and staff and patient safety were all rated as high risk.

Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Information management

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

Staff had access to the equipment and information technology needed to do their work.

Staff engaged in local and national quality improvement activities. Staff on Hawkins ward initiated continuous quality improvement projects including introducing mobile phones for patients, on ward computers, games for patients to play

and decorating the activity room. Hawkins ward won an internal award for their activity room. The provider advised there were nine continuous quality improvement projects in place across the learning disabilities and autistic spectrum disorder division (including female wards) using the plan, do, study, act approach. Staff had not fully completed the cycle for any projects.

The provider reported involvement in various research projects including: Collaboration with a university analysing the perceptions and feelings for service users and carers in terms of restrictive practices; Development of a Learning Disability Physical Activity Questionnaire; Application of the mental capacity act in Black and minority ethnic populations which has been presented in a conference with the academic department; Exploring seclusion and the experiences of women with learning disabilities within secure forensic services in the UK; Experience of Patient with Gender Identity Issues at two learning disability forensic wards; Social Information Processing in Offenders with Autism Spectrum Disorder; Should intellectual disability diagnoses be used in people with a history of developmental trauma; An exploration of staff perceptions and experiences of promoting physical activity among adult male learning disability and autistic spectrum disorder service users within a secure hospital setting.

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

Requires Improvement

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

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

Requires Improvement

Our rating of safe went down. We rated it 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 thorough risk assessments of all ward areas and removed or reduced any risks they identified. For example, ensuring doorways into the garden were always clear. Staff could observe patients in all parts of the ward.

The ward complied with national guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients' safe. Closed circuit television cameras were in place throughout the ward, grounds and garden. The service had an up to date ligature risk assessment audit. The ward staff had access to body cameras to use in the patient bedroom areas, these could be worn to record any incidents with patients' consent. The recordings were reviewed as part of the multidisciplinary team meeting to manage risks, identify any new risks and inform any investigation work post incident.

Staff had easy access to Personal Infrared Transmitter (PIT) alarms and so could summon assistance as and when required. Staff tested alarms regularly. Patients had easy access to nurse call systems.

Staff followed policy and procedures in line with the current COVID-19 government guidelines. Staff checked and cleaned the emergency equipment and "I am clean" stickers were visible. There was adequate supply of hand sanitiser and masks where needed. One patient was in COVID-19 isolation at the time of this inspection. We observed staff donning and doffing masks, aprons and gloves appropriately.

Maintenance, cleanliness and infection control

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

Requires Improvement

Ward areas were clean, well maintained, well furnished and fit for purpose. We saw a dedicated ward housekeeper working throughout the inspection.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed cleaning records and the cleaning audit had an overall compliance of 95%.

Staff followed infection control policy, including handwashing. Infection Prevention and Control training was 100% compliant at the time of this inspection.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. There were no patients in the seclusion room at the time of this inspection. However, there was a strong, unpleasant odour in the seclusion room's en suite area.

We visited the extra-care suite on Heygate ward. At the time of our visit, the extra-care suite was occupied by a patient. Therefore, we were unable to check all aspects of the extra-care suite against the guidance in the Code of Practice.

Clinic room and equipment

The clinic room was large with plenty of space for clinical procedures, it was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. We saw up to date cleaning records in place.

Safe staffing

The ward was regularly short staffed because managers moved staff to other wards to cover shortfalls.

Nursing staff

Managers recruited enough staff with only one registered nurse vacancy and three health care assistant vacancies. The service had enough nursing and support staff to keep patients safe. The service had an establishment of ten registered nurses and 15 healthcare assistants. Levels of sickness were low.

Staff told us that the COVID-19 guidelines for testing impacted on staffing levels, as patients had to be quarantined until they received a negative test result. This meant that staff were having to do more observations on patients whilst in quarantine.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We saw during this inspection a bank member of staff being inducted to the ward at the beginning of a shift with a comprehensive handover of all patient risks.

The service had a low turnover rate of 10% in the 12 months leading up to this inspection.

Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of registered nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. However, staff told us that when they were fully staffed, staff would be moved to cover other wards staff shortages.

Patients did not always have regular one to one sessions with their named nurse, due to staff shortages.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The ward was supported by an occupational therapist to carry out therapeutic activities. Staff told us that leave was very rarely cancelled due to short staffing numbers.

The ward had enough staff on each shift to carry out any physical interventions safely. However, all staff we spoke to expressed concerns about the understaffing on other wards within the division.

