Priory Rehabilitation Services Limited

The Priory Hospital Dewsbury

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The service was not well led. Some of the systems in place were not effective to assess, monitor and improve the quality and safety of services provided. There was an unclear framework to ensure managers disseminated information in a structured manner. Managers had limited oversight and assurance on some aspects of the hospital such as sharing lessons learnt, training and appraisal compliance, cleanliness and maintenance, and timely and accurate record keeping.
- Patients on Hartley ward with a learning disability had not had a positive behaviour support plan created in line with national guidance.
- The facilities on the wards did not fully support the privacy and comfort of the patients. Staff were unable to discreetly observe patients in their bedrooms during the night without disturbing them.
- Jubilee ward required further improvements to ensure it was dementia friendly. The garden area did not create an environment to encourage patients to remain active. Plans for improvement were not robust.
- Ligature risk assessments were not kept on Hartley ward or updated following every admission to the ward.
- There was limited access to the electronic system for agency staff and the use of the electronic systems was very slow.
- Staff on Hartley ward did not always regularly review and update care plans when patients' needs changed.
- The services banned and restricted items list was not service or ward specific and was not reviewed regularly and updated depending on the patient group.

However:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients.

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 	Our rating of this service stayed the same. We rated it as requires improvement because: • The service was not well led. Some of the systems in place were not effective to assess, monitor and improve the quality and safety of services provided. There was an unclear framework to ensure managers disseminated information in a structured manner. They had limited oversight and assurance on some aspects of the hospital such as, sharing lessons learnt, training and appraisal compliance, cleanliness and maintenance, and timely and accurate record keeping. • Patients with a learning disability had not had a positive behaviour support plan created in line with national guidance. • The facilities on the ward did not fully support the privacy and comfort of the patients. Staff were unable to discreetly observe patients in their bedrooms during the night without disturbing them. • Ligature risk assessments were not kept on the ward or updated following every admission to the ward. • There was limited access to the electronic system for agency staff and the use of the electronic systems was very slow. • Staff did not always regularly review and update care plans when patients' needs changed. • The services banned and restricted items list was not service or ward specific and was not reviewed regularly and updated depending on the patient group. • Patients were not always supported by the appropriate advocate when attending Mental Health Act related meetings. • There was limited interaction between ward staff and senior managers who staff said were remote and disconnected from the ward. However,

Summary of findings

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients.

Wards for older people with mental health problems

Requires Improvement

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

- The service was not well led. Some of the systems in place were not effective to assess, monitor and improve the quality and safety of services provided. There was an unclear framework to ensure managers disseminated information in a structured manner. They had limited oversight and assurance on some aspects of the hospital such as, sharing lessons learnt, training and appraisal compliance, cleanliness and maintenance, and timely and accurate record keeping.
- The ward required further improvements to ensure it was dementia friendly. The garden area did not create an environment to encourage patients to remain active. Plans for improvement were not robust.
- The facilities on the ward did not fully support the privacy and comfort of the patients. Staff were unable to discreetly observe patients in their bedrooms during the night without disturbing them.

However:

Summary of findings

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, person-centred care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients.

Summary of findings

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Summary of this inspection

Background to The Priory Hospital Dewsbury

The Priory Hospital Dewsbury is an independent mental health hospital that provides care and treatment for up to 32 male patients across two wards. The hospital is registered to carry out the following regulated activities:

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

At the time of the inspection, there was an overall manager in place who had applied to become the Registered Manager of the hospital. The previous registered manager left at the end of September 2021.

The Priory Hospital Dewsbury delivers in-patient rehabilitation services for adults with mental health problems and in-patient services for adults with dementia. The hospital has two wards for the two different groups of patients.

Hartley ward is a 16 bed long-stay rehabilitation ward for adults of working age. It provides care and treatment for male patients suffering complex and enduring mental health needs including those with an undiagnosed or early onset memory related condition. At the time of the inspection, there were 10 patients detained on Hartley ward. Patients on this ward included individuals who had their detention supervised by the Ministry of Justice.

Jubilee ward is a 16 bed older persons' inpatient ward. It specialises in dementia care and offers care and treatment for male patients with neuro-cognitive conditions. The service cares for patients presenting with very agitated or aggressive behaviour and provides assessment and treatment through to end of life care. At the time of the inspection, the ward had 14 patients, all of whom were detained either under the Mental Health Act or on a Deprivation of Liberty Safeguard, (DoLS).

We last inspected The Priory Dewsbury in March 2020. At that time the service was rated overall requires improvement with a good in the caring domain. We issued the provider with four requirement notices under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to person centred care, premises and equipment, dignity and respect and good governance.

At this inspection, we rated the hospital as requires improvement overall with good in the safe and caring domains. We issued the provider with three requirement notices under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to person centred care, dignity and respect and good governance.

What people who use the service say

Hartley ward: long stay/rehabilitation mental health wards for working age adults

We spoke with six patients on Hartley ward. One patient said that they could not access all their escorted leave due to there not being enough staff on the ward and another patient said food was not of a good quality. One patient said staff did not always check on him at night and said the bedroom doors were noisy when patient observations were completed.

Summary of this inspection

We spoke with relatives of two patients. Whilst one relative was unable to comment, one relative told us they were happy with the care being received and that staff were always very helpful. Both relatives told us escorted leave had been cancelled due to there not being enough staff to facilitate the leave and one relative told us that the food was not always good.

Jubilee ward: Wards for older people with mental health problems

We spoke with seven patients on the ward; our conversations were limited due to their dementia. They told us that the staff were good, they liked their room and the food.

We spoke with the relatives of six of the patients. They told us they felt their relatives were safe at the hospital and were well looked after by staff. Most of them informed us that they felt involved with their relative's care plan and they were aware of how to complain if needed. Not all relatives had attended a review meeting and were unsure if they had been invited. One carer told us they had requested to attend but informed it was not appropriate.

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 sought feedback from a range of stakeholders including service commissioners.

During the inspection visit, the inspection team on Hartley ward:

- visited the ward, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients on Hartley ward
- spoke with two carers of patients from Hartley ward
- spoke with the hospital director and clinical manager of the service
- spoke with the deputy ward manager on Hartley ward
- spoke with ten other staff members: including doctors, nurses, health support workers, and domestic staff
- spoke with two independent advocates
- spoke with the pharmacist
- received feedback from four external agencies including care commissioning and NHS trusts
- attended and observed one morning meeting
- carried out a short observational framework interview for inspection (SOFI)
- looked at eight care and treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

During the inspection visit, the inspection team on Jubilee ward:

Summary of this inspection

- visited the ward, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients on Jubilee ward
- spoke with six carers of patients from Jubilee ward
- spoke with the hospital managers on Jubilee ward
- spoke with 17 other staff members; including doctors, nurses, occupational therapists, health support workers, and domestic staff
- attended and observed one morning flash meeting, a safety huddle, a MDT meeting, and a commissioning meeting
- carried out a short observational framework interview for inspection (SOFI)
- looked at seven care and treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Action the service MUST take to improve:

