Grove Park Healthcare Group Limited

Grove Park

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?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Grove Park is a hospital that has two acute mental health wards for adults of working age and 2 nursing units for older adults with complex needs. We inspected both the hospital and nursing home parts of the service. This report details the findings from the hospital inspection and a separate report details the findings from the nursing home inspection.

This was the first time we rated this service. We rated it as requires improvement because:

- Staff had not carried out a full ligature risk assessment of the mental health unit. This meant that there were potential ligature risks which did not have clear mitigation in place and therefore posed a risk to patient safety.
- There were blanket restrictions in place on the wards. Patients were unable to make hot drinks or snacks without staff support.
- Staff were unaware of the provider's physical health and wellbeing policy which led to inconsistencies in how often physical health monitoring was being carried out on each of the wards.
- The service had a 37% vacancy rate for nurses and a 45% vacancy rate for healthcare assistants. The service used bank and agency staff to fill any gaps.
- We found gaps in physical health monitoring charts which had not been picked up through the provider's quality assurance processes.
- The provider did not ensure that their risk register was kept up to date.
- The service did not have an Occupational Therapist and we found instances where patient's needs had not been assessed.
- Patients told us they had not been involved in their care planning.
- The area where emergency drugs and equipment were stored on Westborne ward was very cluttered and we were concerned this could cause a delay in staff accessing these items in an emergency.
- The provider did not have a clear process in place around the completion of Venous thromboembolism (VTE) assessments.
- Staff did not always ensure capacity assessments were carried out when patients had important decisions to make.
- Staff had not documented whether discussions around consent to informal admission had taken place with patients.
- The provider had improved their mandatory training compliance since their last inspection, however, compliance with some courses was still low.

However:

- The ward environments were pleasant and clean. The wards had enough nurses and doctors. They managed medicines safely and followed good practice with respect to safeguarding.
- Managers ensured that staff received supervision. The ward staff worked closely 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.
- 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
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	This was the first time we rated this service. We rated it as requires improvement because: • Staff had not carried out a full ligature risk assessment of the mental health unit. This meant that there were potential ligature risks which did not have clear mitigation in place and therefore posed a risk to patient safety. • There were blanket restrictions in place on the wards. Patients were unable to make hot drinks or snacks without staff support. • Staff were unaware of the provider's physical health and wellbeing policy which led to inconsistencies in how often physical health monitoring was being carried out on each of the wards. • The service had a 37% vacancy rate for nurses and a 45% vacancy rate for healthcare assistants. The service used bank and agency staff to fill any gaps. • We found gaps in physical health monitoring charts which had not been picked up through the provider's quality assurance processes. • The provider did not ensure that their risk register was kept up to date. • The service did not have an Occupational Therapist and we found instances where patient's needs had not been assessed. • Patients told us they had not been involved in their care planning. • The area where emergency drugs and equipment were stored on Westborne ward was very cluttered and we were concerned this could cause a delay in staff accessing these items in an emergency. • The provider did not have a clear process in place around the completion of Venous thromboembolism (VTE) assessments. • Staff did not always ensure capacity assessments were carried out when patients had important decisions to make.

Summary of findings

- Staff had not documented whether discussions around consent to informal admission had taken place with patients.
- The provider had improved their mandatory training compliance since their last inspection, however, compliance with some courses was still low.

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- The ward environments were pleasant and clean. The wards had enough nurses and doctors. They managed medicines safely and followed good practice with respect to safeguarding.
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- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983.
- Staff treated patients with compassion and kindness and understood the individual needs of patients.

Summary of findings

Contents

Summary of this inspection

Background to Grove Park

Grove Park is provided by Grove Park Healthcare Group Limited. Grove Park is a hospital that has two acute mental health wards for adults of working age, and 2 nursing units for older adults with complex needs. Each of the acute mental health wards has 9 beds and the nursing unit has 58 beds.

Grove Park is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury
- Accommodation for persons who require nursing or personal care.

The hospital has a registered manager in place. A registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations.

Grove Park was registered with the CQC in February 2022. We previously carried out a focused inspection of the service in June 2022. Following this inspection we told the provider it must make the following improvements:

- Ensure all staff working with patients have undertaken the required training to ensure they are competent to deliver safe and good quality care to patients. In addition, they must receive regular supervision and appropriate levels of support from managers.
- Ensure there are appropriate emergency medicines available at all times and that staff are trained and competent to use them when needed.
- Ensure there are effective governance processes in place to assess, monitor and improve the safety and quality of the services as needed. Leaders must ensure they have clear and robust oversight of the service.

