Glancestyle Care Homes Limited

Woodleigh Community Independent Hospital

Inspection report

28 Elmwood Road
Croydon
CR0 2SG
Tel: 02082396033
www.inmind.co.uk

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

Ratings

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

Summary of findings

Overall summary

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

- The service provided safe care. The environment was safe and clean. Staff assessed and managed residents' risks. They minimised the use of restrictive practices, managed most medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. This included prescribing oral antipsychotic medication in conjunction with psychosocial interventions and providing specialist therapies to meet the needs of patients with obsessive compulsive disorders.
- The staff team included a full range of specialists required to meet the needs of patients, including nurses, doctors, a clinical psychologist and occupational therapists. Managers ensured that these staff received supervision and appraisal. Staff worked well together as a multidisciplinary team and worked closely with other people involved in residents care such as the GP, care co-ordinators and commissioners.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated residents with compassion and kindness, respected their privacy and dignity, and understood the individual needs of each resident. They actively involved residents and families and carers in care decisions.
- Residents said that the care and treatment they received was good and that staff behaved kindly towards them.
- The service managed residents' progress to more independent accommodation well. They worked closely with residents' families, commissioners and care co-ordinators to facilitate this. The service also provided a safe, stable and homely environment for residents who stayed there for many years.
- The service was well-led and the governance processes ensured that the service ran smoothly. Leaders had clear oversight of the safety and quality of care provided.
- Staff felt respected, supported and valued. They said the service provided opportunities for development and career progression. They could raise any concerns without fear.

However:

- Staff did not dispose of all out-of-date dressings in accordance with manufacturer's instructions. Staff did not label medicine bottles with the date the bottle was opened.
- Staff did not always update risk assessments after all incidents. Managers did not always discuss incidents with staff to ensure they had a good understanding of why incidents occurred and how they could be avoided.
- Not all staff had received specific training in residents' clinical conditions
- The service did not hold regular team meetings with all staff
- Records of clinical governance meetings did not include details of discussions, conclusions and actions agreed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Good 	We rated this service as good. An overall summary is provided on page one.

Summary of findings

Contents

Summary of this inspection

Background to Woodleigh Community Independent Hospital

Woodleigh Community Independent Hospital is part of the InMind Hospital Healthcare Group.

The service can provide care for up to 23 patients across three floors. Bedroom areas were gender segregated. At the time of our inspection, the capacity of the service was limited to 19 patients because the service was refurbishing residents' bedrooms.

The hospital provided care and treatment to people experiencing severe and enduring mental illness. Approximately half the patients were experiencing mental illness in the form of psychosis, schizophrenia or bi-polar disorder. The other patients experienced obsessive-compulsive disorders. Most patients had comorbidities and complex physical and mental health needs.

Three patients were detained under the Mental Health Act 1983. Two patients were detained in hospital for treatment. One patient was subject to a hospital order with restrictions on their discharge.

Woodleigh Community Independent Hospital is registered to provide:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures; and
- treatment of disease, disorder or injury.

The service has a registered manager.

There have been four previous inspections at the service. The last inspection was in July 2017. At that inspection the service was rated as good.

What people who use the service say

Overall, residents spoke positively about the service. They said the staff were good, kind and caring. Residents who had previously been in more restrictive services enjoyed the freedom to do what they wanted and be able to come and go with very few restrictions. They liked being in a community setting and enjoyed going shopping and going out for coffee. Residents had a good understanding of their treatment. They knew the reasons why the doctor had prescribed their medication. Residents discussed any concerns about the service with staff at regular community meetings. However, some residents said there had occasionally been incidents involving other patients that had caused them to feel upset. Some residents also said they did not see their doctor very often.

We spoke with the parents of two residents. They were very positive about the service. They felt reassured that residents were safe and well looked after. They said that communication with the service was very good and they valued the continuity of staff. However, on family raised concerns that their resident had gained a consider amount of weight.

How we carried out this inspection

The inspection team included four inspectors and an inspection manager.

Summary of this inspection

During this inspection, the inspection team:

- spoke with four residents
- conducted a review of the hospital environment and observed staff supporting patients
- spoke with the registered manager
- spoke with 11 other staff members including registered nurses, support workers, the consultant psychiatrist, the consultant psychologist, occupational therapist and a student nurse.
- spoke with the families of two residents
- reviewed five patients care records and five medical charts.
- reviewed other documents concerning the operation of the service
- attended two handover meetings and a multidisciplinary team meeting to review patients with obsessive compulsive disorders

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

Action the service SHOULD take to improve:

- The service should ensure that all bottles of medicine are clearly labelled with the date they were opened.
- The service should ensure that staff update the risk assessment when a resident is involved in an incident.
- The service should ensure that incidents are discussed with the whole staff team to ensure staff have a good understanding of the causes of incidents and how further incidents may be prevented.
- The service should hold regular meetings with staff to discuss residents needs and matters relating to the running of the service.
- The service should ensure that all staff receive specialist training relating to the needs of residents, such as training on obsessive compulsive disorders.
- The service should ensure that records of clinical governance meetings include details of discussions about the data presented and clear statements of any conclusions and action agreed.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Good

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

Safe and clean care environments

The hospital was safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the hospital layout

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Staff carried out regular checks on the environment. An up to date health and safety risk assessment had been carried out by an external contractor. The hospital had a dedicated staff member who was onsite and would deal promptly with any maintenance issues. The service had fire safety policy and procedures in place. Fire extinguishers and fire safety equipment were in place throughout the building. There was an evacuation chair on each floor which was regularly checked and maintained. Fire drills were carried out annually and fire risk assessments were done once a year and included a review of evacuation plans.

