Broomhill

Quality Report

St. Matthews Limited,
Holdenby Road,
Spratton,
Northampton
NN6 8LD

Tel:01604 841933
Website: www.smhc.uk.com

Date of inspection visit: 11 to 14 February 2020
Date of publication: 13/05/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Inadequate**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

I am 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.

Professor Ted Baker

Chief Inspector of Hospitals.

Overall summary

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

- Staff did not give sufficient attention to safeguarding patients and had not recognised and responded appropriately to abuse or discriminatory practice. Staff did not fully understand how to protect patients from abuse or work well with other agencies to do so. Staff had received training on how to recognise and report abuse, however staff were not fully aware of how to apply it.
- Patients did not feel cared for. Some patients reported staff as rude, impatient, judgmental, dismissive, and mocking. We found that some patients basic needs had not been met. Patients told us that night staff had been observed sleeping, and staff frequently spoke to one another in a language other than English.
- Staff had not assessed and managed risks to patients well. Staff had not fully completed patients risk assessments. Opportunities to prevent or minimise harm were missed. Staff had not updated assessments and risk management plans following incidents.
- Senior managers of the service admitted several acutely unwell patients directly to the rehabilitation wards. Clinical had not been routinely involved in the decision to admit patients, and on occasions had received very short notice of admissions. The provider had not ensured that staff had been prepared or adequately trained to care for all new patients.
- The provider had not updated its scope of registration and its operational policy in line with the changes to the service with regards to admitting acutely unwell patients.
- Patients received care from staff who did not have all the necessary skills, knowledge and experience to enable them to deliver quality care to the current patient group.
- Wards were unsafe. Staff were unaware of ligature points, blind spots and associated risks. Not all staff had access to emergency alarms. Staff did not adhere to the providers policy when undertaking enhanced patient observations. Not all staff had received training or were not competent in accessing key clinical information.
- Staff had failed to comply with the Mental Health Act Code of Practice in respect of explaining rights to patients in a timely manner. Staff were administering medication to three patients illegally and capacity assessments were not in place for five patients.
- We found issues of concern around staff failing to obtain and record consent to treatment in line with the Act. Staff had not assessed and recorded capacity clearly for all patients who might have impaired mental capacity.
- Managers had not ensured that improvement notices identified from the Care Quality Commission inspection in December 2017 had been actioned and embedded into practice.

However:

Summary of findings

- The service had enough nursing and medical staff who knew the patients. Staff had received the providers mandatory training and were up to date with this. Staff could adjust staffing levels when required.

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 	

Summary of findings

Contents

Inadequate

Broomhill

Services we looked at

Long stay or rehabilitation mental health wards for working-age adults;

Summary of this inspection

Background to Broomhill

Broomhill provides rehabilitation, care, treatment, and support to individuals with mental health concerns. Broomhill is part of the St Matthews Limited group, which consists of four care homes and four hospital locations in Northampton and Coventry.

The Commission describe rehabilitation services as those which provide specialist assessment, treatment and support to stabilise the person's symptoms and help them gain/regain the skills and confidence to live successfully in the community. Rehabilitation services that adopt a recovery orientation are more likely to achieve successful community discharge, including individualised, collaborative care planning to help individuals develop self-management skills, positive risk taking and therapeutic optimism. The team should have access to regular group and individual supervision to share concerns and problem solve.

Broomhill provides 95 beds across seven wards:

- Althorp ward - specialist dual diagnosis rehabilitation service - 14 beds. This is an open ward.
- Holdenby ward - complex mental health open rehabilitation service for women - 14 beds. This is an open ward.
- Kelmarsh ward – complex mental health locked rehabilitation service for men - 14 beds for men.
- Lamport ward - specialist Neuro-behavioural rehabilitation for men - 14 beds for men.
- Cottesbrooke ward - complex mental health open rehabilitation service for men - 14 beds.
- Spencer ward - slow stream rehabilitation service for men - 14 beds.
- Manor ward - slow stream rehabilitation service for women - 15 beds.

The Care Quality Commission last inspected Broomhill in December 2017. Overall, it was rated as good, with safe rated as requires improvement, and effective, caring, responsive and well led rated as good.

Following this inspection, the provider was told to take the following action to improve:

Action the provider MUST take to improve

- The provider must ensure that all staff receive mandatory training.
- The provider must ensure that all staff receive supervision in line with their policy.
- The provider must ensure staff under the age of 18 have appropriate risk assessments and support in place.
- The provider must ensure that medications management is effective.
- The provider must ensure that medical equipment was in date or checked regularly.
- The provider must ensure that ligature risk assessments are in place and that these robustly mitigate against all risks across the entire site.
- The provider must ensure that all staff receive an appraisal annually

Action the provider SHOULD take to improve

- The provider should ensure that appropriate alarm systems are in place, available to staff and are tested routinely.
- The provider should ensure that capacity assessments record the rational for decision-making.
- The provider should ensure that care plans are holistic; recovery focused and reflects patients' views and strengths.
- The provider should ensure they carry out regular fit and proper person checks for directors of the company, and hold on file, necessary documentation relating to this regulation.
- The provider should ensure that lessons learnt are disseminated and discussed with staff.
- The provider should ensure that they are no blanket restrictions in place.

At this inspection we had urgent concerns about the safety of patients at Broomhill. We used our powers under Section 31 of the Health and Social Care Act to take immediate enforcement action. We placed six conditions upon the provider's registration in relation to regulation 12 (safe care and treatment); regulation 17 (good governance); regulation 18 (staffing) and regulation 10 (dignity and respect). The provider produced an immediate action plan and continue to work with the care quality commission to improve. Five of the six

Summary of this inspection

conditions of registration have been removed since this inspection. We are continuing to review this service with the provider in relation to the areas of improvement needed which have been highlighted within this report. Because of the enforcement action we have already taken, the ratings for the safe, caring and well led key questions are limited to a rating of inadequate.

Our inspection team

The team that inspected the service comprised one inspection manager, five inspectors and two nurse specialist advisors.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all seven wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 22 patients who were using the service;
- spoke with eight family members and carers;
- spoke with the registered manager, nominated individual, managers and deputy managers for each of the wards;
- spoke with 33 other staff members; including doctors, nurses, occupational therapist, general practitioner and social worker;
- spoke with the service manager of the advocacy service;
- attended and observed a safeguarding meeting;
- looked at 25 care and treatment records of patients;
- carried out a specific check of the clinics and medication management on seven wards;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- looked at the human resource files of eight directors, and
- looked at incident files, patient observation records, risk register and governance files including meeting minutes.