Long stay/rehabilitation mental health wards for working age adults

- The service must ensure suitable systems are utilised to oversee the cleanliness and maintenance of the hospital. (Regulation 17 - good governance)
- The service must ensure all staff have easy access to the electronic patient record system. (Regulation 17 - good governance)
- The service must ensure that any blanket restrictions applied to patients are done so in line with the Mental Health Act Code of Practice and that a blanket restrictions register is kept and reviewed locally. (Regulation 17 - good governance)
- The service must ensure that lessons learnt from incidents and complaints are recorded and shared through systems and governance structures to improve services and that trends and themes on the ward are clearly identified for learning and improvement. (Regulation 17 - good governance)
- The service must ensure staff records relating to supervision and appraisals are up to date and accurate. (Regulation 17 - good governance)
- The service must ensure structured meetings are embedded at both hospital and ward level to disseminate information throughout the hospital. (Regulation 17 - good governance)
- The service must ensure a patient's privacy and comfort is maintained when staff carry out observations during the night. (Regulation 10 - dignity and respect).
- The service must ensure that all patients with a diagnosis of a Learning Disability have appropriate Positive Behaviour Support plans in place. (Regulation 9 – person centred care)
- The service must establish systems and processes to ensure ligature risk assessments are updated following admission of new patients to Hartley ward and that these assessments are kept on the ward so all staff can access them. (Regulation 17 - good governance)

Summary of this inspection

- The service must ensure that debriefs of patients and staff following incidents are recorded. (Regulation 17 - good governance)
- The service must ensure that patient care records and risk assessments are updated when required and patients' involvement in the creation and updating of these are recorded. (Regulation 17 - good governance)

Action the service MUST take to improve:

Wards for older people with mental health problems

- The service must ensure suitable systems are utilised to oversee the cleanliness and maintenance of the hospital. (Regulation 17 - good governance).
- The service must ensure all staff have easy access to the electronic patient record system. (Regulation 17 - good governance).
- The service must ensure that any blanket restrictions applied to patients are done so in line with the Mental Health Act Code of Practice and that a blanket restrictions register is kept and reviewed locally. (Regulation 17 – good governance).
- The service must ensure that lessons learnt from incidents and complaints are recorded and shared through systems and governance structures to improve services and that trends and themes on the ward are clearly identified for learning and improvement. (Regulation 17 - good governance).
- The service must ensure staff records relating to training and appraisals are up to date and accurate. (Regulation 17 - good governance).
- The service must ensure structured meetings are embedded at both hospital and ward level to disseminate information throughout the hospital. (Regulation 17 - good governance).
- The service must ensure the environment and facilities on Jubilee ward are dementia friendly and suitable to meet the needs of the patient group. (Regulation 9 - person centred care).
- The service must ensure a patient's privacy and comfort is maintained when staff carry out observations during the night. (Regulation 10 - dignity and respect).

Action the service SHOULD take to improve:

Long stay/rehabilitation mental health wards for working age adults

- The service should ensure that staff are able to take adequate breaks when needed.
- The service should consider improvements in the service's information technology to enable staff to efficiently access and use systems without delays.
- The service should ensure staff are aware of the provider's vision and the values.
- The service should ensure the local risk register is up to date and updated accordingly.
- The service should ensure leaders are visible, approachable and consider ways to ensure staff feel valued and respected.
- The service should consider reviewing the culture on the ward and ensure staff understand the current staffing levels and requirements.
- The service should ensure the wording on section 17 escorted leave forms are clear so that patients know how much escorted leave they can take each day.
- The service should ensure they review and look to decrease the use of agency and bank staff.
- The service should ensure food is of good quality and consider reviewing the food choices available to those patients on restricted diets.
- The service should ensure that the Independent Mental Health Advocacy information is available to patients on Hartley ward.

Summary of this inspection

Action the service SHOULD take to improve:

Wards for older people with mental health problems

- The service should ensure relatives and carers are involved in review meetings.
- The service should ensure that staff are able to take adequate breaks when needed.
- The service should consider improvements in the service's information technology to enable staff to efficiently access and use systems without delays.
- The service should ensure staff continue to receive training in dementia and consider a dementia lead for the ward.
- The service should ensure staff are aware of the provider's vision and values.
- The service should ensure the local risk register is up to date and updated accordingly.
- The service should ensure leaders are visible, approachable and consider ways to ensure staff feel valued and respected.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe	Good
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?

Good

Our rating of safe improved. We rated it as good.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. However, the documentation for the processes in place were not always accessible or updated as required.

Safety of the ward layout

Managers of the hospital and a manager from another hospital completed thorough risk assessments of all ward areas and removed or reduced any risks they identified. The organisation's policy was for this to be reviewed every six months. The nature of the patient group meant that the risk of deliberate self-harm was significantly less than on other mental health wards. There were no patients on the ward at the time of inspection who may be at risk of ligaturing. Staff we spoke to knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The most recent risk assessment was not kept on the ward for staff to review.

Staff could not observe patients in all parts of the wards. The ward was set out in an L shape with doors for access to the small lounge areas. There was no mechanism for staff to observe all parts of the ward area. There were doors separating the main ward area from the patient's bedroom areas and the two lounge areas. The service had completed a blind spot audit tool in May 2021 and all blind spots were identified as either low or medium risk with the risk accepted due to staff being aware and managing these risks through regular observation in line with each patient's risk assessment.

Staff had easy access to alarms and patients had easy access to nurse call systems. We saw staff responding to alarms on Jubilee ward during our inspection.

Maintenance, cleanliness, and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff did not ensure cleaning records were up to date. There was no process in place to ensure documentation was completed when the regular domestic staff were not available. The ward employed a housekeeper who worked five days per week. During weekends and periods when the housekeeper was absent, healthcare assistants carried out

cleaning duties or agency staff were used. The ward did not have a cleaner on the weekend or the evenings and we were advised during inspection that this job vacancy was out for recruitment. On the week of the 4 October 2021 two days stated "off" and no cleaning had been recorded as being completed. The service did complete a monthly manager housekeeping audit and inspection, but we could only find evidence of this being completed in August 2021.

Although at the time of our inspection the ward was clean, the systems within the service did not always assure managers about the cleanliness of the ward.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. The ward had five staff on duty for a day shift and four staff on duty for a night shift. This included two nurses for days and one nurse for nights. We were told nurses were not always able to take breaks as a qualified nurse was always required on the ward. The hospital informed us that a nurse could take a break on the hospital grounds away from the ward if able to do so. The staff room was closely located to the ward. However, as shifts were 12 hours in duration this meant that nursing staff may not always be able to get the level of respite required particularly during a busy shift.

The service had low vacancy rates. The ward had a 0.5 whole time equivalent vacancy for a qualified nurse and one full time vacancy for a health care assistant.

The service had high rates of bank and agency staff**.** There had been 643 shifts covered by bank or agency to cover sickness absence and vacancies in the previous 12 months. There were 29 shifts that were unable to be covered during this time. Managers requested staff familiar with the service and agency staff were booked on a block basis which meant the staff were regular and familiar with the ward.

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

The service had turnover rates of an average of 37% from September 2020 to August 2021.

Managers supported staff who needed time off for ill health.

Levels of sickness were 6.94% from September 2020 to September 2021. This was higher than the last inspection period in March 2020 where the sickness percentage was 2% for the whole hospital.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The ward manager could adjust staffing levels according to the needs of the patients. When patients went on extended escorted leave additional staffing was brought in.

Patients had regular weekly one-to-one sessions with their named nurse. However, this was not always documented on the patients care records to state when the session had occurred or what had been discussed. One patient care record stated that they had last had a one to one with their named nurse four weeks prior to inspection.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. However, some patients were unhappy that they had not been able to access all their available escorted leave as written on their leave form. This was due to the leave authorisation form stating that some patients could have eight hours escorted leave a day. After discussions with the hospital staff, we were told the extended eight hours leave was for patients on home leave if it was far away from the service. This was discussed with the management team whilst on site who agreed to make the authorisation form clearer, so patients and staff were clear on how much leave was authorised depending on the type of leave activity being carried out.