Medical staff

Managers could call locums when they needed additional medical cover. The service had a locum Consultant and a locum Associate Specialist at the time of our inspection. Both doctors had been in post since March 2021. They told us the service had been unable to recruit to the advertised posts. They said they have enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff completed and kept up to date with their mandatory training which was comprehensive and met the needs of patients and staff.

The manager monitored mandatory training and alerted staff when they needed to update their training. The mandatory training rate on the ward was 97%.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool. The multidisciplinary team were all involved in completing patient risk assessments, so all aspects of care and treatment were considered. All care records for patients had up-to-date risk assessments and during ward rounds, staff discussed specific risks to each patient.

Management of patient risk

Staff undertook patient observations for long periods of time without a break. This impacted on staff well-being, morale and patient care. We saw evidence of one staff member on enhanced observations for over three hours without a break. Observations were not completed in line with policy and guidelines by the National Institute for Health and Care Excellence.

Staff did not always know about risks to patients. Staff did not get the time they required to read patients care plans or review updates to the patients risks. This meant that staff may not be aware of how to identify deterioration in a patient's mental health which could put patients and staff at risk of harm.

All patients had Personal Emergency Evacuation Plans (PEEPS).

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The ward displayed a list of contraband items and patients were aware of what was allowed on the ward.

Use of restrictive interventions

The service used rapid tranquilisation three times in the last month and monitored the patient's physical health in line with National Institute for Health and Care Excellence guidance. Staff successfully de-escalated patients and prevented the need for more restrictive interventions. Interventions were well documented, and restrictions had been reduced over time.

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

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The ward had a safeguarding lead. Managers ensured staff compliance with safeguarding training. At the time of the inspection 100% of staff had received basic safeguarding training.

Staff said they felt confident to raise safeguarding issues with the senior management team. They knew when they should make referrals to the local authority and which safeguarding concerns to report direct to the regulator. They were aware of risks to children who were part of a patient's family or circle of friends and would act if concerns were raised about their safety as well.

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

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

We looked at four patient records, they were electronic format and were comprehensive, and all staff could access them easily. They included up-to-date risk assessments, care plans for mental health and physical health, personal evacuation plans and COVID-19 information. Authorised staff, including bank and agency, could access patient notes.

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

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. They followed current national practice to check patients had the correct medicines. Medicines records were complete and contained details on dose, when patients received them, and controlled drugs were double checked.

Staff regularly reviewed the effects of medicines on each patient's physical health. For example, blood testing, electrocardiogram (ECG) and following the use of rapid tranquilisation.

Staff stored and managed medicines and prescribing documents in line with the service's policy. There was an up-to-date stock list with all medicines in date and no excess stock. All medicines were stored safely in locked cupboards.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff reviewed the effects of each patient's medication on their physical health. The pharmacist gave advice and checked patients' medicines , particularly when their prescription changed. Patients and carers said they were encouraged to say when they experienced any problems with their medicines.

Decision making processes ensured that people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff knew which patients were prescribed medicines that could lead to addiction. They described how they monitored those patients and what they would do if they saw any signs a patient was becoming dependent.

Staff reviewed the effects of patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

The service had a variable track record on safety.

The provider reported 115 incidents for this service between 1 April 2021-30 June 2021. The most common incident type across all wards was 'Physical aggression and violence' accounting for 37 reported incidents.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers did not always share lessons learned from investigated incidents with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff managed patient safety incidents well, we saw a reduction in incidents in the six months leading up to this inspection. The nature of the incidents were fully recorded, along with the contributing factors and the actions staff needed to take to minimise the risk of reoccurrence.

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

Requires Improvement

Staff recognised incidents and reported them appropriately. The manager investigated incidents. However, there were no records to show that the manager shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff described what incidents to report and how to report them, incidents in the preceding 24 hours were also discussed at the morning management meeting.

Staff reported serious incidents clearly and in line with the providers policy.

Staff were able to describe their responsibilities in relation to duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

The manager debriefed and supported staff after any serious incidents.

The manager investigated incidents thoroughly. Patients and their families were involved in these investigations where appropriate.

Staff did not receive feedback from investigation of incidents via regular team meetings. No changes had been made as a result of feedback.

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

Good

Our rating of effective stayed the same. We rated it as 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 through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

During this inspection the multidisciplinary team told us care plans were reviewed daily at the morning meeting.

We looked at four care records, all of which were personalised, holistic and recovery orientated. The notes were well written with a psychiatric intensive care unit crisis plan in place informing, supporting and educating those in crisis to develop strengths and strategies to reach identified goals.