What people who use the service say

We spoke with 22 patients and eight carers at the service:

Summary of this inspection

- Patients did not find staff caring, helpful, polite and respectful.
- Sixteen out of the 22 patients we spoke with raised concerns regarding staff attitudes and behaviours.
- Two patients alleged that they had been physically assaulted by staff. A safeguarding concern had been raised for one of these incidents. Inspectors raised a safeguarding alert for the second allegation during inspection.
- Two patients stated that they did not feel safe.
- Two patients stated that staff had been talking in another language to one another, other than English on the ward.
- Two patients described having been physically assaulted by fellow patients.
- Two patients of the 22 we spoke with stated that some staff were good.
- Two patients alleged that staff regularly slept at night.
- One carer of the eight we spoke with was happy with the care delivered.
- Three carers stated that they had no current issues or concerns at the time of this inspection.
- Three out of eight carers we spoke with, reported a lack of information and involvement in their relative's care.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- Staff did not give sufficient attention to safeguarding and had not recognised and responded appropriately to abuse or discriminatory practice. Staff did not fully understand how to protect patients from abuse or work well with other agencies to do so. Staff had received training on how to recognise and report abuse, however staff were not fully aware how to apply it.
- Staff had not assessed and managed risks to patients well. Staff had not fully completed patients risk assessments. Opportunities to prevent or minimise harm were missed. Staff had not updated assessments and risk management plans following incidents.
- Staff had not always ensured that the Mental Health Act and Mental Capacity Act were being followed. We identified that of 25 clinical records, eleven showed evidence that treatment was not being delivered in line with requirements. Staff were administering medication to three patients illegally and capacity assessments were not in place for five patients.
- The service had not always managed patient incidents well. Staff were not fully aware of which incidents to report and how to report them. Managers investigated incidents, however staff were not able to identify lessons learned for their team or the wider service. When things went wrong, staff had not always apologised.
- Two ward areas were not clean in places and had a strong smell of urine. The provider did not have a recording system in place to monitor cleanliness of communal areas.
- Wards were not safe. Each ward had a number of ligature points. Not all staff were aware of the ligature risks and how to mitigate these. We identified blind spots on each ward. Staff were not aware of these or associated risks. Not all staff had access to emergency alarms.
- Staff did not always follow the provider's policy for patient observations. Documentation had not always been completed including gaps in recording and absence of staff signatures.

Are services effective?

Inadequate

We rated effective as inadequate because:

Summary of this inspection

- Patients received care from staff who did not have all the necessary skills, knowledge and experience to enable them to deliver high quality care to the current patient group.
- Staff had failed to comply with the Mental Health Act Code of Practice in respect of explaining rights to patients in a timely manner. We found issues of concern around staff failing to obtain and record consent to treatment in line with the Act.
- Staff had not assessed and recorded capacity clearly for all patients who might have impaired mental capacity.
- Staff had not always assessed the physical and mental health of all patients when required. This included physical health assessments of patients on admission in a timely manner and ensuring that ongoing physical assessments were undertaken as required.
- Staff had not written all patient care plans from the patient's perspective and care plans were not always comprehensive.
- Managers had not always dealt with poor staff performance promptly and effectively. We had concerns about how poor staff performance had been managed.

However:

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies; support for self-care; development of everyday living skills, and to meaningful occupation.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards.
- Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Are services caring?

Inadequate

We rated caring as requires improvement because:

- The service had not supported a caring environment and approach to patient's care, treatment and support. Patients did not feel cared for. Of the patients we spoke with, 73% reported negative feedback about staff interactions. Some patients reported staff as rude, impatient, judgmental, dismissive, and mocking. We found that some patients basic needs had not been met. Patients told us that night staff had been observed sleeping, and staff frequently spoke to one another in a language other than English.

Summary of this inspection

- We identified that some carers and stakeholders had expressed concerns about the way staff treat people at this service. Three out of eight carers we spoke with, reported a lack of information and involvement in their relative's care.
- We found that individual preferences and choices were not always acted upon.
- Some patients had not been supported to understand information they had been given about their care and treatment.
- Some patients did not know or did not understand what is going to happen to them during their care. Some patients did not know who to ask for help.
- Staff had not always involved patients when appropriate in decisions about the service. At the time of inspection there was building works. Patients had not been informed of the reason for this, plans for the service, and had not been consulted or apologised too for any potential noise and disruption.

However:

- Staff enabled families and carers to give feedback on the service they received, via suggestion boxes, community, care programme approach and multi-disciplinary meetings.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Senior managers of the service admitted several acutely unwell patients directly to the rehabilitation wards. Clinical had not been routinely involved in the decision to admit patients, and on occasions had received very short notice of admissions. Ward staff did not have an opportunity to provide a view on the safety of the patient's pending admission in view of staffing levels, current levels of observations and the acuity of other patients on the ward.
- The wards did not fully meet the needs of all patients who used the service – including those with a protected characteristic. Staff had not helped all patients with communication, cultural and spiritual support. Seven patients told us that the food was not always of a good quality and did not always meet individual patient dietary needs. One patient had not had access to a required interpreter, despite having been at the hospital for several weeks.
- Complaints had not been used as an opportunity to learn. The service had not ensured that the outcome of complaints, including lessons learned, had been shared from senior management through to front line staff.

Summary of this inspection

- Patients on wards on the first floor did not have free access to fresh air.
- Patients were not offered keys to lock their rooms. Staff searched every patient upon return from leave routinely, as opposed to being individually risk assessed. We viewed this as a blanket restriction.

However:

- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Patients could make hot drinks and snacks at any time.
- Staff ensured patients had access to education and work opportunities and supported patients to maintain contact with their families and carers. Staff had planned and managed discharge well.

Are services well-led?

Inadequate

We rated it well led as inadequate because:

- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and risks were not managed well at ward level. The leadership, governance and culture did not support the delivery of good quality person-centred care. Leaders did not have a full understanding of the culture within the organisation and were not fully in touch with what was happening on the front line. Leaders did not have a formal way in which to deal with concerns expressed by patients regarding the behaviour and attitudes of some staff. Managers had not always dealt with poor staff performance when needed.
- Governance processes did not operate effectively at ward level and risks were not managed well. Leaders had not ensured that patients were safeguarded. The provider did not have a robust systems and processes to record, investigate and monitor safeguarding allegations to local authority or oversee and take necessary action about allegations that did not meet local authority thresholds. Not all staff were aware of the recommendations from serious incidents, incidents, complaints and safeguarding outcomes. Learning opportunities had been missed.
- Patients and carers had not been involved in decision-making about changes to the service. This included recent redesign of services including building works.

Summary of this inspection

- The provider had not updated its scope of registration and its operational policy in line with the changes to the service with regards to admitting acutely unwell patients. The provider had not ensured that staff had been prepared or adequately trained to care for all new patients.
- Managers had not ensured that improvement notices identified from the Care Quality Commission inspection in December 2017 had been actioned and embedded into practice. The provider had not ensured that the requirements relating to the fitness of directors of St Matthew's Limited had been followed.
- There was limited visibility of leaders at service level. The service had four deputy managers to cover seven wards who reported into one service manager (the registered manager). There was a lack of effective communication between the senior leaders and front-line staff. Ward staff described a divide between qualified and unqualified staff.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

All staff did not fully understand their roles and responsibilities under the Mental Health Act 1983. In total 76% of staff had received training in the Mental Health Act. Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice.

Staff generally tried to ensure that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted.

