Baldock Manor

Quality Report

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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	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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

Baldock Manor is an independent hospital that provides a rehabilitation and intensive care service, to people who have needs related to their mental health and who are detained under the Mental Health Act 1983, Mental Capacity Act 2005, or are voluntarily staying at the hospital.

Following our inspection, we served a Notice of Decision because of the immediate concerns we had about that safety of patients. We told the provider it must not admit any further patients until further notice, it must review care plans, observation levels for patients, incidents, its systems and process for oversight of incidents and care, ensure it had enough suitably qualified, experienced staff on all shifts and that staff had adequate knowledge about the use of the Mental Capacity Act. We told it that it must provide CQC with an update relating to these issues on a weekly basis.

The provider has complied with these requirements. All patient care plans and observations have been reviewed and systems and processes are now in place for their ongoing review. The provider has reviewed its incident reporting system and process for the review of incidents. Notifications to external bodies have been made as required. Staff have been tested for competencies around patient observations, diabetes, choking and the Mental Capacity Act. The provider has produced weekly staffing figures, which have confirmed that most shifts have been covered.

We rated Baldock Manor as Requires Improvement because:

- The number of incidents for the provider had increased between September and October 2019. Staff across both wards reported 131 incidents in October 2019. Leaders had not always ensured that all incidents had been reported and that referrals had been made to external bodies as required. The provider had not reported all incidents that required a safeguarding notification and had not made notifications to external bodies including local authorities and the Care Quality Commission as required.
- The provider had a 75% vacancy rate for qualified staff to lead and manage care and a 21% vacancy rate for support workers. We heard how staffing issues adversely affected patient care. Whilst agency staff were provided with an induction, during inspection some staff did not have a full understanding of patients' risks or care planned needs.
- Whilst we accept that managers had updated the ligature assessments for the wards, these were not available to staff.
- There were several restrictive practices in place. Patients on Radley and Mulberry did not always have free access to outside space and fresh air. Patients on Radley only had access to cold, hot drinks and snacks on request to staff over the 24-hour period.
- Leaders had not always ensured that services were safe, clean and well maintained.
- Staff were not all aware of the identified ligature points or how to manage these risks.
- Staff were not fully adhering to infection control requirements. Staff were wearing nail varnish, were not bare from the elbow and were wearing jackets on the ward when completing personal care tasks with patients.
- Some staff did not display a good understanding of the Mental Capacity Act and the provider cared for patients who lacked capacity to make decisions. Staff did not know how to apply the main principles to their work.
- The provider did not ensure that training in the Mental Health Act or safeguarding children was mandatory.
- Although managers at the hospital were fully committed to the service they were not fully aware of all aspects of their roles and did not have the knowledge or skills to run the service effectively.
- The provider had not fully ensured that effective governance systems were in place. The provider did not have an effective system to oversee and assure itself of the quality of the services and ensure patients were kept safe and received good quality care.
- The provider did not have a clear model for the rehabilitation service. This service was supporting people with dementia which was not appropriate.
- Managers did not have immediate access to business information relating to staffing, patient observations,

Summary of findings

incidents, safeguarding referrals and notifications to support them to carry out their role. Leaders could not clearly explain how the teams were working to provide high quality care.
- Ward areas and patient bedrooms were sparse, and patients on Radley did not have access to alarms.
- There was little evidence of rooms being personalised. Not all care plans were comprehensive or met the needs identified during assessment.
- Care plans were not always recovery-orientated or written from the patient's perspective. There were no best interest assessments to support the care plans written in the third person.
- The information shared at handovers was not always understood by staff.
- Patients and carers interviewed stated that staff did not always communicate with patients, families and carers so that they understood their care and treatment. Patients and carers told us that staff did not fully inform and involve all families and carers.

However:

- There had been a reduction in seclusions and an overall reduction in patient restraints.
- The provider delivered mandatory training for all staff. The majority of staff had completed their mandatory training (99%). Staff had the required mandatory skills and knowledge to meet the needs of the patient group.
- Staff had access to regular supervision and appraisal.
- Staff had completed comprehensive mental health assessments and risk assessment for patients. Staff used recognised rating scales to assess and record severity and outcomes.
- When interacting with patients, staff attitudes and behaviours generally showed that they were discreet, respectful and responsive. Patients said staff treated them well and behaved appropriately towards them.
- Staff had enabled patients to give feedback on the service they received and ensured that patients could access advocacy.
- Staff supported patients during referrals and transfers between services, and supported patients to maintain contact with their families and carers.
- Staff described an improvement in the culture of the hospital. Staff felt respected, supported and valued. Leaders were very visible in the service, were approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	**Requires improvement** 	Start here...
Long stay or rehabilitation mental health wards for working-age adults	**Requires improvement** 	Start here...

Summary of findings

Contents

Requires improvement

Location name here

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Long stay or rehabilitation mental health wards for working-age adults;

Summary of this inspection

Background to Baldock Manor

Baldock Manor is an independent hospital that provides a rehabilitation and intensive care service, to people who have needs related to their mental health and who are detained under the Mental Health Act 1983, Mental Capacity Act 2005, or are voluntarily staying at the hospital.

Baldock Manor is registered to provide the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983.

• Treatment of disease, disorder or injury.

• Personal care.

The provider had a registered manager and controlled drugs accountable officer.

At the current time the hospital has two wards (in four locations) at Baldock Manor with 20 patients in total. These wards are

- Radley Psychiatric Intensive Care Unit - mental health, female ward with 8 beds
- Burberry ward: Mental health high dependency (including patients with dementia), mixed sex ward with 22 beds. Male patients were being nursed on Burberry ward (which was on the ground floor), and Mulberry (which was on the second floor) of the same building. Staff nursed female patients on Oakley ward, which was in a separate building.

The Care Quality Commission inspected Baldock Manor in December 2018. The provider had breached regulations 12, 13, and 17 of the Health and Social Care Act and was given an overall rating of Requires Improvement. We told the provider it must make the following improvements

Action the provider MUST take to improve

- ensure that seclusion facilities comply with Mental Health Act guidance including having no blind spots in the seclusion or its ensuite room on Radley ward.
- follow guidance of least restrictive environment. Individual risk assessments to be undertaken for any risk identified and restrictions required for example; access to drinks and TV remotes.
- ensure that they have sufficient staff to care out treatment and care.
- ensure that agency staff on fixed term contracts are provided with clinical supervision.
- ensure that systems and process operate effectively, including ensuring that there are sufficient numbers of supervised staff, the seclusion room is safe for use and that blanket restrictions were not identified and reviewed in line with the code of practice.

At this inspection we found that the provider had made some improvements related to these issues. However, we had significant concerns about the quality of care and the safety of patients. Following our inspection, we served a Notice of Decision because of the immediate concerns we had about that safety of patients. We told the provider it must not admit any further patients until further notice, it must review care plans, observation levels for patients, incidents, its systems and process for oversight of incidents and care, ensure it had enough suitably qualified, experienced staff on all shifts and that staff had adequate knowledge about the use of the Mental Capacity Act. We told it that it must provide CQC with information relating to these issues each Monday.

The provider has complied with these requirements. All patient care plans and observations have been reviewed and systems and processes are now in place for their ongoing review. The provider has reviewed its incident reporting system and process for the review of incidents. Notifications to external bodies have been made as required. Staff have been tested for competencies around patient observations, diabetes, choking and the Mental Capacity Act. The provider has produced weekly staffing figures, which have confirmed that the majority of shifts have been covered.

Summary of this inspection

Our inspection team

The team that inspected the service comprised of one CQC inspection manager, four CQC inspectors, a specialist advisor and an expert by experience.

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

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 all two wards (in four locations) at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 12 patients who were using the service
- spoke with three carers
- spoke with the registered manager and managers for each of the wards
- spoke with 30 other staff members; including doctors, nurses, support workers, occupational therapist, psychologist, psychology practitioner, and psychology assistant
- received feedback about the service from an associate hospital manager
- spoke with an independent advocate
- attended and observed a multi-disciplinary meeting, two observations of care, community meeting, and an incident meeting
- looked at 12 care and treatment records of patients
- reviewed nine seclusion records
- reviewed Mental Health Act paperwork for one patient
- carried out a specific check of the medication management and emergency equipment on both wards, and
- looked at a range of policies, procedures and other documents relating to the running of the service including incident data, complaints, safeguarding referrals, ligature audits.

What people who use the service say

We spoke with 12 patients at the service:

- Overall patients found staff caring, helpful, polite and respectful.
- One patient had described staff as being, 'ten out of ten'.
- Three patients indicated that they did not feel safe on the ward, due to the number of incidents
- Four patients referred to low levels of staffing and stated that nurses were not always available and that activities were often cancelled.
- We spoke to three carers, who were mainly positive about caring, kindness and dedication of staff and the quality of care delivered.
- One carer stated that, 'staff had gone out of their way to help'.

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?

