Sturdee Community Limited

Sturdee Community Hospital

Inspection report

52-62 Runcorn Road
Leicester
LE2 9FS
Tel: 01628826944
www.inmind.co.uk/
sturdee-community-hospital-apartments

Date of inspection visit: 18, 22, 26 November and 7 December 2021
Date of publication: 31/01/2022

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	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We carried out this unannounced focused inspection following the notification of a serious incident on one of the wards and we received information of concern about the safety and quality of the services.

We did not look at all key lines of enquiry during this inspection. However, the information we gathered, the significance of the concerns and clear impact on patients provided enough information to make a judgement about the quality of care and to re-rate the provider.

We found that the provider was failing to comply with Regulation 12 Safe Care and Treatment, Regulation 15 Premises and Equipment and Regulation 17 Good Governance. As a consequence and under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we issued three warning notices to the provider as set out in the enforcement section of this report.

In addition, the Care Quality Commission is placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Our rating of this location went down. We rated it as inadequate because:

- The service did not always provide safe care. Not all ward environments were safe and well maintained. The wards did not always have enough nurses. Staff did not always assess and manage risk well.
- The service did not always record or investigate patient incidents or complaints.
- The governance processes at the service did not ensure ward procedures ran smoothly or patients Mental Health Act detention papers, section 17 leave forms and patient rights and legal position adhered to the Mental Health Act Code of Practice.

However:

- Staff minimised the use of restrictive practices and always had access to medical cover.

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	Inadequate 	Our rating of this service went down. We rated it as inadequate. • See the summary above for details

Summary of findings

Contents

Summary of this inspection

Background to Sturdee Community Hospital

Sturdee Community Hospital is part of the Inmind Healthcare Group. Located in Leicester, the hospital provides longer term high dependency rehabilitation for female patients with complex mental health disorder, some of whom were detained under the Mental Health Act 1983.

At the time of the inspection the location did not have a registered manager. The provider had submitted an application for the hospital director to become registered. The provider currently does not have a controlled drugs accountable officer as the previous controlled drugs accountable officer left and this has not been updated.

Since September 2016, the hospital had operated as an all-female hospital. It had a 16-bed ward known as Rutland ward and nine supported self-contained flats known as Aylestone unit. We inspected both Rutland ward and Aylestone unit.

At the time of the inspection, there were a total of 14 female patients across the hospital. Thirteen of these patients were detained under the Mental Health Act.

Sturdee Community Hospital is registered to provide the following regulated activities:

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

• diagnostic and screening procedures

• treatment of disease, disorder or injury

Sturdee Community Hospital first registered with the Care Quality Commission in April 2011.The last comprehensive inspection of the hospital was in November 2019. The Care Quality Commission carried out a focussed inspection in April 2018, in response to concerns flagged up by intelligence monitoring and issued a warning notice where issues had been identified surrounding the proper and safe administration, management and storage of medicines which was in breach of Regulation 12.

The follow up inspection in August 2018 found the provider had addressed most of the issues identified in that warning notice relating to safe and proper prescribing, administration and storage of medicines. However, in August 2018 we found that whilst staff had improved the monitoring of controlled drugs we found occasional gaps in the controlled drugs record, the standard operating procedures for medicines management was not easily accessible to staff in the clinic, some emergency equipment was out of date and had not been removed or replaced, the fridge in the clinic room was too small for the stock stored in it and staff had not identified this therefore airflow was restricted and the providers instructions for recording the fridge temperature range were not clear which was in breach of Regulation 17. We found the provider had addressed these issues at the inspection on 26 and 27 November 2019 and we rated the provider as good in all domains.

What people who use the service say

We spoke with one patient who told us the hospital was always short staffed and five to six weeks prior to our inspection a member of non-clinical staff was doing another patients' enhanced observations.

Summary of this inspection

Two patients told us although they have therapy groups and activities in place they do not happen and do not feel they are rehabilitation therapy focussed.

Two patients told us communication between staff and patients is not good and things are discussed in morning meetings and not always fed back to staff impacting on patient care.

One patient told us staff used their mobile phones whilst carrying out patient observations.

One patient told us the washing machines are always breaking down and the WIFI is bad and patients keep being told these are going to be fixed and they are not.

