Bradley Complex Care

Quality Report

Bradley Road
Grimsby
DN37 0AA
Tel: 01472 875800
Website: www.elysiumhealthcare.co.uk/learning-disabilities-autism/hospitals/bradley-complex-care

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Bradley Complex Care as Good because:

- Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- 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 recognised rating scales to assess and record severity and outcomes.
- The hospital included or had access to the full range of specialists required to meet the needs of patients. Managers ensured that these staff received training, supervision and appraisal. The hospital staff worked well together as a multidisciplinary team and with those outside the hospital 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.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They involved patients in decisions around their care and treatment.
- Staff managed admissions and bed occupancy well and ensured patients always had a bed on return from leave. They carefully planned patients' discharges with external services to make sure this went well and supported patients when they were transferred to prevent readmission.
- Managers had the skills and experience to perform their roles, Staff felt supported and able to raise concerns without fear. The provider had an effective governance structure to monitor and improve performance.

However:

- The service did not have enough night time medical cover available to attend the hospital quickly in an emergency. Managers could not be assured that staff were recognising incidences of seclusion and therefore keeping appropriate records which are required to ensure the necessary safeguards are applied.
- The hospital environment had some areas where staff had limited visibility and some of the apartments had bathrooms which were damp and musty.
- Staff did not document all the patient's needs in their care plans and ensure that they were recovery orientated. Records did not clearly show the patient's discharge plans.
- Staff did not fully involve families and carers in decisions around the care and treatment of the patient.
- The service did not always use effective communication formats for patient information such as signage and care plans.

Summary of findings

Contents

Good

Location name here

Services we looked at

Long stay or rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Bradley Complex Care

Bradley Complex Care is a high dependency long stay rehabilitation unit located on the outskirts of Bradley near Grimsby. The hospital was taken over by Elysium Healthcare in October 2017. In April 2018 they became a locked rehabilitation hospital having previously been a low secure provision. The hospital provides care and treatment for up to 20 patients both male and female that have learning disabilities and complex conditions such as a personality disorder, mental health problems and autistic spectrum disorders.

At the time of our inspection, the hospital had 14 patients; of these, 12 were detained under the Mental Health Act 1983 and two patients were on Deprivation of Liberty Safeguards. Two patients were on Section 17 leave and therefore not present during the days of inspection. There were seven males present and five females. Patients were admitted to the hospital from throughout the country; there were no patients from the local area.

The inpatient accommodation consisted of 20 beds in eight separate apartments surrounding a central courtyard, with a gymnasium, physical health room, clinic room, activity room, advocacy office and computer room. Each apartment had between one and four individual bedrooms. One apartment had been adapted for wheelchair or bariatric patients. Apartments could be used for either gender, depending on the patient's presentation, but an apartment was never used by patients of different genders at the same time.

Bradley Complex Care has been registered with the Care Quality Commission (CQC) since 2011 to provide the following regulated activities:

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

The hospital has a registered manager in place.

There have been eleven previous inspections carried out at Bradley Complex Care. The Care Quality Commission's last comprehensive inspection of the hospital took place in February 2018 where it was rated good in all domains. Following the comprehensive inspection, we carried out a responsive focussed inspection in June 2019 looking at the safe and well led domains following concerns. During this inspection, the overall rating for the hospital went down to requires improvement with an inadequate rating in the safe domain and a requires improvement rating in the well led domain. The service has since made improvements to address these concerns.

Our inspection team

The team that inspected the service comprised two CQC inspectors, one CQC Mental Health Act Reviewer, two specialist advisors and one expert by experience.

An expert by experience is a person who has lived experience of using health and care services or the carer of a person using services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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Summary of this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the apartments at the hospital, looked at the quality of the environment and observed how staff were caring for patients;
- spoke with 11 patients who were using the service;
- spoke with the relatives or carers for five patients;
- spoke with the registered manager;
- spoke with 22 other staff members; including the psychiatrist, nurses, recovery workers, the psychologist, occupational therapists and agency staff;
- spoke with an independent mental health advocate;
- attended and observed one hand-over meetings, one daily MDT meeting and five individual care review meeting;
- observed one patient activity and one positive behaviour support workshop;
- looked at eight care and treatment records of patients including mental health documentation;
- looked at 11 staff files including six agency records;
- carried out a specific check of the medication management and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 11 patients and the relatives or carers of five patients. Patients told us that they thought the staff were kind, that they could talk to them about their medicines and that they understood them. They informed us that staff knocked before entering their bedrooms and that they could phone their families when they wanted to. They felt the hospital was clean and that they mostly felt safe. They were able to attend their own meetings and some were able to describe their care plans.

Relatives or carers were generally happy with the service. Most were unable to visit regularly due to the distance to travel but received regular phone calls. They told us that the hospital had moved their loved ones forward in leaps and bounds and they were more stable. They believed the patients to be really happy.