Inadequate

We rated safe as **inadequate** because:

- The provider had a 75% vacancy rate for qualified staff to lead and manage care and a 21% vacancy rate for support workers. We heard how staffing issues adversely affected patient care. Whilst agency staff were used to cover most shifts, continuity of care could not be assured given the number of agency staff required to carry out care. During inspection some staff did not have a full understanding of patients' risks or care planned needs.
- There had been a marked increase in incidents between September 2019 and October 2019, including self-harm and violence and aggression. Three patients indicated that they did not feel safe on the ward, due to the number of incidents .
- The provider had not ensured that the environment was safe, clean and well maintained.
- There were blanket restrictions in place on the wards. Patients on Radley were not aware that they could access cups for the water fountain and therefore did not have free access to cold drinks. Patients on Radley and Mulberry did not have access to snacks. This had been highlighted at our previous inspection in 2018. Patients on Radley and Mulberry could only access fresh air when escorted, as the ward was on the first floor and both ward doors were locked.
- Staff did not have access to up to date ligature risk assessments on the wards.
- Managers had updated ligature risk assessments. However, staff did not have immediate access to the ligature audits and there were no easy read plans on the ward. Not all staff were aware of ligature points on the wards. The seclusion room on Radley ward was not ligature free. We identified potential ligature points in seclusion, which had not been identified by the provider. Staff were not therefore aware of these, so were not taking steps to mitigate the associated risks.
- Managers had not taken steps to ensure the regular and safe maintenance of essential equipment on Radley ward.
- Patients on Radley did not have access to nurse call alarms.
- Staff did not fully adhere to infection control requirements. Some staff were wearing nail varnish, were not bare from the elbow and were wearing jackets on the ward when completing personal care tasks with patients.

However:

Summary of this inspection

- There had been a reduction in seclusions and an overall reduction in patient restraints.
- Ward managers were able to adjust staffing to take account of patient case mix.
- There was adequate medical cover.
- Staff were up to date with mandatory training.

Staff had completed a risk assessment for every patient.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Staff had not always developed comprehensive care plans that fully met the needs identified during assessment. Of the 12 care plans reviewed, five care plans were not written from the were recovery-oriented or written from the patient's perspective". There were no best interest assessments to support the care plans written in the third person".
- The provider reported that the patients had access to a range of activities, including individual and group interventions. However, there was limited evidence of activities taking place during inspection, and six patients reported that activities had been cancelled.
- Some staff did not display a good understanding of the Mental Capacity Act and the provider cared for patients who lacked capacity to make decisions. Staff did not know the main principles of the Act and therefore could not apply them to their work.
- Some staff did not have a good understanding of patients' physical health status, despite the fact that shift handovers had taken place.

However:

- Staff had completed comprehensive mental health assessments for patients. Staff used recognised rating scales to assess and record severity and outcomes
- Patients had good access to a range of disciplines to assess and manage their physical healthcare.
- Staff participated in several clinical audits.
- Staff had good access to supervision and appraisal.

Are services caring?

Good

We rated caring as good because:

- When interacting with patients, staff attitudes and behaviours generally showed that they were discreet, respectful and responsive.

Summary of this inspection

- Patients said staff treated them well and behaved appropriately towards them.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.
- Staff maintained the confidentiality of information about patients.
- Staff had enabled patients to give feedback on the service they received.
- Staff had ensured that patients could access advocacy.

However:

- Patients and carers interviewed stated that staff did not always communicate with patients, families and carers so that they understood their care and treatment. Patients and carers interviewed, told us that staff did not fully inform and involve all families and carers.
- Staff did not always ensure that patients received an orientation to the ward and to the service. Patients and carers told us that staff did not always ensure patients fully understood why they were receiving the care and treatment being provided.
- Staff did not fully inform and involve all families and carers. Staff did not always provide carers with information about how to access a carer's assessment.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- Patients did not have any means to lock their rooms and keep their belongings safe.
- Ward areas and patient bedrooms were sparse, and bedrooms lacked any form of personalisation.
- Staff and patients did not have access to the full range of rooms and equipment to support treatment and care. The provider had no dedicated activity rooms, therefore staff had to use the patients' sitting or dining room.

However:

- Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital.
- Staff supported patients to maintain contact with their families and carers and had encouraged patients to develop and maintain relationships with people that mattered to them.
- Staff made information leaflets available in languages spoken by patients.

Summary of this inspection

- Patients knew how to complain or raise concerns.

Are services well-led?

Requires improvement 

We rated well-led as **requires improvement** because:

- Although leaders were fully committed to the service they were not fully aware of all aspects of their roles and did not have the knowledge or skills to run the service effectively.
- Leaders had not ensured that there was a clear model of care for the rehabilitation ward, and patients with dementia were being managed on the rehabilitation ward.
- Managers did not have did not have immediate access to business information relating to staffing, patient observations, incidents, safeguarding referrals and notifications to support them to carry out their role. Leaders could not clearly explain how the teams were working to provide high quality care.
- The provider had not fully ensured that effective governance systems were in place. The provider did not have an effective system to oversee and assure itself of the quality of the services and ensure patients were kept safe and received good quality care.
- The provider had not made notifications to external bodies of all relevant incidents as required.

However:

- Leaders were very visible in the service and approachable for patients and staff.
- 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. Staff reported that there had been an improvement in the culture of the hospital.

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.

- Although the provider did not provide training in the Mental Health Act as part of their mandatory training staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was.
- The provider had relevant policies and procedures that reflected the most recent guidance and staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.
- Patients had easy access to information about independent mental health advocacy.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.
- Staff generally tried to ensure that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. However, patients and managers told us that this there had been instances where staff had experienced problems facilitating section 17 leave.
- Staff had requested an opinion from a second opinion appointed doctor when necessary.
- Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them. These were detailed and had full details of patient's leave.
- Care plans did not always refer to identified Section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment (where applicable).
- Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Whilst overall, 98% of staff had received training in the Mental Capacity Act, staff understanding of the Mental Capacity Act, and its implementation was poor.
- The provider previously had arrangements to monitor adherence to the Mental Capacity Act via the social worker, who had left the service. Staff were not aware of any interim arrangements. Staff did not know where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.
- The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it.
- Staff had not audited the application of the Mental Capacity Act.

However:

- Staff had made Deprivation of Liberty Safeguard applications when required and monitored the progress of applications to supervisory bodies.
- For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions.
- When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

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

Requires improvement

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Inadequate

Safe and clean environment

Safety of the ward layout

Staff completed regular environmental and ligature risk assessments of the care environment. A ligature is a place to which patient's intent on self-harm could tie something to harm themselves. The ligature assessments were not kept on the wards. Staff did not have immediate access to the ligature audits and there were no easy read plans on the ward. Managers had identified potential ligature anchor points and had identified mitigation in the form of patient observation. However, not all staff understood the risk, and were not always present in high risk areas.

The ward layout allowed staff to observe all areas of the ward. The provider had also installed CCTV in all main ward areas and seclusion room.

The provider had complied with guidance on eliminating mixed-sex accommodation, as the ward was female.

Staff on Radley had easy access to alarms, however patients on Radley ward did not have access to nurse call alarms. One patient described having to wait an hour for a nurse to respond. Managers had identified this and were planning to order patient alarms.

Maintenance, cleanliness and infection control

Wards were generally clean, had good furnishings and were well-maintained. We found ward areas to be sparse, and patient bedrooms lacking personalisation.

Staff cleaned the premises regularly. However, we found that the condition and cleanliness of the toilets on Radley was poor.

Staff adhered to certain infection control principles, including handwashing. However, some staff were wearing nail varnish, were not bare from the elbow and were wearing jackets on the ward when completing personal care tasks with patients.

Managers had not taken steps to ensure the safe maintenance of essential equipment. We found during inspection that defects had been identified in two out of the six gas boilers in June 2019. However, both the heating and hot water were unaffected. Managers were aware, however had not taken immediate action to rectify these defects. During inspection, managers provided a copy of a quote for repair; however, this was dated the 19 November; the date of our inspection. Following inspection, we received communication from the chief executive confirming that following a visit from a heating engineer on the 26 November 2019, in the hospital, four of the boilers were operational and safe. The heating engineer had issued a safety certificate accordingly. Two boilers were deemed inoperable and were therefore "capped off" due to two faulty electronic control boards.

Seclusion room

The seclusion room allowed clear observations and two-way communication, had toilet facilities and a clock. However, there was limited lighting to the ensuite, which was not well lit.

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

Requires improvement

The seclusion room was not ligature free. There were potential ligature points in seclusion. During inspection we found potential ligature points on the ensuite door hinge and the window frame, which had not been identified by the provider. Staff were not therefore taking mitigating actions to reduce the risk.

Clinic room and equipment

Clinic rooms were well-equipped with the necessary equipment to carry out physical examinations. Managers had recently purchased new medical equipment.

Staff generally maintained equipment well and kept it clean. The provider had secured one medication trolley to the wall, which did not facilitate easy cleaning. Staff had also stored dressing and other clinical supplies under the sink, which could have led to contamination of the supplies. Staff addressed this issue when raised.

Safe staffing

A manager was in post for the ward.

The establishment for qualified nurses on Radley was eight whole time equivalents and the vacancy rate at the time of inspection was 100%. The establishment for healthcare assistants on Radley was 11 whole time equivalents. There was one vacancy for healthcare assistants on Radley.

At the time of inspection, the providers' overall vacancy rate for support workers was 21% and the overall vacancy rate for qualified staff was 75%. At the time of inspection, the registered manager did not indicate that there was a recruitment strategy in place. However, following inspection, the provider shared a copy of the organisation's staffing and recruitment strategy.

The provider had secured a contract with 11 agency staff to help cover staff vacancies. These workers were called 'care partners' and formed the providers' own agency staff who provided regular shifts to cover substantive vacancies. Managers reported that this had helped with consistency and continuity of care. However, this number did not cover all shifts on both wards.

