Coveberry Limited

The Willows

Inspection report

The Willows
Fitton End Road, Gorefield
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Tel:

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

Ratings

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

Summary of findings

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	We rated this service as requires improvement because: • The ward environments were not always safe. Not all ligature risks were identified nor removed or reduced if they were. Maintenance work identified as needing repair to keep patients safe had not been completed. • The treatment room was not clean and there was a gap in the kitchen cleaning rota. • The service had a high number of vacancies for nursing and support staff and relied heavily on bank and agency staff to cover shifts. There was not sufficient medical cover in an emergency. • Not all safeguarding incidents were reported to the local safeguarding authority. Staff were not up to date with safeguarding training. • Records were paper-based and cumbersome and were not always complete. There were no plans in place to introduce a more effective and accessible electronic based system. • There were no records of patients being offered debrief after an incident of restraint. • It was not clear from records that patients had their physical health assessed on admission or that discharge plans were recorded in patient notes. • Staff did not always follow the service's search policy or complete search records. • Staff did not update risk assessments prior to patients taking section 17 leave and records did not demonstrate that staff reviewed the outcome of leave. • There was evidence that smoking opportunities were removed from patients as a punishment. • Staff did not always follow systems and processes when safely prescribing, administering and recording medicines. • There was a lack of information for patients displayed within the ward.

Summary of findings

- The provider had not ensured that all staff had completed or were up to date with their mandatory training
- There were governance structures and risk management processes in place. However, these had not yet been fully embedded or were effective in identifying and addressing all the issues found in this inspection.

However:

- Physical interventions were used as a last resort and restraints were low.
- Patients with on-going physical health conditions had relevant care plans in place and staff regularly monitored patients' physical health.
- The multidisciplinary team were all involved in completing patient risk assessments, so all aspects of care and treatment were considered.
- Patients had access to psychological therapies and the service had recently recruited an occupational therapist.
- Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.
- Patients told us that staff were respectful, polite and they felt listened to.
- Patients were able to personalise their bedrooms and held their own bedroom door keys.
- Patients told us the quality of food was very good.
- Staff ensured there were opportunities for patients and carers to be involved in care and treatment and give feedback on the service.
- The hospital manager was visible and approachable for patients and staff.
- Staff felt respected, supported and valued.

Summary of findings

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Summary of this inspection

Background to The Willows

The Willows is an independent hospital owned by Coveberry Limited and is part of the CareTech group.

The hospital is a 14-bed recovery and rehabilitation ward for male patients aged 18 and over.

On the day of inspection there were 13 patients admitted to the ward. Eleven patients were detained under the Mental Health Act (MHA). Two patients were informal.

The hospital was registered with the Care Quality Commission in March 2020. This is the first inspection since registering.

The hospital is registered to carry out the following regulated activities:

• Treatment of disease, disorder or injury

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

The Registered Manager has been with the hospital since it opened.

What people who use the service say

We spoke with six patients and one carer.

Most patients told us they could access a wide range of activities that included playing table tennis, cooking, going for walks and going fishing.

Patients' comments about the hospital were generally positive. A patient who had been in different hospitals over several years told us The Willows was the best. However, one patient told us that it did not feel like a rehabilitation unit because some patients were unwell.

Patients told us they got on well with the staff. They said they were respectful, and they listened. They had one to one time with nurses if they requested it.

Feedback from the carer was overall positive. They felt their relatives were safe and were happy with the care their relatives received. Staff had spoken to them had given them time to ask questions and they felt encouraged to be involved.

How we carried out this inspection

We carried out an unannounced visit to The Willows on 17August 2021 and carried out further remote interviews with staff, patients and carers on 18 August 2021.

We focused on all five key lines of enquiry within the safe, effective, caring, responsive and well-led domains.

Summary of this inspection

During the inspection we:

• spoke with the registered manager

• spoke with six patients and one carer

• spoke with one consultant psychiatrist

• spoke with seven staff (nurses, health care assistants and occupational therapist, psychologist)

• spoke with an independent advocate

• spoke with a mental health act administrator and reviewed Mental Health Act procedures for six patients

• reviewed five care plans

• reviewed three physical health plans

• reviewed the clinic room and treatment room

• attended the multi-disciplinary team meeting

• reviewed five risk assessments

• reviewed six prescription charts

• and reviewed a range of policies and procedures, data and documentation relating to the delivery of the service.