Staff completed comprehensive physical health care check and a mental health assessment of each patient either on admission or soon after. This included an ECG, drug screening test, blood tests, blood pressure and temperature. The ward staff completed base line physical observations on all patients daily. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. However, we found that not all patients had a detailed pre- admission assessment form present in their care records.

Staff regularly reviewed and updated care plans when patients' needs changed.

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

Requires Improvement

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff completed a 72 hour care plan on admission and within the first week the named nurse completed the keep connected, keeping safe, keeping well, keeping healthy and COVID-19 current restrictions care plans. Patients were offered a copy of their care plan and staff documented in the patient notes if this had been refused.

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. Staff used health of the nation outcome scores to measure the health and social functioning of people with mental illness.

The service participated in clinical audit, benchmarking and quality improvement initiatives.

Staff identified patients' physical health needs and dietary needs which were recorded in their care plans. Patients had access to physical health care, including specialists as required, for example podiatry and dentist.

Skilled staff to deliver care

The ward team 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 appraisals, 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 on the ward.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers made sure staff received any specialist training for their role. A health care assistant told us they had received training to undertaking ECG's and blood testing on patients.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Staff appraisal rates were 100% and clinical supervision rates were 100%.

Managers did not ensure staff attended regular team meetings or give information to those that could not attend. Staff were not updated on hospital governance and regional clinical governance, legal, ethical issues, relational security, environmental update, monitoring of clinical information, supervisions, appraisals, service user related issues, training, clinical risk management, therapeutic engagement, safe staffing, medication management, controlled drugs and service developments.

The manager recognised poor performance, could identify the reasons and dealt with these with support from the providers human resource team.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

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

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

Ward teams had effective working relationships with external teams and organisations, for example clinical commissioning groups and local authority safeguarding teams.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The provider reported 92% of permanent staff completed training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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 and patients who lacked capacity were automatically referred to the service.

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 and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Requires Improvement

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We looked at the Mental Health Act detention paperwork of two patients. The detention paperwork was complete and appeared to be in order. In both patients' paperwork, the MHA administrator had identified issues, during the scrutiny process, which they had raised with the approved mental health professionals.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The provider reported 92% of permanent staff completed training.

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

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

There were no Deprivation of Liberty Safeguards applications at the time of this inspection.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

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

Good

Our rating of caring stayed the same. We rated it as good

Kindness, privacy, dignity, respect, compassion and 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.

We observed staff were discreet, respectful, and responsive when caring for patients. They provided help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly.

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

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

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

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, easy read versions of information leaflets.

Staff involved patients in decisions about the service, when appropriate. Patients made suggestions on therapeutic activities.

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

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. The ward staff had access language interpreting services.

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this during the community meeting, the service displayed a “you said” “we did” board in the lounge area, which clearly demonstrated changes had been made based on feedback.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients had access to advocacy services.

Involvement of families and carers

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

Requires Improvement

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. The two carers we spoke with gave positive feedback about the staff. They said they felt well informed and could always talk to a staff member on the telephone.

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

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers made sure bed occupancy did not go above 85%. At the time of inspection there were six patients admitted to the ward.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. At the time of inspection one patient was being discharged back to home area after a five day stay. Managers and staff worked to make sure they did not discharge patients before they were ready.

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

Discharge and transfers of care

The service had one delayed discharge due to appropriate placement needs, in the past year.

Managers monitored the number of delayed discharges. The only reasons for delaying discharge from the service were clinical.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise based on risk assessment.

Patients had a secure place to store personal possessions in their bedrooms. Any contraband items were stored in a separate locker.

Staff used a full range of rooms and equipment to support treatment and care. The ward had several rooms to use for one to one time with patients, including a sensory room, a multi faith room and a de-escalation suite.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could make phone calls in private.

The service had an outside space that patients could access easily, with access to raised garden beds for the patient's therapeutic activities.

Patients could make their own hot drinks in the day room and snacks and were not dependent on staff.

The service offered a variety of good quality healthy food, snacks were available, and patients could access these when required.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff helped patients to stay in contact with families and carers. Patients had access to technology to enable them to keep in touch with family virtually. All patients had use of their own mobile phones. Staff supported the patients to charge their phones.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients regularly used the shops in the hospital grounds, the gym and walked around the hospital grounds. Staff told us the ward participated in a walking challenge around the hospital grounds with patients.