The sickness rate reported as of July 2019 was two percent. Managers did not provide data for the turnover of staff.

The provider had determined safe staffing levels by calculating the number and grade of nurses and healthcare assistants required. Managers had produced a staffing level matrix for Radley. Staff were able to identify the number of staff required on Radley depending on the number of patients who had been admitted.

The provider was asked on the three days of inspection for details of staffing, and levels of patients enhanced observations.

This information showed that during the three-month period beginning of August to end October 2019, only three percent of shifts had not been fully covered.

The ward manager could adjust staffing levels daily to take account of case mix.

When agency and bank nursing staff were used, those staff received an induction and were generally familiar with the ward.

A qualified nurse was generally present in communal areas of the ward at all times.

Staffing levels were supplemented by bank and agency staff, which generally allowed patients to have one-to one time with a nurse.

Staff shortages had resulted in staff cancelling escorted leave or ward activities on a few occasions. A manager told us that facilitating section 17 leave had been problematic in the past. However, they advised that the situation was improving further to the allocation of one twilight staff member. A patient, carer and staff also advised that activities had been cancelled on a few occasions and that activities were not always provided seven days a week.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward in an emergency. The provider also had access to a GP who visited the service weekly.

Mandatory Training

Staff had received and were up to date with appropriate mandatory training. Managers had identified the mandatory learning needs of staff and provided them with opportunities to develop their skills and knowledge. The number of staff overall who had attended mandatory training at the time of inspection was 99%.

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

Requires improvement

Managers informed us that most of the training was accessed on line. Mangers stated that they were in the process of setting up a training academy.

For all the mandatory training courses there was a completion rate of over 75%. However, staff had not completed children's safeguarding training, and we found that some staff had a limited understanding of the Mental Capacity Act.

Assessing and managing risk to patients and staff

Assessment of patient risk

We examined six patient care records on Radley. Staff had completed a risk assessment of every patient at initial triage/assessment and updated it regularly, including after any incident. However, we found that not all incidents had been reported. For one patient we found evidence that two incidents had not been reported.

Staff used a recognised risk assessment tool, which was part of the electronic health record. Staff also completed specialised assessments where required.

Management of risk

Managers had identified issues with incident reporting in the monthly service report dated October 2019.

Managers had identified the need to 'improve reporting' and 'improve reviews'.

Following inspection, the provider initiated a review of its incident reporting system and process.

Staff had not always responded to deterioration in a patient's physical health in a timely manner. For example, the care plan for a patient with epilepsy, was not specific in terms of the patient's non-compliance with medications. This care plan lacked guidance and information relating to the effects of non-compliance on the patient's physical health.

Staff had not always identified and responded to changing risks to, or posed by, patients. We saw one incident where a patient had made serious threats to another patient. However, the patient had left her room and was moving towards the co-patient before being redirected by staff.

Staff had not always followed policies and procedures for use of enhanced observation to minimise risk from potential ligature points. Staff were not always available in areas where high risks had been identified.

Staff undertook pat down searches of patients and their bedrooms, where clinically indicated. However, staff did not have immediate access to ward ligature risk assessments.

Staff on Radley ward applied blanket restrictions on patients' freedom. Patients were not aware that they had access to paper cups for the water fountain and did not have access to snacks. This had been highlighted at our previous inspection in 2018. Patients on Radley could only access fresh air when escorted, as the ward was on the first floor and both ward doors were locked.

There were no informal patients on Radley ward.

Use of restrictive interventions

There had been a marked reduction in the numbers of seclusions. In the six-month period between 01 April 2019 and 31 August 2019, there had been 33 episodes of seclusion (an average of six seclusions per month. The number of seclusions had markedly reduced to one episode in September 2019.

There had been a downward trend in the number of restraints across both wards. In the six-month period between 01 February 2019 and 01 August 2019 there had been 326 episodes of restraint, across both wards (which was a mean average of 47 per month during this period). The number of restraints in July 2019 was 39 (three of these on Burberry), and had further reduced to 14 incidents in September 2019. However, there was a slight increase in the number of restraints in October 2019, with 22 episodes reported.

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquillisation.

Staff had kept all records for seclusion in an appropriate manner.

Safeguarding

Staff had received mandatory adult training in safeguarding; however, staff were not trained in children's' safeguarding. We found evidence that safeguarding processes had not been followed as required in all cases. Managers indicated that there was a high use of agency staff and that they may not be fully aware of the need and process for safeguarding alerts.

Staff had not reported all incidents of harm that met the threshold for a safeguarding referral to the local authority

safeguarding team and the care quality commission where required. During inspection we examined the safeguarding file on Radley ward, which contained 79 incidents. Of these 42 (53%) had not been raised to safeguarding, however 17 of the 42 referrals (40%), met the threshold and for which a safeguarding alert should have been raised. The provider held regular meetings with the local safeguarding designated authority, provided by the local NHS trust. However, we could not be assured that all incidents had been raised to them for oversight.

We reviewed the incident folder for Radley ward from 30 November 2018 to 02 November 2019. Out of 79 incidents recorded, 37 had been raised to safeguarding. Of the remaining 42, seven had not been referred to safeguarding. Examination of these incidents confirmed that seven out of the 42 incidents (17%) met the referral criteria and should have been raised to safeguarding.

Managers indicated that several safeguarding referrals had been missed, due to the fact that incidents had occurred at weekends. Following inspection, the provider submitted more detailed information regarding the incident data for the provider. This indicated that of 98 incidents which should have been referred, that six referrals (six percent) had not been made as required. The referrals made to the care quality commission following inspection, about incidents that had previously taken place included patient on patient assaults, a patient stubbing out a cigarette on another patient and threats from one patient to kill another.

Managers had not updated the safeguarding policy in line with the providers' requirements. We found that the safeguarding policy was last amended on 03 October 2018. Managers were due to complete a review this policy 03 December 2019,12 months from this date.

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

The awareness of some staff members of how to identify adults and children at risk of, or suffering, significant harm varied. This included working in partnership with other agencies.

Staff followed safe procedures for children visiting the hospital.

Staff access to essential information

The provider used electronic patient records.

All information needed to deliver patient care was available to relevant staff (including agency staff) when they needed it and in an accessible form.

Where staff recorded information on paper and electronic systems, it did not cause them any difficulty in entering or accessing information.

Medicines management

Staff followed good practices in medicines management (that is, transport, storage, dispensing, administration, recording, disposal) in line with national guidance. However, we observed one incident where a delivery of medication for both wards remained unsecured in the reception area of the hospital. Staff collected this medication once inspectors raised the issue.

Staff had reviewed regularly the effects of medication on patients' physical health. This included review of patients who were prescribed antipsychotic medication or lithium. These reviews were line with guidance from the National Institute for Health and Care Excellence (NICE). However, we found that one patient was refusing blood tests. Staff had not identified this as a concern and the patient continued to be prescribed medication. This was not in line with NICE guidance.

Track record on safety

The provider reported that there had been four serious incidents in the 12 months prior to inspection. Two incidents related to unauthorised leave, one related to a self-harm incident and the other an environmental incident.

Reporting incidents and learning from when things go wrong

Some staff did not fully know what incidents to report and how to report them internally. Managers told us that staff reported all incidents and that these were discussed in the multi-disciplinary meeting each morning. However, we found that staff had not reported all incidents that should be reported. These incidents contained several safeguarding concerns.

The number of incidents for the provider had increased between September and October 2019. Staff across both

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

Requires improvement

wards reported 131 incidents in October 2019. This was a 72% increase from September 2019. The highest number of incidents related to patient self-harm (38 incidents) followed by incidents of physical aggression (34 incidents).

Staff understood the duty of candour. They were open and transparent, and explained to patients and families a full explanation when something went wrong.

Not all staff had received feedback from investigation of all incidents.

Managers met each morning to discuss key issues relating to the hospital, including incidents. Inspectors requested a copy of the minutes from these meetings, however these were not supplied during the inspection as requested.

The provider had ineffective systems and processes in place to accurately record episodes of restraint. The provider reported nine prone restraints to the CQC, and reports of prone restraints were made to the executive board. We examined meeting minutes from June 2019, and the provider had identified to the executive board, there was an issue with the reporting system.

At the time of inspection, we found the provider had taken no action to address this and there was no mitigation in place to manage the issue in the interim. However, there was evidence that the provider was in the process of making the required changes to the incident reporting forms.

Managers were in the process of reviewing the incident reporting data base. Managers showed us the changes to the incident reporting form which had led to incorrect reporting of prone restraints. However, no immediate action had been taken in June 2019, when issues of concern were identified in June 2019.

The provider had made several improvements relating to the reduction of patient restraints. Managers were delivering training which focused on a hands-off approach to the management of violence and aggression.

Staff were debriefed and received support after a serious incident.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

The inspection team examined six care records on Radley. Staff had completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission.

Staff had assessed patients' physical health needs in a timely manner after admission. However, staff had not always developed comprehensive care plans that met the needs identified during assessment. For example, the care plan for one patient with epilepsy was not specific in terms of the patient's lack of compliance with medications.

Care plans were generally personalised however we found that two out of six (33%) care plans viewed, were not always recovery-oriented and had not been written from the patient's perspective and that of care plans. There were no best interest assessments to support the care plans written in the third person".

Staff had updated care plans when necessary.