The hospital complied with guidance on mixed sex accommodation. The first and third floor provided single sex accommodation. The second floor was mixed, with male and female bedrooms on separate corridors. The female area was locked and could only be access using a code number.

Staff knew about any potential ligature anchor points and mitigated the risks to keep residents safe. The hospital had a specific ligature risk assessment. Ligature point audits were up to date and action plans were in place to mitigate any risks identified. Staff managed this through individual risk assessments and observations. There were two ligature cutting devices available on each floor.

Maintenance, cleanliness and infection control

Hospital areas were clean, well maintained, well furnished and fit for purpose. All areas of the hospital were maintained to a high standard. The reception area was bright and clean. The communal areas included a lounge area with comfortable seating, tables and chairs. There was a pool table which residents and staff were using during our visit. The hospital was completing a programme of refurbishment. Builders were on site during our inspection visit. Care had been taken to keep disruption to a minimum. Hospital areas were still calm and welcoming.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff made sure cleaning records were up-to-date and the premises were clean. The service employed two housekeepers. Clinical and public areas were visibly clean, bright and well organised. The hospital had implemented COVID-19 procedures for staff and visitors at the start of the pandemic.

Staff followed infection control policy, including handwashing. The service controlled infection risks well. Staff used equipment and control measures to protect residents, themselves and others from infection. Staff kept equipment and the premises visibly clean. The service displayed guidance on handwashing in all toilets.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Records showed the staff checked emergency medicines each day.

Staff checked, maintained, and cleaned equipment. Staff ensured electrical equipment was tested. Staff applied stickers to clinical equipment to show it had been calibrated in line with the manufacturer's guidance. The temperature of the medicines fridges was monitored regularly. Staff disposed of waste safely. Staff disposed of sharps and infectious clinical waste in separate bins. This was audited on a regular basis.

Safe staffing

The service had enough nursing and medical staff, who knew the residents and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep residents safe. The service employed 11 registered nurses and 14 support workers. Both staff and residents said they thought there were enough nurses and support workers assigned to each shift.

The service had low vacancy rates. The service had one vacancy for a registered nurse and a vacancy for a support worker. The service was recruiting for these posts.

The service had low rates of bank and agency nurses. The service used agency staff occasionally, usually because specific residents needed extra support.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service used staff from a specific agency that they had worked with for over 15 years. The managers explained that the agency had a good understanding of the needs of residents at Woodleigh. The agency provided staff with previous experience of working at the hospital.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service provided agency staff with an induction pack. This pack provided details of policies, procedures and instructions on how to call for help.

The service had low turnover rates. In the six months from January to June 2022, one nurse had left the service.

Levels of sickness were low. The deputy manager monitored staff sickness. The sickness rate between January and May 2022 was 2%.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service assigned two registered nurses and three support workers to the early and late shifts. This reduced to one registered nurse and two support workers at night.

The hospital manager could adjust staffing levels according to the needs of the residents. For example, the service assigned an additional member of staff to provide enhanced observations to new residents. The service also provided additional staff when a resident needed extra support or to facilitate appointments and recreational activities in the community.

Residents rarely had their escorted leave or activities cancelled, even when the service was short staffed. Managers said the service provided additional staff for leave and activities whenever necessary. One resident said that they required additional support from staff when they were on leave and there were often insufficient staff to provide this. However, this was not consistent with the views of other residents.

Staff shared key information to keep residents safe when handing over their care to others. Staff held a handover meeting at the start of each shift.

Medical staff

The service had enough medical cover. The service employed a consultant psychiatrist who attended the hospital for one day each week. The consultant psychiatrist was available to staff on an on-call basis when they were not on site. The service contacted residents' GP when additional support, care and treatment was provided. Staff contacted emergency services if residents required urgent medical assistance. However, three of the four residents we spoke with said they see the doctors very often. One resident said they had seen the doctor four times in six months, another said they had not seen the doctor for a long time and another said they would like to see the doctor more often. We raised this matter with the hospital during the inspection. Staff said that the multidisciplinary team frequently reviewed residents. The doctor prioritised seeing residents according to their clinical need and the stage of their recovery. Staff said the consultant psychiatrist and the consultant psychologist tried to meet with residents whenever they were able to.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. In June 2022, overall compliance with mandatory training was 90%. Each of the mandatory training courses had been completed by over 80% of staff.

The mandatory training programme was comprehensive and met the needs of residents and staff. The service provided a comprehensive programme of training courses that all staff were required to complete. This included courses on first aid (including basic and intermediate life support), infection prevention and control, safeguarding adults, safeguarding children, record keeping and supporting residents who were distressed.

Managers monitored mandatory training and alerted staff when they needed to update their training. The deputy hospital manager monitored compliance with mandatory training and reminded staff when further training was due.

Assessing and managing risk to residents and staff

Staff assessed and managed risks to residents and themselves well, although they did not always update risk assessments after incidents. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate residents' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. The hospital staff participated in the provider's restrictive interventions reduction programme.