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

However, we identified several issues of concern regarding application of the Mental Health Act:

- five patients had no capacity assessment in place
- two patients had no section 58 certificate for consent to treatment
- one patient did not have a section 62 (urgent treatment) in place
- one patient had not had their rights explained to them for seven days
- one patient did not have their rights explained to them for 10 days
- there was no evidence that one patient had their rights explained to them for section 5(2) (a temporary holding power which can be put on by the ward doctor or an approved clinician), or for section 5(4) – (a temporary holding power which can be put on by a registered nurse), five (four)
- there had been 23 incidents (during the six-month period prior to inspection), when patients had been absent without authorised section 17 leave. Patients detained under section are required to have authorisation for any period of leave. Patients absconding from hospital without permission is a significant risk issue, which could result in negative consequences for the patient, relatives and staff
- we found one example where medication not approved by a second opinion doctor, had been administered.

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall, 93% of qualified staff had had training in the Mental Capacity Act as of 11 November 2019. However, staff did not fully understand their roles and responsibilities under the Mental Health Act Code of Practice. We could not be assured that staff had identified impaired mental capacity for all patients where relevant.

Nine patients were subject to Deprivation of Liberty Safeguards at the time of inspection. These were highest on Lamport, where three patients were subject to Deprivation of Liberty Safeguards.

Not all staff we spoke with, were aware of where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.

For patients identified by staff as having impaired mental capacity, staff had not always recorded capacity to consent appropriately. We reviewed 25 care records and found that staff had failed to record patient consent for 80% of patients.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

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

Inadequate

Safe and clean environment

Staff conducted daily environmental risk assessments of the environment. However, there were several potential ligature anchor points on all wards, which did not have mitigation for staff to follow or be aware of. A ligature is a place to which patient's intent on self-harm could tie something to harm themselves. These included door closures, handles, toilet and bathroom fittings and non-collapsible curtain rails.

Managers had completed and regularly updated ligature risk assessments for each of the wards, but staff had older versions in use on Cottesbrooke. On Cottesbrooke ward, the ligature risk assessment used by staff was dated September 2016. Staff were not all aware of the ligature assessments and could not identify ligature risks on all the wards, or associated mitigation. Managers had completed the ligature risk assessments using the scoring system for rehabilitation patients. Managers therefore had not ensured that the ligature risk assessments fully reflected the risks posed to patients who had been admitted with acute mental health conditions.

We found that the ligature risk reduction policy and procedures on some wards, were not in date. On Lamport ward, the staff referred to and used a policy dated June 2016, which was due for review in June 2019.

All staff did not have easy access to emergency alarms, however patients had access to nurse call systems.

Staff could not observe patients in all parts of the wards. We identified several blind spots, where staff could always not observe patients. Staff were not aware of these and could not identify how to mitigate the risks. The blind spots were not recorded in ligature risk assessments.

The wards complied with guidance on reducing mixed sex accommodation; there was no mixed sex accommodation.

Maintenance, cleanliness and infection control

Most wards were clean and well kept. Furniture was in a good state of repair and furnishings were appropriate to the environment. The provider had installed new flooring across all units, including bedrooms and communal areas. Some ward areas were not always clean, well maintained, and fit for purpose. The Manor was dirty and unkempt in places. We saw dirty showers and shower screens, damaged plaster work and missing wallpaper. There was also a strong smell of urine on Spencer. This was raised with the provider during inspection. The provider did not have a system in place to monitor cleanliness of communal environments. Managers informed us following inspection, that these had since been put in place.

Staff had completed cleaning records which were up-to-date for the toilets and patient bedrooms. Individual bedrooms had daily cleaning schedules on the back of the door.

The provider was in the process to deliver a programme of works to change two wards to anti-ligature environments to be able to admit patients with acute mental health conditions. Door handles and shower heads had been

replaced with anti-ligature fittings. An airlock was being constructed on Cottesbrooke. We saw some holes in the wall for electrical sockets, and some painting and redecoration that was required.

Staff adhered to infection control principles, including handwashing.

Clinic room and equipment

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

Safe staffing

There was one unit manager in post across seven wards. This was the same person as the registered manager. There were four deputy managers across the seven wards. Following the inspection, we told the provider about our concerns. The provider confirmed that funding had been agreed to appoint a deputy manager to each ward.

At the time of inspection, the providers' overall vacancy rate (January 2020) for support workers was 15%. The overall vacancy rate for senior support workers was 13% and the overall vacancy for qualified nurses was 26%. The provider had four occupational therapists and four occupational therapy assistants in post.

The service used bank and agency staff where required. Where possible, the provider used the same agency provider, and chose staff when possible who had previously worked within the service. The number of shifts filled by bank and agency to cover sickness, absence or vacancies was 875 shifts over the three-month period 1 August 2019 to 31 October 2019. On average this was equivalent to eight additional staff members.

The sickness rate was 1% between 1 November 2019 and 31 October 2019. This rate is lower than the benchmark figure for the provider of 3%.

The service had high turnover rates. There had been a total of 57 staff leavers between 1 November 2019 and 31 October 2019. Staff identified this as a concern and were unable to identify why staff chose not to stay.

The provider had determined staffing levels by calculating the number and grade of grade of nurses and healthcare assistants required. Managers had produced a staffing level matrix for the wards. However, at the time of inspection, the staffing matrix only indicated the need for one qualified staff for some of the wards. This impacted the wards where patients with acute mental health conditions had been admitted. The turnover of patients with acute mental health conditions and patient risks were higher. This required a need for undertaking more frequent nursing assessments, risk assessments and updating risk management plans.

The number of nurses and healthcare assistants matched this number on most shifts. However, patients and staff reported that the wards had been short staff on occasions.

The deputy managers could adjust staffing levels according to the needs of the patients.

Managers had ensured that when agency and bank nursing staff were used, those staff received mandatory training and an induction, and were familiar with the ward. However out of the 11 agency files viewed, five (45%) did not show evidence of Mental Capacity Act training.

A qualified nurse was not always present in communal areas of the ward. However, support workers were generally available in ward areas.

Staffing levels allowed most patients to have regular one-to-one time with their named nurse. However, in some cases the patients told us that their key worker was working on night duty. Therefore, these patients reported that they had not received regular 1:1 time with their key nurse.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward in an emergency. The provider also had access to a GP who visited the service weekly. The service level agreement with a GP service, reported at our last inspection, remained in place.

Mandatory Training

Staff had received and were up to date with appropriate mandatory training. Overall, staff in this service had undertaken 84% of the various elements of training that the trust had set as mandatory.

Training was delivered mostly through via e-learning and work books and some practical training. The provider conducted a recent training review across the company. There were 82 respondents who took part in the review, 49 replies from staff at Broomhill. Sixty three percent of staff at Broomhill said they preferred training to be delivered via

'talking'. Eighty two percent of staff said face to face classroom training was their preferred teaching method, 47% through coaching and mentoring and 28% preferred workbooks and 17% preferred web-based training.

None of the individual elements of training were rates were less than 75%. However, despite this, we found that some staff had a limited understanding of the Mental Capacity Act.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff had not assessed and managed risks to patients well. We examined 25 patient care records. We found that staff had not completed a full risk assessment for every patient at initial assessment. Staff had not always updated risk assessments regularly, including after every incident.