Best practice in treatment and care

We inspected six patient records on Radley ward. Staff delivered a range of interventions delivered in line with, guidance from the National Institute for Health and Care Excellence. These included medication and psychological therapies including a range of psychological assessments. We found that two out of six care plans were not comprehensive.

Staff had not fully supported all patients to live healthier lives – for example staff did not generally adhere to best practice in implementing a smoke-free policy, as the hospital was a smoking site. However, some smoking cessation advice had been given to patients in the multi-disciplinary meeting.

However, managers advised us on inspection that some patients had been provided with smoking cessation advice in the multi-disciplinary reviews.

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

Requires improvement

Staff used recognised rating scales to assess and record severity and outcomes. Staff used the CORE outcome measure which include a patient self-report questionnaire designed to be administered before and after therapy.

Staff were not using technology to support patients effectively (for example, for prompt access to blood test results and online access to self-help tools).

Staff participated in several clinical audits. These included audits relating to the Mental Health Act, patient records, seclusion and infection control.

Skilled staff to deliver care

The team included or had access to a range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, patients had access to occupational therapists, psychologists, pharmacists, speech and language therapists (on a referral basis), dietitian and physiotherapist. The provider had funding for a social worker, however the previous post holder had recently left. Managers had recently appointed to this vacancy.

Managers had provided new staff with appropriate induction. This had included agency staff.

Managers had provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. The percentage of staff that received regular supervision overall was 92%. However, during inspection we were unable to examine a sample of the supervision records, as these were provided late in the afternoon on the third day of inspection.

Managers had ensured that staff had access to regular monthly team meetings.

The percentage of staff that had had an appraisal overall in the last 12 months was 94%.

Managers had ensured that staff received some aspects the necessary specialist training for their roles. For example, 18 staff members had received training regarding positive behaviour support and nine staff had attended training delivered by the speech and language therapist. However, staff had not recently attended any specialised training for their roles, for example training in the Mental Health Act.

Managers had dealt with poor staff performance promptly and effectively. Managers provider us with several examples where performance and disciplinary action had been taken.

Multi-disciplinary and inter-agency team work

Staff held regular and effective weekly multidisciplinary meetings. Staff and patients updated care plans and risk assessments at the end of the weekly multidisciplinary meetings. However, there was limited evidence of how information from these meetings had been cascaded to staff.

Staff shared information about patients at handover meetings within the team (for example, shift to shift). However, some staff members had not been able to identify key clinical information regarding patient care and identified risks. For example, non-compliance with epilepsy medication. This suggested that the quality of the information shared at handovers was not robust. However, following inspection, the provider shared handover sheets dated 31 August 2019 and 20 October 2019. These were comprehensive and covered all key information, including current risks.

The ward teams had good working relationships, with other relevant teams within the organisation (for example, psychology and medical staff).

Staff completed assessments prior to all transfers and maintained contact with the patients' care commissioning group throughout the patient's admission.

The ward teams had effective working relationships with teams outside the organisation (for example, the local NHS trust, commissioners and local authority).

Adherence to the MHA and the MHA Code of Practice

The provider did not provide training in the Mental Health Act as part of their mandatory training. This should be mandatory. However, we found that staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was.

The provider had relevant policies and procedures that reflected the most recent guidance.

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

Requires improvement

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff generally tried to ensure that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. However, patients and managers told us that this there had been instances where staff had experienced problems facilitating section 17 leave.

Staff had requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.

There were no informal patients on Radley ward.

Care plans did not always refer to identified Section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment (where applicable).

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the MCA

Overall, 98% of staff had had training in the Mental Capacity Act as of 11 November 2019. However, we found that some staff had a limited understanding of the Mental Capacity Act. Therefore, we could not be assured that staff had identified impaired mental capacity for all patients where relevant.

There had been no Deprivation of Liberty Safeguard applications applied during the last 12 months on Radley ward.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it.

Staff knew where to currently get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.

Staff took all practical steps to enable patients to make their own decisions

For patients identified by staff as having impaired mental capacity, staff had recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions. However due to the fact that some staff demonstrated a lack of understanding around the Mental Capacity Act, we could not be assured that staff had identified impaired mental capacity for all patients where relevant.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Staff had made Deprivation of Liberty Safeguard applications when required and monitored the progress of applications to supervisory bodies.

The provider previously had arrangements to monitor adherence to the Mental Capacity Act via the social worker. Staff were not aware of any interim arrangements, however the registered manager advised that he had assumed this duty.

Staff had not audited the application of the Mental Capacity Act.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients generally showed that they were discreet, respectful and responsive. Staff provided patients with help, emotional support and advice at the time they needed it.

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

Requires improvement

Staff had not always supported patients to understand and manage their care, treatment or condition. Five out of 12 (42%) of patients interviewed overall, stated that they had received little information from staff.

Staff had directed patients to other services when appropriate and, if required, supported them to access those services. This included access to acute care.

Patients said staff treated them well and behaved appropriately towards them. However, 25% of patients interviewed raised concerns about their safety on the ward, due to the number of incidents of violence and aggression.

Staff generally understood the individual needs of patients, including their personal, cultural, social and religious needs.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

Staff had not always used the admission process to inform and orient patients to the ward and to the service. Five out of 12 (42%) of patients interviewed overall, stated that they had received little information from staff.

Staff had not involved all patients in care planning and risk assessment.

Staff had not always communicated with patients so that they understood their care and treatment. Overall five out of 12 patients (42%), stated that patients had not been given information regarding their care and treatment.

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

Staff had enabled patients to give feedback on the service they received, and there was evidence of feedback being actioned. Staff held regular community meetings for patients. Staff also held a patients' forum.

Staff had not enabled patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate.

Staff had ensured that patients could access advocacy.

Involvement of families and carers

Staff had not always informed and involved all families and carers appropriately and provided them with support when needed.

Staff enabled families and carers to give feedback on the service they received, for example, via multi-disciplinary meetings).

Staff had not provided all carers with information about how to access a carer's assessment.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Requires improvement

Access and discharge

Bed Management

The wards within this core service had not reported average bed occupancies ranging above the provider benchmark of 85% in the 12-month period prior to inspection.

There was always a bed available when patients returned from leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient.

When patients were moved or discharged, this was planned and happened at an appropriate time of day

A bed was always available in a psychiatric intensive care unit (PICU) if a patient required more intensive care. The provider accepted referrals from a wide range of authorities, therefore due to the nature of the service, these were not always sufficiently close for the person to maintain contact with family and friends.

Discharge and transfers of care

In the 12-month period prior to inspection. period prior to inspection, there was one delayed discharge from Radley ward.

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

Requires improvement

Staff had not always planned for patients' discharge at an early stage. However, there was good liaison with care managers/co-ordinators, when discharge was being considered.

Discharge had been delayed for one patient. This was due to delays in finding an appropriate placement, following re-diagnosis of patient needs.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital.

The service complied with transfer of care standards.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. However, patients did not have keys to lock their rooms.

Staff advised that patients could personalise their own bedrooms. However, during inspection we observed little evidence of rooms beings personalised. One patient on Radley ward advised that they were not allowed to personalise their rooms. Patients had somewhere secure to store their possessions on the wards.

Staff and patients did not have access to the full range of rooms and equipment to support treatment and care. Staff and patients did not have access to activity rooms, therefore ward sitting rooms were used for all ward activities

There were quiet areas on the ward and a room where patients could meet visitors.

Patients could make a phone call in private. Patients had access to a cordless phone. Staff supervised this access where required.

Patients did not always have free access to outside space. Patients on Radley were on the first floor and could only access fresh air when escorted by staff.

Patients stated that the standard of food varied. Patients stated that there was a lack of healthy options including salads and fruit. One patient complained that there was not enough food available.

Patients on Radley only had access to cold, hot drinks and snacks on request to staff over the 24-hour period. The provider had installed a water fountain on Radley, however patients were not aware they had access to paper cups. Staff advised that cups would be supplied when requested. This was raised as a concern during our previous inspection in 2018.

Patients' engagement with the wider community

Staff had not ensured that when appropriate, patients had access to education and work opportunities.

Staff supported patients to maintain contact with their families and carers. The provider had ensured good links with families and carers.

Staff had encouraged patients to develop and maintain relationships with people that mattered to them.

Meeting the needs of all people who use the service

The service had made several adjustments for disabled patients. However, for patients on Radley there was stair access to the garden area. The provider has therefore not admitted any patients with mobility problems, as they would have difficulty accessing the garden.

Staff had ensured that patients could obtain information on patients' rights and how to complain. However, we found evidence of a delay in one patient being explained their rights under section 132 of the Mental Health Act.

The information provided was in a form accessible to the patient group. For example, the provider had produced easy to read leaflets for detained patients regarding their rights under section 132 of the Mental Health Act.

Staff made information leaflets available in languages spoken by patients. For example, we saw evidence that one patient in the hospital had been a copy of his rights (under section 132 of the Mental Health Act) in Russian. `

Managers had ensured that staff and patients had easy access to interpreters when required.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups.

Staff ensured that patients had access to appropriate spiritual support. However, one patient interviewed on Radley indicated that they had not had access to spiritual support.

