Brighton & Hove Clinic

Quality Report

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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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.

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

Overall summary

We rated The Brighton and Hove Clinic as good because:

- The service was compliant with same sex accommodation guidance and separated male and female bedrooms and grouped these to achieve as much separation as possible. Staff told us that risk would outweigh gender separation and if a patient was assessed as high risk they would be put in a bedroom nearest to the nursing office. Additional staff could be arranged to nurse a patient in their own room if required, and all bedrooms were en-suite so patients did not have to pass other patients to use bathroom or toilet facilities.
- Staff completed thorough patient risk assessments at point of admission and reviewed these frequently throughout admission.
- The ward had a comprehensive safeguarding policy. Staff training rates for safeguarding were 97% for safeguarding adults training and 99% for safeguarding children training.
- Staff completed comprehensive and timely assessments of all patients when they were admitted. Patient care plans were holistic, recovery focused and personalised. Patients all had a copy of their care plan.
- Staff had regular supervision and annual appraisals were up to date. All staff had current disclosure and barring service checks. Staff whose check was due for renewal had all applied for their renewal in advance so there was no time that the service had staff working without full checks in place.
- Patients were very complimentary about the care they received and said they felt safe on the ward. Patients reported that staff always had time for them and activities or leave were rarely cancelled. Staff were responsive to individual patient needs.
- The ward had a full range of rooms suitable for patient use. All patient bedrooms had a safe for patients to store items, and patients were able to personalise their own bedroom. The communal lounge had a drinks machine which patients could use to get a hot drink at any time of day or night. Patients had access to an outside space on the ground floor and a first floor outside terrace.
- Staff reported that senior managers were a visible presence on the ward and they felt able to approach them if they had any issues. Staff reported a high degree of job satisfaction and motivation. We observed a supportive staff culture and a real sense of team working. Staff were passionate about their job and spoke highly of the management structure in place.
- The hospital had good governance systems in place. This was reflected in the high rates of mandatory training, supervision and staff appraisals.

However:

- The ward did not have paper copies of incident forms to use in the event of the electronic system not being available for use.
- Patients told us there was little in the way of structured activities at weekends, and no access to activities providing physical exercise.

Summary of findings

Contents

Good

Brighton & Hove Clinic

Services we looked at

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

Summary of this inspection

Background to Brighton & Hove Clinic

The Brighton and Hove Clinic is part of the Elysium Healthcare group. It had previously been part of The Priory Group until September 2016, and so this was the first inspection of the location under Elysium Healthcare. It is an independent provider of psychiatric care and therapy for patients with a range of mental health conditions including anxiety and depression as well as addictions. The hospital provides medical detoxification for the full range of substances including medically complicated detoxification and supports patients with their on going rehabilitation. The hospital is a single ward 18-bed mixed-gender unit. The service provides day care, outpatient and inpatient treatments, mainly for patients who fund their own treatment but also for some NHS patients.

The hospital is registered for the following regulated activities:

- Accommodation for persons who require treatment for substance misuse
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

There is a registered manager in place.

Our inspection team

Team leader: James Holloway, CQC inspector

The team that inspected the service comprised three CQC inspectors and one specialist professional advisor with experience working within in-patient mental health settings.

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 the the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with four patients who were using the service;
- looked at five patient care and treatment records;
- reviewed eight prescription charts
- spoke with the clinical services manager, medical director, support services manager and therapy services and enquiries manager;

Summary of this inspection

- spoke with eight other staff members; including ward doctor, nurses, healthcare assistants, therapists and pharmacist;
- spoke with support services staff including housekeeping and catering staff;
- attended and observed one multidisciplinary meeting;
- carried out a specific check of the medicine management on the ward;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us they felt safe and cared for on the ward. They said staff treated them with kindness and respect and showed a genuine interest in their wellbeing. Patients valued the fact staff had allocated time for them and appreciated the flexibility the two group programmes offered.

However, patients did report that there was a lack of structured activities at weekends and a lack of activities offering physical exercise.

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?