How we carried out this inspection

The inspection team visited Sturdee Community Hospital between on 18 and 26 November 2021 and completed further off-site inspection activity until 7 December 2021. During the inspection we:

- Visited the service and observed how staff cared for patients
- Toured the clinical environment
- Spoke with six patients who were using the service
- Interviewed 11 staff and managers
- Observed one morning meeting
- Reviewed seven patient care records
- Reviewed six prescription charts
- Reviewed staffing hours from 1 June to 29 November 2021
- Reviewed 30 allocation sheets for both day and night staff from 8 November to 22 November 2021
- Reviewed observation records for eight patients from 7 November to 17 November 2021
- Reviewed 12 patients' risk management plans
- Reviewed seven incident forms
- Reviewed policies and procedures relevant 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 trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure the emergency response bag is easily accessible to all wards at the hospital. (Regulation 12(1))
- The provider must ensure the emergency response bag is stored securely. (Regulation 12(1))
- The provider must ensure staff follow the providers policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. (Regulation 12(1))

Summary of this inspection

- The provider must ensure staff observe patients in line with patients prescribed observation times and accurately record when observations take place. (Regulation 12(1))
- The provider must ensure staff take breaks in line with the Health and Safety at Work Act. (Regulation 12(1))
- The provider must ensure staff complete their own records and not complete records on behalf of their colleagues. (Regulation 12(1))
- The provider must ensure regular reviews are completed of patients on high dose antipsychotic medicines and prescription cards. (Regulation 12(1))
- The provider must ensure staff review the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence guidance and the Royal College of Psychiatrists consensus statement. (Regulation 12(1))
- The provider must ensure all complaints and incidents are fully recorded, investigated and changes made to practice to ensure they do not reoccur when required. (Regulation 17(1))
- The provider must ensure staff report all incidents on the electronic recording system in line with patients notes as required. (Regulation 17(1))
- The provider must ensure they have robust systems in place to ensure the Section 58(3)(a) – Certificate of consent to treatment was valid, correct and available for staff to review prior to administering treatment. (Regulation 17(1))
- The provider must ensure patients' section 17 leave of absence authorisation forms are written in line with the Mental Health Act Code of Practice. (Regulation 17(1))
- The provider must ensure patients' section 17 leave forms are reviewed in line with the Mental Health Act Code of Practice. (Regulation 17(1))
- The provider must ensure staff provide patients with information about their legal position and rights regularly in line with the Mental Health act code of Practice. (Regulation 17(1))
- The provider must ensure staff provide patients with information about their legal position and rights when the renewal of the patients' detention is being considered or when a decision has been made to renew the patients' detention in line with the Mental Health act code of Practice. (Regulation 17(1))
- The provider must ensure staff provide patients with information about their legal position and rights at the time of their transfer to the hospital in line with the Mental Health act code of Practice. (Regulation 17(1))
- The provider must ensure governance systems are in place so patients have access to Hospital Managers' panels before the current period of the patients' detention under the Mental Health Act ends in line with the Mental Health Act code of Practice. (Regulation 17(1))
- The provider must ensure governance systems are in place to receive and scrutinise Mental Health Act detention papers. (Regulation 17(1))
- The provider must ensure ward areas and furniture are well maintained, well-furnished and fit for purpose. (Regulation 15(1))
- The provider must ensure they follow the infection prevention and control guidelines set out by the government. (Regulation 12(1))
- The provider must ensure managers take appropriate action when observing staff not following infection prevention and control guidelines set out by the government. (Regulation 17(1))
- The provider must ensure the ligature risk assessment is complete with actions recorded and addressed with timescales. (Regulation 12(1))
- The provider must ensure there are enough staff on shift to keep patients safe. (Regulation 12(1))
- The provider must ensure staff are up to date with their mandatory training. (Regulation 12(1))
- The provider must ensure they effectively manage and mitigate risks to patients. (Regulation 12(1))
- The provider must ensure they support staff through regular supervision of their work and keep effective logs of data compliance. (Regulation 12(1))
- The provider must ensure staff complete all sections of the staff allocation sheets in full. (Regulation 12(1))
- The provider must ensure all staff have access to the equipment and information technology needed to do their work. (Regulation 17(1))

Summary of this inspection

Action the service SHOULD take to improve:

- The provider should ensure all staff have access to the incident recording system.
- The provider should ensure staff receive feedback from investigation of incidents.
- The provider should ensure lessons learned from incidents get shared with all staff across the service.
- The provider should ensure all staff and patients get the opportunity to regularly feedback on the service and service development.