One relative thought their son needed more continuity in his care due to staff understanding of his rare condition.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- The service did not have enough night time medical cover available to attend the hospital quickly for a psychiatric emergency.
- Managers could not be assured that staff were recognising incidences of seclusion and therefore keeping the appropriate records which are required to ensure the necessary safeguards are applied.
- The hospital had some blanket restrictions in place, however these were being addressed during our inspection.
- One apartment in the hospital did not allow staff to observe all areas; there was limited visibility from the kitchen area.
- The bathrooms in some apartments were inadequately ventilated with a damp and musty smell.

However:

- The service had enough nursing and medical staff during the daytime, who knew the patients and received basic training to keep patients safe from avoidable harm. They had reducing rates of agency staff and had improved recruitment checks and the induction process for those agency staff used.
- Staff assessed and managed risks to patients and themselves well. 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. All staff were trained in appropriate restraint techniques.
- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The hospital had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt with the whole team.

Summary of this inspection

Are services effective?

Good

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes.
- The hospital included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with a 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.
- 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.
- 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.

However:

- Staff did not ensure care plans were recovery orientated or that they reflected all assessed needs.
- Staff did not always ensure a patient's rights were explained without delays on admission.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity.
- Staff understood the individual needs of patients and supported them to understand and manage their care, treatment or condition. Patient meetings were person-centred and conducted in a way to fully involve the patient in decisions.

Summary of this inspection

- Staff ensured that patients had easy access to independent advocates.

However:

- Staff did not always involve families and carers in decisions around the patient's care and treatment.

Are services responsive?

Good

We rated responsive as good because:

- Staff managed admissions and bed occupancy well and ensured patients always had a bed on return from leave.
- Staff carefully planned patients' discharges with external services to make sure this went well and supported patients when they were transferred to prevent readmission.
- The design and layout of the hospital supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and easy access to outside space.
- When appropriate, staff supported patients to self-cater. They could make hot drinks and snacks at any time.
- Staff supported patients with activities. These included outside the service.
- The hospital met the cultural and spiritual needs of patients who used the service and made adjustments for those with physical disabilities.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results, and shared these with the whole team.

However:

- Staff did not clearly document a patient's discharge plans in their care and treatment records.
- Patients were not always offered a secure place to store personal possessions.
- The service had limited information around the hospital and in patient records which was in a format to support effective communication.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

Summary of this inspection

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at hospital level and that performance and risk were managed well.
- Staff had access to the information they needed to provide safe and effective care and used that information to good effect.

Detailed findings from this inspection

Mental Health Act responsibilities

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

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

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 all patients were automatically referred to the service.

Staff mostly explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. However, it was not always clear if staff explained the rights to the patients as soon as possible after admission or the reasons for any delays.

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

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

Mental Capacity Act and Deprivation of Liberty Safeguards

CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

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 the principles.

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 if this was required.

Staff gave patients 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.

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

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Notes

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Requires improvement

Safe and clean environment

The apartments were in the process of being refurbished; this was due to be fully completed early in 2020. This included all fixtures, fittings and flooring as well as communal areas.

The provider completed risk assessments of the care environment. This included an annual ligature assessment which was last completed in August 2019. Staff mitigated identified risks adequately. Staff were allocated to individual apartments and could observe all areas. However, one apartment had limited visibility to the kitchen area with only a viewing hole in the door; this meant staff could not fully see if a patient was present on the other side of the door.

The hospital 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. The hospital's recent patient survey showed that all nine of the patients who responded felt safe and looked after.

The hospital was generally clean, well maintained and well furnished. However, there were some gaps in the cleaning records and the showers had a damp smell. This had been identified by managers due to the bathrooms not having extraction fans and was on the hospital's risk register with actions relating to the current refurbishment programme. Members of the multi-disciplinary team discussed maintenance in their daily meeting and had introduced daily walk arounds with both clinical and maintenance staff to address issues.

Staff followed infection control principles, including handwashing.

The hospital did not have a dedicated seclusion room.

The clinic room was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it clean.

Safe staffing

The service had enough nursing and recovery workers to keep patients safe. Managers calculated the number of staff required on a daily basis. All patients had bespoke packages of care with their clinical commissioning groups which could change. Managers were able to adjust staffing levels to take account of this along with changing levels of observations.

Between 1 October 2018 to 30 September 2019, the service had 116 substantive staff. They had an ongoing recruitment drive which had reduced the number of vacancies. At the time of our inspection there was a vacancy for 1.75 nursing posts and 20 recovery workers. There was also a vacancy for a speech and language therapist and a housekeeper. There was a sickness rate of 9.5%. The provider had introduced walk around sessions for potential new staff which was patient led. The aim being to allow people to see the environment and patient group prior to commencing employment and there to aid retention.