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

Areas for improvement

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

Action the service MUST take to improve:

- The provider must ensure that environmental risks including ligature point risks are reviewed, and actions are taken to mitigate identified risks (Regulation 12(2) (b) & (d)).
- The provider must ensure maintenance is completed to keep patients safe (Regulation 12(2)(d)).
- The provider must ensure there are no restrictive practices at the hospital (Regulation 13(2)).
- The provider must ensure that all safeguarding incidents are reported (Regulation 13(3)).
- The provider must ensure that all patient records are complete and accessible (Regulation 17(2)(c)).

Summary of this inspection

- The provider must ensure all medication is prescribed and administered in line with the Mental Health Act and Mental Health Act Code of Practice requirements and the proper and safe management of medicines (Regulation 12(g)).
- The provider must ensure that searches are carried out in accordance with the service policy (Regulation 12(2)(b)).
- The provider must ensure that staff are kept up to date with mandatory training (Regulation 18(2)(a)).
- The provider should ensure they complete risk assessments for section 17 leave and record the outcomes of leave (Regulation 12 (a)).
- The provider must ensure they have robust governance systems and risk management processes in place to identify and address areas of concern (Regulation 17(2)(a)).
- The provider must ensure sufficient and timely medical support and appropriate management resources (Regulation 18(1)).

Action the service SHOULD take to improve:

- The provider should ensure that the treatment room is kept clean and that cleaning rotas are complete.
- The provider should ensure that patient information is easily accessible.
- The provider should ensure that equipment is labelled with test date and missing equipment are replaced.
- The provider should consider introducing a more effective and accessible electronic based system for patient records.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

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

Requires Improvement

Safe and clean care environments

Safety of the ward layout

Staff completed and updated environmental and ligature risk assessments of all ward areas. However, staff did not identify all potential risks of ligature anchor points to keep patients safe. There were potential ligatures in patient bedrooms that were not on the ligature risk assessment. Staff did not remove all identified ligature risks. There were door hinges to the patient's bathroom and a picture frame that had not been sealed to the wall.

Staff could observe patients in all parts of the wards. The ward was laid out so staff had a good view of all communal areas. There were convex mirrors in communal areas to mitigate blind spots. However, we found unidentified blind spots in the patient garden.

Staff had access to alarms and patients had access to nurse call systems. However, action had not been taken to address nurse call bells in need of repair that had been identified and raised by the manager.

Maintenance, cleanliness and infection control

Maintenance work to repair the fire board to show the correct location of a fire had not been addressed. The manager had raised this on the service's risk register however, the provider had not addressed this.

Ward areas were clean and tidy. However, there were outstanding actions for some furniture, fixtures and fittings that had been identified as in need of repair or replacement.

Staff were supplied with appropriate personal protective equipment (PPE) to ensure staff and patient safety. Manager's undertook regular infection control audits and hand sanitisers were placed throughout the ward and corridors.

We found the daily kitchen cleaning rota had not been signed for two days so it was unclear whether the cleaning had taken place.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Clinic room and equipment

Staff checked, maintained and cleaned equipment. Records showed that equipment had been calibrated however not all items had been clearly labelled to show they had been tested.

All equipment, including the crash bag, was clearly labelled and all items were within their expiry dates. However, safety pins were recorded as missing in the first aid box, but no action had been taken to resolve this.

The clinic room and treatment room were mostly clean and tidy. However, the floor was visibly dirty within the treatment room although the cleaning checklist had been completed.

Safe staffing

Nursing staff

The service did not have enough permanent nursing and support staff. The service had vacancies for a deputy manager; registered nurses and support workers.

The service relied heavily on bank and agency staff to cover shifts particularly during periods of unexpected sickness or absence. This put patients at risk of being supported by staff that were unfamiliar with or who did not know their personal care needs and individual preferences. Managers mitigated this by covering shifts themselves or calling in familiar and regular agency and bank staff when needed to or asked permanent staff to worked over-time to ensure the ward was safe. However, four patients said escorted leave was delayed at times; one member of staff told us it was sometimes difficult to take breaks and two patients we spoke with told us there was not enough activities to do because there were not enough staff.