Good

We rated safe as good because:

- Staff showed a good awareness of risks and mitigated these by use of a minimum of hourly observations of all patients. Depending on the assessed risk staff would carry out more frequent visual observations. The service had a comprehensive ligature risk audit and accompanying action plan.
- The ward was compliant with same sex accommodation guidance and separated male and female bedrooms and grouped these to achieve as much separation as possible. Staff told us that if a patient was assessed as high risk they would be put in a bedroom nearest to the nursing office and these all offered ensuite bathrooms.
- The ward had a fully equipped clinic room which was clean and well maintained. All equipment was regularly checked and within date. Staff monitored the fridge temperatures in the clinic room and these were within the recommended range.
- Staff completed thorough patient risk assessments at point of admission and reviewed these frequently throughout admission. Risk assessments included self harm, neglect, risk to others historic and current.
- The ward had a comprehensive safeguarding policy. Staff training rates for safeguarding were 97% for safeguarding adults training and 99% for safeguarding children training.

However:

- The ward did not have paper copies of incident forms for staff to record on if an incident occurred when the electronic system was not available for use.
- Not all staff clearly understood definitions of restraint.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive and timely assessments of all patients when they were admitted. The ward doctor also completed full physical health checks and patient records showed evidence of on-going physical health monitoring. Patient care plans were holistic, recovery focused and personalised. Patients all had a copy of their care plan.
- The hospital offered two distinct treatment programmes on the ward. One was for patients with substance misuse issues or addictions, the other for patients with mental health issues.

Summary of this inspection

Within these programmes the hospital offered two types of groups including therapy groups and less intense wellbeing groups. Patients could be flexible and move between the two programmes.

- Patients had good access to physical healthcare as a doctor lived on site, giving access to medical care 24 hours a day, seven days a week.
- Staff had regular supervision and annual appraisals were up to date. All staff had current disclosure and barring service checks. Staff whose check was due for renewal had all applied for their renewal in advance so there was no time that the service had staff working without full checks in place.
- Mandatory training rates for Mental Health Act training were 97% and staff demonstrated a good understanding of the legislation. Staff completed Mental Capacity Act training as part of their mandatory training. Staff training rates were 94% compliant. Advocacy was available to all patients and we saw evidence of staff requesting advocacy for detained patients.

Are services caring?

Good

We rated caring as good because:

- Patients were very complimentary about the care they received and said they felt safe on the ward.
- Patients reported that staff always had time for them and activities or leave were rarely cancelled. Staff were responsive to individual patient needs.
- We reviewed five patient care records which all showed evidence of patient involvement in care planning. Patients could attend a weekly community meeting chaired by the hospital director to raise any issues or concerns they had.
- Staff gave patients an induction pack on admission to the ward. This gave the patients information on mealtimes, ward routines, available therapy groups, details of advocacy and how to make a complaint.
- Patients were given the opportunity to discuss their on-going care and treatment at the hospital at the twice weekly consultant ward round.

Are services responsive?

Good

We rated responsive as good because:

- Admissions were managed at an appropriate time of day. Patients were required to present for admission before 2pm,

Summary of this inspection

unless otherwise planned and staff were aware of the admission. Staff liaised with external support agencies and families to ensure patients were discharged in an appropriate manner.

- The ward had a full range of rooms suitable for patient use. All patient bedrooms had a safe for patients to store items, and patients were able to personalise their own bedroom.
- The communal lounge had a drinks machine which patients could use to get a hot drink at any time of day or night. Patients had access to an outside space on the ground floor and a first floor outside terrace.
- Patients reported that food was of good quality and varied. There was always a vegetarian option and dietary requirements could be catered for depending on spiritual or allergy needs. The hospital chef ensured they had an up to date list of all patient requirements.
- Staff could support patients to attend local religious centres if requested and they had access to interpreter services if needed.

However:

- Patients told us there was little in the way of structured activities at weekends, and no access to activities providing physical exercise.

Are services well-led?

Good

We rated well led as good because:

- Staff reported that senior managers were a visible presence on the ward and they felt able to approach them if they had any issues. Staff knew the values of the new organisation and this was reflected in the way they interacted with patients on the ward.
- The hospital had good governance systems in place. This was reflected in the high rates of mandatory training, supervision and staff appraisals.
- Staffing rotas showed that there were always sufficient numbers of staff on each shift. The clinical services manager had flexibility in using healthcare assistants to ensure there were always appropriate numbers on duty.
- The working relationship between the pharmacy and the ward continued to develop ensuring ward staff and the pharmacy team had simultaneous computer access to the same information.
- Staff reported a high degree of job satisfaction and motivation. We observed a supportive staff culture and a real sense of team working. Staff were passionate about their job and spoke highly of the management structure in place.