The service had enough staff on each shift to carry out any physical interventions safely. The service had a service wide response team that was allocated at the beginning of each shift. Staff from Hartley ward were seen responding to the alarm from Jubilee ward during the inspection.

Staff shared key information to keep patients safe when handing over their care to others. The ward had a comprehensive handover between staff each morning to discuss the previous shift and any patient risks. Although the staff we spoke to could tell us the patient risks and most up to date information, the handover document was not always fully completed

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The ward had two permanent doctors who were able to attend the hospital quickly out of normal working hours if required and an out of hours consultant rota was used which included three additional doctors.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff were required to complete units which included breakaway training, safeguarding, infection control, the Mental Health Act, the Mental Capacity Act and basic life support with defibrillator.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training system informed managers when a staff member's individual training units were due to expire. They then ensured they were booked for updates as needed.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating, and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff did not always complete risk assessments for each patient on admission and did not always review this regularly, including after any incident. We were told that a ligature risk assessment had been completed previously for one patient who was a risk of suicide but that the clinical discussion for this had probably not been documented. Of the eight risk assessments we reviewed, there was no initial risk assessment for two patients. The current risk assessments were regularly updated following monthly multi-disciplinary meetings or incidents, but the information within the risk assessments was not always comprehensive and the data from incidents was not always fully captured.

Staff used the organisation's risk tool which covered the appropriate domains including risks specific to their patient group such as risk of falls.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Although documentation was not always thorough, documentation did outline patient risks and the staff we spoke to were aware of all the patients risks.

The provider had a banned and restricted items list that was used across the healthcare division services supplied by the Priory. However, this was not site or ward specific and was not reviewed regularly and updated depending on the patient group. As per the Mental Health Act Code of Practice 8.9, "No form of blanket restriction should be implemented unless expressly authorised by the hospital managers on the basis of the organisation's policy and subject to local accountability and governance arrangements."

Staff identified and responded to any changes in risks to, or posed by, patients and followed procedures to minimise risks where they could not easily observe patients. They followed the provider's observation policy and monitored the whereabouts of all patients regularly and in accordance with the levels prescribed in risk assessments.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The provider had an up-to-date policy that was followed, and searches were only completed with agreement from the responsible clinician.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff had used restraint eight times from September 2020 to September 2021. This was less than the nine times recorded on the previous report from May 2019 to October 2019.

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

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

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff followed NICE guidance NG10: Violence and aggression: short-term management in mental health, health and community settings when using rapid tranquilisation. Staff on Hartley ward used rapid tranquilisation twice from September 2020 to September 2021. The hospital carried out twice yearly audits for rapid tranquillisation to ensure protocols were followed.

Safeguarding

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

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

Staff kept up to date with their safeguarding training. At the time of inspection 100% of staff were compliant with safeguarding adults and safeguarding children training. The hospital also delivered face to face combined training of which 88.9% of staff had attended.

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

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

Staff followed clear procedures to keep children visiting the hospital safe. Children were not allowed on the ward but could meet patients in a separate visitor's space away from the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We observed safeguarding discussions in the hospital's morning meeting, and staff told us that safeguarding was included in staff handover meetings and in multi-disciplinary team discussions.

Staff access to essential information

Staff did not always have easy access to clinical information, and it was not always easy for them to maintain high quality clinical records.

Patient notes were not comprehensive and not all staff could access them easily. Agency staff who were not qualified nurses were not able to access the online system and relied on permanent or qualified staff to update electronic notes. The service used a combination of electronic and paper records, and staff did not always make sure they were up-to-date and complete. The online system used by the service was very slow and all staff said the system was slow and hard to navigate.

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

Records were stored securely on the online system or within the nurse's office on the ward.

Medicines management

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff followed systems and processes when safely prescribing, administering, recording, and storing medicines. They carried out regular medication audits and an external pharmacy carried out a weekly audit. There were no controlled drugs at the time of inspection.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. The ward had a clear pathway to support patients to self-medicate and there were three patients on the ward who were on this pathway.

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

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

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. They monitored a patient's physical health using the recognised National Early Warning Score tool.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. However, managers did not always document that incidents had been investigated and lessons learned shared with the whole team and the wider service.

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

Staff reported serious incidents clearly and in line with provider policy.

The service had no never events on any wards.

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

Managers and the service psychologist debriefed and supported staff after any serious incident and had meetings called safety huddles to discuss incidents. However, these discussions were not always documented. We were told that debriefs were logged into the ward incident book, but this had not been done. Incident records on the online system that we reviewed did not have debriefs logged.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

It was not always clearly evidenced that managers investigated incidents thoroughly and lessons were learnt. A choking incident from 1 September 2021 did not provide an analysis into how the incident occurred or any actions or lessons learned from the incident.

The service was unable to search their electronic system by categories, for example severity, dates, times, or ward locations. This meant it would be difficult for them to identify themes such as when patients fought with other patients or times of day; this would enable a wider investigation to enable improvements for the whole ward.

We reviewed 16 incidents from September 2021 on the provider's electronic system. The section to detail lessons learnt or where the incident had been shared was empty on all the records we looked at. Follow up actions had not been included in any of the records, for example if a risk management plan had been updated. There had been limited clinical governance meetings or team meetings in the previous months to show where lessons learnt would be shared across the hospital. However, staff did tell us that they would be shared in handover meetings. Staff also had twice daily huddle meetings for incidents to be discussed and immediate actions shared. The hospital had recently appointed a new hospital director who had introduced morning hospital flash meetings where we observed discussions around incidents and their future prevention.

The deputy ward manager advised us that the service had recently implemented a weekly clinical and medicines management tool due to medication issues that had arisen previously on Jubilee ward and a weekly audit schedule to ensure governance processes were in place.

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

Requires Improvement

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

Assessment of needs and planning of care

Staff did not always assess the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion but did not always update as needed. Care plans did not always reflect patients' assessed needs, and were not always personalised, holistic and recovery oriented.

Staff did not always complete a comprehensive mental health assessment of each patient either on admission or soon after. Of the four care records we reviewed, there was one that did not have a comprehensive mental health assessment available.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. All patients were registered with a local GP on an admission. The GP attended the service weekly and made emergency call outs as needed.

Staff did not always develop a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were not always personalised, holistic and recovery orientated. Patients with a learning disability had not had a positive behaviour support plan created in line with national guidance. The new Hospital Director advised us plans were in place to start completing these.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff did not always regularly review and update care plans when patients' needs changed. We were informed by two staff members about a patient who had two very serious choking incidents on the ward. Although we could see that choking was a risk factor on the patient's risk assessment, there were no details about the incidents provided within the patients care record and a staff member could not locate this for us. One care plan did not provide the time scales permitted for escorted leave and one staff member told us they had supported one patient on escorted leave and was not aware that the places the patient was allowed to visit had changed even though the patient was aware of this.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. They delivered care in line with best practice and national guidance. However, this was not always documented within the care plans.

Staff identified patients' physical health needs and met patients' dietary needs and assessed those needing specialist care for nutrition and hydration, but these were not always recorded in their care plans. Four of the patients were on a food plan that had been created by a speech and language therapist and the plans were put on the wall in the kitchen for staff and patients to review. When we asked to review the food plan for one patient on their care records this could not be located. Three patients were supervised during meals due to their risks.