Listening to and learning from concerns and complaints

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

Requires improvement

Patients knew how to complain or raise concerns. The provider had received six patient complaints in the 12-month period 01 August 2018 to end August 2019. All of these complaints related to Radley ward. Of these three complaints (50% had been upheld, one (17%) partially upheld and two (33%) were not upheld. The three complaints which had been upheld related to loss of patient belongings, assault on patient by staff and poor care/unprofessional manner by staff. Managers had acknowledged and responded to these within the locate timescale.

When patients complained or raised concerns, they received feedback.

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

Staff generally knew how to handle complaints appropriately, were open and transparent.

Staff received feedback on the outcome of investigation of complaints and acted on the findings.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement

Leadership

Leaders had not always ensured that services were safe. There had been a marked increase in incidents, and leaders had not always ensured that all incidents had been reported and had not ensured that referrals had been made to external bodies as required. Leaders were fully committed to the service and service improvement, however were not fully aware of all aspects of their roles.

Leaders did not have did not have immediate access to information relating to key information including staffing, patient observations, incidents, safeguarding referrals and notifications to the care quality commission. Leaders could not clearly explain how the teams were working to provide high quality care.

At the time of inspection, leaders did not have a good understanding of the services they managed. They could explain clearly how the teams were working to provide care, however did not have immediate access to information relating to key information including staffing, patient observations, incidents, risk registers, safeguarding referrals and notifications to the care quality commission. Leaders were very visible in the service and approachable for patients and staff. Leaders had focused on promoting an open culture, changing staff attitude and had lost focus on key safety issues.

Leadership development opportunities were not always available, including opportunities for staff below team manager level.

Vision and strategy

Staff knew and understood the providers' vision and values and how they were applied in the work of their team.

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

Staff had the opportunity to contribute to discussions about the strategy for their service, in team meetings and away days.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. Staff reported that there had been an improvement in the culture of the hospital over the past six to 12 months. The staff survey for August 2019 indicated that 86% of staff would recommend Baldock Manor as a place to work.

Overall staff felt positive and proud about working for the provider and their team.

Staff stated that they felt able to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process.

Managers dealt with poor staff performance when needed. Managers reported that they had experienced problems with staff sleeping on duty. Managers had taken immediate steps to address this, including the suspension of six staff members. Managers had also met with staff and were conducting unannounced visits to the unit at night.

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

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

Requires improvement

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.

The service's staff sickness and absence were similar to the provider target.

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

The provider had not recognised staff success within the service – for example, through staff awards.

Governance

The provider had not ensured that effective and adequate governance systems were in place. Staff had not reported all incidents. Not all incidents which met the threshold for referral to the local safeguarding team had been raised. The provider had not notified the care quality commission of all relevant incidents, which is a legal requirement.

Systems to ensure that wards were safe were not effective. The provider did not have effective oversight of safety. Ligature risk assessments, documentation, staff adherence to infection control was poorly monitored.

The provider had not ensured that their safe staffing numbers were met on a day to day basis, to ensure the facilitation of activities and patient's leave.

Some staff had a poor understanding of the Mental Capacity Act, and training in the Mental Health Act was not mandatory.

Management of risk, issues and performance

Staff maintained and had access to a risk register for the organisation. However, staff did not have access to a risk register at ward or hospital level. Staff at ward level could escalate concerns to senior managers when required.

Leaders indicated that staff concerns matched those on the risk register.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. Where cost improvements were taking place, they did not compromise patient care.

Information management

The service used systems to collect data from wards that were not over-burdensome for frontline staff. However, managers didn't have access to full information regarding incidents and safeguarding.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Team managers did not have access to all the information required to support them with their management role. This included information on the funded establishments for the ward.

Clinical information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff had not made notifications to external bodies as needed. This included notifications to the care quality commission and safeguarding alerts.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used through the inter and intranet.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback.

Leaders engaged with external stakeholders such as commissioners.

Learning, continuous improvement and innovation

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

Requires improvement

Some staff had been given the time and support to consider opportunities for improvements and innovation and this led to changes. For example, the current work on reducing restrictive interventions, however there was no formal plan in place for this.

Staff had not had opportunities to participate in research.

Innovations were not taking place in the service.

Staff did not participate in national audits relevant to the service.

Staff on Radley are currently working towards quality network for psychiatric intensive care unit accreditation.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

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

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

Inadequate

Safe and clean environment

Safety of the ward layout

Staff did regular environmental and ligature risk assessments of the care environment. A ligature is a place to which patient's intent on self-harm could tie something to harm themselves. We found inaccuracies on the ligature audit. Staff had indicated that all cables had been covered on Oakley ward. However, we found that television cables had not been covered and were loose. The outcome of the ligature assessments was not kept on the wards. Managers had identified potential ligature anchor points and had identified mitigation in the form of patient observation. However, staff did not have access to the outcome of ligature audits and there were no easy read plans on the ward. All staff did not understand the risk, and were not always present in high risk areas.

The ward layout allowed staff to observe all areas of the ward. The provider had also installed CCTV in all main ward areas.

The wards complied with guidance on eliminating mixed-sex accommodation. Male patients resided on Burberry and Mulberry wards and managers had used Oakley ward for female patients.

Staff had easy access to alarms, and patients on Burberry, Mulberry and Oakley had access to nurse call alarms.

Maintenance, cleanliness and infection control

Wards were generally clean, had good furnishings and were well-maintained. Managers had recently replaced the flooring for the ward areas from carpets to cushion flooring. We found ward areas and patient bedrooms to be sparse and were not dementia friendly.

Staff cleaned the premises regularly. However, we found that staff had not cleaned one of the clinics thoroughly. Staff addressed this immediately, once identified by inspectors.

Staff adhered to certain infection control principles, including handwashing. However, some staff were wearing nail varnish, were not bare from the elbow when delivering personal care and were wearing jackets on the ward. We also saw one staff member carry a red medical waste bag through the ward area without wearing gloves.

Managers had not taken steps to ensure the safe maintenance of essential equipment. We found during inspection that defects had been identified in all three gas boilers in June 2019. However, both the heating and hot water were unaffected. Managers were aware, however had not taken immediate action to rectify these defects. Managers provided a copy of a quote for repair; however, this was dated the 19 November 2019, which was the date of our inspection. However, following our inspection, we received communication from the chief executive confirming that following a visit from a heating engineer on the 26 November 2019, the hospital. four of the boilers were operational and safe. The heating engineer had issued a safety certificate accordingly. Two boilers were deemed inoperable and were therefore "capped off" due to two faulty electronic control boards.

Seclusion room

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

There was no seclusion on Burberry, Oakley or Mulberry.

Clinic room and equipment

Clinic rooms were well-equipped with the necessary equipment to carry out physical examinations. Managers had recently purchased new medical equipment.

Staff were not fully compliant with the storage of oxygen. Staff kept the oxygen and emergency bag in the ward office on Burberry, however there was no oxygen sign on the door.

Staff generally maintained equipment well and kept it clean. However, staff had stored also stored dressing and other clinical supplies under the sink, which could have led to contamination of the supplies. Staff addressed this issue when raised.

Safe staffing

A manager was in post for the ward, however, patients were being nursed in three separate locations in the hospital. Male patients were being nursed on Burberry ward (which was on the ground floor), and Mulberry (which was on the first floor) of the same building. Staff nursed female patients on Oakley ward, which was in a separate building. The ward manager covered these three locations.

The establishment for qualified nurses on Burberry was eleven whole time equivalents. There were eight vacancies at the time of inspection; a vacancy rate of 73%. The establishment for healthcare assistants on Burberry was 18 whole time equivalents. There were six vacancies for healthcare assistants, a vacancy rate of 33%.

At the time of inspection, the providers' overall vacancy rate for support workers was 21% and the overall vacancy for qualified staff was 75%. At the time of inspection, the registered manager did not indicate that there was a recruitment strategy in place. However, following inspection, the provider shared a copy of the organisation's staffing and recruitment strategy.

The provider had secured a contract with 11 agency staff to help cover staff vacancies. These workers were called 'care partners' and formed the providers' own agency staff who provided regular shifts to cover substantive vacancies. Managers reported that this had helped with consistency and continuity of care. However, this number did not cover all shifts on both wards.

The sickness rate July 2019 was two percent. Managers did not provide data for the turnover of staff.

The provider had determined safe staffing levels by calculating the number and grade of nurses and healthcare assistants required. Managers had produced a staffing level matrix for Burberry (including Oakley), however the staffing matrix provided to us during inspection, did not include Mulberry. Staff were able to identify the number of staff required on Burberry and Oakley depending on the number of patients who had been admitted.

The ward manager could adjust staffing levels daily to take account of case mix.

When agency and bank nursing staff were used, those staff received an induction and were generally familiar with the ward.

A qualified nurse was not always present in communal areas of the ward at all times. The provider had allocated one qualified nurse to Burberry, Oakley and Mulberry wards. This nurse was generally occupied with other duties.

Staffing levels were supplemented by bank and agency staff, which generally allowed patients to have one-to one time with a nurse.

Staff shortages had resulted in staff cancelling escorted leave or ward activities on a few occasions. A manager told us that facilitating section 17 leave had been problematic in the past. However, advised that the situation was improving further to the allocation of one twilight staff member. A patient, carer and staff also advised that activities had been cancelled on a few occasions and that activities were not always provided seven days a week.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward in an emergency. The provider also had access to a GP who visited the service weekly.

Mandatory Training

Staff had received and were up to date with appropriate mandatory training. Managers had identified the mandatory learning needs of staff and provided them with opportunities to develop their skills and knowledge. The number of staff overall who had attended mandatory training at the time of inspection was 99%.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Managers informed us that the majority of training was accessed on line. Mangers stated that they were in the process of setting up a training academy.