Long stay or rehabilitation mental health wards for working age adults

Good

Assessment of resident risk

Staff completed risk assessments for each resident on admission, using a recognised tool, although they did not always review risk assessments after incidents. Risk assessments were clear and linked to the individual's care plan. Residents were involved in developing their risk management plans. However, staff did not always update risk assessments after incidents. For example, staff had not updated a risk assessment after a resident had taken an overdose of pain relief tablets on two occasions. Staff had also failed to update a falls risk assessment after a resident had experienced two falls in two weeks.

Staff used a recognised risk assessment tool. Staff completed a standard risk assessment form. This was stored in the residents' records. For residents with a forensic history, risks were assessed using a formal, nationally recognised, risk assessment document.

Management of resident risk

Staff knew about any risks to each resident and acted to prevent or reduce risks. For example, one resident occasionally used sharp items to harm themselves when they felt distressed. They had agreed staff would help them to do their hair. This enabled them to feel more comfortable handing over any items that could be used to harm themselves.

Staff identified and responded to any changes in risks to, or posed by, residents. Staff identified and acted upon residents at risk of deterioration. The hospital used the National Early Warning Score (NEWS2) track and trigger system. NEWS2 is a tool used to score a residents' vital signs to identify residents at risk of deterioration, including possible sepsis.

Staff followed trust policies and procedures when they needed to search residents or their bedrooms to keep them safe from harm. Staff carried out checks of residents' rooms once a month. These checks focused on environmental risks.

Use of restrictive interventions

Levels of restrictive interventions were low. The service accepted referrals for people who were generally stable and compliant with medication. This meant that residents presented a relatively low level of risk. This allowed the hospital to operate with few restrictions on residents. The service did not use restraint, seclusion or rapid tranquilisation. Restrictive interventions involved limiting leave for residents detained under the Mental Health Act, enhanced levels of observation and specific measures to address the health and safety of some residents. The service had carried out an audit of restrictive practices in April 2022. The audit found that residents gave consent to restrictive practices being used. Staff explained that if a resident did not have capacity to consent to a restriction, the service would hold a clinical review, talk to the resident's family and, if appropriate, implement a best interest's decision.

Safeguarding

Staff understood how to protect residents 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. Eighty-one percent of staff had completed training on safeguarding adults. Ninety percent of staff had completed training on safeguarding children. The safeguarding policy for the organisation covered definitions, duties of staff and the procedure for reporting safeguarding. The policy had been reviewed in December 2021.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Between January and June 2022, the staff had raised two safeguarding concerns. One related to a threat to a number of health services in the local area. Staff had reported this matter to the police and the local authority. Staff also reported concerns from a resident that they were being harassed by someone they used to know.

Staff followed clear procedures to keep children visiting the hospital safe. The organisation had a policy on the arrangements for children visiting the hospital. Any resident wishing to invite a child to visit them on the premises required permission in advance from the hospital director.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff said that if they had any concerns, they would report these to the hospital director. The hospital director was assigned the role of safeguarding lead.

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.

Residents' notes were comprehensive and all staff could access them easily. Paper records included progress notes, physical and mental health assessments and management plans, observation scores, personal care records, advanced care directives, risk assessments, and care plans. Care plans included details of the resident's Exposure and Response Prevention (EPR) programme, capacity and consent, therapy assessments and drug charts. Staff kept detailed records of residents' care and treatment. Records were clear and information was in order. This meant it was easy for staff to find essential resident information quickly.

Records were stored securely. Resident records were stored securely within a locked room in the hospital, which all clinical staff had a key to access.

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 resident's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Robust management of medicines was in place. This covered ordering, storage, administration, recording, reconciliation and disposal of medicines. Medicines were well organised in storage units so that staff could easily keep track of what medications were assigned to which day of the week.

Staff reviewed each resident's medicines regularly and provided advice to residents and carers about their medicines. Residents had a good understanding of the medication they were taking. They understood the reason the doctor had prescribed the medicine and any possible side-effects.

Staff completed medicines records accurately and kept them up-to-date. Medication administration records were correctly completed. The pharmacy service carried out audits of medicine administration records each month.

Staff stored and managed all medicines and prescribing documents safely. The hospital commissioned a pharmacy service to manage their medicines. Staff completed a stock take of medicines once every month. Controlled drugs were

held within a locked safe and checked twice a day. However, three bottles of liquid medicine did not have a label showing the date on which they had been opened. This meant that staff may not know if the medicine bottles had been opened for too long. We also found that ten packs of dressing had passed their 'use-by' date. We raised this with the staff and they disposed of the dressings straight away.

Staff learned from safety alerts and incidents to improve practice. Staff audited medication management to help minimise the risk of medication errors.

Staff reviewed the effects of each resident's medicines on their physical health according to the National Institute of Health and Care Excellence (NICE) guidance. In the nurses' office, staff displayed a schedule of the physical health tests that needed to be carried out for each resident. This included blood tests for residents prescribed lithium or clozapine, other blood tests, electro-cardiograms for residents on high doses of antipsychotic medicines, monthly checks of residents' body mass index and other checks of residents' vital signs.

Track record on safety

The service had a good track record on safety.

In the six months from January to May 2022, staff at the service had recorded 30 incidents. There had been no incidents recorded in June 2022.