Staff made sure patients had access to physical health care, including specialists as required. This included speech and language therapists and cardiologists. There was a physical health lead on the ward.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There was a smoking cessation lead for the hospital.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included the DIALOG scale where patients rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale, the Life Skills Profile, Waterlow score and Lester Tool.

Staff were not always able to use technology to support patients. Staff, patients, and external agencies told us that video calls were not always able to be completed due to the number of issues with the services internet. Where video calls could not be made, the service had facilitated telephone calls instead.

Staff took part in clinical audits and had a weekly and monthly audit schedule.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with opportunities to update and further develop their skills. Appraisals and supervisions were completed but these were not always documented. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included input from psychology, psychiatry, occupational therapy and speech and language therapy.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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 before they started work.

Managers supported staff through regular, constructive appraisals of their work. However, the documentation provided by the service stated that out of 39 members of staff across the site, there were 22 members of staff who had not received their appraisals which were listed to be completed by 18 June 2021. We were told this information was inaccurate as staff appraisals had not been recorded by the previous manager.

Managers supported medical and non-medical staff through regular, constructive clinical supervision of their work. From January 2021 to September 2021 the service documentation stated that the service had only completed 55% of supervisions due but staff we spoke to said they received regular supervision and documentation issues were known within the service.

Managers did not make sure staff attended regular team meetings or give information from those who could not attend. We requested the team meeting minutes for the previous three months to inspection but only June 2021 and August 2021 were available. There were team meeting minutes available for April 2021 and May 2021 and a nurse's meeting in September 2021, but the minutes did not state which ward these were for. We requested the previous three months operations meeting minutes but only received two meeting minute documents for February 2021 and one for October 2021.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The hospital introduced a development programme to support and sponsor health care assistants to gain a nursing qualification. At the time of inspection, there were three staff members from the service currently participating in this scheme.

Managers made sure staff received any specialist training for their role. Some staff had attended training to enable them to take a patient's blood and the ward had started completing dual diagnosis as a topic for monthly discussions with the staff.

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

Multi-disciplinary and interagency teamwork

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

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

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

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Ward teams had effective working relationships with external teams and organisations. We spoke with two independent advocates, two NHS trusts and one care commissioning group. The ward had regular meetings with commissioners and regular input and communication from district nursing teams and external community services. However, there were concerns about governance and completion of investigations.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. On Hartley ward, 100% of staff had completed the provider's training.

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

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

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

Patients did not always have easy access to information about independent mental health advocacy and patients who lacked capacity were not automatically referred to the service. The service used a general advocate who was known by all the patients and whose details were available on the ward information board. The advocate met weekly with the patients. The independent mental health advocates details were not available, and the ward told us this was due to patients removing items from the board. A Mental Health Act reviewer from CQC had attended the ward during a Mental Health Act visit in August 2021 and had advised that the board should be encased to stop information being removed in the future. This had not been done. Because the patients tended to use the general advocate, they were not always supported by the appropriate advocate when attending mental health act related meetings.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and with the Ministry of Justice.

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

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

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

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Good practice in applying the Mental Capacity Act

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. 94% of Hartley ward staff had completed the training.
There were no Deprivation of Liberty Safeguards applications made in the last 12 months.

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

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

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

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

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

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

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

Good

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

Kindness, privacy, dignity, respect, compassion, and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment, or condition.

Staff were discreet, respectful, and responsive when caring for patients. They gave patients help, emotional support and advice when they needed it. We carried out a short observational framework for inspection (SOFI). This is an observational tool used to help us collect evidence about the experience of people who use services, especially where they may not be able to describe these themselves because of cognitive or other difficulties. We observed staff interacting with patients which demonstrated they were skilled at interpreting their emotions, requirements, and responses. During a staff interview, we observed one interaction between a patient and a staff member where the patient had used derogatory language towards the staff member, the staff member responded in a respectful manner and the deputy ward manager supported both the staff member and the patient immediately and the incident did not escalate.

Staff supported patients to understand and manage their own care treatment or condition. Staff worked with patients to create timetables for unescorted leave so patients were happy with how this was being utilised. Patients were supported to start on the self-medication pathway where appropriate so they could gain independence and help towards discharge.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients. Ward managers had implemented a system when patients went out on community leave that staff would review the location and peers and ensure patients were safe and respected. If staff felt the location for community leave was not appropriate this was discussed with the patient and an alternative agreed.

Staff followed policy to keep patient information confidential.

Involvement in care

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

Involvement of patients

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

Staff involved patients and gave them access to their care planning and risk assessments. However, this was not always documented, and staff told us that most patients did not want to have access to the documentation due to the information detailed within them.

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

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

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients had regular community meetings and there was a "You Said, We Did" board on the ward where patient feedback received a response from the ward. There was also the internal complaints procedure available for patients to review on the ward.

Staff supported patients to make decisions on their care.

Staff made sure patients could access general advocacy services. The general advocate met with the patients at least once a week. However, patients did not regularly access the Independent Mental Health Advocate who would be needed for any Mental Health Act meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families or carers. Families, where appropriate, were invited to all the patient's meetings.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff helped families to give feedback on the service. The provider sent out a regular relative's satisfaction survey and the provider website had a compliments, comments, and complaints section for people to feedback about the service. We spoke with relatives of two patients. One relative was happy with the care being received and said staff were always very helpful. Both relatives told us escorted leave had been cancelled due to there not being enough staff to facilitate the leave and one relative told us that the food was not always good.

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

Requires Improvement

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

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.

Managers made sure bed occupancy did not go above 85%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. However, out of the ten patients on the ward, five patients were detained on the ward by the Ministry of Justice, so lengths of stay were dependent on the Ministry of Justices decision.

The service had five out-of-area placements out of the ten patients. The service ensured these patients were provided home leave and worked with other services to be placed in the community in their local area where possible.

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

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

Discharge and transfers of care

There were no delayed discharges from the service.

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

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, however, there were no vision panels on the bedroom doors to ensure privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. However, patient's bedroom doors did not have vision panels for staff to use when observing patients. This meant patients could be disturbed when staff were on night-time observations. All ten patients were on staff observations that ranged from one-to-one continuous observations to two checks every 24 hours. Four patients were on four checks per hour. During the night staff members must open the bedroom door of patients to be able to complete observation checks. When patients were asleep in their bedrooms the doors were heavy and the opening and closing of the door was loud. One patient told us the noise from the doors was very loud.

Patients had a secure place to store personal possessions. There was a lock box in each patient's bedroom.

Staff used a full range of rooms and equipment to support treatment and care. There were a range of rooms available, but patients could not always access them easily. Some of these were locked and patients were only allowed into them with a staff member. For example, the activities of daily living kitchen and the laundry room. The ward had a quiet room which patients were able to use but we were told the patients had agreed to keep this room locked due to another patient's behaviour in that room. Off the ward, patients had access to a gym and a multi-faith room.

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

Patients could make phone calls in private.

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

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

The service did not always offer a variety of good quality food. Some staff and patients said the food was not of a good quality and some staff said the food did not always consider the dietary requirements of patients or offer enough choices. However, the service had recently implemented a new menu on the week of our inspection.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. There were information leaflets on the ward about finding work in the area.

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

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. On the first day of our inspection the service was attending a community lantern parade in celebration of World Mental Health Day with eight out of the ten patients. The purpose of the walk was to raise awareness of mental health. Patients had access to ward-based and community-based activities. There was a locum occupational therapist who worked across both wards and a full-time occupational therapy assistant solely for the Hartley ward who had recently been recruited but had not yet started. Staff encouraged patients to engage in the activity programme.