Staff used a recognised risk assessment tool, which was part of the electronic health record. On review of clinical records, we found that several clinical risk assessments lacked quality and detail. The hospital used a risk assessment tool, which was comprised of four elements. These were, working with risk 1 - current situation, working with risk 2 - detailed review, working with risk 3 - positive risk-taking and working with risk 4 – safety plan.

We found that 18 out of 25 (72%) of patient records reviewed, had "working with risk 1" documents in place. Of these 15 were comprehensive and had been completed in a timely manner. However, staff had not updated the "working with risk 1" following identification of increased patient risks or following incidents. One risk assessment had been completed one month after admission; another completed five months after admission. These assessments should be completed within 24 hours following a patient's admission.

We found that only one out of 25 "working with risk documents 2 and 3" reviewed had been completed. None of the "working with risk 4" documents reviewed had been completed. However, following inspection managers explained that the working with risk documents three and four, were only completed where required.

Management of risk

Staff were aware of and dealt with any specific risk issues, such as falls or pressure ulcers.

Staff had not always followed good policies and procedures for use of patient observation (including to minimise risk from potential ligature points). We examined 45 observation records of which 55% had been completed fully. The remaining 45% of observation records had missing entries and missing signatures.

Staff followed the provider's policy and procedure on patient searches. Two staff members searched all patients following periods of unescorted leave (in line with policy). Searches were also conducted of patient bedrooms when a potential risk had been identified.

All patients were searched on their return from leave. This was a blanket restriction. Staff did not risk assess patients individually in order to identify if a search was required.

Staff adhered to best practice in implementing a smoke-free policy. The service was non-smoking, and patients could access advice and supporting regarding smoking cessation.

Informal patients could leave at will and knew that. We found evidence of informal patient notices on the wards.

Use of restrictive interventions

In the six-month period 01 May 2019 to 31 October 2019, there were no episodes of seclusion or long-term segregation. There were 71 episodes of restraint across six wards in this six-month period. These were highest on Holdenby with 30 restraints. The lowest number of restraints was on Althorp with one restraint.

There was one prone restraint on Cottesbrooke. This incident resulted in the patient receiving rapid tranquillisation. Staff reported that the patient fell to the floor in this position and was turned immediately by staff.

Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff used restraint only after de-escalation had failed and used correct techniques. All staff interviewed indicated that the use of restraint was a last resort. Staff described the use of de-escalation as a first intervention.

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

Safeguarding

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff did not fully understand how to protect patients from abuse. Staff did not know how to make a safeguarding alert and did not always make referrals when appropriate. Staff received training in safeguarding principles.

Safeguarding training was delivered by a member of staff trained to Level 3 adult safeguarding training. This member of staff had written the providers' policy for the safeguarding of both adults and children. However, they were not able to describe the providers' process for child visiting

We found a lack of robust systems and processes to record, investigate and manage outcomes of incidents and allegations made by staff, patients, carers and external agencies. The provider used different approaches to manage safeguarding allegations. The safeguarding lead described a process where they reviewed incident forms. Those which were of a safeguarding concern, were raised with a deputy ward manager to manage locally. We also heard of meetings that took place between three senior staff, usually the registered manager, the medical director and the safeguarding lead. They met to discuss allegations of poor staff performance and discussed ways to deal with each situation.

There were inconsistent processes to manage staff behaviour in relation to safeguarding concerns. We were given examples where some staff had been suspended, pending investigation. Other staff had been moved between wards without any internal investigation into allegations. Some staff had been managed through supervision discussions and others had been asked to attend training.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

At the time of our inspection there were 18 safeguarding cases registered with the local authority in Northampton. These were submitted between 09/01/2019 and 22/02/2020, however 16 of these referrals were made three months before our inspection. Four of these referrals were subject to a section 42 enquiry from the local authority. The Care Act 2014 (section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

All staff were not able to give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff were not all aware of how to identify adults and children at risk of, or suffering, significant harm. However, staff followed safe procedures for children visiting the wards, as children were not permitted into ward areas.

Staff access to essential information

The provider had introduced an electronic patient record system. However, they used a combination of paper and electronic health records. Staff had not ensured that patient notes were fully comprehensive. A number of staff were not able to navigate the electronic health record and find information easily.

Staff reported that there was a lack of clarity around where certain information should be recorded. Staff were not sure what information was available electronically or remained paper based. This did not make it easy for staff to maintain high quality clinical records.

All information needed to deliver patient care was therefore not always immediately available to all relevant staff (including agency staff) when they needed it. Staff had not always made sure that records were up-to-date and complete. We found that 24 out of 25 patient risk assessment documentation had not been fully completed.

When patients transferred, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service generally followed systems and processes when safely prescribing, administering, recording and

Long stay or rehabilitation mental health wards for working age adults

Inadequate

storing medicines. The provider had a contract with an outside pharmacy, who reviewed patients' medicines regularly, and provided specific advice to patients and carers about their medicines. The pharmacy also conducted weekly medicines audits. However, we found that one patient was being given medicine which was not covered under section 62 (authorisation for urgent treatment), and there was no high dose anti-psychotic monitoring form in place for one patient who required it. These two issues were raised with the provider and resolved the same day. We also found evidence that for two patients, medicines were being given covertly. The responsible clinician had not been made aware, and we found no evidence of liaison with pharmacy.

Staff reviewed regularly the effects of medicines on patients' physical health. This includes review of patients who were prescribed antipsychotic medicine or lithium. These took place in the multi-disciplinary review in line with guidance from the National Institute for Health and Care Excellence. However, these reviews took place monthly, which did not reflect the needs of the acutely ill patients who had been admitted to the service.

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

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

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

Track record on safety

The number of serious incidents for the 12-month period first October to 31 November 2019 was three. Two of the serious incidents related to patient deaths (one of which was expected), and the third related to a patient injury sustained whilst on authorised section 17 leave.

Reporting incidents and learning from when things go wrong

The provider had an electronic system to record incidents, incident investigations and the outcome of incident reviews. However, we had concerns about the current process for the review of incidents. We found that some staff had received little training in how to use the reporting system. Staff were not able to identify lessons learned for their team, of the wider service when asked.

Staff did not always know what incidents to report and how to report them. We found several incidents which had been reviewed in the patient's daily record had not been transferred to the patient's risk assessment or risk management plan.

All staff had been trained in the duty of candour, however not all staff understood the principles. Patients and carers told us that staff had not always been open and transparent. However, managers told us that they had introduced 'back to basics training' in response to concerns which had been raised regarding staff attitude and behaviours.

Managers debriefed and supported staff after any serious incident.

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

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

The inspection team examined 25 care records across the seven wards. Staff had completed a comprehensive mental health assessment for all patients. However, staff had not always completed these in a timely manner at, or soon after, admission. We found evidence that documentation for one patient had been completed one month after admission and another five months following admission.

Staff had not developed comprehensive care plans that met the needs identified during assessment for all patients. We found that the care outlined in 11 out of 25 care plans (44%) were not fully comprehensive. Care plans generally were not personalised and were not always recovery-oriented. Of the 18 care plans viewed, four (22%), had not been written from the patient's perspective, however this had not adversely affected the quality of care delivered to patients. Staff had not reviewed all patient care plans when necessary. Staff had not reviewed all patient following incidents.