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	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Well-led	Inadequate

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

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Not all wards were well maintained, well-furnished and it for purpose. However, wards were well equipped.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We saw evidence of the environmental checks staff were completing daily.

The ward complied with guidance and there was no mixed sex accommodation. The hospital was a female only hospital.

The ligature risk assessment was not complete. Where remedial actions were identified there was no time frame for completion or who they are allocated to. There was nothing to identify when these actions had been completed. There was no specific mitigation for ligature risks. The mitigation for all ligature risks recorded was the same despite the risk. However, staff knew about any potential ligature anchor points as they were identified in the comprehensive ligature risk assessment.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Not all ward areas were well maintained, well-furnished and fit for purpose. We found in the communal bathroom the metal around the sink was damaged and sharp. We were concerned patients could remove the metal and harm themselves. In addition, we noted the wooden surround around the toilet was damaged and in need of repair. Due to the damage staff could not ensure it could be cleaned in line with infection control guidance. A patient showed us their bedroom and pointed out the damage, possibly mould, above the entrance to their en suite area and showed us an area of the flooring in their bedroom which was lifting away from the floor which created a potential trip hazard. In the main communal lounge on Rutland ward we found five sofas and chairs were worn and/or torn in places. Due to the damage we were not assured the furniture could be effectively and safely cleaned, posing an increased infection control risk.

Not all staff followed the infection control policy or government guidelines regarding wearing face masks in healthcare settings. We saw eight staff on day one of our site visit not wearing face masks or wearing masks inappropriately under their nose or below their chin, across the hospital. We raised this with the provider who took action to address the matter. When we returned for day two of our site visits, we saw staff wearing face masks appropriately. We reviewed the hospitals' CCTV for four periods of 30 minutes over two days to establish how many staff were wearing face masks

correctly during these periods in a given area of the hospital. All CCTV footage made available to us covered the main foyer area. We could see staff and patients accessing and exiting the building via the main foyer door, accessing and exiting the communal lounge area and using the corridor leading to the bedrooms and other areas of the hospital. We reviewed 163 staff movements across in this timeframe. We found that for 99 of these staff movements staff were either not wearing a face mask or not wearing it correctly, such as either under the nose or under the chin.

Clinic room and equipment

Resuscitation equipment was not easily accessible to both wards at the hospital. The emergency response bag was kept on Rutland ward but there are two locked gates to get to Aylestone unit which staff would have to get through in an emergency. We were concerned this could cause undue delay getting emergency aid to patients on Aylestone ward.

Managers failed to ensure the emergency response bag was stored securely. The bag contained emergency medicines that were not sealed and should have been locked away but still accessible to authorised personnel only. Two nursing staff we spoke with were not aware the emergency response bag contained medicines and was required to be sealed. Due to staff lack of awareness of the contents of the bag and where the bag was situated, we were concerned staff would not respond quickly, effectively and safely if an emergency occurred. Staff failed to ensure the emergency response bag was checked in line with policy to ensure all equipment and medicines were available and in date. The emergency response bag had not been checked since 26 October 2021.

The clinic room was fully equipped. Staff maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough nursing staff to keep patients safe. The staffing establishment requires two nurses to be on shift at all times. We spoke with three staff who told us there were not always two nurses on shift across the two wards and sometimes nurses were working alone. We spoke with one patient who told us the hospital was always short staffed and five to six weeks prior to our inspection a member of non-clinical staff was doing another patients' enhanced observations. We reviewed staffing hours from 1 June to 29 November 2021. We reviewed the levels of unfilled shifts across the service and noted from June the unfilled shift rate decreased from 349.5 hours across 34 shifts to 178.5 hours across nine shifts in November. However, in September the service was overstaffed by 141 hours or 11 shifts.

The service had a reducing vacancy rate of qualified staff. The service reported a vacancy rate of 37% for qualified staff as of 6 December 2021. There were no vacancies for unqualified staff. However, managers still had to use a high rate of agency to cover core staffing hours and patient enhanced observations. In October 5187 hours were worked by agency staff. In November agency staff usage had decreased for the first time in six months at 4263 hours.