Long stay or rehabilitation mental health wards for working age adults

Good

The service had reducing rates of agency staff. They had increased staff on the hospitals bank; these were all staff who were employed by the hospital working regular shifts at Bradley Complex Care. During our focussed inspection in June 2019, agency staff filled 30% of the daytime shifts and 55% of the night shifts. In the three months prior to our inspection, there were six unfilled shifts in total; agency use was at 54% overall, however, 43% of these were long term locum staff who wished to remain on an agency contract for personal reasons. These staff were block booked through one agency and received supervision and inductions as per permanent staff.

Managers requested agency staff familiar with the service. They had decreased the number of agencies they used from 12 to six agencies and improved their checks relating to training and risks.

They ensured all bank staff had a full induction and understood the service before starting their shift. The hospital had improved the induction process for agency staff to include two-day classroom-based introduction, a welcome pack along with the walkaround of the hospital.

Patients rarely had their leave or activities cancelled due to staff shortages. In the three months prior to our inspection, leave was cancelled in 1.8% of cases due to resources.

The hospital had enough staff on each shift to carry out any physical interventions safely.

The hospital had enough day time medical cover. However, it did not have adequate provision for medical cover during a night time. There was a full-time psychiatrist working day time hours. The provider had an on-call duty rota outside normal working hours. This consisted of the psychiatrist for Bradley Complex Care and doctors from other hospitals from the provider group. It could take the psychiatrist from Bradley Complex Care an hour to attend the hospital out of hours if required in an emergency. The other doctors on the rota would take longer to attend. Both the registered manager and the service manager would take over 30 minutes to attend if required. The psychiatrist told us that they would be available outside their rota's duties and that they would provide telephone advice if needed. Hospital staff would use the 999 emergency services for all physical health emergencies. However, they would not be available in person at the hospital within an hour if required to instigate or authorise medical care in a psychiatric emergency.

Staff completed and kept up to date with their mandatory training. The compliance for mandatory training course at the time of our inspection was 85.4%, this had improved since our inspection in June 2019. The provider set a target of 85% for completion of mandatory training. There were five units with low compliance rates. Safe administration of medications had a compliance rate of 67% and level two infection control had a compliance rate of 72%; both these units had included recovery workers in their data and managers were addressing this as they did not require this level of training. Training units for Prevent, Security and suggestions were now all covered in staff inductions, the provider was therefore due to remove these units from their mandatory training list.

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.

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient on admission using a recognised tool and reviewed this regularly, including after any incident. They used the Historical, Clinical, Risk Management-20 assessment tool to help estimate a patient's probability of risk. Staff identified and responded to changing risks and discussed in handover meetings and care reviews. We reviewed eight patient's records; all had up to date risk assessments and management plans.

Staff knew about any risks to each patient and acted to prevent or reduce these. They identified and responded to changes in risks to or posed by patients. They followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The responsible clinician was required to authorise any searches.

Staff participated in the provider's restrictive interventions reduction programme which was led by the regional provider lead. This was in its infancy and there had only been one meeting at the time of our inspection. The meeting looked at themes, staffing, proactive and preventative measures; it was attended by responsible clinicians, psychology, nurses and external stakeholders. The local aim was to reduce the incidence of harm caused

to patients and staff as a result of the use of physical restraint. The strategy considered positive behavioural plans and training, keeping safe care plans, service user surveys, ligature audits, community meetings and debriefs.

Levels of restrictive interventions were reducing. There were 482 incidents of restraint (15 patients) in the 12-month period prior to our inspection. Twelve restraints were in the prone position. We were told this was where the patient had put themselves face down. There were 55 incidences of rapid tranquilisation over the reporting period. Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation. Staff made every effort 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. The hospital used Therapeutic Management of Violence & Aggression (TMVA) training for all their permanent staff. They only employed agency staff who were either trained in this or Prevention and Management of Violence and Aggression (PMVA) as both techniques worked alongside each other. We looked at 11 staff files (six of these agency workers), all had received this level of training with certification. There had been no instances of mechanical restraint over the reporting period. All incidents were discussed in the daily multi-disciplinary meeting including the techniques used and what could be done to reduce these. Patients told us that staff talked to them during and after the restraint and explained what they were doing and why.

The hospital was reducing the number of blanket restrictions which limited a patient's freedom to move around the hospital freely without limiting their independence. Our inspection in June 2019 evidenced blanket restrictions with all apartment doors being locked. On this inspection all apartment doors (with the exception of one risk assessed door) were unlocked for patients. However, the current locks meant that patients could freely open the apartment door from the inside but would need a key if they wished to enter their apartment from the outside as handles were not present. However, at the time of the inspection, the hospital had contractors in who were in the process of installing a fob system for all apartment doors. This work was underway and due to go 'live' by the end of the week following our inspection. The new system would enable staff to individually programme each patient's fob to enable patients to access all hospital doors and areas depending on their risk factors.