Staff had not undertaken ongoing physical assessments as required for all patients. For example, the physical health

section for three patients did not contain a completed an assessments of the patient's cardiac and metabolic health, which assists in reducing mortality for people with mental illness.

Best practice in treatment and care

We inspected 25 patient records. Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff delivered interventions delivered in line with, guidance from the National Institute for Health and Care Excellence.

Staff completed a screening tool to identify adults, who are malnourished, at risk of malnutrition

and met patients' needs for food and drink and for specialist nutrition and hydration

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. A GP visited the service on a weekly basis, and we saw evidence of patients attending dentist and optician services within the local area.

Staff had supported patients to live healthier lives – for example the provider had a smoke-free policy and provided patients with education and advice regarding healthy living and smoking cessation.

Staff used the health of the nation outcome score; a recognised rating scale to assess and record the health and social functioning of people with severe mental illness. However, there was limited evidence of other outcome measures being used.

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

Staff participated in several clinical audits. These included audits relating to medication management, infection control, handwashing, case files and the Mental Health Act.

Skilled staff to deliver care

The ward teams included or had access to a range of specialists required to meet the needs of patients on the wards. As well as doctors and nurses, patients had access to occupational therapists, and clinical psychologists.

Pharmacists and speech and language therapists were available on a contractual basis. The provider did not have a social worker in post, however were able to access input via the patient's care coordinator.

During inspection, we found the provider had admitted patients to the service who had acute mental health conditions, including schizophrenia and, psychosis. They had been directly admitted from the community, accident and emergency, care homes, from acute mental health wards, and from mental health-based places of safety. Some patients had been admitted to Broomhill under Section 2 of the Mental Health Act. Managers had not always made sure they had staff with the range of skills needed to provide high quality care to all patients. Whilst staff were experienced and qualified in the care of mental health rehabilitation, staff did not always have all of the right skills and knowledge to meet the needs of the patients with acute mental health conditions. Staff told us they did not feel they had the knowledge of how to manage patients with acute mental health conditions. In the training survey conducted by the provider, seven staff said they would like training on mental health conditions. Whilst this hospital is designated as a mental health rehabilitation setting, we saw have seen evidence that patients with an acute mental health diagnosis had been admitted directly to the hospital. Managers advised that these patients had been previously admitted to hospital, therefore had known histories. However, these patients were admitted whilst acutely unwell into a rehabilitation setting.

Managers had provided all new staff with an induction to the service, but this did not include training on acute mental health conditions. This had included agency staff.

Managers had provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. The percentage of staff that had had an appraisal overall at the time of our inspection was 85%. The percentage of staff that received regular supervision overall at the time of our inspection was 89%.

Managers had ensured that staff had access to regular monthly team meetings. The provider held separate staff meetings for both qualified and unqualified staff.

Managers had not always dealt with poor staff performance promptly and effectively. We had concerns about how poor

staff performance had been managed. The provider did not have a robust system in place to consistently review allegations of poor staff performance in consultation with Human Resources (HR) in an effective and timely way. Following our inspection, the provider addressed this issue and developed a weekly meeting with human resources where any allegation made about poor staff performance was recorded, investigated and appropriately managed.

Multi-disciplinary and inter-agency team work

Staff held multidisciplinary meetings on each ward monthly. Whilst this frequency met the needs of rehabilitation patients, this frequency did not fully meet the needs of patients who were acutely unwell. We found that five patients had been admitted under section two of the Mental Health Act. This section for 28 days is for patient assessment. Patients admitted under section two of the Mental Health Act would therefore only have access to one multi-disciplinary during this period of detention.

Staff shared information about patients at handover meetings within the team (for example, shift to shift).

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

The ward teams had effective working relationships with teams outside the organisation (for example, the local NHS trust, commissioners and local authority. However, prior to and during our inspection, we had been made aware of allegations of a safeguarding nature made by the local advocacy service. This led to a number of formal investigations to be carried out by the local authority safeguarding team. At the time of our inspection, the relationship between the two parties was experiencing some difficulty. The advocacy service and the provider had an action plan to meet to discuss expectations for both parties and were planning to meet. However, at the time of inspection, this meeting had not taken place.

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

In total 76% of staff had received training in the Mental Health Act. However, not all staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. We identified several issues of concern regarding application of the Mental Health Act. These included five patients had no capacity assessment in place, two patients had no section 58 certificate for consent to treatment, and there was no section 62 (urgent treatment) in place for one patient.

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

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy. However, at the time of our inspection the provider had raised concerns about the current advocacy provision. However, we were assured that patients would continue to have access to this service.

Managers had not always made sure that staff could explain patients' rights to them. Staff had explained to most patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. However, we found evidence of significant delays for two patients. One patient had their rights explained to them seven days after commencement of their section. A second patient had their rights explained to them ten days after commencement of their section. In addition, there was no evidence for one of these two patients that their rights for section five (two) and five (four) had been explained.

Staff generally tried to ensure that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. However, patients and managers told us that this there had been instances where staff had experienced problems facilitating section 17 leave. We found that there had been 23 incidents (during the six-month period prior to inspection), when patients had been absent without authorised section 17 leave.

Staff had requested an opinion from a second opinion appointed doctor when necessary. Although we found one example where medication not approved by a second opinion doctor, had been administered.

Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms)

correctly and so that they were available to all staff that needed access to them. However, we found that there was no allied health professional report for one patient admitted 12 days previously.

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

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of some learning from those audits. However, during inspection we found a number of errors in the application of the Mental Health Act.

Good practice in applying the Mental Capacity Act

Overall, 93% of qualified staff had had training in the Mental Capacity Act as of 11 November 2019. However, staff did not fully understand their roles and responsibilities under the Mental Health Act Code of Practice. All staff did not have a comprehensive understanding of the Mental Capacity Act. Therefore, we could not be assured that staff had identified impaired mental capacity for all patients where relevant.

There were nine patients subject to Deprivation of Liberty to protect people without capacity to make decisions about their own care. These were highest in Lamport, where five patients were subject to Deprivation of Liberty Safeguard applications.

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

Not all staff were aware of where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.

Staff had not taken all practical steps to enable patients to make their own decisions.

For patients identified by staff as having impaired mental capacity, staff had not always recorded capacity to consent appropriately. We reviewed 25 case records and found that patient consent had not been recorded in the consent section for 20 patients. Due to the fact that some staff demonstrated a lack of understanding around the Mental Capacity Act, we could not be assured that staff had identified impaired mental capacity for all patients where relevant.

The service had arrangements to monitor adherence to the Mental Capacity Act. However, these had not been fully effective.

Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

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

Inadequate

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients did not always show that they were discreet, respectful and responsive. Whilst we observed several positive staff interactions with patients, and some staff appeared to be committed to their roles, some staff had not always treated patients with compassion and kindness. Patients reported a range of negative staff behaviours including patient reports of staff being rude and abrupt. In total 16 out of 22 patients interviewed (73%) raised concerns about staff behaviour and attitude. Patient concerns included allegations of staff assault, of staff being nasty, not speaking in English in front of them, having a 'fiery temper, being threatening and being 'treated like a child'. During our inspection, we raised a safeguarding concern to the local authority directly from a report by a patient of staff poor performance. We notified the provider immediately, who took necessary steps to safeguarding the patient and promptly dealt with the staff members implicated.