Managers calculated and reviewed the number and grade of nurses and health care support workers for each shift. They used a staffing 'ladder' to calculate how many staff were needed for the number of patients on the ward. The service therefore knew how many staff were required on each shift to keep patients safe.

Staff shared key information to keep patients safe when handing over their care to others. There was a handover at the end of each shift and a handover book was accessible to staff in the nurses' office.

Medical staff

There was insufficient medical cover. The service employed one psychiatrist who visited the ward once a week and was available to access support or attend 24/7 if needed.

The hospital had an on-call rota which ensured staff could always access support out of hours, or in the psychiatrist's absence.

However, the substantive and on-call medical staff travel time to the ward did not meet Royal College of Psychiatrist national guidance of 30 minutes in an emergency and one hour in a normal day. This meant that medical staff could not attend immediately in an emergency.

Staff were available to drive patients to hospital and GP appointments and contacted emergency services for physical health needs if appropriate.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Mandatory training

Managers kept a record of training. At the time of inspection overall 71% of staff were up to date with their mandatory training, this fell below the target for the service. Not all staff had received face to face training due to the Covid-19 pandemic. Staff told us they had not been given future dates for face to face training. Staff were not up to date with courses delivered by e-learning. For example, risk assessment in care (60%); safeguarding of vulnerable adults (63%) and person-centred thinking (63%) and 70% of staff had completed immediate life support training.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission or arrival and reviewed and updated these daily.

Care records for patients had up-to-date risk assessments and during ward rounds, staff discussed specific risks to each patient.

The multidisciplinary team were involved in completing patient risk assessments, so all aspects of care and treatment were considered.

There were no records of risk assessments prior to patients taking section 17 leave in the local community. Staff did not record the outcome of the leave, specifically the patient's views.

Management of patient risk

Multidisciplinary staff discussions determined the level of risk for each patient and the level of observation needed. Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff followed the service's observation policy. The multidisciplinary team made decisions to decrease the level of observation.

Staff did not always follow the service's search policy when they needed to search patients or their bedrooms to keep them safe from harm. For example, records of personal searches were incomplete, searches were carried out by single staff and were sometimes carried out by female staff only, and only one record indicated whether any items were found during the search. Staff did not receive training to conduct searches.

We saw an incident report which referred to a room search where contraband items were found. There was no record of the search, who conducted it, whether they had the patient's permission and whether the patient was given a receipt for the items they removed.

Use of restrictive interventions

Staff were trained in verbal de-escalation and physical intervention and the rate of restraint was low. There were five incidents of restraint in the three months prior to our visit.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff had been successful in practices of de-escalation with patients and prevented the need for more invasive interventions.

Interventions were documented however, there were no records of patients being offered debrief after an incident.

The service took part in the restrictive interventions reduction network and physical interventions were used as a last resort. Each patient had a positive behaviour support plan. Records showed the holds used were the least restrictive and the restraint lasted the shortest time possible.

However, section 17 leave to enable patients to go out specifically to smoke was sometimes withdrawn for reasons other than a change in the patient's risk assessment. Patients told us staff used this as punishment. Patient smoking opportunities were restricted to one per hour.

On the day of inspection, the garden was locked. Patients told us they could ask to go out for fresh air whenever they wanted.

The service did not have a seclusion room and there had been no incidents of seclusion since the ward opened.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. However, staff were not kept up to date with their safeguarding training. At the time of inspection 63% of all staff had completed e-learning for adult safeguarding.

Staff we spoke to knew who the safeguarding lead for the hospital was and were confident to seek advice when necessary.

Managers had oversight of safeguarding incidents. However, four incidents we reviewed had not been reported to the local authority safeguarding team.

Staff access to essential information

Staff accessed patient notes however these were paper-based and cumbersome making it difficult to find information. There were no planned dates in place to introduce a more effective and accessible electronic based system.

They included up-to-date risk assessments, care plans and positive behaviour plans. Information on patients' physical health was kept in a separate folder.