Reporting incidents and learning from when things go wrong

The service managed resident safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents. When things went wrong, staff apologised and gave residents honest information and suitable support. However, managers did not always discuss incidents in depth with the whole staff team.

Staff knew what incidents to report and how to report them. Staff recorded incidents relating to self-harm, safeguarding, falls and medical emergencies.

Staff reported serious incidents clearly and in line with trust policy. Staff recorded incidents on a specific electronic record. The system ensured that all incidents were reviewed by a senior member of staff. The service provider was able to use this system to collate data on the frequency, trends and themes of incidents.

Managers debriefed and supported staff after some serious incidents. For example, a medicines error was identified during an audit. This was discussed in detail during a clinical governance meeting. However, for some incidents we found there was minimal discussion with the staff and no evidence of staff considering how to minimise the risk of such incidents happening again. For example, one resident took an overdose of pain relief tablets on two occasions within two weeks. These incidents led to the resident attending the emergency department at the local hospital. Although staff responded to the incident appropriately, and mentioned the incident in the handover meetings, there was no evidence that staff had discussed the causes of the incident or how to support the resident to prevent further incidents. We discussed this with staff during the inspection. They explained that all staff knew the residents very well.

Staff received feedback from investigation of incidents and there was evidence that changes had been made as a result of feedback. For example, staff discussed an incident relating to the management of medicines at a clinical governance meeting. Staff at the meeting discussed the findings of the investigation. Staff agreed action to be taken to prevent such an incident happening again. This included further training for registered nurses in medicines management and a review of the procedures for the disposal of medicines.

Long stay or rehabilitation mental health wards for working age adults

Good

Are Long stay or rehabilitation mental health wards for working age adults 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 residents on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected residents' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each resident either on admission or soon after. Staff completed a comprehensive assessment of each resident at the point of referral and when the resident was admitted to the hospital. This included reviewing the reasons for admission, history of the resident's mental health, family history and an assessment of the resident's mental capacity.

Residents had their physical health assessed soon after admission and regularly reviewed during their time at the hospital. The physical examination was comprehensive. When residents were admitted to the hospital, staff ensured they registered with the GP. Staff recorded residents' vital signs in accordance with their care plan.

Staff developed a comprehensive care plan for each resident that met their mental and physical health needs. Resident's records included specific care plans for their physical health, rehabilitation goals, independent living skills, social and family networks, work and occupation, safety and risk management plans as well as personal recovery goals. Resident records also included 'care passports' setting out a statement of the resident's likes and dislikes, their expectation in terms of independent living and advance directives for care and treatment. Each resident had written their own 'one-page profile' that described the things that were important to them in their own words.

Staff regularly reviewed and updated care plans when residents' needs changed. Residents' care plans were reviewed weekly in the MDT meetings.

Care plans were personalised, holistic and recovery-orientated. Care plans were written with the involvement of residents and clearly reflected their views. Staff encouraged residents to engage in care planning and setting their recovery goals.

Best practice in treatment and care

Staff provided a range of treatment and care for residents 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 residents with their physical health and encouraged 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.

Staff provided a range of care and treatment suitable for the residents in the service. The service provided treatment pathways for two groups of residents. Nine residents had obsessive compulsive disorders (OCD), alongside other comorbidities such as autistic spectrum disorders, personality disorders and functional neurological disorders. Treatment for these conditions included exposure and response prevention (ERP) programmes and cognitive

behavioural therapy (CBT). Other residents experienced enduring mental illness including schizophrenia, bi-polar disorder and psychosis. Treatment primarily involved the use of anti-psychotic medicines alongside therapeutic care. Therapeutic care involved, for example, trauma informed formulation, mindfulness and symptom management. All residents had access to a range of different groups and activities. For example, each resident had their own weekly timetable which was personalised to their needs and included regular sessions with the psychologist and occupational therapist. The occupational therapists provided a programme of therapeutic, creative and recreational activities. The service had supported many residents to make significant progress. For example, on admission, one resident had struggled to carry out basic self-care. Over the course of their treatment, they had progressed to being able to shower and change their clothes regularly.

Staff delivered care in line with best practice and national guidance. Care and treatment for residents with schizophrenia and psychosis was consistent with the general principles set out in guidance by NICE. This involved offering a full range of psychological, pharmacological, social and occupational interventions. The service also provided a multidisciplinary team with expertise in the pharmacological and psychological treatment of obsessive-compulsive disorders (OCD). The treatment of OCD was led by the consultant psychologist. Treatments included exposure and response prevention (ERP) programmes and cognitive behavioural therapy. Residents met with the psychologist or intensive therapy co-ordinator each week to review their progress towards achieving their ERP treatment goals and revise these plans when necessary. The consultant psychiatrist prescribed antidepressant medication. For some residents, the psychiatrist offered anti-psychotic medicines to help residents with emotional dysregulation.

Staff identified residents' physical health needs and recorded them in their care plans. Residents were encouraged to attend appointments with their GP and dentist. Comprehensive care plans for specific physical health needs and conditions were in place.

Staff made sure residents had access to physical health care, including specialists as required. Staff completed regular physical health checks of residents. Staff used the Waterlow scale to record the severity of tissue damage experienced by one resident. During a handover meeting, staff discussed referring a resident for physiotherapy.