Managers block booked agency staff and requested staff familiar with the service.

Managers made sure agency staff understood the service before starting their shift.

The service had fluctuating turnover rates. The service reported an average turnover rate of 4.8% from 1 January to 31 October 2021.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers supported staff who needed time off for ill health.

Levels of sickness were low, however, they had increased over the previous two months prior to our inspection. The service reported an average of 2.7% from 1 December 2020 to 30 November 2021.

Managers reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers told us they had recently recruited extra staff in new roles to support the service.

Managers could adjust staffing levels according to the needs of the patients.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Staff told us there had been a few occasions where patients had their escorted leave or activities cancelled but this was rare. Two patients told us although they have therapy groups and activities in place they do not happen and do not feel they are rehabilitation therapy focussed.

The service had enough staff on each shift to carry out any physical interventions safely. Staff told us they rarely use physical intervention.

Staff shared key information to keep patients safe when handing over their care to others. We observed a morning meeting where patients were discussed in detail with multidisciplinary staff attending.

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 service had an out of hours on call psychiatrist who attended site as and when required.

Mandatory training

Staff were not up-to-date with their mandatory training. The overall compliance rate for all permanent staff was 58%.

Whilst the mandatory training was comprehensive it did not always meet the needs of patients who were placed at the hospital for rehabilitation. There was no specialist or mandatory training for staff that related to recovery or rehabilitation.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, one staff member told us there was a time when the hospital had no one checking or alerting staff regarding their training so they got behind and now they have lots of training to catch up on.

Assessing and managing risk to patients and staff

Staff did not manage risks to patients and themselves well. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. 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.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised risk assessment tool, and reviewed this regularly but not necessarily after each incident.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Management of patient risk

Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others.

Staff did not always act to prevent or reduce risks despite knowing any risks for each patient. Staff were not completing observation records in line with patients prescribed observation times or in line with the provider policy.

We found observation records were not completed accurately at the time that staff completed the observations. On 17 November 2021 on Aylestone Unit at 8pm and 2am staff recorded observations had taken place at the exact same time for each of the six flats in the unit. At 8.05am and 2pm staff had recorded observations had taken place at the exact same time for five of the flats. Due to this we were concerned patients could be at risk of harm if not being observed as per their risk management plans which stipulated frequency and level of observation required to keep them safe.

The paperwork for staff to complete for patients on 30 minute observations was pre-printed. Therefore, all patients on 30 minute observations had to be observed at the same time. This is not physically possible, therefore the observation records for these patients are not accurate or contemporaneous.

We were concerned staff may become fatigued during their shift as they were not taking regular breaks which could place patients at risk. We reviewed 30 allocation sheets for both day and night staff from 8 November to 22 November 2021. There was not an easy way to distinguish between day and night allocation sheets. Day staff were never allocated a break. Not all night staff were allocated a break. Two staff told us they do not take breaks as it is difficult to fit in a break and they do not get paid for breaks so they would rather work through. This meant staff can work up to a 12.5 hour shift without any breaks and could be on patient enhanced observations for longer than two hours. This was not in line with Health and Safety at Work Act or published national guidance on observations.

Staff had been allocated to or completed patient enhanced observations for longer than two hours. We found the same staff member on enhanced observations for between three and seven hours on 23 occasions between 8 November and 21 November 2021. This also went against the providers own supportive observation policy which states "No nurse allocated to a Service User receiving Level 3 (Close Observation) should perform this function for longer than one-hour at a time. This is in order to minimise staff stress".

We found one member of staff had completed 30 minute observations for a patient for over 11 hours on 17 November 2021.

We found patients' observations had not been carried out at the intervals prescribed. We reviewed observation records for eight patients from 7 November to 17 November 2021. We found the intervals in between patient's observations exceeded their prescribed observation interval four times of between an hour and 15 minutes and two hours each time.

We found observation records where staff had failed to write their name or sign the record to confirm the observations had actually taken place. We reviewed observation records for eight patients from 7 November to 17 November 2021. We found staff had not signed or recorded their name on three occasions four occasions and staff had not signed to say they had completed the observation on one occasion. We were concerned that should a patient have been harmed during these times no one would know who had been responsible for the patient at the time and any investigation into the harm or risk would be hampered and lessons learned could not be followed through.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

We found on one occasion it appeared a staff member was completing records on behalf of their colleague. While the handwriting in the narrative and the printed name was the same the signatures were different. If this is the case then staff were potentially completing / falsifying records contrary to provider policy and good practice.