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.

- Mandatory training rates for Mental Health Act training were 97% and staff demonstrated a good understanding of the legislation.
- Informal patients were made aware of their right to leave the ward at any time.
- Mental Health Act paperwork was all securely stored and correctly completed. Staff had clearly completed capacity to consent to treatment documentation in all patient files.
- Staff had links with the local authority approved mental health professional service and knew the process for requesting a Mental Health Act assessment.
- Advocacy was available to all patients and we saw evidence of staff requesting advocacy for detained patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed Mental Capacity Act training as part of their mandatory training. Staff training rates were 94% compliant.
- At the time of the inspection no patients were subject to an authorised Deprivation of Liberty Safeguard, although staff demonstrated an understanding of when this would be appropriate.
- Staff would not ask a patient who they assessed as lacking capacity through intoxication to sign a consent to treatment form as they would not understand what they were agreeing to. Staff showed an understanding of the principles of capacity and consent, and always presumed capacity unless they had reason to question this, in accordance with the Mental Capacity Act.

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

Good

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

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Good

Safe and clean environment

- The ward was laid out over two levels. The upper floor had patient bedrooms and two staff offices. The lower floor had patient bedrooms, nursing office, laundry, art room, communal areas and kitchen. There was also a women's only lounge. All the bedrooms on both floors were en-suite. The hospital dining room, staff offices and consulting and therapy rooms were situated on the ground floor.
- Due to the ward layout there were numerous blind spots within the ward and not all bedrooms were visible from the nursing office. Staff showed a good awareness of this and risks were mitigated by use of a minimum of hourly observations of all patients. Depending on the assessed risk staff would carry out more frequent visual observations.
- There were potential ligature points throughout the service. The service had a comprehensive ligature risk audit and accompanying action plan. There were on going refurbishments to reduce ligature risks and some bedrooms had ligature free taps whilst all had collapsible shower curtains and window curtain rails. Electrical items with cords such as bedside lamps, television and telephone were removed from the bedrooms when a patient was admitted. If the patient was assessed as low risk of self harm then these would be returned to the bedroom. Ligature cutters were easily accessible in the nursing office.
- Staff separated male and female patients to ensure compliance with guidance on same sex accommodation. This practice did mean that patients could be moved within the ward at times to maintain gender separation. All patient bedrooms were en-suite so no patients had to walk past patients of the opposite sex to use bathroom or toilet facilities. Staff told patients when they were admitted that they may need to move bedrooms during their admission. Staff told us that risk would outweigh gender separation and if a patient was assessed as high risk they would be put in a bedroom nearest to the nursing office. The ward had two bedrooms directly opposite the nursing office, which would be used for patients assessed as higher risk. Staff would re-zone the ward to ensure a suitable gender mix as necessary. Additional staff could also be used to provide nursing to a patient in their room if required.
- The ward had a fully equipped clinic room which was clean and well maintained. All equipment was regularly checked and within date. Emergency medicines were kept securely and staff completed regular stock checks. Staff monitored the fridge temperatures in the clinic room and these were within the recommended range. This ensured that patients medicine was stored at the correct temperature to maintain their effectiveness.
- All patient bedrooms had emergency call buttons so patients could alert nursing staff in case of an emergency.

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

Good

- The ward areas were kept clean by housekeeping staff. Housekeeping staff maintained cleaning records and took part in regular audits to ensure on going health and safety was maintained.
- The ward had an infection control nurse specialist who showed us records of infection control measures and regular audits.

Safe staffing

- The service had recently recruited two nurses who were due to start in April 2017. There remained one part time nurse vacancy, although interviews had been arranged. The ward had no healthcare assistant vacancies at the time of the inspection.
- Staff worked a two shift pattern of 7.30am – 8pm and 7.30pm – 8am. This allowed for a 30 minute handover between staff at the start of each shift. On each shift there were two qualified nurses and between one and three healthcare assistants. The number of healthcare assistants would depend on the number of patients on the ward. For up to nine patients there would be one healthcare assistant, between 10 and 13 patients there would be two and for 14 or more patients a third healthcare assistant would work a twilight shift of 2pm – 10pm.
- Use of agency staff had reduced from 22 shifts being covered with agency staff in October 2016 to one shift in February 2017. When agency staff were used staff used the same agency to ensure continuity and consistency. The agency staff got to know and understand the ward policies and procedures.
- In addition to nursing staff the service employed a range of therapists including psychotherapists, cognitive behavioural therapists and specialists in addictions.
- Patients reported that one to one time with their named nurse was rarely, if ever, cancelled and there were always enough staff to facilitate groups or activities outside of the ward.