Staff met residents' dietary needs and assessed those needing specialist care for nutrition and hydration. The chef attended handover meetings once a week and regularly met with residents to understand their dietary needs. Staff could refer residents to a dietician when necessary. Staff were specifically monitoring the fluid intake of one resident.

Staff helped residents live healthier lives by supporting them to take part in programmes or giving advice. Staff provided gym equipment. Staff encouraged residents to be active in the community. The chef provided a balanced menu for residents.

Staff used recognised rating scales to assess and record the severity of residents' conditions and care and treatment outcomes. For example, staff used the Yale-Brown Obsessive-Compulsive Scale Test to assess the severity of residents' condition. This test was repeated to measure each residents' progress. Staff also used the Becks indices for depression and anxiety.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff conducted clinical audits of the quality of records, care plans, risk assessments and medicines management. The results of audits were shared across the organisation to enable benchmarking against other services.

Long stay or rehabilitation mental health wards for working age adults

Good

Skilled staff to deliver care

The hospital team included or had access to the full range of specialists required to meet the needs of residents on the hospital. 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 a full range of specialists to meet the needs of the residents at the hospital. The service employed a consultant psychiatrist, a clinical psychologist, two occupational therapists, an intensive therapies co-ordinator, eleven registered nurses and 14 health care assistants. The service also employed chefs, house keepers and maintenance staff.

Managers gave each new member of staff a full induction to the service before they started work. All new staff received an information pack that provided details of staffing, fire safety and health and safety. All new staff worked alongside an experienced member of staff for between three and five shifts. New staff were required to read the staff handbook and organisational policies. New staff completed a competency checklist with their supervisor after six weeks. If they had not achieved all the competencies, the induction period would be extended.

Managers supported staff through regular, constructive appraisals of their work. Managers carried out formal appraisals of staff each year. At the time of the inspection, the form used for appraisals was being updated.

Managers supported staff through regular, constructive clinical supervision of their work. Staff said they discussed their work in supervision with a manager every three months. They said they found this helpful.

Managers made sure staff attended team meetings or gave information from the meetings to those who could not attend. However, these meetings were not held regularly. During 2022, there had been one team meeting for registered nurses and one meeting for support workers.

Managers made sure staff received any specialist training for their role. Training on autism and learning disabilities had recently been added to the programme of mandatory training courses. Senior staff had recently completed online training on obsessive compulsive disorders specifically relating to fears of contamination. Senior nursing staff had also completed training in venepuncture for primary care services. However, four members of staff we spoke with said they had not had any training on obsessive compulsive disorders.

Managers recruited, trained and supported volunteers to work with residents in the service. A former resident provided assistant to the occupational therapy programme. Staff knew this volunteer very well and provider them with support.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss residents and improve their care. Senior staff held a multidisciplinary team meeting with the consultant psychiatrist once a week. The consultant psychologist facilitated an MDT meeting each week to review the residents with obsessive-compulsive disorders.

Staff made sure they shared clear information about residents and any changes in their care, including during handover meetings. Staff held a handover meeting at the start of each shift. At these meetings, staff agreed the allocations for

specific tasks during the shift. Staff also provided a brief update on each resident. Staff assigned a risk rating to each resident. Residents were rated as green if there were no concerns, amber if they were unwell and red if they required special observations. At the time of inspection, staff rated all residents as 'green'. The chef, housekeepers and maintenance staff attended the handover meeting once a week. Staff said they found the handovers to be very helpful.

Hospital teams had effective working relationships with other teams in the organisation. The hospital director met with other hospital directors within the InMind group every two weeks. The consultant psychiatrist and hospital director also provided external support and shared good practice with the two other InMind hospitals in the region.

Hospital teams had effective working relationships with external teams and organisations. The service worked closely with the residents' general practitioner (GP). The GP understood the needs of residents and arranged appointments for residents with OCD at times when the surgery was quiet. Staff carried out physical health monitoring checks every three weeks and sent the results to the GP. The service worked closely with residents' commissioners and care co-ordinators. The service also had a good relationship with the National OCD Centre, based within a nearby NHS trust.

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 residents' 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. All registered nurses had completed training on the Mental Health Act, although this training was not compulsory.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The deputy hospital manager was responsible for the administration of the Mental Health Act. They had completed an appropriate qualification in mental health law, policy and practice. They were based at the hospital and provided support and advice to colleagues.

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 could access all policies on the organisation's intranet. Copies of the Act and Code of Practice were available in the deputy manager's office.

Residents had easy access to information about independent mental health advocacy and residents who lacked capacity were automatically referred to the service. The service provided a comprehensive information pack to all residents detained under the Mental Health Act. This included information about their rights under the Act, guidance on how to complain about the service and details of how to contact the advocacy service.

Staff explained to each resident their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the resident's notes each time. Staff took such steps as were practicable to ensure residents understood the relevant provisions of the Act and residents' rights to appeal to a tribunal. Staff carried out these discussions every six months and whenever a resident's detention was renewed. Details of these discussions, including a statement of whether the resident understood the information, was stored on the resident's record.

Staff made sure residents could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and with the Ministry of Justice. For example, the responsible clinician had provided authorisation

for a resident to leave hospital for emergency appointments, to have short periods of leave each day with a member of staff, to have longer periods of leave with staff each week and to have weekly visits to their family. The responsible clinician reviewed residents' leave each month. Documents authorising each resident's leave were stored on the resident's record.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. At the time of the inspection, the treatment of one resident required authorisation by a SOAD. A certificate completed by the SOAD was stored on the resident's record.