When a patient was placed in seclusion, staff did not keep clear records or followed best practice guidelines. The hospital did not have a dedicated seclusion room. The registered manager told us that staff would follow the necessary safeguarding requirements (for seclusion) if a person was to be locked in their apartment or room. They had an organisational seclusion policy and documentation to be used if a patient was secluded. We asked for the data relating to incidents where a patient may be 'secluded' and these safeguards were carried out. The provider told us there were no incidents in the 12-month period prior to inspection.However, we asked staff during interviews if they had ever been aware of patients being locked in their apartment or rooms. One staff member told us of a patient that had been locked in his room for approximately two minutes on the afternoon of inspection. We were told that this had not happened in the last two months but indicated that this had occurred prior to this. We followed this up and saw that the patient had a positive behaviour support plan in place to describe why this would occur. This was in agreement with the patient and the patient was in eyesight view during this time. We spoke to the staff nurse on duty who agreed that this was in fact seclusion regardless of the length of time (the patient was secluded for his own safety and that of others; this was while the nurse and consultant psychiatrist were called to talk to the patient).This meant that managers could not be assured that staff were appropriately recognising seclusion and therefore, keeping appropriate records or applying the necessary safeguards.

Safeguarding

Staff understood what constituted a safeguarding concern and worked with other agencies to protect patients from abuse. They had training on how to recognise and report abuse, and they knew how to apply it.

Staff could give examples of how to protect patients from harassment and discrimination including those with protected characteristics under the Equality Act. They followed clear procedures to keep children safe if visiting the hospital.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. A safeguarding referral is a request from a member of the public or a professional to

the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The hospital made 10 safeguarding referrals in the reporting period. They also submitted a monthly low-level log detailing those concerns which did not meet an agreed threshold for an individual concern. These mostly consisted of patient on patient altercations. The hospital had a safeguarding lead and safeguarding was included in discussions at handover meetings, the daily multi-disciplinary meeting and in individual patient reviews.

Staff access to essential information

Staff had access to clinical information and it was easy for them to maintain clinical records. The hospital used a combination of electronic and paper records, staff made sure they were up to date and complete. Care plans and risk assessments were printed from the system to provide paper copies for staff to access. These were kept in the nurse's office and within the apartment area, Staff we spoke with told us that they knew where to access records and could describe how this was done and the details around the care needed and the risks of the patient. However, the paper notes kept in patient's apartments were not always maintained in a consistent manner. This meant that if staff moved around apartments, the information required was accessible but may not always be found in the same place in the files. There were laptops in some apartments for staff to enter notes; some apartments did not have laptops due to damage and these were being replaced. Staff were able to use the nurse's station to record notes if needed. Agency workers were given access to electronic records. They also now recorded on a daily timesheet whether they had any issues accessing notes.

Medicines management

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

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. However, we identified four gaps in patient's medication records to confirm if information about their medicines was discussed. They stored and managed medicines and prescribing documents in line with the provider's policy and followed current national practice to check patients had the correct medicines.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The hospital was involved in the Stopping over medication of people with a learning disability, autism or both (STOMP) agenda and had a hospital audit and action plan to monitor this.

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

Medicines reconciliation was done daily by the night time site co-ordinator. Nurses conducted daily checks for controlled drugs and checks on patient's medications on admission. The hospital had a contract with a pharmacy who carried out quarterly audits.

Track record on safety

The service had a good track record on safety.

Between 1 October 2018 and 30 September 2019 there were four serious incidents reported by this service. This comprised one incident where the police were called to assist with a patient, a call to the fire service for a small fire, one patient absconding and one incident where a patient had assaulted a member of the public while on an activity. The provider carried out full investigations for all serious incidents.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers investigated incidents and shared lessons learnt with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The majority of incidents within the service were low level violence and aggression. The service very rarely had serious incidents however, regardless of the severity, all were reviewed by the multi-disciplinary team. Incidents were recorded electronically with full details enabling the team to monitor themes and respond with actions and lessons to be learnt.

Staff understood the duty of candour. The provider familiarised staff with their duty of candour policy during induction and included this in their annual refresher training.

Managers debriefed and supported staff after any serious incident. Staff received 'hot' debriefs immediately after an incident and 'cold' debriefs later to enable reflective discussions and any lessons learnt. Patients told us that staff talked to them following an incident.

Staff met to discuss the feedback and look at improvements to patient care in reflective practice sessions and in positive behaviour support workshops.

Managers shared learning with their staff about themes, investigation outcomes and lessons learnt in staff meetings.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

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

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 at the hospital.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed the care plans for eight patients. All had detailed and up to date plans. The care plans were simple to follow with four domains, keeping well, safe, connected and healthy. All patients also had positive behaviour support plans. The information from the positive behaviour support plans was reflected in the care plans.