One patient told us staff used their mobile phones whilst carrying out patient observations.

Staff identified and responded to any changes in risks to, or posed by, patients. We reviewed 12 patients' risk management plans which were regularly updated with any changes discussed in the morning meeting.

Staff developed care plans to minimise risks where they could not easily observe patients and followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff told us they rarely used restrictive intervention.

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.

Safeguarding

Most staff were out of date with their safeguarding training. However, staff knew how to recognise and report abuse. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Clinical staff did not keep up-to-date with their safeguarding training. There was a 0% compliance rate for safeguarding training across all permanent clinical staff. However, there was a 100% compliance rate for safeguarding training across all permanent non-clinical staff.

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

Although staff safeguarding training was out of date, staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff had easy access to clinical information.

Patient notes were comprehensive and all staff could access them easily. The services used paper records which were up-to-date and complete.

Records were stored securely in staff offices.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Medicines management

Staff did not regularly review the effects of medicines on each patient's mental and physical health. The service used systems and processes to safely prescribe, administer, record and store medicines.

Nurses followed systems and processes to administer medicines safely and completed medicines records accurately.

Medics did not ensure that patient medicine documents were current and up to date. We found one prescription card had not been updated since February 2021. The patients care plan was last reviewed at the end of August 2021 and this should be reviewed monthly. The meant no one could be sure the patient had not developed side effects to the medicines which would put them at risk. Also, medicines information was not up to date this could lead to medication errors.

Responsible Clinicians failed to complete regular reviews of patients on high dose antipsychotic medicines and prescription cards. We found this on three out of six medicine charts. We found two patients on high dose anti-psychotic treatment which had not been reviewed for between two and nine months. We found one patient who was on a high use of as-and-when-required medicines which were not captured in multidisciplinary reviews. This meant other staff providing care and treatment may not be aware of all the medicines the patient was receiving, this could interfere with the effectiveness of other treatments the patients receives and you cannot be assured the patient is receiving the best treatment option.

Staff stored and managed all non-emergency medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff did not always review the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence guidance and the Royal College of Psychiatrists consensus statement. We found one of the patients on high dose anti-psychotic treatment had declined their physical health monitoring but it was not documented how staff had tried to encourage them to have their physical health monitored or to inform the patient why this needed to be monitored. We found one patient's physical health monitoring grab sheet had not been updated since July 2020.

Track record on safety

The service did not have a good track record on safety. The service had reported a high number of serious incidents for its size.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Staff did not always recognised incidents and report them appropriately. We could not be assured managers investigated incidents appropriately and managers 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.

Not all staff had access to the incident recording system. One permanent staff member told us they did not have access to the electronic incident recording system. Staff told us agency staff did not have access to the incident recording system and they relied on permanent staff to record any incidents.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff did not always report incidents in line with trust policy. We reviewed seven incident forms, the lessons / changes to practices box was not complete for any of these incident forms. We reviewed CCTV footage of one incident and compared this to the written incident form. Whilst the incident details were accurate, the time of the incident was not recorded at the time we viewed the incident on the CCTV. The incident occurred at 12.36pm, however, staff recorded on the incident form the incident occurred at 1pm.

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 debriefed and supported staff after any serious incident.

Staff did not report all incidents on the electronic incident recording system in line with patient notes as required. During our inspection visit we found two incidents / complaints documented in patient notes but no corresponding incident on the electronic incident recording form or a complaint logged.

Staff did not always receive feedback from investigation of incidents. One staff member told us they had never received feedback from incidents and another said they only sometimes received feedback. Staff did not receive feedback or lessons learned from incidents external to the service.

Managers and multidisciplinary staff met to discuss incident feedback and look at improvements to patient care in morning meetings and governance meetings. However, not all frontline staff attend these meetings. Two patients told us communication between staff and patients is not good and things are discussed in morning meetings and not always fed back to staff impacting on patient care.