Records were stored securely in the nurses' office. Authorised staff, including bank and agency, could access patient notes.

Medicines management

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff did not always follow current national practice to check patients had the correct medicines administered. Medication had been wrongly administered to a patient on one occasion. This had been reported to the local safeguarding authority and a managers investigation was being undertaken.

Staff did not always complete medication records. The service's medication audit identified three occasions where a signature was missed.

Staff stored medicines and prescribing documents in line with the provider's policy. However, we found one item of Gaviscon medication that had been opened and was past its expiry date.

The service did not keep all required emergency medication following the use of rapid tranquilisation.

There was an up-to-date stock list with all medicines in date and no excess stock. However, two entries were not double signed in accordance with hospital policy.

All medicines were stored safely in locked cupboards.

Medicines records were complete and contained details on dose, when patients received them, this included controlled drugs (CDs).

Track record on safety

The service had a good track record on safety. There has been limited episodes of incidents and restraints since the service opened.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them.

There were systems in place and incidents were regularly reviewed by managers. Managers understood the duty of candour.

Incidents were shared with staff and staff met to discuss the feedback and look at improvements to patient care at monthly reflective practice meetings, clinical governance meetings and staff team meetings.

There was evidence that changes had been made as a result of feedback. For example, following a patient failing to return from leave the process for signing out patients was reviewed and changed.

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

Requires Improvement

Assessment of needs and planning of care

We looked at five care plans and physical health records. Staff completed risk assessments for

each patient on admission. Patient notes included risk assessments, care plans and positive behaviour support plans. Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were personalised, holistic and included recovery-goals.

Patients' physical health were regularly reviewed during their time on the ward. Patients were registered with a local GP and staff escorted them to appointments at the surgery as necessary. Nursing staff completed general physical health observations and there were records of blood tests and other routine screening. Patients with on-going physical health conditions had relevant care plans in place and there were records of appointments with external healthcare professionals in files. However, records were not always clear whether patients had their physical health assessed on admission.

Best practice in treatment and care

Staff provided a range of care and treatment for the patients in the service. Staff met patients' dietary needs and provided personalised menus for patients with specific nutrition requirements.

Patients had access to psychological therapies. The service had a clinical psychologist and assistant psychologist and had recently recruited an occupational therapist providing a holistic approach to care by using a multi-disciplinary approach with patients being at the centre of their care.

Staff supported patients with their physical health and encouraged them to live healthier lives for example patients could access a therapy kitchen, daily walks and self-care skills.

Staff used recognised scales to assess and record severity and outcomes for example: the MOHOST (Model of Human Occupation Screening Tool); The St Andrews Sexualised Behaviour Scale and Glasgow depression and anxiety scales.

Patients were offered a variety of activities seven days a week. Most patients said there were things to do, such as playing table tennis, cooking, going for walks, arts and crafts and going fishing and camping.

During Covid-19 restrictions there was no opportunity for patients to access work and training within the wider community. Patients were supported to apply for online courses. Recently the occupational therapist was supporting patients to find work opportunities including charity shops, animal boarding kennels and litter-picking within the community.

Skilled staff to deliver care

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

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

Managers gave each new member of staff a full induction to the service.

Managers supported staff through regular, constructive appraisals of their work. At the time of inspection 97% of all staff had an appraisal.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. At the time of inspection 70% of eligible staff had received clinical supervision.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers did not always ensure staff attended regular team meetings. Monthly staff meetings had not taken place between April and August 2021. Monthly clinical governance meetings and reflective practice sessions were attended by staff.

Managers recognised poor performance, could identify the reasons for this and dealt with relevant issues.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients.

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

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

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

Staff received and kept up to date with, training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of inspection 100% of eligible staff had this training.

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

The MHA administrator had effective systems in place to receive and scrutinise detention papers. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

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

Patients told us staff explained their rights under the Mental Health Act.

Not all staff were aware of how to find copies of the T2 (certificate of consent to treatment) and T3 (certificate of second opinion) treatment certificates on the electronic prescribing system in order to check that they were administering medication that was authorised.