Patients reported that staff had not always provided help with emotional support and advice at the time they needed it.

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Several patients said staff had not treated them well and behaved inappropriately towards them. One patient reported that staff had called them a "white witch', another patient reported that staff "had shouted one inch from their face".

Patients also made reports of staff sleeping on nights and of speaking in a foreign language in front of them. There was documentary evidence in meeting minutes that the provider had been made aware of these issues and were taking steps to address the issue.

Staff generally understood the individual needs of patients, including their personal, cultural, social and religious needs. However, we found evidence that two months following a patient admission, the provider remained unclear what language the patient spoke. Staff told us that they were unsure if the patient was unwell or did not understand them. However, the provider had not arranged for the patients to see an interpreter.

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

Staff maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service.

Staff had not involved all patients in their care planning and risk assessment. Whilst we saw several examples where patients had been fully involved in their care, we also saw four records where care plans were written in the third person and did not reflect the patient's views. Staff had not recorded in these records that the four patients did not have capacity to be involved in the care planning process.

Staff had not always involved patients when appropriate in decisions about the service. At the time of our inspection, building work was taking place in the service. This involved the use of scaffolding and additional noise, which had adversely affected the patient's experience. One patient told us the adaptations made to their shower, (anti-ligature fitting) had limited their access to the water stream and this meant they required the support of staff to shower. Another patient told us they were unable to open and close their window without staff assistance, as the anti-ligature fitting no longer provided them with a handle to open and close the window. We raised this with the provider and all window handles were replaced the next day. The senior management team told us they had plans to adapt the environments for patients with acute mental health conditions. However, managers had not informed patients of the reason for the building works, plans for service development or apologised for the disruption.

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

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

Staff had ensured that patients could access advocacy. However, at the time of our inspection, the provider reported concerns regarding the advocacy service. It was not clear how this issue was going to be resolved however, the provider could be assured that patients would still have access to independent advocacy.

Involvement of families and carers

Staff had informed and involved most families and carers appropriately and provided them with support when needed. However, three out of eight carers (37%), reported a lack of information and involvement in the patient's care.

Staff enabled families and carers to give feedback on the service they received, via care programme, friends and family tests and multi-disciplinary meetings. The provider provided a carers forum, however due to the poor level of attendance, this had not taken place regularly.

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

Requires improvement

Access and discharge

Bed Management

The service had clear criteria for which patients would be offered a service. However, whilst the service was designated as a mental health rehabilitation setting, we saw evidence (from staff interviews, review of patient records, supervision records and review of the Mental Health Act detentions), that patients with an acute mental health diagnosis being admitted directly to the hospital.

The admission of acutely unwell patients onto rehabilitation wards, had resulted in staffing numbers, skills and competencies not reflecting the needs of all patients on the ward. Patients with acute mental health needs presented with a different risk to patients with rehabilitation needs. Staff could not therefore be assured that the environment and staff would meet the needs of the new client group. The provider had not updated their statement of purpose or operational policy to account for the change in patient group. The provider rectified this immediately after inspection.

Staff told us that they were not routinely involved in the decision to admit patients, and on occasions have received very short notice of an admission (e.g. in some cases a couple of hours). As a result, ward staff were unable to provide a view on the ward's safety and current client group. Ward staff did not have the opportunity to provide a view on the safety of the patient's pending admission in view of staffing levels, current levels of observations and the acuity of other patients on the ward.

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

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

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

Discharge and transfers of care

In the 12-month period first of November 2018 to end of October 2019, the provider had reported no delayed discharges.

Staff had planned for most patient's discharge at an early stage. However, we found that out of the 25 records viewed, two care records did not have a discharge care plan in place.

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

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. However, all patients did not have a key or access to their rooms during the day, this was risk assessed by staff. Patients had somewhere secure to store their possessions.

Staff advised that patients could personalise their own bedrooms. During inspection we observed evidence of rooms beings personalised.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. The main building provided a large space with a pool table, a hairdresser, a visitor's room and a café area. There was extensive grounds and garden areas.

There were quiet areas on the ward and a room where patients could meet visitors. The service also had a marquee in the grounds, where family visits took place.

Patients had access to a cordless phone. Staff risk assessed access to this at the patient's clinical review.

Patients on the ground floor had access to fresh air throughout the day. However, patients on the first floor who did not have access to Section 17 leave, did not have free access to outside space or fresh air due to the ward being located on the first floor.

Patients stated that the standard of food varied. Seven patients stated that the standard of food was poor. Patients also complained that food was not always provided for patients with specific dietary needs.

Patients could make hot and cold drinks and had access to snacks throughout the 24-hour period.

Patients' engagement with the wider community

Staff ensured that when appropriate, patients had access to education and work opportunities. The provider accessed local services for patients with substance misuse issues and day care facilities.

Staff supported patients to maintain contact with their families and carers.

Patients were encouraged to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service had made several adjustments for disabled patients. However, the provider had not ensured that the needs of all patients had been fully met. Staff had not ensured that the correct shower chair had not been provided for a patient with mobility problems. We noted that one patient who had bed rails on their bed, did not have bumpers in place to prevent patient harm by entrapment. Managers had not always ensured that staff and patients had easy access to interpreters when required. One patient who had been admitted for over a month, had not had access to interpreters. Staff had recorded in the patient record, that they were not sure which language the patient spoke. This patient was detained under the Mental Health Act.

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

Staff advised that information leaflets were available in languages when required.

Patients had not always received food which met their dietary requirements. Patients had access to a choice of food to meet the needs of religious and ethnic groups.

Staff ensured that patients had access to appropriate spiritual support.

Listening to and learning from concerns and complaints

The total number of formal complaints recorded in the six-month period from the first of August 2019 to 31 January 2020 was 11. Managers received complaints regarding staff attitudes and behaviour, alleged staff assaults, concerns regarding patient care and staff talking in their native language. The total number complaints upheld by the provider was one. Managers partially upheld four complaints and did not uphold four complaints. One complaint investigation was ongoing, and one complaint was resolved informally. We were not assured that the provider had a consistent process in place to manage the culture and poor staff behaviour consistently in collaboration with human resources. Following inspection, the provider put a process in place to manage this. There were no complaints referred to the Ombudsman during this six-month period.

Patients knew how to complain or raise concerns. However, some patients were reluctant to raise concerns. In total, sixteen out of the 22 patients interviewed (73%) raised issues regarding staff attitude and behaviours toward them. Staff had not always protected patients who raised concerns or complaints from discrimination and harassment. Patients told us that they were reluctant to raise concerns, due to staff behaviours. Three patients told us that there was no point raising a concern as they had received no response from previous concerns they had raised. However, the provider had received 25 compliments (from families, patients, students and external agencies) during the 12-month period February 2019 to January 2020.

When patients complained or raised concerns, they did not always receive feedback. Three patients interviewed advised that they had not received a response to the concerns they had raised.

Staff generally knew how to handle complaints appropriately, however patients stated that they were not always were open and transparent.