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 make adjustments for disabled people and those with communication needs or other specific needs. All patients had a personal emergency evacuation plan in place.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Posters were displayed throughout the ward.

The service had information leaflets available in languages spoken by the patients and local community. One patient told us they had their rights read to them in their spoken language with the help from translation services.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. One patient told us the food was excellent with plenty of healthy options.

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

Requires Improvement

Patients had access to spiritual, religious and cultural support and a multi faith room was available.

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.

We saw evidence of a recent complaint that the manager dealt with at local level with positive resolution. There had been no formal complaints in the last 12 months.

The service clearly displayed information in patient areas about how to raise a concern. Patients, relatives and carers we spoke to knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them.

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

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Requires Improvement

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they manage. However, the leadership, governance and culture of the ward did not always support the delivery of high-quality person-centred care.

Improvements were not always identified or shared within the team. Where changes were made, the impact on the quality and sustainability of care was not fully understood in advance or monitored.

We saw that staff satisfaction was mixed, one member of staff told us that improving staff satisfaction is not seen as a high priority. Staff did not always feel actively engaged or empowered. All staff we spoke with expressed concerns about the understaffing on other wards within the division. They told us that when they were fully staffed, managers moved staff to cover shortages of staff on other wards.

Leaders were not always aware of the risks, issues and challenges in the service as this information was not shared within the ward team meeting.

Vision and strategy

Staff did not fully understand the provider's vision and values and how they applied to the work of their team.

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

Requires Improvement

The ward displayed the organisational strategy, “relieve suffering, give hope and promote recovery”. The ward offered an evidence based clinical model that introduced a number of interventions that increase safety and improves relations between staff and patients, resulting in fewer assaults on staff. However, staff told us they were not fully informed at team meetings about the running of the hospital, risks and staffing. This impacted on staff morale and then patient care as a result. Staff did not fully understand how their role contributed to achieving the strategy.

We saw that progress against delivery of the strategy and plans was not effectively monitored or reviewed and there was no evidence of progress.

Culture

Staff did not feel respected, supported and valued. However, they said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression.

Staff did not always raise concerns as they felt they were not always taken seriously, appropriately supported, or treated with respect when they did.

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

The provider had a care awards initiative to celebrate success and improve the quality of care across the organisations four core values, accountability, compassion, respect and excellence. This award was presented monthly to nominated staff across the division.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

The arrangements for governance and performance management did not always operate effectively.

Managers advised that clinical audits were undertaken mainly by staff external to the wards. These included medication, infection control, clinical notes and case tracking. The staff we spoke with did not know the outcomes or action plans from audits, they did not know how this affected patient care and what improvements could be made.

However, managers had oversight to ensure mandatory training, appraisals and supervisions were completed. Managers ensured that staff were aware of the service COVID-19 testing arrangements. We were told COVID-19 risk assessments were in place, and posters were displayed in staff areas.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care.

The manager maintained and had access to the risk register and staff could escalate concerns in the daily meeting for adding to the risk register.

The service had plans for emergencies. For example, COVID-19 pandemic, fire plans and health emergencies.

Information management

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the population.

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

Requires Improvement

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.

The manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used.

Patients and carers had opportunities to give feedback on the service via feedback forms to reflect their individual needs.

The ward had a folder with compliments, thank you cards and complaints available for all staff to review. The manager ensured that feedback from patients was listened to and acted on.

Patients were involved in decision making about changes to the service.

Directorate leaders engaged with external stakeholders, such as commissioners and independent champions for health and social care.

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints On the wards for people with a learning disability or autism senior managers and staff were sometimes dismissive of complaints from patients with autism.

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 On the long stay rehabilitation wards staff had not completed discharge plans for all patients. Patients were not always aware of their specific goals for discharge. On the wards for people with a learning disability or autism the service had not fully responded to the needs of patients with autism in the ward environment. The design, layout, and furnishings of the ward did not always support patients' treatment. Staff did not always support, inform and involve families or carers. Patients regularly had their therapies or activities cancelled or cut short.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment On the forensic wards staff had not recognised or reported one safeguarding incident and we were not assured staff

This section is primarily information for the provider

Requirement notices

knew when to escalate incidents such as financial issues. Staff secluded another patient for longer than necessary, recording that the patient had been “relatively stable for the past two weeks whilst in seclusion”.

On the long stay rehabilitation wards the providers compliance with safeguarding level three training on two of the three wards was low at 60% and 63%.