We found a patient was receiving medication authorised under MHA section 62 (urgent treatment) for one week. However, the prescription had not been revoked after that time and a referral had not been made to a second opinion appointed doctor (SOAD).

Staff did not always request an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. A patient was receiving medication authorised under MHA section 62 (urgent treatment) for one week. However, the prescription had not been revoked after that time and a referral had not been made to a second opinion appointed doctor (SOAD).

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers and staff made sure the service applied the Mental Health Act correctly by completing regular audits undertaken by the Mental Health Act administrator and findings were discussed at the monthly clinical governance meetings.

Good practice in applying the Mental Capacity Act

Staff received and kept up to date with, training in the Mental Capacity Act. At the time of inspection 81% of eligible staff had received training.

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

There was one Deprivation of Liberty Safeguards application made in the previous 12 months.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes. For example, a best interest decision was used in respect of a patient with Covid vaccine hesitancy who did not have capacity.

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

Good

Kindness, privacy, dignity, respect, compassion and support

We spoke with six patients who told us that staff were respectful, polite and they felt listened to.

Patients told us they got on well with the staff and they had one to one time with nurses if they requested it.

Patients told us staff would knock on the door if they wished to speak with them.

During the inspection we saw evidence of positive interactions between staff and patients.

Staff were caring and gave emotional support and advice when patients needed it. They supported patients to understand and manage their own care, treatment or condition.

However, patients told us that their leave to have a cigarette could be stopped as a punishment.

We saw a poster on the cupboard door containing smoking items that threatened patients would miss their next smoking opportunity should they try to enter.

Involvement in care

Involvement of patients

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

Staff involved patients and gave them access to their care planning and risk assessments.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could access coffee and chat sessions and there were weekly community meetings for patients to raise any concerns and provide feedback. However, whilst patients' comments were documented it was not always clear whether actions had been taken.

Staff involved patients in decisions about the service, when appropriate. Four patients told us they had a copy of their care plan and three patients told us they were involved in care decisions. One patient said they had been involved in writing it. However, one patient was not sure whether he had a care plan. Three patients said they were involved in their ward rounds and felt that the doctor listened to them.

Staff made sure patients could access advocacy services and the advocate visited the ward weekly. The independent mental health advocate told us patients were involved in discussions and decisions about their care and treatment. We saw examples of ward round diaries completed by patients. There was a document called the patient's voice, which summarised the points the patient wanted to discuss during their care programme approach meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke with one carer who told us staff supported, informed and involved families or carers.

Carers knew how to give feedback on the service and would be comfortable to do so.

We saw carer involvement was recorded in patient notes.

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

Good

Access and discharge

Bed management

Staff managed bed occupancy and when patients went on leave there was always a bed available when they returned.

The service had been opened since March 2020. Managers had a target length of stay for patients to ensure they did not stay longer than they needed to. This was twelve to eighteen months. One person had been discharged since the service opened. The longest length of stay was eighteen months.

The service accepted out-of-area placements.

Discharge and transfers of care

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

There were no delayed discharges.

There had been one discharge since the service opened. Staff had planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Discharge planning was discussed and recorded in multi-disciplinary team meetings. However, were not clearly recorded in patient notes and only one of the patients we spoke with was aware of their discharge plan. The patient said staff had helped him to practice skills he would need when he moved into the community.

Staff supported patients when they were referred by giving information and showing them around the ward.

There had been no transfers out of service.

Facilities that promote comfort, dignity and privacy

Patients were able to personalise their bedrooms and held their own bedroom door keys. Patients told us they could have privacy when they were in their bedrooms and staff would knock on the door if they wished to speak with them.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

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

Patients could make phone calls in private.

The service had an outside space that patients could access. On the day of inspection, the garden was locked. Patients could ask to go out for fresh air whenever they wanted.

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

Patients told us that the food was really good, it was cooked at the hospital and patients had a good choice.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. However, patient access to the wider community had not been possible during the Covid-19 pandemic.

The recently appointed occupational therapist told us that links were being made with local charity shops and animal boarding services for work experience opportunities.