Assessing and managing risk to patients and staff

- All patients on the ward were on a minimum of hourly observation checks. If nursing staff assessed at any time that the risk had increased then they could increase the level of observation. For a patient's observation levels to be reduced this would need a full multidisciplinary team agreement discussion and could only be agreed with the consultant's approval. This ensured that staff could increase patient observations levels quickly to reduce risk. Patients could not be moved to the upper level of the ward without discussion and consultant agreement. The ward did not have a seclusion room.
- Staff completed thorough patient risk assessments at point of admission and reviewed these frequently throughout admission. Risk assessments included self harm, neglect, risk to others historic and current. The service was clear in that it would not accept patients they considered were too high a risk considering the layout of the ward with blind spots and potential ligature points.
- All staff were aware of the potential ligature points and the associated risks. The clinical services manager completed regular ligature and blind spot risk audits and shared these with the staff team at monthly governance meetings.
- Staff used restraint on patients very rarely. Not all staff, however, clearly understood the definition of restraint and so incidents of gently guiding a patient were not always considered to be formal restraints, and not recorded as such. Between October 2016 and February 2017 there had been no recorded incidents of patient restraint, however staff had used restraint four times in March 2017 on the same patient. Staff had recorded this appropriately in patient notes and on incident forms on all but one occasion. On one occasion at a weekend the electronic recording system was not available and so staff did not complete the incident notification until the Monday. This meant that the record was not contemporaneous to the incident.
- The ward had a comprehensive safeguarding policy which made reference to the six safeguarding principles outlined in the Care Act 2014. The service had safeguarding leads within the senior management team and nursing teams. Staff training rates for safeguarding were 97% for safeguarding adults training and 99% for safeguarding children training. At the time of inspection there were six incidents on the service safeguarding log, of which five had local authority involvement from the children and families team. The other incident was of historical abuse. Staff demonstrated a good awareness of safeguarding and the service had good links with the local authority.
- The service had direct on-line access to pharmacy support in real time. The pharmacist from the local pharmacy visited the ward at least weekly to check

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

Good

patient prescription charts and medicine stock levels. The pharmacist completed regular medication audits and provided training to ward staff every three months. The pharmacy service delivered medicine twice daily to the ward. At the time of the inspection no patients were on high dose anti-psychotic medicines, although we were shown a comprehensive protocol for when this may be needed.

- Informal patients told us they knew they could leave the ward. This was reiterated at the weekly community meeting so informal patients were aware of their rights. Staff on the ward would notify reception staff that a patient wished to leave and so when the patient got to reception staff there would unlock the door.
- The ward did not have a designated family room, although therapy rooms could be booked out to accommodate family visits. Children did not go into communal areas on the ward, but staff would make arrangements for children to visit on an individual basis.

Track record on safety

- Data from the hospital showed no serious incidents occurred on the ward in the six months prior to the inspection.

Reporting incidents and learning from when things go wrong

- All staff had access to the electronic reporting system. Staff witness to any incident would complete the form before they sent this to the clinical services manager to review. Part of the review process included lessons learnt, which the senior management team would discuss at monthly governance meetings. Outcomes from these lessons would be passed on to the ward staff via emails and ward meetings.
- Staff practice had changed regarding accepting admissions to the addictions therapy programme as a result of incidents of patients arriving at the hospital intoxicated in the evening and at night. This had put night staff at potential risk, and also they were having to refuse admission to patients who would not be able consent to an admission or treatment plan. Patients due to be admitted were asked to arrive before 2pm for admission. If they arrived after this time staff asked them to come back the following day.
- Staff followed the hospital duty of candour policy and were open and transparent in discussing incidents with patients. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We looked at five patient care records which all showed staff had completed comprehensive and timely assessments of patients at point of admission.
- Staff completed physical health monitoring and the ward doctor completed a full physical health check for all patients when they were admitted. The physical health check included height, weight, electro-cardiogram, blood tests and a urine dip stick to screen for substances or infections. Patient records showed evidence of on-going physical health monitoring
- All patient care records contained up to date, holistic, personalised and recovery focused care plans. Care plans were developed with nursing staff and staff from the therapy team to ensure the appropriate programme was developed for each individual patient.
- Care plans were stored in electronic records. The move from Priory systems to Elysium had caused some issues with staff having to log on to multiple systems to record notes, but these had not resulted in any loss of patient information. Governance structures were in place to ensure a smooth transition.