We found that the provider had taken action to ensure emergency medicines were in place. With regards to mandatory training, the provider had implemented a one day training course which covered the key training for health and social care staff identified by the core training and skills framework, however, compliance with some other mandatory training courses remained low. Governance processes had improved since the previous inspection but still required strengthening.

What people who use the service say

Patients told us that they felt safe on the wards and that staff treated them well. They told us the wards are very clean and nicely decorated. Patients did not feel they had been involved in their care plans. Patients told us that staff ensured their family members were kept updated.

How we carried out this inspection

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.

The team that inspected the hospital comprised an inspection manager, an inspector, a specialist advisor with a background in mental health nursing and an expert by experience.

Summary of this inspection

Before the inspection we reviewed information we held about the hospital.

During the inspection the team:

- conducted a tour of both Westborne and Saunderson wards
- spoke with the clinical director, medical director and hospital director
- spoke with 6 other members of staff including a ward manager, nurses, healthcare assistants and and members of the psychology team
- reviewed HR files for 4 staff members
- spoke with 6 patients and a carer
- reviewed care records for 8 patients and medicines records for 12 patients
- observed a daily manager's huddle
- reviewed a range of documents relating to the running of the service.

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 blanket restrictions are kept to a minimum and applied only when absolutely necessary [Regulation 13 (4) (b) safeguarding service users from abuse and improper treatment].
- The provider must ensure that gaps in care are identified and actioned, and that learning from audits and complaints is embedded [Regulation 17 (2) Good governance].
- The provider must ensure ligature risks are identified and there are clear plans to mitigate these risks to keep patients safe from avoidable harm [Regulation 12 (2) (a) Safe care and treatment].
- The provider must ensure patients have their needs assessed by people with the required levels of skills and knowledge for the particular task [Regulation 9 (3) (a) Person-centred care].
- The provider must ensure patients are involved in their care [Regulation 9 (3) (a) Person-centred care].

Action the service SHOULD take to improve:

- The provider should ensure the area where emergency drugs and equipment are stored on Westborne ward is kept free from clutter [Regulation 12 (2) (d) Safe care and treatment].
- The provider should ensure there is a clear process in place around the completion of Venous thromboembolism (VTE) assessments [Regulation 12 (2) (a) Safe care and treatment].
- The provider should ensure that staff receive training in carrying out searches, in line with their search policy [Regulation 12 (2) (c) Safe care and treatment].
- The provider should ensure staff consider and document whether capacity assessments have been carried out [Regulation 9 (3) (a) Person-centred care].
- The provider should ensure there are clear records of discussions around patients consenting to informal treatment and any wishes or preferences they have [Regulation 11 (1) Need for consent].
- The provider should ensure mandatory training compliance continues to improve [Regulation 18 (2) (a) Staffing].
- The provider should ensure they continue trying to recruit to vacant posts [Regulation 18 (1) Staffing].

Summary of this inspection

- The provider should ensure patients can store personal belongings securely in their bedrooms [Regulation 15 (1) (b) Premises and equipment].

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

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

Requires Improvement

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

Is the service safe?

Requires Improvement

This was the first time we rated this service. We rated safe as requires improvement.

Safe and clean care environments

All wards were clean, well equipped, well furnished, well maintained and fit for purpose. However, environmental risk assessments were not yet fully complete.

Safety of the ward layout

Staff could observe patients in all parts of the wards. Closed circuit television (CCTV) was in place in communal ward areas but staff did not have access to a live feed. Bedroom doors had vision panels on them to enable staff to carry out observations from outside patient bedrooms. These had murals on them so they looked like pictures.

There was no mixed sex accommodation. There were separate wards for male and female patients.

There was no ligature risk assessment on Saunderson ward. This meant that there was no documented mitigation in place for any potential ligature risks, and therefore that patients were exposed to avoidable harm. Managers were in the process of completing this and had completed this on Westborne ward. The ligature assessment for Saunderson ward was completed shortly after the inspection and managers created a ligature hot spot map to share with staff.

Staff had easy access to alarms and patients had easy access to nurse call systems. Patients had call buttons near their beds and in their en-suite bathrooms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. The wards were very pleasant and nicely decorated. Staff told us that any maintenance issues were resolved promptly. The hospitality manager attended the daily manager's safety huddle.

Managers carried out weekly audits to ensure that the wards and communal areas were clean and tidy.