Care plans were personalised and holistic. However, they did not clearly document how they reflected the patient's views, and they did not record what a patient's goals were to progress. For example, they did not show what steps a patient would need to achieve to either reduce their observation levels or move towards discharge. Our observations of the patient's meetings with the multi-disciplinary team evidenced these conversations took place with the patients yet they were not reflected in the care plan records. The hospital also had one patient whose apartment was sparsely furnished. This was by the request of the clinical commissioning group and the patient. However, there were no specific details in the patient's care plan to reflect this.

Staff from the hospital participated in care and treatment reviews which were co-ordinated by the clinical commissioning groups.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. They delivered care in line with best practice and national guidance. They used a positive behaviour support approach underpinned by a range of

therapeutic models including cognitive behavioural therapy, dialectical behaviour therapy and compassion focussed therapy. Staff, including nurses and recovery workers, attended positive behaviour support workshops for individual patients. These were led by the psychology department and attended in part by the patient.

Staff identified patients' physical health needs and recorded them in their care plans. All patients were registered with a local GP provider who visited the hospital weekly. Patients were also able to attend the practice outside of these weekly visits. The hospital had a full-time physical health co-ordinator who conducted annual checks. The provider had a regional physical health lead. The hospital nurses were a combination of general nurses, mental health nurses and learning disability nurses. Staff made sure patients had access to physical health care, including specialists as required. Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, some patients participated in walking activities using electronic devices, a local gym organisation attended the hospital weekly for patients to participate in gym sessions such as football and basketball. One patient delivered mindfulness sessions to other patients and two patients had recently attended a healthy lives conference. Staff also helped patients produce a healthy recipe book.

On our previous inspection, we observed that the hospital had implemented a no smoking policy for patients. However, there was a designated smoking area used by staff. We observed patients walking past this area on several occasions while staff were smoking. Since the inspection in June 2019, the hospital extended the no smoking policy to include staff.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included the Wechsler Adult Intelligence Scale (WAIS) to measure intelligence and cognitive ability, the Behavioural Assessment of the Dysexecutive Syndrome (BADS) and The Modified Overt Aggression Scale (MOAS). They completed the Adaptive Behaviour Assessment Systems (ABAS-3) for all patients. The hospital's occupational therapists used the The Functional Independence Measure (FIM&FAM) to measure the patient's disability. The hospital had recently received the licence to introduce the Model of Human Occupation (MOHO) tool to help staff consider individual therapies. The hospital used the health of the nation outcomes scales to measure the health and social functioning of their patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. For example, nurses used the National Early Warning Score tool to detect and respond to clinical deterioration. They participated in the STOMP audit - to reduce medication for those who have a learning disability due to physical health care concerns.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients. 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. They had improved their recruitment of agency workers since our inspection in June 2019 to confirm the necessary training. The service had a current vacancy for a speech and language therapist at the time of our inspection. Whilst this post was out for recruitment, patients had access to a bank therapist from another hospital.

Managers gave each new member of staff a full induction to the service before they started work. This included a new induction process for agency staff which involved both classroom training and an induction around the hospital before starting their shift. All agency staff also received an induction pack detailing policies, members of the multidisciplinary team and induction checklists.

Managers supported staff through regular, constructive appraisals of their work. The service had an 80% compliance for staff appraisals.

Managers supported staff through regular, constructive clinical supervision of their work. The provider's target for supervision was for staff to receive four 1:1 supervisions in a twelve-month period. The hospital had an overall compliance of 77.5% for permanent staff (88.5% for nurses and 77.5% for recovery workers). Agency staff gave us a varied account of supervision. They mostly informed us that supervision was not always formal. They did however feel supported and received informal supervision where they felt able to be open and honest. One agency worker told us they did not receive either formal or informal supervision. All staff had the opportunity to attend reflective practice sessions which were held monthly.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers made sure staff attended regular team meetings or gave information from those they could not attend. The meetings were held monthly at varying times to help facilitate different shifts. They were attended by members of the multidisciplinary team and minutes were taken for those unable to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. They made sure staff received any specialist training for their role. This included training in Makaton, epilepsy, autism, diabetes, dysphagia and phlebotomy. Nurses participated in monthly continual professional development days where they were able to meet as a team to look at their roles and issues.

Managers recognised poor performance, could identify the reasons and dealt with these. They followed the provider's policy and were supported by regional leads.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. They made sure they shared clear information about patients and any changes.

Members of the multidisciplinary team attended a daily meeting to discuss the previous days incidents and address necessary actions. The meeting included discussions on staffing levels, observations, activities for the day, admissions, discharges and any maintenance work.

There was a staff handover meeting for all staff starting their shift. All patients were discussed including observation levels, risks, allocations and incidents.