Meeting the needs of all people who use the service

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service could support and adjust for disabled people and those with communication needs or other specific needs. The ward was all on one level and allowed for wheelchair access if needed. Staff adjusted by providing necessary equipment suited to their needs. One patient's physical health had recently deteriorated and had required the use of a wheelchair which was facilitated. The patient was provided with a specialised seat cushion and the service was awaiting the arrival of a bed mat to reduce the risk of falls when getting out of bed.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The information boards around the ward provided a lot of information for patients.

The service had information leaflets they could access if needed in languages spoken by the patients and local community.

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

The service provided a variety of food to meet the cultural needs of individual patients. There were two patients on the ward who followed cultural diets, and this was supported by the service.

Patients had access to spiritual, religious, and cultural support. There was a multi-faith room off the ward and patients were supported to attend mosque, church, or other various religious places whilst their beliefs were also supported on the ward. The service had recently celebrated Eid and photos from the event were displayed on the ward.

Listening to and learning from concerns and complaints

The service received feedback from patients and acted on the concerns. However, there was no formal documentation of any compliments or complaints received in 2021.

Patients, relatives, and carers knew how to complain or raise concerns. The patients and carers we spoke to knew how to make a complaint.

The service clearly displayed information about how to raise a concern in patient areas. Feedback forms were available on the ward notice board.

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

There was no evidence that managers investigated formal complaints and identified themes. We asked on inspection to review the complaints and compliments folder and there was nothing from 2021. However, there was a complaints policy in place.

Staff protected patients who raised concerns or complaints from discrimination and harassment. They showed an awareness and provided examples of how to protect patients who raised concerns from discrimination and harassment.

There was no evidence that the service used compliments to learn, celebrate success and improve the quality of care due to there being no compliments logged in 2021.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Requires Improvement

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

Leadership

Leaders had the skills, knowledge, and experience to perform their roles but had a limited understanding of the services they managed. They were not visible in the service or approachable for patients and staff. Ward managers and senior nurses were qualified in mental health nursing. Staff told us that they felt disconnected from higher managers, and they were rarely seen on the ward. At the time of our inspection, the hospital director had been in post for just one week and was therefore still in the process of getting to know how the hospital worked. We saw evidence that governance concerns had been identified by the new director and improvements were being implemented. For example, the implementation of a daily management meeting to provide leaders with a better oversight of the hospital and assurances needed.

Vision and strategy

Staff did not know and understand the provider's vision and values and how they applied to the work of their team. Staff members based on the ward could not tell us the vision or values of the organisation. All staff were able to describe positive behaviours they believed the ward demonstrated, such as person-centred care. However, they were unable to relate these to the statemented values of the provider and, unable to describe the organisation's purpose and strategy of what it aimed to look like.

Culture

Staff felt respected, supported, and valued at ward level. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They felt able to raise concerns without fear of retribution and knew how to use the whistleblowing process. Staff felt positive and proud to work within their ward team. Staff were positive about the opportunities provided for progression in the organisation.

However, most staff felt invisible and less valued and respected from senior managers. They told us there was limited interaction and that senior managers were remote and disconnected from the ward.

Governance

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

The service had some systems and procedures in place. These ensured safe staffing levels, health and safety adherence, patients were assessed and treated well, that medicines were managed safely, and staff adhered to the requirements of the Mental Health Act and Mental Capacity Act. However, although the hospital had introduced flash meetings for daily ward updates; this was in its infancy as had only been introduced the week of our inspection.

There were limited or no systems to provide managers with the oversight necessary for assurance about some aspects relating to the quality of the hospital or to facilitate continuous improvement.

Patients with a learning disability had not had a positive behaviour support plan created even though it was recognised these were required. There were no systems to ensure wards had been properly cleaned, particularly at weekends and

when domestic staff had time off. Meetings at all levels were irregular and there was no clear framework for what should be discussed at a ward, team or directorate level. This meant staff at ward level were unaware of information such as organisational changes, lessons learnt and hospital risks. This also meant hospital managers had limited oversight around ward information such as supervisions and risks.

Managers did not record debriefs, lessons learnt or information sharing for reported incidents. They used an electronic incident reporting system. On all records we looked at, this section was left blank. Managers were also unable to easily search for themes. This meant that they had no process in place to share lessons learnt from incidents or to monitor trends for future prevention and improvement.

Managers could not be assured that all patient records were maintained accurately and in a timely manner. This was because some agency healthcare assistants had to rely on permanent staff to transcribe any patient note such as observations onto the electronic system. This meant there could be delays or errors in interpreting written notes.

The provider's systems to monitor training and appraisals was not accurate. Appraisal compliance was not up to date and managers had no plans to rectify this.

Management of risk, issues, and performance

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

We requested the service's local risk register and were supplied with a document dated 2015, 2016 and 2017. The risks were dated from August 2016 to June 2020 with only one of eight risks showing as closed. Some of the risks were not dated and did not have a date for completion. There was no evidence that this document had been updated since June 2020 so we could not be assured there was proper oversight of risk in the service.

Ligature risk assessments were not kept on the ward or updated following every admission to the ward.

Information management

Staff did not collect analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

All staff we spoke with told us that access and the use of the electronic systems was very slow. We observed this during the inspection. This meant staff were unnecessarily taken away from patient care due to delays in updating and viewing needed information.

The system was very slow at the service which meant video calls to advocacy could not always be supported and it slowed down access to the electronic systems.

Staff had mandatory training in information governance, and each staff member had their own secure passwords with individual authorisations to access confidential information.

Engagement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership. We received feedback from multiple third-party stakeholders who were positive about the services engagement.

Learning, continuous improvement and innovation

We were not aware of any continuous improvement initiatives taking place at the hospital. Staff did not participate in any national audits and did not participate in any accreditation schemes relevant to long stay rehabilitation wards.

Requires Improvement

Wards for older people with mental health problems

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

Are Wards for older people with mental health problems safe?

Good

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

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and updated a risk assessment of the ward. The last ligature audit was dated May 2021. The organisation's policy was for this to be reviewed every six months. The audit and risks were available in the office and online. However, some staff were unaware where the ligature risks were. There were no patients on the ward at the time of inspection who may be at risk of ligaturing. Staff told us that individual patient risks are identified on admission and necessary mitigations put in place if needed. The nature of the patient group meant that the risk of deliberate self-harm was significantly less than on other mental health wards. In addition, many anti-ligature fittings would be inappropriate for the patients on Jubilee ward, all of whom had a diagnosis of dementia.

Staff could not observe patients in all parts of the wards. The ward comprised a main corridor with the bedroom doors directly from the corridor and an alcove for the dining area. There were some low-level blind spots without mirrors for mitigation. Staff managed these risks through regular observation in line with each patient's risk assessment.

Staff had easy access to alarms and patients had easy access to nurse call systems. Some patients had special equipment installed in their bedroom such as falls mats, which alerted staff to their urgent need for support. This was because not all patients had the capacity to use the alarm call points. Prior to our inspection, the ward had limited staff alarms which were being allocated on a priority basis. During the inspection, new alarms were delivered to the ward ensuring all staff had access.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff did not ensure cleaning records were up to date. The ward employed a housekeeper who worked five days per week. During weekends and periods when the housekeeper was absent, healthcare assistants carried out cleaning duties or agency staff were used. However, the daily records were not maintained. Cleaning records had been prepared for future dates with details of work to be completed. However, we found that some days were crossed through and had been annotated to show annual leave.

Additionally, a monthly managers housekeeping audit and inspection was also not carried out for five months from April to August 2021.