Staff stored copies of residents' detention papers and associated records correctly and staff could access them when needed. Three residents at the service were detained under the Mental Health Act. Two residents were detained for treatment. One resident was subject to a hospital restriction order. All statutory documents were stored in a locked filing cabinet.

Informal residents knew that they could leave the hospital freely and the service displayed posters to tell them this. Informal residents could come and go as they liked and were made aware of their right to leave at any time. The service displayed notices detailing the rights of informal patients.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The service completed audits of compliance with the Mental Health Act and the accompanying Code of Practice. For example, staff had completed audits of statutory documents, records of consent to treatment and the quality of care plans.

Good practice in applying the Mental Capacity Act

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of principles of the Act. Ninety-four percent of staff had completed mandatory training on the Mental Capacity Act.

One resident was subject to deprivation of liberty safeguards. Records provided a clear explanation of why the deprivation of liberty safeguards application had been made.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. All polices, guidance and the Code of Practice were available in the deputy manager's office.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Clinical oversight and guidance for staff was provided by the consultant psychiatrist and the clinical nurse manager.

Staff assessed and recorded capacity to consent clearly each time a resident needed to make an important decision. All assessments of residents' capacity to consent to treatment provided details of whether the resident could understand, retain and weigh up the information needed to make a decision along with a statement of whether the resident could communicate their decision. All assessments of mental capacity were stored on residents' records. Staff audited these assessments to ensure they were compliant with the policy.

When staff assessed residents as not having capacity, they made decisions in the best interest of residents and considered the resident's wishes, feelings, culture and history. When staff made a decision in the best interests of a resident, the recorded details of the conversation they had had with the resident about the decision and provided comprehensive of why the decision was in the resident's best interests. Staff involved the resident's family in any decision taken in the resident's best interest.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. An application had been submitted for one resident. Staff were monitoring the progress of this application. At the time of the inspection, they were waiting for a response to the application.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. For example, staff completed audits of assessments of mental capacity to ensure they were compliant with the policy.

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

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for residents. Many members of staff had worked at the hospital for a number of years and knew the residents very well. Staff were kind and friendly. We frequently saw staff chatting to residents. Staff were genuinely very pleased when residents made progress and were able to move on from the hospital.

Staff gave residents help, emotional support and advice when they needed it. They had a good understand of their needs, routines, preferences and relationships. Staff used this understanding to give emotional and practical support whenever necessary.

Staff supported residents to understand and manage their own care, treatment or condition. Residents had a good understanding of their care and treatment. Residents knew what medication they were taking and why they were taking it. Residents' also understood the therapy programmes they participated in.

Residents said staff treated them well and behaved kindly. Three of the four residents we spoke with were very positive about the staff. They described the staff as nice, kind and caring.

Staff understood and respected the individual needs of each resident. All staff knew the residents well. Staff provided personal care in a supportive and sensitive manner.

Most staff and residents felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards residents. Overall, residents felt safe at the hospital. However, three residents said they had had problems with other residents. One resident said they had been upset by a resident frequently swearing in the queue for medication. One resident said they had been physically threatened by a resident. Another resident said they had experienced racist abuse. Whilst these incidents were not typical of residents' experiences, they had caused the

residents involved to feel upset. We raised this matter with staff during the inspection. They explained that on rare occasions, residents could become aroused in response to internal stimuli. This occurred as a result of their illness. Staff said that they managed these situations in a sensitive manner and supported any residents involved in such a situation. Staff assessed and managed risks in accordance with their risk assessment procedure.

Staff followed policy to keep resident information confidential. All information about residents was stored in locked filing cabinets. The residents' information booklet provided details of the personal information held by the organisation and how it would be used, in accordance with the General Data Protection Regulations (GDPR).

Involvement in care

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

Involvement of residents

Staff introduced residents to the hospital and the services as part of their admission. Staff and residents had created a booklet for new residents, providing information about the service. Staff recognised that admission to the hospital could be a difficult and worrying time for residents and their families. They were committed to welcoming residents to the service in a friendly, reassuring manner.

Staff involved residents and gave them access to their care planning and risk assessments. Records showed that residents had been involved in the development of risk assessments and care plans. They included details of residents' preferred ways of communicating.

Staff made sure residents understood their care and treatment. The consultant psychiatrist met with residents during multidisciplinary team meetings and discussed their care and treatment with them.

Staff involved residents in decisions about the service, when appropriate. The service held community meetings with residents. During the meeting in June 2022, staff and residents discussed maintenance, house keeping, smoking, garden activities and general comments from residents. The hospital director provided a written response to all concerns raised by residents. Minutes of these meetings were displayed on a notice board.

Residents could give feedback on the service and their treatment and staff supported them to do this. In November 2021, managers asked the advocacy service to conduct a survey of residents' views. Feedback from residents was mixed. Managers had asked the advocacy service for more information about residents' concerns in order to address them. However, this information had not been received and matter had not been followed up.

Staff supported residents to make decisions on their care. For example, staff supported residents to make advance decisions about their care and treatment. Advance decisions reflected the views of patients.