The service is in a remote location approximately four miles from the nearest town. However, transport is provided for patients to go into the local community for example to go shopping.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Meeting the needs of all people who use the service
The service could support and make adjustments for disabled people and those with communication needs or other specific needs. For example, a patient had access to Smartbox assistive technology to help communications and independence.

Staff made sure patients could access online information on treatment, local service, their rights and how to complain. However, there were no leaflets or posters on display within the ward.

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

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

Patients had access to a multi-faith room.

The advocate visited the ward weekly and patients knew this.

Listening to and learning from concerns and complaints
Patients, relatives and carers knew how to complain or raise concerns. However, the service did not display information about how to raise a concern in patient areas.

Managers investigated complaints. There had been one complaint in the two months prior to the inspection. The complaint was investigated and resolved. Patients received feedback from managers after the investigation into their complaint.

Staff protected patients who raised concerns or complaints from discrimination and harassment and knew how to identify complaints.

Managers shared feedback from complaints and compliments with staff through monthly meetings.

The service used compliments to learn, celebrate success and improve the quality of care. There had been 11 compliments received since January 2020.

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

Requires Improvement

Leadership

The registered hospital manager joined the hospital in March 2020 when it opened and had the skills, knowledge and experience to perform their role. They had a good understanding of the service they managed and were visible and approachable for patients and staff.

However, the service had been unable to recruit the right candidate to the deputy manager vacancy for twelve months. This meant there was insufficient capacity for management oversight and sustainability for the service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Culture

Most staff knew and understood the provider's vision and values.

Core staff often worked overtime, and the service relied on bank and agency staff and the hospital manager to fill shifts. The service had developed a workforce plan; resourcing and retention plan and an ongoing recruitment drive was underway to fill a high number of nursing and support worker vacancies.

Staff felt respected, supported and valued and were provided with opportunities for professional development.

Staff told us they could raise any concerns without fear and felt comfortable to do so.

Governance

The hospital had developed governance practices and had a framework for staff meetings.

Management information was reviewed and regularly shared with senior management. For example, the manager had oversight of staff vacancies and sickness; staff training, appraisals and supervision and an audit programme covering a range of topics.

However, governance practices were not yet fully embedded or effective. For example, governance had failed to identify poor record keeping, address low mandatory training completion, ensure the proper and safe management of medicines and cleaning audits had failed to identify a dirty floor. Monthly staff team meetings had not taken place between April and August 2021.

Management of risk, issues and performance

The manager had oversight of performance and risk and compiled monthly reports on key performance indicators that were shared with senior managers.

The manager identified, collected and reviewed issues via a risk register. However, maintenance work to repair the fire board to show the correct location of a fire had not been actioned by the provider.

Information management

Teams accessed the information they needed. However, patient records were paper-based and cumbersome. There were no planned dates in place to introduce a more effective and accessible electronic based system.

Patients' confidential personal information was stored securely.

Staff had the technology required to carry out their role.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was provided to meet the needs of patients.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff encouraged patients to feedback on the service. For example, patients could provide feedback during one-to-one discussion, community meetings, and exit interviews.

Learning, continuous improvement and innovation

Managers from the service attended quarterly hospital manager meetings networking across other mental health services within the provider group to share information, discuss best practice, pull knowledge and experience together to improve services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider did not ensure there were no restrictive practices at the hospital.** **The provider did not ensure that all safeguarding incidents were reported.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not ensure all patient records were complete and accessible.** **The provider must ensure they have robust governance systems and risk management processes in place to identify and address areas of concern**

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure that environmental risks including ligature point risks were reviewed, and actions taken to mitigate identified risks.** **The provider did not ensure maintenance was completed to keep patients safe.** **The provider did not ensure that searches were carried out in accordance with the service policy.**

This section is primarily information for the provider

Requirement notices

The provider did not ensure risk assessments for section 17 leave were completed and the outcome of leave recorded.

The provider did not ensure they had robust governance systems and risk management processes in place to identify and address areas of concern.

The provider did not ensure all medication was prescribed and administered in line with the Mental Health Act and Mental Health Act Code of Practice requirements and the proper and safe management of medicines.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that staff were kept up to date with mandatory training. The provider did not ensure there were sufficient and timely medical support and appropriate management resources.