Although at the time of our inspection the ward was clean, this meant that systems within the service were not a reliable method to assure managers about the cleanliness and maintenance on the ward at all times.

Staff followed infection control policy, including handwashing.

The hospital did not have a seclusion room and they had not secluded or segregated any patients in the 12 months prior to our inspection.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. The ward had nine staff on duty for a day shift and eight staff on a night shift. This included two nurses for days and one nurse during a night shift. We were told nurses were not always able to take breaks as a qualified nurse was required on the ward at all times. The hospital informed us that nurses could take a break on the hospital grounds away from the ward if able to do so. The staff room was closely located to the ward. However, as shifts were 12 hours in duration this meant that nursing staff may not always be able to get the level of rest required particularly during a busy shift.

The service had low vacancy rates. The ward had a vacancy for a deputy ward manager, two nurses and four health care assistants.

The service had low rates of bank and agency nurses. The ward used agency nurses to cover the vacancies until filled. This cover was booked on a block basis which meant the staff were regular and familiar with the ward.

The service had low rates of bank and agency nursing assistants. Agency staff were mostly used when the ward had increased numbers of patients requiring higher observation. The same agency staff were used and were therefore familiar with the ward and patient group. The hospital ensured agency staff were compliant with the hospital's mandatory training requirements.

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

Patients had regular one- to-one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

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

Requires Improvement

Wards for older people with mental health problems

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The ward had two permanent doctors who were able to attend the hospital quickly out of normal working hours if required.

Mandatory training

Staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff were required to complete units which included breakaway training, safeguarding, infection control, the Mental Health Act, the Mental Capacity Act and basic life support with defibrillator.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training system informed managers when a staff member's individual training units were due to expire. They then ensured they were booked for updates as needed.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, and reviewed this regularly, including after any incident. They used the organisation's risk tool which covered the appropriate domains including risks specific to their patient group such as falls. Assessments were updated monthly and reviewed with the multi-disciplinary team and with additional updates when circumstances changed.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. We looked at the records of seven patients. All records had comprehensive risk assessments and management plans in place. There were detailed plans for individual patients identified with specific risks such as falls or pressure ulcers.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff followed procedures to minimise risks where they could not easily observe patients. They followed the provider's observation policy and monitored the whereabouts of all patients regularly and in accordance with the levels prescribed in risk assessments.

The provider had a banned and restricted items list that was used across the healthcare division services supplied by the Priory. However, this was not site or ward specific and was not reviewed regularly and updated depending on the patient group. As per the Mental Health Act Code of Practice 8.9, "No form of blanket restriction should be implemented unless expressly authorised by the hospital managers on the basis of the organisation's policy and subject to local accountability and governance arrangements."

The ward had a staff lead for the prevention of patient falls. They had introduced procedures in the last four months to monitor and prevent falls. There was a falls log and a clear chart in the office to highlight when and where a fall had occurred so that themes could be identified. The office board highlighted individual patient falls over time so actions could be considered. Podiatrists and physiotherapists reviewed the patients when needed. Falls were discussed in a daily hospital meeting and as part of multi-disciplinary team reviews. Staff had received training in falls prevention.

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff individually assessed the restrictions to a patient's freedom of movement on the ward. Due to their dementia, patients could be disorientated and could hurt themselves if they had unrestricted access to their bedrooms. During our inspection, all bedrooms were locked, however, staff had assessed one patient to safely have their own key.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. In the three months prior to our inspection, staff had restrained patients on 26 occasions where de-escalation techniques had failed; staff did not use prone restraint.

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

Staff followed NICE guidance when using rapid tranquilisation. The hospital carried out twice yearly audits for rapid tranquillisation to ensure protocols were followed. Staff used rapid tranquillisation on one occasion In the three months prior to our inspection. Records showed the appropriate physical health monitoring required.

In the 12 months prior to our inspection, there were no episodes of seclusion and no episode of long-term-segregation.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. The ward manager, who had been in post for six weeks, was awaiting additional training to support them to act as a safeguarding lead for staff and patients. In the meantime, staff referred to the hospital's clinical director if needed.

Staff kept up to date with their safeguarding training. At the time of our inspection, 100% of staff were compliant with safeguarding adults training. Over 95% of staff were compliant with their safeguarding children training. The hospital also delivered face to face combined training of which 76% of staff had attended.

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

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

Staff followed clear procedures to keep children visiting the service safe. Children were not allowed on the ward but could meet patients in a separate visitor's space away from the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We observed safeguarding discussions in the hospital's morning meeting, in multi-disciplinary team discussions and staff told us that safeguarding was included in staff handover meetings.

Staff access to essential information

Not all staff had easy access to clinical information, and it was not always easy for them to maintain high quality clinical records.

At the time of our inspection, some agency health care assistants did not have access to the electronic patient record system. Managers had to print copies of care plans and risk management plans, so they were available for those unable to access the electronic records. Risks were discussed in handover meetings and were highlighted on notice boards in the office. Agency workers without access made handwritten notes which then needed to be transcribed into the patient's electronic record by other staff members. This could be time consuming taking them away from patient care and at risk of being missed or incorrectly recorded.

Staff told us, and we observed difficulties in the electronic systems used by the hospital. The issues included an exceptionally slow connection and systems difficult to navigate. This meant there may be delays in the ability for staff to quickly access patient information.

Records were stored securely.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. They carried out regular medication audits and an external pharmacy carried out a weekly audit. Internal audits included full medication counts and controlled drugs were checked twice daily.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Medications were reviewed daily with a formal complex clinical review at least monthly. Staff informed relatives about medicines as most patients were unable to receive this information due to their diagnosis.

Staff followed current national practice to check patients had the correct medicines. At the time of our inspection, there were no patients on the ward where staff had prescribed above the recommended British National Formulary limits.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. They monitored a patient's physical health daily using the recognised National Early Warning Score tool.

Track record on safety

The service had a good track record on safety.

Requires Improvement

Wards for older people with mental health problems

The ward had reported no serious incidents in the last 12 months.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents in line with the provider's policy.

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

Managers investigated incidents however, lessons learnt were not clearly evidenced or fed back to staff. They investigated individual patient incidents but were unable to search their electronic system by categories, for example severity, dates, times or ward locations. This meant it would be difficult for them to identify themes such as patient altercations or times of day; this would enable a wider investigation to enable improvements for the whole ward.

We reviewed 16 incidents from September 2021 on the provider's electronic system. The section to detail lessons learnt or where the incident had been shared was empty on all the records we looked at. Follow up actions had not been included in any of the records, for example if a risk management plan had been updated. There had been limited clinical governance meetings or team meetings in the previous months to show where lessons learnt would be shared across the hospital. However, staff did tell us that they would be shared in handover meetings. Staff also had twice daily huddle meetings for incidents to be discussed and immediate actions shared. While on the ward we observed an incident and the follow up conversations around changes of medication, care plan updates and updating records. The hospital had recently appointed a new hospital director who had introduced morning hospital flash meetings where we observed discussions around incidents and their future prevention.

Managers debriefed and supported staff after any serious incident. Most staff told is they received a debrief when this was needed. Depending on the incident, debriefs were carried out by managers, nurses or the ward's psychologist.

Are Wards for older people with mental health problems effective?