For all the mandatory training courses there was a completion rate of over 75%. However, staff had not completed children's safeguarding training and we found that some staff had a limited understanding of the Mental Capacity Act.

Assessing and managing risk to patients and staff

Assessment of patient risk

We examined six patient care records. Staff had completed a risk assessment of every patient at initial triage/ assessment and updated it regularly, including after any incident. However, we found that not all incidents had been reported. For example, we found evidence that two incidents relating to pressure sores had not been reported.

Staff used a recognised risk assessment tool, which was part of the electronic health record. Staff also completed specialised assessments where required.

Management of risk

Managers had identified issues with incident reporting in the monthly service report dated October 2019. Managers had identified the need to 'improve reporting' and 'improve reviews'.

Staff had not always responded to deterioration in a patient's physical health in a timely manner. Staff had not reported all instances to safeguarding and the care quality commission where required. Following inspection, the provider initiated a review of its incident reporting system and process.

Staff were not always aware of and dealt with specific risk issues such as falls, choking or pressure ulcers. Three staff members on one ward were not able to identify patients who were at risk of falls and or choking. We found evidence that an incidents had not been recorded or a safeguarding referral made in response to two pressure sores. However, we found that staff had taken appropriate steps to clinically manage the pressure sores appropriately. This included occupational therapy and district nurse assessment.

Managers had identified issues with incident reporting in the monthly service report dated October 2019. Managers had identified the need to 'improve reporting' and 'improve reviews', and the incident report was under at the time of inspection.

Staff had not always responded promptly to sudden deterioration in a patient's health in a timely manner. Staff had not always included referrals to external agencies including the care quality commission and safeguarding where required. This included the reporting of two pressure sores. Following inspection, the provider initiated a review of its incident reporting system and process.

Staff had not always identified and responded to changing risks to, or posed by, patients. For example, one patient told us that staff had been reluctant to help them when they experienced aggression towards them.

Staff had not always followed policies and procedures for use of enhanced observation to minimise risk from potential ligature points. Staff were not always available in areas where high risks had been identified.

Staff undertook pat down searches of patients and their bedrooms, where clinically indicated. Managers had identified potential ligature anchor points and had identified mitigation in the form of patient observation. However, staff did not have access to the outcome of ligature audits and there were no easy read plans on the ward. All staff did not understand the risk, and were not always present in high risk areas.

Patients on Mulberry could only access fresh air when escorted, as the ward was on the first floor and both ward doors were locked. Informal patients were not able to leave at will as the ward doors were locked, however the provider had informal patient leaflets which staff read to patients.

Use of restrictive interventions

There were no episodes of seclusion on Burberry (Oakley or Mulberry) ward.

There had been a downward trend in the number of restraints across both wards. In the six-month period between 01 February 2019 and 01 August 2019 there had been 326 episodes of restraint, across both wards (which was a mean average of 47 per month during this period). The number of restraints in July 2019 was 39 (three of these

on Burberry) and had further reduced to 14 incidents in September 2019. However, there was a slight increase in the number of restraints in October 2019, with 22 episodes reported.

Safeguarding

Staff had received mandatory training in safeguarding; however, we found evidence that safeguarding processes had not been followed as required in all cases. Managers indicated that there was a high use of agency staff and that they may not be fully aware of the need and process for safeguarding alerts.

We reviewed the incident folder for Burberry ward from 02 January 2019 to 15/11/2019. Out of 28 incidents recorded, 15 (54%) had been referred to safeguarding and e-mail confirmation had been received for another two incidents. Staff had not raised a safeguarding alert for the other 12 incidents (43%) which met the criteria for referral. Managers indicated that several safeguarding referrals had been missed, because incidents had occurred at weekends. Following inspection, the provider submitted more detailed information regarding the incident data for the provider. This indicated that of 98 incidents which should have been referred, that six referrals (6%) had not been made as required.

Managers had not updated the safeguarding policy in line with the providers requirements. We found that the safeguarding policy was last amended on 03 October 2018. Managers were due to complete a review this policy 03 December 2019,12 months from this date.

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

The awareness of some staff members of how to identify adults and children at risk of, or suffering, significant harm varied. This included working in partnership with other agencies.

Staff followed safe procedures for children vising the hospital

Staff access to essential information

The provider used electronic patient records.

All information needed to deliver patient care was available to relevant staff (including agency staff) when they needed it and in an accessible form. However not all staff were aware of patient's current risk status and identified needs.

Where staff recorded information on paper and electronic systems, it did not cause them any difficulty in entering or accessing information.

Medicines management

Staff followed good practices in medicines management (that is, transport, storage, dispensing, administration, recording, disposal) in line with national guidance. However, we observed one incident where a delivery of medication for both wards remained unsecured in the reception area of the hospital. Staff collected this medication once inspectors raised the issue.

Staff had reviewed regularly the effects of medication on patients' physical health. This included review of patients who were prescribed antipsychotic medication or lithium. These reviews were line with guidance from the National Institute for Health and Care Excellence. However, we found that one patient was refusing blood tests. Staff had not identified this as a concern and the patient continued to be prescribed medication. This was not in line with NICE guidance.

Track record on safety

The provider reported that there had been two serious incidents in the last 12 months. One of these incidents related to a patient death and the other an alleged staff on patient assault.

Reporting incidents and learning from when things go wrong

Some staff did not fully know what incidents to report and how to report them internally. Managers told us that staff reported all incidents and that these were discussed in the multi-disciplinary meeting each morning. However, we found that staff had not reported all incidents that should be reported. These incidents contained several safeguarding concerns.

The number of incidents for the provider had increased between September and October 2019. Staff across both wards reported 131 incidents in October 2019.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

This was a 72% increase from September 2019. The highest number of incidents related to patient self-harm (38 incidents) followed by incidents of physical aggression (34 incidents).

Not all staff had received feedback from investigation of all incidents both internal and external to the service.

Staff understood the duty of candour. They were open and transparent, and explained to patients and families a full explanation when something went wrong.

Managers met each morning to discuss key issues relating to the hospital, including incidents. Inspectors requested a copy of the minutes from these meetings, however these were not supplied during the inspection as requested.

The provider had ineffective systems and processes in place to accurately record episodes of restraint. The provider reported nine prone restraints to CQC and reports of prone restraints were made to the executive board. We examined meeting minutes from June 2019, and the provider had identified to the executive board, there was an issue with the reporting system. At the time of inspection, we found the provider had taken no action to address this and there was no mitigation in place to manage the issue in the interim. However, there was evidence that the provider was in the process of making the required changes to the incident reporting forms.

Managers were in the process of reviewing the incident reporting data base. Managers showed us the changes to the incident reporting form which had led to incorrect reporting of prone restraints. However, no immediate action had been taken in June 2019, when issues of concern were identified in June 2019.

The provider had made several improvements relating to the reduction of patient restraints. Managers were delivering training which focused on a hands-off approach to the management of violence and aggression.

Staff were debriefed and received support after a serious incident.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

The inspection team examined six care records. Staff had completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission.

We examined six care plans for Burberry (including Oakley and Mulberry). Staff assessed patients' physical health needs in a timely manner after admission. Staff had not always developed care plans that met the needs identified during assessment. For example, one patient was having weekly blood monitoring tests, when the care plan indicated that this should be done daily. We also found evidence that staff had not always delivered physical care in line requirements laid out in the patient's care plan.

Three of the patient care plans examined (50%) were not comprehensive. This included care plans for diabetes, nutrition and personal evacuation.

Care plans were generally personalised however we found several references in care plans to 'him' or 'her'. Three out of six care plans (50%), were not recovery-oriented and had not been written from the patient's perspective. There were no best interest assessments to support the care plans written in the third person".

Staff had updated care plans when necessary.

Best practice in treatment and care

We inspected six patient records on Burberry (Oakley and Mulberry). We found staff had delivered a range of interventions delivered in line with, guidance from the National Institute for Health and Care Excellence. These included medication and psychological therapies including a range of psychological assessments and psychological therapies. However, the provider did not have a rehabilitation strategy in place, and staff had not developed care plans with patients with clear recovery or discharge plans. For example, there were limited therapies and activities in relation to rehabilitation, including training and work opportunities intended to help patients acquire living skills.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Patients had requested more activities off the ward, including excursions and visits to the cinema. Patients on Burberry had requested access to a PAT dog. Staff were in the process of facilitating these requests.

Staff had ensured that patients had good access to a range of disciplines to assess and manage their physical healthcare. For example, the provider had accessed physiotherapy input twice weekly, dietitian input monthly, chiropody input six to eight weekly and speech and language therapy input on referral. However, nursing staff had not always delivered care in line with patient care plans. For example, one care plan stated that a patient should have daily blood tests for glucose, however this was being done weekly.

Staff had assessed and completed care plans to meet patients' needs, however, we found that care plans were not always comprehensive.

Staff had not fully supported all patients to live healthier lives – for example staff did not generally adhere to best practice in implementing a smoke-free policy, as the hospital was a smoking site. However, some smoking cessation advice had been given to patients in the multi-disciplinary meeting. However, managers advised some patients had been provided with smoking cessation advice in the multi-disciplinary reviews.