Staff had not always received feedback on the outcome of investigation of complaints and acted on the findings.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

Inadequate

Leaders had not always ensured that services were safe. There had been a marked increase in safeguarding concerns and leaders had not ensured that robust systems and processes were in place to safeguard all patients.

Leaders were fully committed to the service and service improvement. Leaders had the skills, knowledge and experience to perform their roles. However, there was a disconnect of communication between leaders and front-line staff. The provider had not ensured that directors had met the requirements for fit and proper person tests. This issue had been highlighted at our last inspection. We sampled seven files of directors of the company. All seven files did not have appropriate financial checks. Five files did not have evidence of the two required reference checks, three did not contain the required health checks, and six did not contain interview notes for their positions held on file. For example, one associate director had a reference on file, dated after their appointment to position and it had been completed by a relative, who also held a position on the board. A non-executive director (NED) appointed to the board, was closely related to the chief executive and their file held no references or interview notes for their position. A senior member of the board could not articulate what the role of the NED was on the board.

Leaders did not have a good understanding of the services they managed. Leaders were not fully aware of all concerns being expressed by several patients regarding the behaviour and attitudes of some ward staff.

There was limited visibility of leaders at service level. There was one manager for the service and four deputy managers covering the seven wards. However, following our inspection, the provider confirmed that funding had been agreed for a deputy manager for each of the seven wards.

Leadership development opportunities had been made available for some of the more senior staff. This had included opportunities for some staff below team manager level. The senior team had developed a succession planning strategy and training plan to develop their own staff.

Vision and strategy

The service had in place it's 2020 vision for what it wanted to achieve. This covered seven key areas, and leaders had a strategy to turn it into action. However, the provider's senior leadership team had not successfully communicated the provider's vision and values to the frontline staff in this service. Staff had not contributed to discussions about the strategy for their service.

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

Culture

Managers had not ensured that there was an open, responsive, caring and transparent culture within the organisation. Patients had described a range of negative staff behaviours, however there was limited evidence that managers had taken robust steps to address these issues.

Some staff told us that there was a divide between qualified and unqualified staff. These staff reported that this had adversely affected team working. However, staff generally felt respected, supported and valued.

Staff interviewed generally felt positive and proud about working for the provider and their team.

Staff felt able to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process. However, there was no evidence that staff had used this process within the organisation to raise issues relating to patient care or other concerns. However, one whistle-blowing complaint had been raised with the Care Quality Commission in December 2019.

Managers had not always dealt with poor staff performance when needed and had not always sought advice from human resources when making key decisions.

Teams did not always work well together and where there were difficulties managers had not always dealt with issues appropriately. There were inconsistent processes to manage staff behaviour in relation to safeguarding concerns. We were given examples where some staff had been suspended, pending investigation, other staff had

been moved wards without internal investigation into allegations. Some staff had been managed through supervision discussions and others had been asked to attend training.

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

Staff reported that the provider had not always promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff described a split between staff from different ethnic minority backgrounds and a difference in the way staff were treated.

The service's level of staff turnover was higher than the provider's target. Leaders were not able to identify the reason for the high turnover of staff. However, staff sickness and absence were similar to the provider target.

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

The provider recognised staff success within the service – for example, through staff awards.

Governance

Systems to ensure that wards were safe were not effective. There was an increase in the number of safeguarding referrals and there were several concerns regarding staff attitudes and behaviours toward patients.

The provider did not have effective oversight of patient safety. Leaders had completed ligature risk assessments for each of the wards, however all staff were not aware of the content of these, the risks identified or required mitigation. Staff were therefore unable to identify areas of high risk on the ward in order to safely manage acutely unwell patients. The identification and mitigation of ligature risks was identified as a breach in the last inspection in December 2017.

Leaders had not ensured that patient risk assessments had been fully completed for all patients, or that risk assessments were updated following risk incidents. Staff were therefore unable to obtain and accurate, up to date picture of patient's presenting risks when reading current risk assessment documentation.

We found that there was a disconnect in communication between the senior management and front-line staff. Leaders had introduced structures, processes and systems of accountability for the performance of the service. However, not all staff at ward level were aware of these.

Staff at ward level were not aware of systems and processes to ensure effective communication from ward to board, and staff at all levels were not clear about their roles and accountabilities. However, managers told us that the service had a clear structure for governance between the ward and board. Managers shared documentation which evidenced how this should have worked in practice.

We identified a number of issues regarding the application of the Mental Health Act. Staff had not ensured that a section 58 certificate for consent to treatment was in place for two patients. One patient did not have a section 62 in place for urgent treatment and one medication had been administered to a patient without a second opinion being undertaken. Staff had not read all patients their rights under the Mental Health Act in a timely way. Some staff had a poor understanding of the Mental Capacity Act.

Staff were not aware of the recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. The framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was not effective. Staff were not therefore able to identify essential learning and changes in practice.

Staff undertook or participated in local clinical audits. However, the audits were not fully sufficient to provide assurance around the quality of records and application of the Mental Capacity Act.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients

Management of risk, issues and performance

Managers had not ensured that improvement notices identified from the Care Quality Commission inspection in December 2017 had been actioned and embedded into practice.

Staff on most wards did not have easy access to emergency alarms. However, staff of Kelmarsh and Lamport wards had been issued with emergency alarms. Patients had access to

nurse call alarms in their bedrooms and communal areas. Staff had not completed care plans which were holistic; recovery focused and reflects patients' views and strengths. Managers had not ensured that capacity assessments recorded the rationale for decision making. However, staff maintained and had access to the risk register at service level. Staff at ward level could escalate concerns when required via the deputy managers. Staff concerns matched those on the risk register. The service had plans for emergencies – for example, adverse weather or a flu outbreak.

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

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. A dashboard had been introduced to monitor key performance on all wards. Senior managers were able to take each area of performance and drill down into more detail and further analyse performance.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, all staff had not received adequate training to ensure that they were able to easily navigate the electronic patient record or incident reporting system.

Information governance systems included confidentiality of patient records.

Deputy team managers had access to information to support them with their management role. This included information on the performance of the service and staffing. However, deputy managers were not routinely involved in decisions regarding patient assessment for admission.

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

Engagement

Staff, patients and carers had access to information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and staff meetings. However, this information was not fully comprehensive. Patients and staff had not been informed about key plans for planned changes to the wards, including the admission of acute patients to the wards.

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

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

Patients and carers had not been involved in decision-making about changes to the service. This included recent redesign of services including building works.

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

Senior leaders engaged with external stakeholders, including commissioners, providers and the local authority.

Learning, continuous improvement and innovation

Staff were not given the time and support to consider opportunities for improvements and innovation and this led to changes.

The provider had received funding for research into polydipsia, where patients drink excessive amounts of fluids. Leaders had plans in place to appoint a research assistant to assist with this research.

Innovations were taking place in the service. Leaders had plans in place for career development. This included the introduction of apprenticeships, succession planning and bridging programmes to enable staff to access nurse training.

The provider had a number of quality improvement plans in place, including a six-monthly quality improvement report and quality improvement plan. Staff did not use quality improvement methods.

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

Wards did not participate in accreditation schemes relevant to the service.