Staff made sure cleaning records were up-to-date and the premises were clean.

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

Requires Improvement

Staff followed infection control policy.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The service had clear signage on both wards indicating where the emergency equipment was located. On Westborne ward the area in the nursing office where the equipment was stored was very cluttered which could cause a delay if staff needed to access the equipment in an emergency.

Staff did not consistently use maintenance stickers to indicate that equipment had been checked. The weighing scales, tympanic thermometer, height machine and blood pressure machine had maintenance stickers on them, however, the ECG machine and suction equipment did not.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe and had not had any incidents where the wards were not safely staffed. There was always a qualified nurse on shift on each ward. When the wards were full there were 3 healthcare assistants on each ward, however, these numbers were reduced when there were fewer patients.

The service had high vacancy rates although these were reducing as managers carried out recruitment. The service had a 37% vacancy rate for nurses and a 45% vacancy rate for healthcare assistants.

The service had reducing rates of shifts filled by bank and agency nurses. The service was using fewer bank and agency nurses as vacancies were being filled. The service had used 10% fewer agency nurses in January 2023 than in December 2022. Managers tried to ensure that there were always permanent members of staff on each shift. Staff and patients told us that this was usually the case during the day but not always at night. However, managers had recently recruited a registered nurse to work permanently on nights to help address this. In addition, since January 2023 3 senior managers had stepped into vacant nursing roles to help provide continuity of staffing.

The service had high rates of bank and agency healthcare assistants. The service had used agency healthcare assistants for 46% of shifts in December 2022 and January 2023.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers had block booked agency staff so that they were staff who knew the service and patients.

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

The turnover rates had reduced in the 3 months prior to the inspection, 12 staff had left in the 3 months prior to the inspection, compared with 45 staff in the 6 months prior to the inspection.

Levels of sickness were low. During the 6 months prior to the inspection the sickness absence rate was 2.2%.

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

The ward managers could adjust staffing levels according to the needs of the patients. For example, where a patient needed to be placed on enhanced observations. Healthcare assistants could also be moved between the 2 wards as necessary. Managers held a huddle every morning where they could discuss any staffing issues and agree plans.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Staff told us that activities had only ever been cancelled when no patients had wanted to attend.

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

Staff shared key information to keep patients safe when handing over their care to others. Staff completed handovers at every shift. Staff we spoke with told us they felt these were effective in enabling the sharing of key information.

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. A doctor and a consultant were on call at evenings and weekends.

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

Compliance with mandatory training had improved since the last inspection. Managers had implemented a one day training course which staff completed as part of their induction. This covered the core elements of training for health and social care staff including infection prevention and control, information governance, fire safety, health safety and welfare, equality diversity and human rights, preventing radicalisation, NHS conflict resolution, safeguarding adults and children, manual handling and resuscitation levels 1, 2 and 3. Compliance with this training was 93% with those who had not yet attended due to complete it shortly after the inspection. However, compliance with some other mandatory training courses remained low. For example, only 39% of staff had completed duty of candour training.

Managers monitored mandatory training and alerted staff when they needed to update their training. An allocated person maintained a training log which showed when training was due to expire.

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, using a recognised tool, and reviewed this regularly, including after any incident. All of the care records we reviewed included up to date risk assessments and we saw that risk assessments were updated following any changes in risk.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

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

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

Requires Improvement

The provider had a search policy in place. All the patients we spoke with told us they knew what items they should not bring onto the wards but told us they did not feel confident that staff were conducting thorough searches when they were first admitted to the unit or when they returned from leave. The search policy stated that staff should receive training in how to search patients, however, managers were unable to evidence whether staff had completed this. They told us they were confident staff had been shown how to do this, but that they did not keep a record of this. Managers planned to implement a way to evidence that staff had completed this going forwards.

Use of restrictive interventions

In January 2023 there were 4 instances of restraint. Managers reviewed the use of restraint in their monthly clinical governance meetings.

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.

The provider needed to review the number of unnecessary blanket restrictions that patients experienced. Patients were dependent on staff to access snacks and hot drinks. Kitchen facilities were available but these were away from the main ward areas. There were 3 locked doors between the main ward areas and the kitchen. Following the inspection the provider commenced works to install tea and coffee making facilities on each ward. These works were expected to be completed in April 2023.

Staff followed NICE guidance when using rapid tranquilisation.

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. Ninety-three percent of staff had completed training in safeguarding adults and children.