Staff told us lessons learned from incidents don't always get shared. One staff member told us lessons learned from incidents aren't always shared between day and night staff. We saw one lessons learned bulletin for October 2021. The service had only recently had a new manager appointed who had implemented a monthly lessons learned bulletin.

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

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They were visible in the service and approachable for patients and staff. It was too soon to recognise the impact the new hospital director had in their role as they had only been in post for three weeks at the time of our inspection.

There had been a recent change in management of this hospital. They had applied to be registered with the Care Quality Commission.

The hospital director had already made changes to their staff team recruiting more staff and had ensured staff were in roles to enhance improvements as well as strengthen governance processes at the service.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Hospital leaders were visible in the service and approachable for most patients and staff. Staff knew who the local leaders were.

Not all staff knew who the most senior managers in the organisation were.

Vision and strategy

Not all staff knew and understood the provider's vision and values or how they were applied to the work of their team.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

Staff said the changes in leadership and management were positive and had improved their experience of working at the service.

Most staff felt stress free coming to work. However, one staff member told us they felt a lot of stress down to staff shortages and having a lack of time to do their work.

Staff knew how to use the whistle-blowing process if they needed to.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that risks were not always managed well.

The hospital director had already made changes to strengthen governance processes at the service. We read the governance minutes for November and staff at all levels had had the opportunity to meet, discuss and learn from the performance of the service. There was a clear framework of what must be discussed at senior management team level and staff team level meetings to ensure essential information, such as learning from incidents and complaints, was shared and discussed.

Managers failed to have robust systems in place to ensure the Section 58(3)(a) – Certificate of consent to treatment was valid, correct and available for staff to review prior to administering treatment. We found a "Section 58(3)(a) — Certificate of consent to treatment" (Form T2) with the patient's medicines chart, which had been completed by the patient's former Responsible Clinician at an external hospital. This meant staff were administering medicines against a T2 form which ceased to authorise treatment, as there had been a permanent change in the patient's Responsible Clinician. The deputy hospital director spoke with the responsible clinician who reported they had handwritten a new T2 form, but this was not provided to the inspection team during the inspection, despite being requested.

Managers failed to ensure the Mental Health Act 1983, and the associated Code of Practice was adhered to in relation to patients' rights. We found incomplete records in three patient files and associated detention paperwork.

Three patients' section 17 leave of absence authorisation forms were not written in line with the Code of Practice, paragraph 27.16 which states "The parameters within which this discretion may be exercised should be clearly set out by the responsible clinician, e.g. the particular places to be visited, any restrictions on the time of day the leave can take

place, and any circumstances in which the leave should not go ahead". We found examples where the location was defined as "local area" and the duration and frequency "as per care plan". We were concerned the plan and care plans were not attached to the leave authorisation forms and the local area was not clearly defined which meant patients may have unauthorised section 17 leave in places they were not authorised to go.

The Responsible Clinician failed to regularly review one patients' section 17 leave form in line with the Code of Practice, paragraph 27.17 which states "Responsible clinicians should regularly review any short-term leave they authorise on this basis and amend it as necessary". The section 17 leave form was last written up on 15 October 2020 and should have been reviewed on 25 November 2020, this was over a year out of date.

In four patients' Mental Health Act folders there was no evidence of staff providing the patients with information about their legal position and rights since at least July 2021. This was not in line with the Code of Practice, paragraph 4.28 which states "Those with responsibility for patient care should ensure that patients are reminded from time to time of their rights and the effects of the Act. It may be necessary to give the same information on a number of different occasions or in different formats and to check regularly that the patient has fully understood it. Information given to a patient who is unwell may need to be repeated when their condition has improved".

In four of the patients' Mental Health Act folders we looked at there was no evidence of staff providing the patients with information about their legal position and rights when the renewal of the patients' detention was being considered or when a decision had been taken to renew the patients' detention in line with the Code of Practice, paragraph 4.29, which states "A fresh explanation of the patient's rights should be considered in particular where: … renewal of their detention, or extension of their CTO is being considered… a decision is taken to renew their detention or to extend their CTO".

In one patients' records, there was no evidence of staff providing the patient with information about their legal position and rights at the time of their transfer to the hospital (in September 2021) or at any point since. This was not in line with the Code of Practice, paragraph 4.29.