Good

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

Assessment of needs and planning of care

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

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

Requires Improvement

Wards for older people with mental health problems

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff discussed patients' physical health changes and needs in their daily flash meeting. They commenced food and fluid charts for all patients on their admission.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed the records of seven patients; all care plans demonstrated the individuality of the patient, included their broader needs relating to their dementia and were up to date.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. They delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans. They made sure patients had access to physical health care, including specialists such as speech and language therapists. All patients were registered with a local GP on admission. The GP attended the service weekly and made emergency call outs as needed.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. At the time of our inspection there were no patients on the ward who smoked. Staff told us if they received a patient who was a smoker, they would support them with smoking cessation interventions as needed.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included the National Early Warning Score tool, the Malnutrition Universal Screening Tool and the Cognitive Use Mini Mental State Examination tool.

Staff used technology to support patients. Electronic tablets were used to assist patients with their engagement with their loved ones; this had been particularly important during the COVID pandemic.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills.

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included input from occupational therapy, psychology and psychiatry.

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 supported staff through regular, constructive appraisals of their work. Staff told us that they had received an annual appraisal. However, managers were unable to provide evidence of this. The appraisal data showed that 44% of staff had received an appraisal across the hospital. This information was inaccurate as staff appraisals had not been recorded by the previous managers.

Managers supported staff through regular, constructive clinical supervision of their work. Records showed there was a 78% compliant rate of supervisions across the hospital. Staff we spoke with told us that they received regular supervision and support.

Managers did not ensure staff attended regular team meetings or give information from those who could not attend. The ward's manager had been in post for six weeks. During this time, they had conducted a nurse's team meeting. However, the most recent team meeting for other members of staff on the ward was a healthcare staff meeting in July 2021. Most of the staff we spoke with told us they were unaware of attending a team meeting or receiving information. There was no clear structure to meeting minutes we reviewed and no meeting to cover all ward staff such as housekeeping and occupational therapy.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The hospital introduced a development programme to support and sponsor health care assistants to gain a nursing qualification. At the time of inspection, there was one staff member from the ward currently participating in this scheme. The service had trained some staff in a therapeutic programme to help patients. Additionally, some staff had attended training to enable them to take a patient's blood.

Managers made sure staff received any specialist training for their role. On induction staff received an introduction to dementia. They then attended two further level sessions to expand their knowledge. Staff told us that they had received this training. However, managers were unable to provide the compliance of staff completion for these units. They told us this was because their organisation's training system had removed this training unit in error. The ward did not have a dementia lead.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed a meeting which was well attended by the disciplines within the hospital. Staff held comprehensive discussions covering holistic areas of concern with clearly identified actions.

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

The ward team had effective working relationships with external teams and organisations. They had weekly meetings with commissioners and regular input and communication from district nursing teams and external community services.

Requires Improvement

Wards for older people with mental health problems

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Across the hospital, 93% of staff had completed the provider's training.

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

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

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

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

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Across the hospital, 96% of staff had completed training.

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. They were able to give examples of how they encouraged patients to make independent choices and where this was not possible, referred to family knowledge to inform choices on their behalf.

Requires Improvement

Wards for older people with mental health problems

For every patient admitted to the ward who lacked capacity, medical staff wrote to the Office of the Public Guardian to identify if there were any court appointed deputies in place. This is someone appointed by the Court of Protection to make decisions for a patient who is unable to do so on their own. Where staff could not identify a patient's nearest relative, they involved an independent mental capacity advocate.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. The daily flash meeting included conversations around best interest decisions and staff we spoke with were able to describe examples.

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

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

Are Wards for older people with mental health problems caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. They gave patients help, emotional support and advice when they needed it. We carried out a short observational framework for inspection (SOFI). This is an observational tool used to help us collect evidence about the experience of people who use services, especially where they may not be able to describe these themselves because of cognitive or other difficulties. We observed staff interacting with patients which demonstrated they were skilled at interpreting their emotions, requirements and responses. We did not observe any negative interactions during our inspection. We spoke with six carers of current patients, they all praised staff for their kindness and care.

Staff understood and respected the individual needs of each patient. They had taken time to get to know each patient's personal cultural and social needs by reading about their history and speaking with their families.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

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

Requires Improvement

Wards for older people with mental health problems

Involvement of patients

Staff introduced patients to the ward and encouraged family members to bring in familiar items for the patient. They supported patients to make decisions on their care if this was possible.

Staff made sure patients could access advocacy services and this included their families. An advocate visited the ward every week and was involved in ward rounds and patient care.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with six carers. They told us staff were approachable and kept them informed. Most told us they had been involved in the patient's care plan. However, they had not been invited or involved in reviews. One carer told us they had asked if they were able to attend a review meeting and informed it was a professionals only meeting.

Are Wards for older people with mental health problems responsive?

Requires Improvement

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

Access and discharge

Staff managed beds well. A bed was available when needed and patients were not moved between wards unless this was for their benefit.

Bed management

Managers made sure bed occupancy did not go above 85%. They were able to refuse admissions if they had reason to do so, for example, due to a patient's observation needs.

Of the 14 patients on the ward at the time of our inspection, 11 of them were not from the local area.

Managers and staff worked to make sure they did not discharge patients before they were ready. Patients from the ward were mostly discharged to care homes.

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

Discharge and transfers of care

The service had low numbers for delayed discharges in the past year. These were due to onward care bed availability.

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

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

The service followed national standards for transfer.

Requires Improvement

Wards for older people with mental health problems

Facilities that promote comfort, dignity and privacy

The facilities of the ward did not support patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

Each patient had their own bedroom, which they could personalise. However, only one of the bedroom doors had a vision panel. This meant that at night, staff had to physically enter a patient's bedroom in order to observe them. Some patients required observing four times every hour. The bedroom doors were heavy and would have to be opened, this meant that a patient's privacy and comfort was disturbed.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. The ward had a sensory room which needed some updating to make it fit for its purpose. The sensory board was too low for patients and the equipment was not in working order.

The ward had equipment and resources available for patients assessed as frequent fallers. Bedrooms had fall sensor mats. A hoist was available where patients needed it and there were disabled bathroom facilities including showers. The ward had an electronic accessible bath.

Off the ward, patients had access to a gym and a multi-faith room.

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

The service offered a variety of good quality food.

Patients' engagement with the wider community

Staff supported patients with activities and family relationships.

Staff helped patients to stay in contact with families and carers. Where visits were not possible, they assisted patients to use an electronic tablet to see and hear their relatives remotely.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients had access to ward-based activities. There was a hospital occupational therapist across both wards and a full-time occupational therapy assistant solely for the Jubilee ward. Staff encouraged patients to engage in the activity programme. We observed individual staff and patient activities across the ward when group work was challenging.

Meeting the needs of all people who use the service

The service did not meet the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Some of the patients on the ward had restricted mobility. The ward was all on one level and allowed for wheelchair access if needed. Staff made adjustments by providing necessary equipment suited to their needs. One patient on the ward required a walking frame due to a weak knee leading to an increase in falls. However, due to the patient's capacity this proved unsuitable. Through consultation with the necessary professionals, staff supported the patient to wear a knee brace as an alternative to better meet his needs.

Requires Improvement

Wards for older people with mental health problems

The ward was not dementia friendly. Dementia-friendly environments are important in the care, support, health and well-being of people living with dementia. The right environment will allow people to feel valued as an individual, independent and safe with a sense of normalcy therefore enhancing their quality of life. The service had made some improvements to the environment. The ward included signage, individual photos and pictures on bedroom doors and around the ward. They had painted a mural on the dining room wall to give the impression of a tearoom.

The service had an outside space that patients could access easily. However, the garden area was not a dementia friendly space. There was a black tarmac pathway. Patients with dementia may perceive this as a deep black hole making them feel nervous and unsteady. The garden also had low shrubbery which may not be seen due to a patient's limited vision; this could also contribute to falls and impact on a patient's confidence.