The provider was in the process of implementing a two-year strategy for nurses and allied health professionals.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers plan as part of this strategy to undertake a range of initiatives including a redesign of the workforce, developing new models of care, promotion of the use of technology and to establish a training and development centre for the provider.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all ward areas are safe and clean. Regulation 15(1)(2).
- The provider must ensure that systems to ensure that wards remain safe are effective. Regulation 12(1)(2).
- The provider must ensure that there is a current and comprehensive ligature assessment and all staff are aware of ligature and blind spots and how to mitigate against these risks. Regulation 12(1)(2).
- The provider must ensure that medications are administered in line with local and national guidance, in line with legal requirements. Regulation 12(2).
- The provider must ensure compliance with the duty of candour requirement and that all staff are open and transparent. Regulation 20 (1).
- The provider must ensure that risk assessments and risk management plans are completed for every patient and that these are updated following every risk incident. Regulation 12(1)(2).
- The provider must ensure that the mandatory training for safeguarding adults and children are sufficient to support staff to have a clear understanding how to safeguard and protect patients from abuse. Regulation 13(1)(2)(3), 12(2).
- The provider must ensure that they check staff understanding and competence following safeguarding training. Regulation 13(2).
- The provider must ensure that staff had adequate training in order that that staff are able to access to locating key clinical documents on the electronic health record. Regulation 18(2).
- The provider must ensure that staff conduct patient observation in line with the provider's policy and that documentation is fully completed. Regulation 12(1)(2).
- The provider must ensure that staff have the range of skills needed to provide high quality care to the current patient group. Regulation 18(1)(2).
- The provider must ensure staff have knowledge and understanding of the needs and risks of patients to be able to safely care for them. Regulation 18(1)(2).
- The provider must ensure that lessons from incidents and complaints and any associated learning are shared. Regulation 12(2).
- The provider must ensure that all patients and staff are able to call for help in an emergency. Regulation 12(2).
- The provider must ensure that care plans are written with engagement of the patient, from the patient's perspective, which are recovery-oriented and comprehensive. Regulation 9(1)(3).
- The provider must ensure that managers deal with poor staff performance promptly, consistently and effectively. Regulation 12(2).
- The provider must ensure that they review their statement of purpose. Regulation 17(1)(2).
- The provider must ensure that they review their operational policy in order to fully reflect the needs of the patients with acute mental health needs. Regulation 17(1)(2).
- The provider must ensure that staff treat patients with compassion, respect and kindness. Regulation 10(1).
- The provider must ensure that patients have access to an interpreter in a timely manner. Regulation 10(1)(2).
- The provider must ensure that staff fully comply with requirements laid out in the Mental Health Act, including Mental Health Act recording and discharging duties under the Mental Health Act appropriately. Regulation 12(2).
- The provider must ensure that the mandatory training for the Mental Capacity Act is sufficient to support staff to have a clear understanding of Mental Capacity Act, and Deprivation of Liberty Safeguards and the implications for their practice. Regulation 18(2)
- The provider must ensure that staff record patient capacity to consent appropriately. Regulation 11(1)(2)
- The provider must ensure that patients and carers are fully informed and involved where appropriate in decisions about the service. Regulation 17(2)
- The provider must ensure that staff are made aware of communication processes in place from board to ward staff. Regulation 17(1)(2)
- The provider must ensure that the fit and proper person checks are fully undertaken for all Directors. Regulation 5(1)(2)(3)

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the provider be placed into special measures.

Outstanding practice and areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all wards have a manager in place to ensure that ward staff are fully supported, and that communication is effective. Regulation 18(1)
- The provider should ensure that when providing equipment to meet the needs of disabled patients' appropriate adjustments are made, in order to fully meet the patient's needs. Regulation 15(1)
- The provider should ensure that patients have access to food which meets their dietary needs. Regulation 14(1)(4)

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 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors • The provider had not ensured that the required fit and proper persons test for directors had been undertaken. **This was a breach of regulation 5.**

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 • Staff had not completed care plans for all patients which were comprehensive, recovery orientated or written from that patient's perspective. **This was a breach of regulation 9.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • Staff behaviour had not always met the values of the organisation. This included patient allegations of staff assaults, staff being abrupt, not being kind and mimicking patients. **This was a breach of regulation 10.**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • Staff did not have a clear understanding of Mental Capacity Act, and Deprivation of Liberty Safeguards and the implications for their practice. • Staff had not assessed and recorded capacity clearly, for all patients who might have impaired mental capacity. • Patients and carers were not fully informed about care and treatment or service decisions. • The provider had not accessed interpreters in a timely way for all patients. This was a breach of regulation 11.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose • Wards were not safe. There were blind spots and staff were not able to identify ligatures and their mitigation. • Risk assessments and risk management plans were not kept up to date for all patients or updated following every risk incident. • Patient observations had not always been undertaken in line with the providers policy. We found gaps in recording and a lack of staff signatures on documentation. • Staff were not able to identify lessons learned for their team or the wider service. • All staff did not have easy access to alarms. • Managers had not dealt with poor staff performance promptly, consistently and effectively.

This section is primarily information for the provider

Requirement notices

- The provider had not fully complied with the Mental Health Act, relating to authorisation for medications. We acknowledge that these have been rectified.
- The provider had not ensured that staff had fully complied with requirements laid out in the Mental Health Act, including Mental Health Act recording and discharging duties under the Mental Health Act appropriately.
- The provider had not ensured that the mandatory training for safeguarding adults and children, was sufficient to support staff to have a clear understanding how to safeguard and protect patients from abuse.

This was a breach of regulation 12.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The provider had not ensured that safeguarding training supported staff to have a clear understanding of how to safeguard and protect patients. • Staff were not able to fully evidence understanding following safeguarding training. This was a breach of regulation 13.

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 organisations operational policy and statement of purpose did not reflect the needs of the current client group.

This section is primarily information for the provider

Requirement notices

- The provider had not ensured there were effective communication processes in place from board to ward staff. This included communication of, incidents and learning lessons.
- The provider had not ensured that patients and carers were fully informed and involved where appropriate in decisions about the service.

This was a breach of regulation 17.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not ensured that staff had adequate training to ensure that staff had easy access to locating key clinical documents on the electronic health record. • Staff did not have the full range of knowledge and skills required to safely care for all patients on the wards. • The provider had not ensured that the mandatory training for the Mental Capacity Act was sufficient to support staff to have a clear understanding of Mental Capacity Act, and Deprivation of Liberty Safeguards and the implications for their practice. This was a breach of regulation 18.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour • The provider had not ensured that compliance with the duty of candour requirement and that all staff are open and transparent. This was a breach of regulation 20.

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 10 HSCA (RA) Regulations 2014 Dignity and respect **We have served an urgent notice of decision under section 31 of the Health and Social Care Act 2008.**

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 have served an urgent notice of decision under section 31 of the Health and Social Care Act 2008.**

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 **We have served an urgent notice of decision under section 31 of the Health and Social Care Act 2008.**

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 **We have served an urgent notice of decision under section 31 of the Health and Social Care Act 2008.**

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We have served an urgent notice of decision under section 31 of the Health and Social Care Act 2008.