Staff used recognised rating scales to assess and record severity and outcomes. Staff used the CORE outcome measure which include a patient self-report questionnaire designed to be administered before and after therapy.

Staff were not using technology to support patients effectively (for example, for prompt access to blood test results and online access to self-help tools).

Staff participated in several clinical audits. These included audits relating to the Mental Health Act, patient records, seclusion and infection control.

Skilled staff to deliver care

The team included or had access to a range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, patients had access to occupational therapists, psychologists, pharmacists, speech and language therapists (on a referral basis), dietitian and physiotherapist. The provider had funding for a social worker, however the post holder had recently left. Managers had recently appointed to this vacancy.

Managers had provided new staff with appropriate induction. This had included agency staff.

Managers had provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. The percentage of staff that received regular supervision overall was 92%. However, during inspection we were unable to examine a sample of the supervision records, as these were provided late afternoon on the third day of inspection.

Managers had ensured that staff had access to regular monthly team meetings.

The percentage of staff that had had an appraisal overall in the last 12 months was 94%.

Managers had ensured that staff received some aspects the necessary specialist training for their roles. For example, 18 staff had received training regarding positive behaviour support and nine staff had attended training delivered by the speech and language therapist. However, whilst dementia training was addressed as part of the staff away day, staff had not recently attended any specialised dementia training for their roles.

Managers had dealt with poor staff performance promptly and effectively. Managers provider us with several examples where performance and disciplinary action had been taken.

Multi-disciplinary and inter-agency team work

Staff held regular and effective weekly multidisciplinary meetings. Staff and patients updated care plans and risk assessments at the end of the weekly multidisciplinary meetings. However, there was limited evidence of how information from these meetings had been cascaded to staff.

Staff shared information about patients at handover meetings within the team (for example, shift to shift). However, three staff members had not been able to identify key clinical information regarding patient care and identified risks. During inspection, three staff members were unable to identify patients who were at risk of falls or at risk of choking, and a registered nurse was unable to identify who was subject to Deprivation of Liberty Safeguards on the ward. This suggested that the quality of the information shared at handovers was not robust.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

However, following inspection, the provider shared handover sheets dated 31 August 2019 and 20 October 2019. These were comprehensive and covered all key information, including current risks.

The ward teams had good working relationships, with other relevant teams within the organisation (for example, psychology and medical staff).

Staff completed assessments prior to all transfers and maintained contact with the patients' care commissioning group throughout he patient's admission.

The ward teams had effective working relationships with teams outside the organisation (for example, the local NHS trust, commissioners and local authority.).

Adherence to the MHA and the MHA Code of Practice

The provider did not provide training in the Mental Health Act as part of their mandatory training. This should be mandatory. However, we found that staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was.

The provider had relevant policies and procedures that reflected the most recent guidance.

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff generally tried to ensure that patients were able to take Section 17 leave permission for patients to leave hospital) when this has been granted. However, patients and managers told us that this there had been instances where staff had experienced problems facilitating section 17 leave.

Staff had requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them. These were detailed and had full details of patient's leave.

The service had not displayed a notice on the ward door to tell informal patients that they could leave the ward freely. However, once highlighted by inspectors, staff addressed this immediately. The provider had also developed informal patient leaflets to inform patients of their rights.

Care plans did not always refer to identified Section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment (where applicable).

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the MCA

Overall, 98% of staff had had training in the Mental Capacity Act as of 11 November 2019. However, we found that some staff had a limited understanding of the Mental Capacity Act, in particular the five statutory principles.

There had been two Deprivation of Liberty Safeguards applications applied and seven pending in the last 12 months by the provider, to protect people without capacity to make decisions about their own care. These were highest in Burberry ward with eight applications made.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it.

Staff knew where to currently get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards. For patients identified by staff as having impaired mental capacity, staff had recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions. However due to the fact that some staff demonstrated a lack of understanding around the Mental Capacity Act, we could not be assured that staff had identified impaired mental capacity for all patients where relevant.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff had made Deprivation of Liberty Safeguard applications when required and monitored the progress of applications to supervisory bodies.

The provider previously had arrangements to monitor adherence to the Mental Capacity Act via the social worker. Staff were not aware of any interim arrangements, however the registered manager advised that he had assumed this duty.

Staff had not audited the application of the Mental Capacity Act.

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

Good

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients generally showed that they were discreet, respectful and responsive. Staff provided patients with help, emotional support and advice at the time they needed it.

Staff had not always supported all patients to understand and manage their care, treatment or condition. Five out of 12(42%) of patients interviewed overall stated that they had received little information from staff.

Staff had directed patients to other services when appropriate and, if required, supported them to access those services. This included access to acute care.

Patients said staff treated them well and behaved appropriately towards them. However, overall 25% of patients interviewed raised concerns about safety issues on the wards, including assaults from co-patients.

Staff generally understood the individual needs of patients, including their personal, cultural, social and religious needs.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

Staff had not always used the admission process to inform and orient patients to the ward and to the service. Six out of 9 (76%) patients interviewed overall, stated that they had received little information from staff.

Staff had not involved all patients in care planning and risk assessment. Staff had not always communicated with patients so that they understood their care and treatment. Overall six out of nine patients (76%), stated that patients had not been given information regarding their care and treatment.

Staff had involved patients when appropriate in decisions about the service – for example, on Burberry ward, patients had been involved in the morning planning meetings.

Staff had enabled patients to give feedback on the service they received. Staff held regular community meetings for patients. Staff also held a patients' forum, and there was evidence of feedback being actioned.

Staff had not enabled patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate.

Staff had ensured that patients could access advocacy.

Involvement of families and carers

Staff had not always informed and involved all families and carers appropriately and provided them with support when needed.

Staff enabled families and carers to give feedback on the service they received, for example, via multi-disciplinary meetings).

Staff had not provided all carers with information about how to access a carer's assessment.

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

(for example, to feedback?)

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Requires improvement

Access and discharge

Bed Management

The wards within this core service had not reported average bed occupancies ranging above the provider benchmark of 85% in the 12-month period prior to inspection. The average length of stay for Burberry was 99 days.

There was always a bed available when patients returned from leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient.

When patients were moved or discharged, this was planned and happened at an appropriate time of day

A bed was always available in a psychiatric intensive care unit (PICU) if a patient required more intensive care. The provider accepted referrals from a wide range of authorities, therefore due to the nature of the service, these were not always sufficiently close for the person to maintain contact with family and friends.

Discharge and transfers of care

In the 12-month period prior to inspection. last 12 months, there were no delayed discharges from inpatient wards.

Staff had not always planned for patients' discharge at an early stage. However, there was good liaison with care managers/co-ordinators, when discharge was being considered.

Staff had not always planned for patients' discharge at an early stage. However, there was good liaison with care managers/co-ordinators, when discharge was being considered.

Discharge was never delayed for other than clinical reasons.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital.

The service complied with transfer of care standards.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. However, patients did not have keys to lock their rooms.

Staff advised that patients could personalise their own bedrooms. However, we observed little evidence of this during inspection.

Patients had somewhere secure to store their possessions on the wards.

Staff and patients did not have access to the full range of rooms and equipment to support treatment and care. Staff and patients did not have access to activity rooms, therefore ward sitting rooms were used for all ward activities.

There were quiet areas on the ward and a room where patients could meet visitors.

Patients could make a phone call in private. Patients had access to a cordless phone. Staff supervised this access where required.

Patients did not always have free access to outside space. Patients on Mulberry were on the first floor and could only access fresh air when escorted by staff.

Patients stated that the standard of food varied. Patients stated that there was a lack of healthy options including salads and fruit. One patient complained that there was not enough food available.

Patients on Mulberry could not make hot drinks. Patients on Burberry and Oakley had access to hot and cold drinks.

Patients' engagement with the wider community

A number of patients on Burberry had a diagnosis of dementia and such provision would not necessarily meet the needs of the patient population.

Staff supported patients to maintain contact with their families and carers. The provider had ensured good links with families and carers.

Staff had encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

The service made several adjustments for disabled patients. For example, the provider had ensured disabled patients' access to Oakley ward, by widening the doors to allow wheelchair access. However, for patients on Mulberry there was stair access to the garden area. Patients with mobility problems would therefore have difficulty accessing the garden.

Staff had ensured that patients could obtain information on patients' rights and how to complain.

The information provided was in a form accessible to the patient group. For example, the provider had produced easy to read leaflets for detained patients regarding their rights under section 132 of the Mental Health Act.

Staff made information leaflets available in languages spoken by patients. For example, we saw evidence that one patient had been a copy of his rights (under section 132 of the Mental Health Act) in Russian.

Managers had ensured that staff and patients had easy access to interpreters when required.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups.

Staff generally ensured that patients had access to appropriate spiritual support.

Listening to and learning from concerns and complaints

Patients knew how to complain or raise concerns. The provider had not received any formal complaints for Burberry during this time.

When patients complained or raised concerns, they received feedback.

When patients complained or raised concerns, they received feedback.

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

Staff generally knew how to handle complaints appropriately, were open and transparent.

Staff received feedback on the outcome of investigation of complaints and acted on the findings.

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

Requires improvement

Leadership

Leaders had not always ensured that services were safe. There had been a marked increase in incidents, and leaders had not always ensured that all incidents had been reported and had not ensured that referrals had been made to external bodies as required. Leaders were fully committed to the service and service improvement, however were not fully aware of all aspects of their roles.