Patients had an individual care review at least monthly. For new patients and those with increasing risks these were held more frequently. All members of the multidisciplinary team attended and contributed effectively. The patient was invited, and in most cases attended the meeting and were included in all discussions. Commissioners community teams and advocates were invited and could dial into the meeting if unable to attend in person. Family members were not invited routinely. The meeting included discussions around medication, leave, activities, incidents, discharge, capacity, observations and family involvement.

Staff across the hospital had good working relationships and were able to contribute to discussions about a patient's care.

Adherence to the MHA and the MHA Code of Practice

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. All staff were required to complete the training. The hospital had a compliance rate of 85%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who to contact for support and legal advice if needed.

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

Patients had easy access to information about independent mental health advocacy and all patients who were automatically referred to the service. The independent advocate visited the service two days per week and met with all new patients. There was a dedicated advocates room in an area of the hospital accessible to patients. The advocate also visited the individual apartments on a weekly basis and attended the patient's community group.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand and repeated this as necessary and recorded it clearly in the patient's notes each time. This was done by the patient's named nurse or a recovery worker with a good relationship with the patient to aid understanding. Some records showed delays from admission in rights being explained. It was unclear from the records when they should be explained particularly for those patients with a lack of understanding.

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.

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

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

Long stay or rehabilitation mental health wards for working age adults

Good

Good practice in applying the MCA

Staff received and kept up-to-date with, training in the Mental Capacity Act and had a good understanding of the principles. All staff were required to complete the training. The hospital had a compliance rate of 78% which was below the provider's target.

There was one Deprivation of Liberty Safeguards application made in the last 6 months and managers monitored staff so they did 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 if this was required.

Staff gave patients 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. Capacity assessments were discussed as part of a patient's individual care review. We evidenced capacity assessments and discussions around finances and medications

The service monitored how well staff 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 were discreet, respectful, and responsive when caring for patients. They gave patients help, emotional support and advice when they needed it. Each patient was allocated a named nurse and the service aimed to match a core staff team with patients to help provide the most effective care. Patients told us staff knocked before entering their rooms. Staff from the multidisciplinary team offered patients the opportunity to have less staff in their individual care reviews meetings if this made it easier for the patient to join in with discussions.

Staff supported patients to understand and manage their own care treatment or condition. They 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 understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. They followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment where possible and actively sought their feedback on the quality of care provided. However, this was not always clearly evidenced in a patient's care plan documentation. They ensured that patients had easy access to independent advocates.

Staff introduced patients to the hospital as part of their admission. They sought information from the previous provider to help patients feel comfortable on arriving at the hospital. For example, they provided patients with a welcome pack containing the patient's favourite items on their admission, such as colouring books and toiletries. Staff painted a patient's bedroom with her favourite colour ahead of her admission. Staff aimed to link patients according to their interests such as computer games.

Staff involved patients and gave them access to their care planning and risk assessments where this was possible. They took practical steps to help patients understand their care and treatment. These were discussed with patients in their individual meetings and patients attended positive behaviour support workshops. Some patients understood their care plans whilst others had limited understanding. Patient meetings were person-centred and conducted in a way to fully include the patient in discussions about their care.

Staff involved patients in decisions about the service, when appropriate. Patients were able to attend community

Long stay or rehabilitation mental health wards for working age adults

Good

meetings and be involved in the service user involvement meetings. They could give feedback on the service and their treatment and staff supported them to do this through 1:1 sessions with their named nurse or with the advocate. Patients were invited to complete a survey annually and on their discharge. The service used patients in their recruitment process.

Staff did not always inform and involve families and carers appropriately. The hospital held family days such as a Halloween party. However, attendance from family was limited; this may be due to the distance families needed to travel. They were not routinely invited to the patient's individual care reviews unless there were concerns. There was little input from families reflected in care plans especially when the care plan noted that the patient had no comment.

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

Good

Access and discharge

Staff managed admissions and occupancy of the hospital well. They made sure bed occupancy did not go above 85%. The mean average occupancy over the six-month period prior to our inspection was 75%. Members of the multidisciplinary team discussed referrals in their daily meeting and took into consideration the current patient mix and if the patient's treatment needs could be met. When patients went on leave there was always a bed available when they returned.

Managers reviewed the length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay for patients discharged in the 12-month period prior to our inspection was 64 months. This was for 10 patients. The service reported no readmissions for these patients.

Staff planned and managed discharges well. However, this was not always captured in the patient's care records. They used the care treatment review process to plan a patient's discharge pathway. They liaised well with services that would provide aftercare and were assertive in managing the discharge. Discharges were only delayed due to waiting for bespoke accommodation to be built and identifying appropriate staffing teams. We observed discussions in the patient's individual care reviews about their discharge plans. However, patient care and treatment records did not reflect clear plans around discharge. For example, one patient's record showed a care and treatment review with the patient's clinical commissioning group in September 2019, yet there was no action plan from this and no evidence to show the hospital had requested it. We saw templates for discharge planning which were suitable for a patient to understand, however, these had not been completed.