Managers recognised improvements were needed for the ward and particularly the garden area to make the environment better suited to their patient group. They had a plan and budget for the garden update which had previously been delayed due to COVID, this plan did not detail timescales. Staff had contributed ideas for further improvements to the ward, however this had not been actioned into a robust plan with costings or timescales. This meant progress to further improvements could not be clearly monitored.

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

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. A local priest visited the ward weekly, and some patients visited a local church when this had been authorised.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously and investigated them. Learned lessons from the results were not clearly shared with the whole team and wider service.

Relatives and carers knew how to complain or raise concerns. All carers we spoke with confirmed they knew how to make a complaint. One carer had raised a concern and informed us that it was satisfactorily investigated with a clear outcome.

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

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

Managers investigated complaints. However, there were no clear systems to evidence how lessons learnt from complaints were shared due to limited hospital governance meetings and ward team meetings.

Staff protected patients who raised concerns or complaints from discrimination and harassment. They showed an awareness and provided examples of how to protect patients who raised concerns from discrimination and harassment.

The service used compliments to learn, celebrate success and improve the quality of care. We observed compliment and thank you cards displayed on the ward.

Requires Improvement

Wards for older people with mental health problems

Are Wards for older people with mental health problems well-led?

Requires Improvement

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

Leadership

Leaders had the skills and experience to perform their roles. They had a limited understanding of the services they managed. They were not visible in the service or approachable for patients and staff.

Ward managers and senior nurses were qualified in mental health nursing. Staff told us that they felt disconnected from higher managers, and they were rarely seen on the ward. At the time of our inspection, the hospital director had been in post for just one week and was therefore still in the process of getting to know how the hospital worked. We saw evidence that governance concerns had been identified by the new director and improvements were being implemented. For example, the implementation of a daily management meeting to provide leaders with a better oversight of the hospital and assurances needed.

Vision and strategy

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

Staff members based on the ward could not tell us the vision or values of the organisation. All staff were able to describe positive behaviours they believed the ward demonstrated, such as person-centred care. However, they were unable to relate these to the statemented values of the provider and, unable to describe the organisation's purpose and strategy of what it aims to look like.

Culture

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

Staff we spoke with felt positive and proud to work within their ward team. However, most staff felt invisible and less valued and respected from higher managers. They told us there was limited interaction and that higher managers were remote and disconnected from the ward.

Staff were positive about the opportunities provided for progression in the organisation. They felt able to raise concerns without fear of retribution and knew how to use the whistleblowing process.

Governance

Our findings from the other key questions demonstrated that governance processes were not effectively embedded or operated.

The service had some systems and procedures in place. These ensured safe staffing levels, health and safety adherence, staff were supervised, patients were assessed and treated well, that medicines were managed safely, and staff adhered to the requirements of the Mental Health Act and Mental Capacity Act. However, there were limited or no systems to provide managers with the oversight necessary for assurance about some aspects relating to the quality of hospital or to facilitate continuous improvement.

Requires Improvement

Wards for older people with mental health problems

Staff did not disseminate information effectively. Meetings at all levels were irregular and there was no clear framework for what should be discussed at a ward, team or directorate level. This meant staff at ward level were unaware of information such as organisational changes, lessons learnt and hospital risks. This also meant hospital managers had limited oversight around ward information such as supervisions, training and risks. The hospital had introduced flash meetings for daily ward updates; this was in its infancy as had only been introduced the week of our inspection.

Managers did not record lessons learnt or information sharing for reported incidents. They used an electronic incident reporting system. On all records we looked at, this section was left blank. Managers were also unable to easily search for themes. This meant that they had no process in place to share lessons learnt from incidents or to monitor trends for future prevention and improvement.

At the time of our inspection, we found the ward environment to be clean. However, managers did not operate effective systems to assure themselves that the environment was maintained and cleaned. The daily records did not get filled in when the permanent housekeeper was absent and monthly managers checks had not been complete for five months from April to August 2021.

Managers could not be assured that all patient records were maintained accurately and in a timely manner. This was because some agency healthcare assistants had to rely on permanent staff to transcribe any patient note such as observations onto the electronic system. This meant there could be delays or errors in interpreting written notes.

The service had made some improvements to the ward to improve the environment for patients with dementia. There were plans for further work particularly the garden area. However, plans were not detailed to include dates and priorities. This meant managers had no mechanism in place to monitor and review progress.

The provider's systems to monitor training and appraisals was not accurate. Appraisal compliance was not up to date and managers had no plans to rectify this. The training units for dementia had been removed from the training records. This meant managers were unable to identify which staff or when staff had completed dementia specific training.

Management of risk, issues and performance

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

We requested the service's local risk register and were supplied with a document dated 2015, 2016 and 2017. The risks are dated from August 2016 to June 2020 with only one of eight risks showing as closed. Some of the risks were not dated and did not have a date for completion. There was no evidence that this document had been updated since June 2020 so we could not be assured there was proper oversight of risk in the service.

Information management

The service used systems to collect data from wards and these were not overburdensome for staff. However, all staff we spoke with told us that access and the use of the electronic systems was especially slow. We observed this during the inspection. This meant staff were unnecessarily taken away from patient care due to delays in updating and viewing needed information.

Staff had mandatory training in information governance, and each had their own secure passwords with individual authorisations to access confidential information.

Requires Improvement

Wards for older people with mental health problems

Engagement

Patients and carers had access to up-to-date information about the work of the provider through their website.

Staff felt the ward manager would listen to suggestions and they could use the ward's communications book to add ideas. They had been consulted for ideas to improve the environment.

Some staff felt that the ward was isolated from other areas of the organisation as the provider had limited serves for older people and therefore no organisational lead with a speciality for older people's care.

Learning, continuous improvement and innovation

We were not aware of any continuous improvement initiatives taking place but the hospital. Staff did not participate in any national audits and did not participate in any accreditation schemes relevant to older peoples' wards.

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 10 HSCA (RA) Regulations 2014 Dignity and respect The service must ensure a patient's privacy and comfort is maintained when staff carry out observations during the night.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service must ensure the environment and facilities on Jubilee ward are dementia friendly and suitable to meet the needs of the patient group. The service must ensure that all patients on Hartley ward with a diagnosis of a Learning Disability have appropriate Positive Behaviour Support plans in place.

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 service must ensure suitable systems are utilised to oversee the cleanliness and maintenance of the hospital. The service must ensure all staff have easy access to the electronic patient record system. The service must ensure that any blanket restrictions applied to patients are done so in line with the Mental Health Act Code of Practice and that a blanket restrictions register is kept and reviewed locally.

This section is primarily information for the provider

Requirement notices

The service must ensure that lessons learnt from incidents and complaints are recorded and shared through systems and governance structures to improve services and that trends and themes on the ward are clearly identified for learning and improvement.

The service must ensure staff records on Hartley ward relating to supervision and appraisals are up to date and accurate.

The service must ensure staff records on Jubilee ward relating to training and appraisals are up to date and accurate.

The service must ensure structured meetings are embedded at both hospital and ward level to disseminate information throughout the hospital.

The service must establish systems and processes to ensure ligature risk assessments are updated following admission of new patients to Hartley ward and that these assessments are kept on the ward so all staff can access them.

The service must ensure that debriefs of patients and staff following incidents are recorded.

The service must ensure that patient care records and risk assessments are updated when required and patients' involvement in the creation and updating of these are recorded.