Staff 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 ward safe. Staff told us it was rare for children to visit the hospital but if they did then they would utilise the meeting space that was in a separate building for this.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff created good quality clinical records, however didn't always know whether they would be stored in paper files or electronically.

Staff created records electronically then printed them off and stored them in paper files. However, during the inspection staff had struggled to find information we requested because they weren't sure whether it had been printed. This could lead to delays in staff being able to access important information in an emergency.

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 to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients told us they had opportunity to discuss medicines with their care team within weekly ward rounds.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely. Staff used an electronic system to maintain medicines records.

Staff followed national professional practice to check patients had the correct medicines when they were admitted.

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

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared 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. Staff had reported 23 incidents in January 2023.

Staff raised concerns and reported incidents and near misses in line with the provider's policy. Managers discussed any incidents reported the previous day in their daily safety huddle. They also reviewed whether any safeguarding notifications had been made.

The service had no never events on any wards.

Staff we spoke with did not all understand duty of candour and only 39% of staff had completed training in this. Duty of candour is a duty to be open and transparent with people receiving care. However, patients and relatives felt that staff informed them when things went wrong.

Managers debriefed and supported staff after any serious incident. An incident took place during the inspection and we observed managers supporting staff appropriately afterwards. Managers introduced a debrief form in January 2023 so that staff could record details of any debriefs.

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

Requires Improvement

Staff met to discuss the feedback and look at improvements to patient care. In November 2022 managers had set up a weekly Positive Practice and Lessons Learned session where staff could attend to discuss an incident from the previous month and consider what worked well and what could have been done better. Managers also sent out monthly lessons learned bulletins to all staff. Managers also planned to implement an incident review group to explore themes in incidents.

Is the service effective?

Requires Improvement

This was the first time we rated this service. We rated effective as requires improvement.

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, however, did not evidence patient involvement.

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

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Patients had comprehensive care plans in place, however, we found that these were not always consistently followed. For example, a patient who was supposed to have daily checks carried out only had a couple of checks documented between November 2022 and January 2023. Staff told us this was because the patient had refused this intervention, however, it had not been documented that this had been attempted but refused. All of the patients we spoke with told us they had not been involved in their care planning. None of the care plans we reviewed had been signed by patients, nor did they indicate that patients had been offered a copy.

Staff regularly reviewed and updated care plans when patients' needs changed.

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. The ward teams did not have access to the full range of specialists required to meet the needs of patients on the wards. Staff participated in clinical audit.

Staff provided a range of care and treatment suitable for the patients in the service. The psychology team had created a group programme for patients as well as offering individual sessions. They offered sessions focused on mindfulness, grounding techniques, emotional regulation and sleep hygiene.

Staff delivered care in line with best practice and national guidance. However, there were inconsistencies regarding how often physical health observations should be carried out. Staff on Saunderson ward were completing physical observations twice a day for the first 72 hours and then changed to weekly, whereas staff on Westborne ward were completing observations twice a day without reviewing whether the frequency was appropriate.

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

Requires Improvement

The service did not have a full range of specialists to meet the needs of the patients on the ward. The service did not have an Occupational Therapist, although they were trying to recruit one. The provider told us that patients would be able to access occupational therapy via their commissioning trust. They were unable to evidence that patients had accessed occupational therapy in this way.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff met patients' dietary needs.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients were permitted to smoke in outside areas. Managers were in the process of developing some guidance around smoking cessation.

Staff took part in clinical audits. Managers carried out an audit programme to identify gaps in care, however, they did not create action plans to detail how they planned to address any gaps.

Skilled staff to deliver care

Managers supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

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. Staff checked the skills profile and training completed by agency staff prior to them working on the wards.

Managers gave each new member of staff a full induction to the service before they started work. Staff were required to complete the one day mandatory training course and PMVA training during their induction. They also spent a week shadowing other members of the team and were required to have certain competencies signed off prior to being allocated a task, e.g. observation competencies. All staff had completed their medication and observation competencies.

Managers had not given staff an appraisal because none of them had yet worked at the service for more than a year. Managers were aware when staff were due their appraisals and planned to complete these when they were due.

Managers supported staff through regular, constructive clinical supervision of their work. Supervision rates had improved since the previous inspection, with 100% of staff receiving supervision over the last 2 months.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff attended monthly staff meetings and the minutes were circulated afterwards for those who could not attend. Nurses also attended monthly meetings where they met to review clinical practice.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Healthcare assistants were in the process of completing their care certificates.