Managers failed to ensure governance systems were in place so that patients had access to Hospital Managers' panels. Hospital Managers' panels are a panel appointed specially to look at whether people should be discharged. They are independent of the hospital, Clinical Commissioning Group, Local Health Board or any organisation that runs the hospital, because they cannot be officers or employees. In four patients' folders, there was no evidence Hospital Managers' panels had taken place before the current period of the patients' detention under the Mental Health Act ended. This was not in line with the Mental Health Act Code of Practice paragraphs 38.12 and 38.14 which state "Hospital managers: … must undertake a review if the patient's responsible clinician submits a report to them under section 20 of the Act renewing detention or under section 20A extending the CTO" and "Before the current period of detention or the CTO ends, it is desirable that a managers' panel considers a report made under section 20 or section 20A and decides whether to exercise its discharge power".

We were concerned Hospital Managers' panels had not resumed at the hospital. On 27 July 2021, during a Mental Act monitoring visit concerns were raised about three patients not having had a Hospital Managers' panels before their current period of detention ended. We received assurance that these would be completed by 08 October 2021 and that the Mental Health Act administrator would over see this. The Mental Health Act administrator subsequently left their employment and no Hospital Managers panels had been completed. We were informed that they had been booked but had been cancelled due to unforeseen events at the hospital.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers failed to ensure governance systems were in place to receive and scrutinise Mental Health Act detention papers. In two patients' folders, we found a "Section 20 — Renewal of authority for detention" (Form H5) which was incomplete. Part 4 of the forms had not been completed by the hospital managers. We noted the responsible clinician had examined both of these patients. The deputy hospital director contacted the support services manager and corporate Mental Health Act manager who said they would make a file note. However, we were concerned these omissions had not been identified and dealt with prior to our inspection (Code of Practice, paragraphs 35.18 to 35.20).

Managers did not always investigate incidents thoroughly. Managers failed to ensure all complaints and incidents had been fully recorded, investigated and changes were made to practice to ensure they did not reoccur. We were concerned that failing to act on issues could put patients at risk of harm. During our inspection visit we found two incidents / complaints documented in patient notes but no corresponding incident on the electronic incident recording form or a complaint logged. We were not assured the incident or patient complaint had been investigated.

The governance process in place to ensure that staff had the correct keys to move around the hospital, and all staff had ligature cutters, in case of an emergency was not robust. At the beginning of every shift a qualified nurse and an unqualified member of staff were required to sign allocation sheets to say every member of staff on shift had keys and ligature cutters. We reviewed, 30 allocation sheets for both day and night staff from 8 November to 22 November 2021. We found one out of 30 allocation sheets were signed by a qualified member of staff and two out of 30 allocation sheets were signed by unqualified members of staff. We were concerned that should a patient have required emergency care, any investigation into the harm or risk would not be able to be fully investigated.

Management of risk, issues and performance

We were not assured that care and treatment was being delivered in a safe way for patients. The service had not taken every step available to do all that is reasonably practicable to assess and mitigate risk to patients.

Managers had not ensured staff were observing patients as per their prescribed observations times or in line with their policy.

Patients were not always listened to or actions taken to issues brought up by patients. We found in the October 2021 community meeting minutes patients had raised that the furniture is old, worn out, 'dirty & disgusting' and needs to be replaced. We found the same issues with the furniture at the time of our inspection over a month later. The meeting minutes were not fully complete and had no date to be dealt with, no follow up / response / actions taken, no date fed back to meeting, no escalation and no outcome. We found this for 10 out of 18 issues raised. However, we reviewed the November community meeting minutes lead by the new hospital director and the minutes were complete with a full summary given for each point raised by patients. One patient told us the washing machines are always breaking down and the WIFI is bad and patients keep being told these are going to be fixed and they are not.

Managers did not effectively manage risk despite using systems to identify, understand, monitor, and reduce or eliminate risks. We saw evidence in the October governance meeting minutes where it was reported there were no Mental Health Act paperwork errors. Despite this we found multiple Mental Health Act paperwork errors during our inspection. We were concerned to learn there was no Mental Health Act administrator at the hospital. We understood the previous Mental Health Act administrator had left the hospital approximately two months prior to the inspection and recruitment was underway for a replacement. In the interim, the support services manager and corporate Mental Health Act manager was providing cover. However, this individual was not based at the hospital.