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 Across all core services the providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data. At the psychiatric intensive care unit the manager did not share lessons learned with the whole team when things went wrong. Improvements were not always identified or shared within the team. The leadership, governance and culture for the ward did not always support the delivery of high-quality person-centred care. Staff did not always raise concerns as they felt they were not always taken seriously, appropriately supported, or treated with respect when they did. Not all leaders had the necessary experience, knowledge, capacity, capability or integrity to lead effectively. Staff did not understand how their role contributed to achieving the service strategy. Staff did not always feel respected, supported or valued. On the forensic wards managers did not ensure staff kept accurate records. Senior leaders were not always visible on the wards. Two managers told us they did not feel supported by senior leaders on matters such as staffing levels and recording supervision. These managers told us they felt senior managers did not fully appreciate the pressures faced by staff on the wards and their focus was on different priorities for the service. Governance systems and processes were not always robust. We were not assured managers would recognise and identify all potential risk issues.

This section is primarily information for the provider

Requirement notices

On the wards for people with learning disabilities or autism leadership and governance arrangements had not addressed previous issues or ensured concerns were identified and acted on. Leaders did not always have a good understanding of the services they managed. Not all staff felt respected, supported and valued by senior managers. Not all staff felt they could raise any concerns without fear of retribution from senior managers.

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 On the psychiatric intensive care unit staff undertook patient observations for long periods of time without a break. This impacted on staff well-being, morale and patient care. Observations were not completed in line with policy and guidelines by the National Institute for Health and Care Excellence. We were not assured staff knew the individual risks for patients which meant they might not be able to identify a deterioration in patients mental health, which may put staff and patients at risk. On the forensic wards staff were not always completing patient's observation records accurately and staff did not always receive breaks between observing patients. Only 54% of registered nurses completed immediate life support training. This posed a risk to patients who require immediate medical attention. Across the service five out twelve nurse call alarms were either not working or damaged. Five of eighteen care plans we reviewed were incomplete and staff had not followed up on the progress notes. Staff had not followed physical healthcare plans of two patients. Seclusion rooms on all wards met most but not all guidance in the Mental Health Act Code of Practice. There was no exit plan for a patient in long term segregation on one of the wards. Staff did not always keep clear records or follow best practice guidelines when patients were in long term segregation or seclusion. On the long stay rehabilitation wards clinic rooms were not adequately equipped to meet patient need. Two of the three wards did not have access to emergency

This section is primarily information for the provider

Requirement notices

resuscitation equipment on the ward. All three wards did not have oxygen signs on the clinic room door. The seclusion rooms consisted of blind spots that the staff were not aware of. This increased the risk of patients harming themselves when using the facilities. We found blind spots in the garden that the staff were not aware of. Staff did not always learn lessons from incidents and follow processes put into place after incidents.

On the wards for people with a learning disability or autism staff did not always ensure patients' physical healthcare needs were met. Staff were not always following systems and processes when administering, recording and storing medicines. Not all ward areas were safe, clean and well maintained. Seclusion rooms did not meet all of the guidance in the Mental Health Act Code of Practice. When a patient was placed in seclusion or long term segregation staff did not always follow best practice guidelines in the Mental Health Act Code of Practice. Managers had not ensured all staff completed mandatory training.

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 psychiatric intensive care unit was regularly short staffed because managers moved staff to other wards to cover shortfalls. The forensic wards did not have enough nursing or support staff to keep patients safe and ensure all patients care needs were met all the time. On the long stay rehabilitation wards managers allocated therapy staff to frontline shift work due to staffing shortages which impacted on the delivery of therapies to patients. Patients leave was affected by and planned around staffing levels and not around patient choice. We found therapy sessions had been cut short or cancelled due to staffing levels.

Regulated activity	Regulation

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Requirement notices

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

Treatment of disease, disorder or injury

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

On the forensic inpatient/secure wards staff did not always protect the privacy and dignity of a patient in seclusion.

On the wards for people with a learning disability or autism senior managers and staff did not always treat patients with compassion and kindness.

This section is primarily information for the provider

Enforcement actions

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 On the wards for people with learning disabilities or autism staff did not manage risks to patients and themselves well. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. Staff did not always know what incidents to report and how to report them.

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 wards for people with learning disabilities and autism did not have enough nursing and support staff to keep patients safe and the wards were regularly short staffed. Patients regularly had their escorted leave, therapies or activities cancelled or cut short, due to staffing shortages.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment On the wards for people with a learning disability or autism staff were unable to define a closed culture. Staff kept a patient in seclusion for longer than required.