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

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

Requires Improvement

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. The ward teams had effective working relationships with relevant services outside the organisation but relationships within the team could be improved.

Staff held weekly 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.

Some staff told us that they felt working relationships within the team could be improved and that they did not always feel as though their perspectives were valued by other disciplines.

Ward teams had effective working relationships with external teams and organisations.

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.

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 administrator was 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 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, however staff could not always access them when needed. We saw that one patient had been given medication without the appropriate consent to treatment authorisation in place as staff did not have access to this information.

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

Requires Improvement

Informal patients knew that they could leave the ward freely and the wards displayed a 'rights of informal patients' poster to inform them of this. However, we fed back to managers that the wording on the poster could have been simplified as it was quite lengthy and complicated to understand. Managers took prompt action to review and update the poster. A simplified version was provided to us following the inspection. Staff had not documented whether discussions around consent to informal admission had taken place with patients.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005, however did not always assess and record 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.

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 did not always assess and record capacity to consent clearly each time a patient needed to make an important decision. Where a patient refused to take medication for their physical health staff had not assessed their capacity to make this 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. Where a patient had lacked capacity staff had arranged a best interest meeting to agree what was best for them.

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

Is the service caring?

Good

This was the first time we rated this service. We rated caring 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.

Staff gave patients help, emotional support and advice when they needed it.

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

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

Requires Improvement

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. Staff told us they would do this in supervision.

Staff kept patient information confidential.

Involvement in care

Staff sought patient's 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 oriented patients to the ward and gave them a welcome pack on admission.

Staff made sure patients understood their care and treatment.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff and patients had a weekly community meeting where they could discuss any issues on the wards. Staff then presented the feedback on a "you said, we did" board in the communal lounge. Patients were also asked for feedback on discharge from the service. Of the patients who had responded, 75% had said that overall they were satisfied with the care they received from the hospital.

Staff made sure patients could access advocacy services. Staff displayed information about how to access advocacy services on information boards on both wards.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Family members were invited to attend ward rounds where patients consented to this. Patients told us their relatives did not have any difficulties contacting the ward to request information.

Staff did not conduct any carers surveys, however, managers told us they were developing one.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good

This was the first time we rated this service. We rated responsive as good.

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

Requires Improvement

Access and discharge

Staff managed beds well. A bed was available when a patient needed one.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Managers and staff worked to make sure they did not discharge patients before they were ready.

Patients who needed more intensive care could be transferred to a psychiatric intensive care unit (PICU). Managers were aware of the process of requesting a PICU bed from the local NHS trust and had used this on several occasions. Managers told us that they would increase staffing on the ward to ensure that the patient was kept safe while awaiting transfer to PICU.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Senior managers held weekly meetings with ward managers to review expected discharge dates and any potential barriers.

Patients sometimes had to stay in hospital when they were well enough to leave, usually due to issues with sourcing accommodation for them. At the time of our inspection there were 2 patients on the wards who were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff invited care co-ordinators to attend ward rounds.

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

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe in the nursing office but did not have access to lockable storage in their bedrooms. There were quiet areas for privacy. The food was of good quality.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions. Patients could store personal possessions in the nursing office. Patients also had lockable storage cabinets in their bedrooms, however, the keys for these had gone missing and so they could not be locked. Patients also did not have keys for their own bedrooms.

Staff used a full range of rooms and equipment to support treatment and care. There was a lounge available on each of the wards. There was also a larger communal lounge, a kitchen, a multi-faith room and a quiet room which were available off the main ward areas.

The service had a range of toiletries available which patients could use.

The service had quiet areas and a room where patients could meet with visitors in private. Patients had access to a quiet space which had a beanbag, controllable lighting and stars on the ceiling. Patients could meet with visitors in the communal areas off the wards or in a meeting space which was separate from the main building.

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

Requires Improvement

Patients could make phone calls in private. Patients had access to their own mobile phones where this was risk assessed as safe.

The service offered a variety of good quality food. Patients were given a choice of meals and the daily menus indicated which dishes contained certain allergens or would be suitable for specific diets.

Patients' engagement with the wider community

Staff supported patients to maintain their family relationships.

Staff helped patients to stay in contact with families and carers. Family members were encouraged to attend ward rounds where patients consented to this. Where risk permitted patients had access to their own mobile phones to enable them to stay in contact with family.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

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.

The wards were fully accessible for disabled people, however, they did not have suitable beds/washing facilities for people using wheelchairs and so mobility issues were considered at the point of referral. Managers would refuse to accept a referral if they felt they could not meet the person's needs.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Staff displayed this information on boards on each ward.