Staff supported patients when they were referred or transferred between services. They visited the patient's prior and ongoing placements. The patient's core staff team went with the patient to the new provision for a period of time if needed, to help the transition and to support the patient's new staff team.

The facilities promote recovery, comfort, dignity and confidentiality

Each patient had their own bedroom, which they could personalise. They received a budget on their admission towards soft furnishings. Bedrooms had en-suite facilities. All patients had access to a central communal courtyard; five of the apartments also had their own gardens. Staff used a full range of rooms and equipment to support treatment and care. There was a gym, computer room, clinic room, activity room and chill out room for patients to use.

Patients did not all have a secure place to store personal possessions in their apartments. The newly refurbished apartments all contained lockable storage which patients would be offered keys to upon risk assessment. Some of the yet-to-be refurbished apartments had secure storage, but it was unclear whether keys were routinely offered. There was however, a safe in the nurse's office which we were told patients could use.

The service had quiet areas and a room where patients could meet with visitors or make phone calls in private. They had access to their own mobile phone and internet access was available in the computer room following risk assessment.

Patients had access to kitchens in their apartments and could make their own hot drinks and snacks. Staff supported them to plan, shop and cook their meals dependent on their individual risks and abilities. There was an activity programme for five days of the week including trips in the community. Other activities included art therapy, budgeting skills, healthy eating, gardening and computing. One patient had a job inside the hospital keeping the reception area tidy for which they received a weekly voucher. Another patient helped the grounds staff with work such as cleaning windows.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. They had forged positive links with a local organisation for people with disabilities. Patients regularly visited the organisation which provided learning, training, leisure, sporting and social activities. Staff encouraged patients to engage in local activities. For example, patients had attended a flower arranging class, Zumba in the community and golf lessons. The hospital had good relationships with the local swimming pool and a local hairdresser. Some of the patients had bus passes to promote independence in the community.

Staff helped patients to stay in contact with families and carers. All the families were located outside the local area, so this was often via phone and video links.

Meeting the needs of all people who use the service

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

All patient areas in the hospital were on ground floor level and one apartment had been adapted for wheelchair or bariatric patients. The hospital had one patient who was deaf; they had sourced silent fire alarms to accommodate their disability.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There was information boards in communal areas of the hospital and each apartment had a further information board. However, we found that the information visible in each apartment was often inconsistent and did not always include information relating to advocacy.

We were told that the hospital could access information leaflets available in languages spoken by the patients and local community if this was needed. At the time of our inspection, English was the first language for all patients. The provider had used interpreters on previous occasions and had access to them. They could translate information into different languages if required. The multidisciplinary team would consider a referral where English was not the patient's first language prior to admission to ensure they could effectively meet the patient's needs.

There was limited evidence to show how staff communicated with non-verbal patients. We saw one picture communication board in a patient's apartment and observed one 'my life' booklet in easy read format. However, we did not see patient information such as care plans or hospital signage in an easy read format. Some staff had been trained in Makaton methods of communication, but we were told the hospital had no current patients who used this.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients were regularly involved in planning their meals and therefore able to contribute to considerations around their cultural. Staff were educated around specific dietary requirements.

Patients had access to spiritual, religious and cultural support. Staff were able to support patients to attend external venues such as churches or mosques; there was one room which doubled up as a spiritual room if required.

Listening to and learning from concerns and complaints

Patients, relatives and carers knew how to complain or raise concerns to the hospital. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. There was a complaints and compliments book in the main reception area and each patient's apartment had a book where they could raise a complaint. The independent mental health advocate saw patients regularly and supported them with complaints if they had any. The hospital did not display information about how to raise a concern to the CQC in the apartment information boards.

Managers discussed both formal and informal complaints and looked at themes. Formal complaints were recorded on the service's dashboard and escalated to the provider's board meetings.

Long stay or rehabilitation mental health wards for working age adults

Good

Bradley Complex Care reported receiving two complaints in the 12 months prior to the time of reporting. One of the complaints was upheld and none were referred to the Ombudsman.

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 learning was used to improve the service through team meetings, reflective practice sessions and handovers.

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

Good

Leadership

Managers at all levels in the hospital had the right skills and abilities to run the service. They had a good understanding of rehabilitation care and could clearly explain how staff were working to achieve this. Patients and staff knew who they were and could approach them with any concerns.

The provider supported staff to develop their skills into leadership opportunities.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders including patients. Their vision was to empower and support patients to achieve their goals. This was underpinned by their values of innovation, empowerment, collaboration, integrity and compassion.