Managers did not full ensure they consistently implemented or monitored adherence to the government guidelines to ensure staff wore face masks in the hospital to reduce the risk of transmission of Covid-19. We found managers failed to

comply with infection prevention control monitoring of staff wearing face masks appropriately and adhere to the government guidelines and take appropriate action when observing staff not wearing face masks or wearing them inappropriately. However, we did see correspondence from the hospital director to all staff on our second visit to the service reminding all staff to wear face masks appropriately.

Managers did not support staff through regular supervision of their work or keep effective logs of data compliance. Managers told us that due to a gap in administrators and lost data, their current figures showed that supervision compliance was 35% and appraisal compliance was 18%.

The service had systems and processes in place to monitor risk and performance. The service held daily morning meetings to review staffing, incidents, patient risk, patient requests and any issues of concern. Managers formed plans and actions to address these.

The provider had a risk register in place which they used to record, review and manage risks to the service.

Information management

Most staff told us they had access to the equipment and information technology needed to do their work. However, one staff member told us it is difficult to do work on one of the computers as it was extremely slow. They told us someone from the providers information technology department had told them a while ago they needed updated computers but they had not heard anything since.

Engagement

Staff did not always get the opportunity to give feedback on services and input into service development. One member of staff we spoke with told us they did not get the opportunity to give feedback on the service and another staff member told us they had not been asked in a while for feedback.

Learning, continuous improvement and innovation

The hospital did not participate in any accreditation schemes at the time of the inspection.

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 Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not always ensured there were enough registered nurses on each shift, all shifts should have a minimum of two registered nurses on duty. The provider had not ensured that staff had completed all sections of the staff allocation sheets. The provider had not ensured that all staff were up to date with their mandatory training. The provider had not ensured that all staff were supported through regular supervision of their work. The provider did not have effective logs showing compliance with supervision. This is a breach of Regulation 18(1)(2)a

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured they had fully mitigated risks to patients. The provider had not completed the ligature risk assessment with the actions required or timescales to address the issues they had found. This is a breach of Regulation 12(2)b

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We were not assured staff were adhering to infection control principles in line with national guidance. We saw numerous staff not wearing face masks, or wearing face masks inappropriately, across the hospital. We were not assured that staff could access the emergency response bag (crash bag) in a timely manner in an emergency. Or that the emergency response bag was secured securely. The bag contained emergency medications that were not sealed and should have been locked away but still accessible to authorised personnel only. Staff failed to monitor patients' physical health in line with Royal College of Psychiatrists consensus statement. Responsible Clinicians failed to complete regular reviews of patients on High Dose Antipsychotic Medication. Staff were not always observing patients in a way that maintained the patient's safety. Records did not appear to accurately record when observations took place or if they had taken place at all. This is a beach of Regulation 12(1)(2)(b)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The metal around the sink in the communal bathroom on Rutland ward was damaged and sharp. The wooden toilet surround was damaged and in need of repair. Due to the damage staff could not ensure that it could be cleaned in line with infection control guidance.

This section is primarily information for the provider

Enforcement actions

A patient's bedroom had was damaged. There was mould above the entrance to their en suite area. An area of the flooring was lifting away from the floor which created a potential trip hazard.

Five sofas and chairs in the communal lounge on Rutland ward were worn and/or torn in places. Due to the damage we were not assure that the furniture could be effectively and safely cleaned, posing an increased infection control risk.

This is a breach of Regulation 15(1)(b)(e)

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 Managers failed to have robust systems in place to ensure that the Section 58(3)(a) – Certificate of consent to treatment was valid, correct and available for staff to review prior to administering treatment. Managers failed to ensure that medicine records were completed correctly. Managers failed to ensure that the Mental Health Act 1983, and the associated Code of Practice was adhered to in relation to patients' rights. We found incomplete records in respect of each service user and associated detention paperwork. Managers failed to ensure that governance systems were in place to ensure that patients had access to Hospital Managers' panels Managers failed to ensure that governance system were in place to receive and scrutinise MHA detention papers. Managers failed to ensure that all complaints and incidents had been fully recorded, investigated and changes were made to practice to ensure they did not reoccur. We were concerned that failing to act on issues could put patients at risk of harm. This is a breach of Regulation 17(2)(c)