Staff made sure residents could access advocacy services. An advocate visited the hospital once every month.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff at the service knew residents' families well. Records showed that staff and residents had regular contact with resident's families. Staff provided support to residents' families. For example, the hospital director maintained regular contact with a resident's mother as they required regular

Long stay or rehabilitation mental health wards for working age adults

Good

assurance that the resident was safe and well cared for. Staff facilitated regular periods of extended leave for residents to spend time with their families. During the inspection, we spoke with the parents of two residents. They felt assured that residents were safe and cared for. They said they regularly spoke to the hospital and that communication was very good. They found staff very supportive. Parents also valued the consistency of staff. This meant that both they and the residents worked with the same staff over long periods of time and this contributed to the residents' clinical progress.

Staff helped families to give feedback on the service. The service had conducted a survey of the views of families and carers. Six people returned questionnaires. Five of the six respondents said they found staff helpful and took a real interest in their relative. Four respondents provided very detailed comments. One respondent said it could be difficult getting through to the service on the telephone and requested more information about the service. Staff responded by updating the resident's information pack.

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

Good

Access and discharge

Staff planned and managed resident discharge well. They worked well with services providing aftercare and managed residents' move out of hospital. As a result, residents did not have to stay in hospital when they were well enough to leave.

The service had clear criteria for admitting residents. Senior staff, including the consultant psychiatrist and clinical psychologist, met each week to review all new referrals. The service accepted referrals for residents who had a primary diagnosis of mental illness. When reviewing referrals, staff also considered whether they could manage the specific need of the person being referred and whether they would fit in with the other residents. The service usually required people being referred to have an established diagnosis and settled presentation. The service did not accept referrals for residents who presented risks relating to drugs or alcohol.

Managers regularly reviewed length of stay for residents to ensure they did not stay longer than they needed to. The length of stay for residents varied. Eleven of the 19 residents had been at the hospital for less than two years. Three residents had been at the hospital for approximately three years. Five residents had been at the hospital for more than ten years.

Staff did not move or discharge residents at night or very early in the morning. All discharges were planned over a number of months in collaboration with commissioners and care co-ordinators.

Discharge and transfers of care

Residents did not have to stay in hospital when they were well enough to leave. The hospital provided a least restrictive environment and was based in a residential area. For residents who had been at the hospital for many years, the service provided an appropriate place for them to live and there were no specific reasons for them to move elsewhere. For other residents, the service supported them to move to other accommodation once their condition had improved. In the 12 months prior to the inspection, the service had discharged six residents. The service was actively arranging discharge for four residents.

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Good

Staff carefully planned residents' discharge and worked with care managers and coordinators to make sure this went well. The service was working closely with care managers and commissioners to support four residents to move to other accommodation. Staff acknowledged that it could be difficult to find placements to meet each resident's specific needs and this could cause moves to take a long time.

Staff supported residents when they were referred or transferred between services. This included visiting new placements with the resident and facilitating overnight visits to help the resident make the transition to the new service.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the hospital supported residents' treatment, privacy and dignity. Each resident 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 residents could make hot drinks and snacks at any time. When clinically appropriate, staff supported residents to self-cater.

Each resident had their own bedroom, which they could personalise. All residents had their own bedroom with ensuite facilities which included a toilet and a wash basin. Each floor had a step free bathroom and were wheelchair accessible. Residents personalised their bedrooms by displaying pictures, family photographs and other personal possessions.

Residents had a secure place to store personal possessions. Residents had their own key to their bedroom. Each bedroom contained locked cabinets for residents to securely store their belongings.

Staff used a full range of rooms and equipment to support treatment and care. A large group activity room was available for art and music therapy. The activity room also housed a kitchenette which was used by residents during occupational therapy sessions, and to prepare their own drinks and snacks. The activity room was also equipped with two exercise bikes and a punch bag.

The service had quiet areas and a room where residents could meet with visitors in private. Residents could meet with visitors in the garden, in quiet areas of the day area and in the activities room. Residents were also able to go out with their families.

Residents could make phone calls in private. Phone calls could be made in private using a payphone in the entrance to the hospital. Residents also had unrestricted access to mobile phones.

The service had an outside space that residents could access easily. Residents had unrestricted access to a well-maintained garden area that included grass, a pond, seating and shaded areas. All the garden furniture was clean. Residents had been involved in some gardening projects and helped to look after at the fish in the pond.

Residents could make their own hot drinks and snacks and were not dependent on staff. For example, residents said they could make sandwiches or cereal whenever they wished to.

The service offered a variety of good quality food. The service employed a chef who was able to respond to the specific needs and requests of residents. The chef prepared menus that provided a good range of healthy, good quality food. The hospital carried out a survey of residents' views on food twice every year. The results were presented in a "You said, we did" format to show residents how they had responded to their views. Residents we spoke with said the food was nice.

Long stay or rehabilitation mental health wards for working age adults

Good

Residents' engagement with the wider community

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

Staff made sure residents had access to opportunities for education and work, and supported residents. Staff supported residents to engage in activities in the community. One resident participated in voluntary work with animals. Two residents were completing educational courses. The service paid residents to carry out specific jobs at the premises.

Staff helped residents to stay in contact with families and carers. One resident told us that staff had recently helped him to visit his mother and brother.

Staff encouraged residents to develop and maintain relationships both in the service and the wider community. Residents said they enjoyed the regular social and recreational activities in the community. This included going out for coffee, going to the shops and going to the cinema. Residents also enjoyed organised trips such as a recent day in Brighton. Residents were involved in planning a forthcoming trip to Kew Gardens.