Leaders did not have did not have immediate access to information relating to key information including staffing, patient observations, incidents, safeguarding referrals and notifications to the care quality commission. Leaders could not clearly explain how the teams were working to provide high quality care.

At the time of inspection, leaders did not have a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care, however did not have immediate access to information relating to key information including staffing, patient observations, incidents, safeguarding referrals and notifications to the care quality commission. The provider was asked on the three days of inspection for details of staffing, and levels of patients enhanced observations. The provider supplied lists of staffing, but during the inspection, the provider had not provided details of patient observations as requested. Following inspection, the provider submitted details of staffing, patient observations and number of patients. This information showed that during the three-month period beginning of August to end October 2019, only three percent of shifts had not been fully covered.

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

Leadership development opportunities were not always available, including opportunities for staff below team manager level.

Vision and strategy

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. However, the service did not have a clear model for rehabilitation and patients with dementia were managed in this service. This was not appropriate.

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

Staff had the opportunity to contribute to discussions about the strategy for their service, in team meetings and away days.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. Staff reported that there had been an improvement in the culture of the hospital over the past six to 12 months. The staff survey for August 2019 indicated that 86% of staff would recommend Baldock Manor as a place to work.

Overall staff felt positive and proud about working for the provider and their team.

Staff stated that they felt able to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process.

Managers dealt with poor staff performance when needed. Managers reported that they had experienced problems with staff sleeping on duty. Managers had taken immediate steps to address this, including the suspension of six staff members. Managers had also met with staff and were conducting unannounced visits to the unit at night.

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

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.

The service's staff sickness and absence were similar to the provider target.

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

The provider had not recognised staff success within the service – for example, through staff awards.

Governance

The provider had not ensured that effective and adequate governance systems were in place. Staff had not reported all incidents. Not all incidents which met the threshold for referral to the local safeguarding team had been raised. The provider had not notified the care quality commission of all relevant incidents, which is a legal requirement.

Systems to ensure that wards were safe were not effective. The provider did not have effective oversight of safety. Ligature risk assessments, documentation, staff adherence to infection control was poorly monitored.

The provider had not ensured that their safe staffing numbers were met on a day to day basis, to ensure the facilitation of activities and patient's leave.

Some staff had a poor understanding of the Mental Capacity Act, and training in the Mental Health Act was not mandatory.

Management of risk, issues and performance

Staff maintained and had access to a risk register for the organisation. However, staff did not have access to a risk register at ward or hospital level. Staff at ward level could escalate concerns to senior managers when required.

Leaders indicated that staff concerns matched those on the risk register.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Where cost improvements were taking place, they did not compromise patient care.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. However, managers didn't have access to full information regarding incidents and safeguarding.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Team managers did not have access to all the information required to support them with their management role. This included information on the funded establishments for the ward.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff had not made notifications to external bodies as needed. This included notifications to the care quality commission and safeguarding alerts.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used through the inter and intranet.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback.

Leaders engaged with external stakeholders such as commissioners.

Learning, continuous improvement and innovation

Some staff had been given the time and support to consider opportunities for improvements and innovation and this led to changes. For example, the current work on reducing restrictive interventions, however there was no formal plan in place for this.

Staff had not had opportunities to participate in research.

Innovations had taken place in the service. Staff had access to hand devices in order to record patient information in real time.

Staff did not participate in national audits relevant to the service.

Staff on Radley are currently working towards quality network for psychiatric intensive care unit accreditation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff report all incidents, and the provider must ensure that they make notifications to external bodies including safeguarding and care quality commission as required.
- The provider must ensure that they work towards a decrease in incidents, including self-harm and violence and aggression.
- The provider must ensure that any blanket restrictions are proportionate and necessary. The provider must ensure that patients always have free access to outside space and must ensure that patients can always make hot drinks and snacks over the 24-hour period and have free access to cold drinks. The provider must ensure that patients on rehabilitation wards have lockable rooms and safe storage for their possessions.
- The provider must ensure that all patients on Radley are able to call for help in an emergency.
- The provider must ensure that all staff are aware of the identified ligature points and manage these appropriately. The provider must ensure the environment is safe and meet the needs of the patients.
- The provider must ensure that all staff adhere to infection control requirements.
- The provider must ensure that the mandatory training for the Mental Capacity Act is sufficient to support staff to have a clear understanding of Mental Capacity Act and Deprivation of Liberty Safeguards and the implications for their practice. The provider must ensure that training in the Mental Health Act is mandatory.
- The provider must review the model of care for the rehabilitation ward and ensure that patients with dementia are supported to receive care in an appropriate service. The provider must ensure that adequate governance systems to provide oversight and assurance about the quality of care it delivers. The provider must ensure that managers are supported to develop skills to effectively carry out their role in order to ensure services are well led.
- The provider must ensure that staff develop comprehensive care plans that meet the needs identified during assessment and regularly updated. The provider must ensure staff have knowledge and understanding of the needs and risks of patients to be able to safely care for them. The provider must ensure that care plans are written from the patient's perspective or recovery-oriented. Where patients do not have capacity, staff must conduct a best interest assessment. The provider must ensure that staff receive training in children's' safeguarding.
- The provider must ensure that staff and patients have access to the full range of rooms and equipment to support their treatment and care. The provider must ensure that patients have access to therapies and activities in relation to rehabilitation, including training and work opportunities. The provider must ensure that patients on rehabilitation wards have keys to lock their rooms.

Action the provider SHOULD take to improve

- The provider should ensure that patient activities are not cancelled.
- The provider should ensure that staff use the admission process to inform and orient patients to the ward and to the service. The provider should ensure that staff communicate with patients so that they understood their care and treatment. The provider should ensure that staff fully inform and involve all families and carers in the patient's care and provide them with information about how to access a carer's assessment.

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 Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured that care plans were comprehensive and met the needs of patients. The provider had not ensured that care plans were written from the patient's perspective and were recovery-oriented. Not all staff had a clear understanding of the Mental Capacity Act. This was a breach of Regulation 9 (1) (1b) (3) a,b,c,e,h (5).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not made notifications to the care quality commission as required. Staff had not reported all incidents. There was an increase in incidents, including self-harm and violence and aggression. Not all environmental and ligature risk assessments were up to date and fully mitigated against. There were blanket restrictions in place for patients' access to fresh air and access to cold drinks. The provider had not ensured that staff were aware of ligature points and had immediate access to ligature risk assessments. Not all staff complied with infection control requirements.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation12(1) (2) a,b,h.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that all incidents that met the criteria for a safeguarding alert had been made. This was a breach of Regulation 13 (1), (2), (3) and (5

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that adequate governance systems are in place and that leaders have a good understanding, oversight and assurance of the services they manage and have immediate access to key information. This was a breach of regulation 17 (1) (2) (a, b, f)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 (1, 1 b, 3 a,b,c,e,h, 5) HSCA (RA) Regulations 2014 Person centred care.**

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1, 2a,b, h) HSCA (RA) Regulations 2014.Safe care and treatment.**

Regulated activity	Regulation
	Regulation 13 CQC (Registration) Regulations 2009 Financial position **Regulation 13 (1,2 3), & 5 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment.**

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 (1e) HSCA (RA) Regulations 2014 Premises and equipment.**

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1, 2 a, b, f). HSCA (RA) Regulations 2014 - Good governance.**

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) HSCA (RA) Regulations 2014** **Staffing.** **We are serving an urgent notice of decision under Section 31 of the Health and Social Care Act 2008.** **We have imposed the following conditions for the regulated activities:** 1. The provider must not admit any patients to Baldock Manor. 2. The provider must undertake a complete, immediate and continuing review of all patients' care plans, and report to the Commission by 5pm on each Monday what actions you have taken as a result of those reviews. 3. The provider must submit to the Commission, by 5pm each Monday a log of all incidents that have taken place, and action taken following the incident to safeguard patients, including notification to external bodies. This is in addition to the providers' obligation to submit notifications to the Commission. 4. The provider must undertake a complete and immediate review of the systems and processes used to record all incidents of restraint. This review must be completed by and your findings submitted to the Commission by 5pm on Monday 9 December 2019. 5. The provider must conduct immediate and continuing competency checks of all staff of Mental Capacity Act knowledge and understanding and proof of these checks must be sent to the Commission by 5pm every Monday.

This section is primarily information for the provider

Enforcement actions

6. The provider must undertake a complete and immediate review of the handover process for each shift change over to (a) ensure that all handovers are being conducted in a way that ensures patient safety, and (b) carry out checks of staff knowledge of the care needs of patients as per each individual care plan. Confirmation of (a) and (b) be submitted to the Commission by 5pm every Monday.
7. The registered provider must ensure that there are sufficient numbers of suitable qualified, skilled, competent and experienced clinical staff at all times to meet the needs of patients.
8. The provider will submit to the Commission by 5pm every Monday the staffing rota for the previous seven-day period. This will include planned and actual staffing numbers, agency and bank fill rates, to meet the needs of the patients.
9. The provider will submit to the Commission by 5pm every Monday, the total number of patients, and observation levels of patients for the previous seven-day period.
10. The provider must undertake a complete and immediate review of all patient observation levels and report any risk associated failings and actions taken to address the risks by 5pm every Monday.
11. The provider must deliver training to and undertake competency checks of all staff to ensure knowledge and understanding of observation levels and practice and proof of the training and of these checks must be sent to the Commission every Monday.