The provider's vision and values and how these were implemented into working practice was included in all staff inductions. Staff discussed the values within their supervisions. The hospital held staff awards which reinforced staff behaviours demonstrating the values.

Culture

CQC are conscious that services providing treatment for people with a learning disability or autism are a potential risk of providing a closed or punitive culture. During the inspection, the inspection team took practical steps in their commitment to ensure inherent risks and warning signs were considered to ensure Bradley Complex Care's culture protected their patient's human rights. The environment at the hospital meant that staff were regularly in individual patient apartments without manager's oversight; this made the identification of the hospital's culture sometimes difficult to establish during the inspection. However, within these limitations, we did not identify any concerns regarding culture. Managers had taken positive steps to address agency use and therefore mitigate possible risks.

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They felt the hospital was continually improving. Managers recognised the increased complexities of some patients admitted in the previous six-month period and the implications this had on staffing levels and morale. They took steps to address these issues. The hospital had employed a staff engagement officer to support staff and offer conflict resolution if this was required and improved their recruitment to decrease the use of irregular agency staff. All staff could raise concerns without fear and knew how to do this.

Managers ensured staff received support, appraisals and were kept informed through team meetings as needed. They recognised success through annual staff awards and dealt with poor performance appropriately.

Staff had access to support for their own physical and emotional health needs.

Governance

The provider ensured there were structures, processes and systems of accountability for the performance of the service. 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 from location to board incorporating clinical governance and corporate management. The manager of Bradley Complex Care attended these monthly meetings. Agenda items included quality reporting from the hospital, safety, action plans, service risks, changes to policy, incidents, lessons learnt, performance and development.

Long stay or rehabilitation mental health wards for working age adults

Good

Communication to and from the organisation's board, was facilitated through hospital management meetings, staff team meetings and patient community groups. The organisation provided detailed minutes of all levels of meeting which they shared with staff teams.

The organisation produced dashboards for managers to monitor patient information such as care plans, incidents, physical health, and discharges. This information was extracted directly from the patients' electronic records. However, the quality of the care plans was not monitored sufficiently to identify failure to fully reflect patient discussions around their goals and views. Dashboards were also used to monitor staff information including sickness levels, agency usage and training.

Since our last inspection, the provider had implemented recommendations and introduced audit systems around checks for agency staff and improved training. They welcomed external oversight from clinical commissioning groups and other organisations and acted on their comments.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Staff maintained and had access to risk registers. Risks were escalated through the organisation's governance structures.

We saw the hospital's risk register dated September 2019. It included concerns relating to staffing numbers, NHS contractual risks and failures to meet forecasted occupancy levels.

Information management

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

Staff used an electronic system to collect data for both patient and staff monitoring. This included access to information on performance, staffing and patient care. Staff had access to laptops in some apartments or were able to use the nurse's station to access the hospital's electronic patient record database. Information governance included confidentiality of patient records.

Staff and managers did not report any concerns that data collection was overburdensome for frontline staff.

Managers made notifications to external bodies as required.

Engagement

The hospital engaged well with patients, staff and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had access to up to date information about the work of the provider. Elysium had a website which gave details about each of their locations.

Patients were invited to community groups as an opportunity to give feedback. The service used advocates as a further means to ensure patient engagement and conducted an annual patient survey. Staff were able to contribute their views through the staff engagement worker or staff representative. They used staff meetings, supervisions and reflective practice workshops to ensure staff were involved in decision making.

Learning, continuous improvement and innovation

All staff were committed to continually improving services. Quality improvement was a standard agenda item in clinical governance meetings to give staff the opportunity to consider opportunities for improvements and innovation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there is adequate medical cover and a doctor availability out of hours to attend the hospital quickly in an emergency.
- The provider must ensure staff recognise when a patient is secluded, complete the appropriate records and apply the necessary safeguards.

Action the provider SHOULD take to improve

- The provider should ensure blanket restriction are not applied which limits a patient's freedom to enter their apartments.
- The provider should ensure staff have clear visibility of all patient areas.
- The provider should ensure staff reflect all the patient's needs in their care plans and that they are recovery orientated.
- The provider should ensure that family and carers are fully involved in care decisions
- The provider should ensure a patient's discharge plan is clearly reflected in their care and treatment records.
- The provider should ensure all patients have a secure place to store personal possessions.
- The provider should ensure patient information is in a format to support effective communication.
- The provider should ensure there are no delays in a patient's rights being explained at admission.

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 18 HSCA (RA) Regulations 2014 Staffing **How this regulation was not being met:** • The service did not have enough night time medical cover to attend the hospital quickly in an emergency. **This was a breach of regulation 18 (1)**

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 **How this regulation was not being met:** • Managers could not be assured that staff were recognising incidences of seclusion and therefore keeping appropriate records and applying the necessary safeguards. **This was a breach of regulation 12 (2)(b)**