Managers made sure staff and patients could get help from interpreters or signers when needed. These were accessible via the local NHS trust.

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. Patients could use a multi-faith room which was located in the communal area of the hospital. Staff displayed contact details for local faith organisations in here.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously and investigated these.

Patients, relatives and carers knew how to complain or raise concerns.

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.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

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

Requires Improvement

Managers investigated complaints and identified themes. The compliance lead kept a spreadsheet with details of complaints received. The service had received 6 formal complaints in the 6 months prior to the inspection. Half of these were relating to staff conduct and half relating to clinical/medical treatment.

Managers did not ensure that feedback from complaints was used to improve the service. Two out of the 6 formal complaints had been partially upheld, but there were no lessons learned/recommendations documented as a result of this.

Is the service well-led?

Requires Improvement

This was the first time we rated this service. We rated well-led as requires improvement.

Leadership

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

The management team at the service had lots of leadership experience from previous roles. The hospital director had been in post since November 2022 and had overall responsibility for the wards. They were supported by the deputy director, medical director and clinical services director. Staff told us that the clinical director and deputy director were a visible presence on the wards and that they would be comfortable approaching them if they had any concerns.

Each ward had a ward manager. Ward managers had access to leadership training.

Vision and strategy

Staff were unaware of the provider's vision or values.

The provider's values were respect, excellence in mental health care and dignity for all. However, staff we spoke with did not know what the vision or strategy for the organisation were. Some staff were concerned and uncertain about the future direction of the service and what that would mean for them and their roles.

Culture

Staff felt respected, supported and valued. 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.

Managers had spent a lot of time focusing on staff wellbeing and recognition. Staff could nominate one another for recognition awards.

Most staff told us that when they made suggestions for improvements they felt listened to and as though these were quickly implemented.

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

Requires Improvement

Some staff told us that they felt communication from senior managers could be improved as they often found out about important changes from other staff rather than managers. Managers told us they were aware of rumours among the staff team and that they planned to set up an "ask the senior leadership team" session for staff once a month.

Staff had not reported any cases of bullying or harassment.

Governance

Our findings from the other key questions demonstrated that governance processes required improvement.

The provider did not ensure that staff were working in line with policies and procedures. There was a physical and wellbeing policy in place however staff were not following this which led to inconsistencies in how often this was being carried out on each of the wards.

Managers had implemented an audit programme which included a list of all the audits they carried out, how often these should be completed and when they were last done. However, we found that where improvements had been identified as a result of audits, there were not always documented actions in place with regards to how these would be addressed. For example the outcome for the most recent handover audit was 'requires improvement', but there were no actions documented.

Managers had identified that the policies which were in place could be improved and so these were all being reviewed and updated. Managers had set up a weekly policy review group to action this and policies were ratified within clinical governance meetings.

Managers held clinical governance meetings once a month where they reviewed clinical effectiveness, risk management, patient and public involvement, audits, staff management, education and training and key information.

Management of risk, issues and performance

Managers did not have a risk register in place.

The provider had a risk register in place but this was not kept up to date. The risk register had not been reviewed and updated since September 2022.

Managers reported that the key risks to the service included staffing, training and reputation, but it was unclear how these were reviewed and updated.

Managers told us they had access to support from Human Resources to help them with any performance management issues.

Information management

Staff collected and analysed data about outcomes and performance.

Managers collected data about outcomes and performance which was shared with commissioners regularly.

Engagement

Managers collected feedback from patients and staff.

Patients were asked for feedback within community meetings and on discharge.

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

Requires Improvement

Managers had also carried out a staff survey which they planned to repeat every 6 months.

Managers reviewed the results from both patient and staff feedback within their monthly governance meetings.

Learning, continuous improvement and innovation

The service did not participate in any accreditation programmes. Managers told us that they would consider applying to participate in the Accreditation for Inpatient Mental Health Services (AIMS) once the service is more established.

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 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that gaps in care were identified and actioned, and that learning from audits and complaints was embedded.

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 The provider did not ensure that ligature risks were identified and that there were clear plans to mitigate these risks to keep patients safe from avoidable harm.

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 provider did not ensure that patients had their needs assessed by people with the required levels of skills and knowledge for the particular task. They also did not ensure that patients were involved in their care.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

The provider did not ensure that blanket restrictions were kept to a minimum and applied only when absolutely necessary.