Meeting the needs of all people who use the service

The service met the needs of all residents – including those with a protected characteristic. Staff helped residents 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. People with limited mobility were able to use a lift to access to all the floors. An accessible bathroom was installed on each floor. Communal areas and the garden were all easily accessible on ground level. The service also recognised and supported residents with protected characteristics. For example, the information booklet for residents specifically stated that the service welcomed people who were gay, lesbian, bisexual or transgender.

Staff made sure residents could access information on treatment, local services, their rights and how to complain. Staff and residents had produced a booklet containing information about the service.

Managers made sure staff and residents could get help from interpreters or signers when needed. At the time of the inspection, none of the residents required signers or interpreters but staff said this would be arranged if any of the residents needed this.

The service provided a variety of food to meet the dietary and cultural needs of individual residents. The chef met with every resident when they were admitted to the hospital to find out about their likes, dislikes and any special dietary needs they may have. The service offered a wide and varied menu including multi-ethnic foods.

Residents had access to spiritual, religious and cultural support. A pastor visited the hospital to facilitate a church group. Staff had supported a resident to attend church services on a Sunday and supported another resident to attend a Buddhist centre. The hospital had held special services on the premises when residents had died.

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.

Long stay or rehabilitation mental health wards for working age adults

Good

Residents, relatives and carers knew how to complain or raise concerns. Details of how to complain were set out in the information booklet for residents and their families. Staff encouraged residents to raise their concerns in community meetings, with their primary nurse or the hospital manager.

The service clearly displayed information about how to raise a concern in resident areas. The service displayed information about making a complaint on notice boards. If residents or their families wished to raise a complaint formally, a copy of the complaints procedure was available in the lounge and the staff office.

Managers investigated complaints and identified themes. The hospital director or deputy manager investigated all complaints. Between January and June 2022, the hospital had received four complaints. Investigations involved discussions with the complainants and interviews with staff. Complaints related to food, cleanliness, staff attitude and treatment.

Staff knew how to acknowledge complaints and residents received feedback from managers after the investigation into their complaint. Managers acknowledged and investigated complaints promptly. For example, one complaint was received, investigated and resolved on the same day. Another complaint was investigated and resolved within five days. Managers provided complainants with a comprehensive response including details of the findings of the investigation.

Managers shared feedback from complaints with some staff and learning was used to improve the service. Senior staff reviewed information relating to complaints at clinical governance meetings. However, this information was not necessarily shared with other members of staff.

The service used compliments to learn, celebrate success and improve the quality of care. Between January and June 2022, the service had received nine compliments from clinical commissioning groups, care co-ordinators, residents' families, and student nurses. Compliments and cards from residents and their families were displayed in offices.

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

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

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

Woodleigh Community Hospital was a small hospital where all the staff knew each other. All the senior staff at the hospital had worked there for a long time. The hospital director knew all the staff and residents well. They were actively involved in care and treatment. The also spoke to residents' families regularly. Staff said they found the hospital director very open and supportive.

Vision and strategy

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

Long stay or rehabilitation mental health wards for working age adults

Good

The aim of the organisation was to help residents to overcome mental health challenges with dedicated staff and individually tailored care programmes producing high quality clinical outcomes. We saw evidence of this approach throughout the inspection. Staff were very committed to supporting residents. All plans for care and treatment were created to meet the specific, individual needs of residents. The service achieved good clinical outcomes.

Culture

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

Staff said they enjoyed working at Woodleigh. They said they felt valued and supported. One member of staff said the organisation had supported them to become a registered nurse after they started at Woodleigh as a support worker.

Staff said that their colleagues were very supportive. Staff also said they valued the flexibility allowed by managers. For example, a member of staff said the managers allowed them to work flexibly in order to care for their children.

The service displayed the contact details of the Freedom to Speak Up Guardian on notice boards. Staff said they would raise any concerns with colleagues and managers. They felt confident that their concerns would be listened to and that managers would respond.

Governance

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

Senior staff held a clinical governance meeting once a month. At each meeting, staff reviewed data relating to the running of the services including staffing, incidents, safeguarding, complaints and compliments. However, whilst the minutes of meetings included all the data discussed by staff, there were few details of the discussion about the data. Minutes did not include any interpretation of the data or details of action that would be taken to address any problems that the data may have identified.

The hospital director met with senior colleagues at InMind, and other hospital directors, every two weeks. During these meetings, the managers discussed performance, governance and health and safety.

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.

The risk register for the service included details of each risk, the potential impact, a rating of the severity, current mitigations and plans to address the risk. The highest risk for the service was the need to replace fire doors following changes to regulations. Other risks on the register covered business continuity plans, legal risks, governance risks, financial risk and staffing risks.

The hospital had a business continuity plan. This covered escalation procedures and incident management and recovery.

Long stay or rehabilitation mental health wards for working age adults

Good

Information management

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

The service collected information about performance and outcomes. This data was reviewed at clinical governance meetings.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided.

The service worked closely with health and social care services across the pathway of care. The service received many referrals from the national centre for obsessive compulsive disorders. Staff worked collaboratively with the residents' GP to monitor residents' physical health. The service worked closely with residents' commissioners and care co-ordinators to facilitate discharge to appropriate placements.