Best practice in treatment and care

- The hospital offered two distinct treatment programmes on the ward. One was for patient with substance misuse issues or addictions, the other for patient with mental health issues. Both programmes used a combination of goal setting and cognitive behavioural therapy, relaxation and mindfulness. The two programmes were

complimentary and there was some overlap so patients on the addictions treatment programme could access groups in the general psychiatry programme and vice versa.
- The hospital also offered type two wellbeing groups, such as cooking, creativity and art for those patients who were not yet ready to join a full therapy group. Patients could also be flexible in their programme so they could join a combination of type one therapy groups, or less intensive wellbeing groups.
- Some of the therapists had training in specialist therapeutic interventions such as eye movement desensitisation and reprocessing, a research proven technique in trauma therapy.
- Patients had good access to physical healthcare as a doctor lived on site giving access to medical care 24 hours a day, seven days a week. The service had one doctor who covered this role for two weeks at a time, the service used locum doctors to cover the other two weeks.
- We reviewed eight medication charts, which all showed evidence of following National Institute of Health and Care Excellence guidance in prescribing medicine. This ensured that all medicines were prescribed within approved limits to enable best possible patient outcomes.
- Staff undertook clinical audits to ensure practice was up to date and effective, for example in medicine dispensing.

Skilled staff to deliver care

- Staff at the hospital came from various different backgrounds. The staff team included nurses, healthcare assistants, therapists, consultant psychiatrists and housekeeping staff. The pharmacist also visited at least weekly.
- Staff were encouraged to work with other disciplines and we were told of healthcare assistants with an interest in therapy being given opportunities to work alongside the therapy team to gain experience.
- Staff supported each other through peer supervision. We saw evidence that this was happening regularly in line with the policy of four weekly for full time staff and every two months for part time staff.
- Annual staff appraisals took place every March. These were up to date for all staff. All staff had access to regular team meetings.
- All staff had current disclosure and barring service checks. Staff whose check was due for renewal had all applied for their renewal in advance so there was no time that the service had staff working without full checks in place.
- Staff received mandatory training in 18 core subjects, including infection control, Mental Capacity Act, safe handling of medicines and fire safety. Training rates across all mandatory subjects for the service were 92%, which was above the target of 90% compliance.
- New staff received a full induction to include training in policies and processes such as information governance, data protection as well as including a medical questionnaire and evidence of any professional registrations.

Multidisciplinary and interagency team work

- We attended one multidisciplinary planning meeting, which took place every morning. Members of the senior management team and therapy team attended. Staff discussed the plan of the day, any planned admissions or discharges and nursing staff updated the meeting from the morning shift handover. Discussions were patient centred and comprehensive ensuring all members of the team were aware of patient risk and planned activity.
- There was a 30 minute handover from staff at the start of each shift to update the oncoming staff of any incidents, risks or planned patient activity. We saw minutes of these handovers which were thorough and detailed.
- The ward consultants held twice weekly ward rounds to discuss patients. Patients could invite their family or carers to these meetings. Staff from external support agencies could also attend, which was particularly useful to discharge to ensure a continuity of care.
- Staff had good working relationships with external agencies such as the local authority and local NHS trust. Staff from the ward liaised with staff from the NHS trust crisis service often when discussing potential admissions. Staff also liaised with authorities throughout the country as patient could potentially come from any area. We saw evidence of clear communication with safeguarding authorities in other areas.

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

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

Good

- Mandatory training rates for Mental Health Act training were 97% and staff demonstrated a good understanding of the legislation.
- Informal patients were made aware of their right to leave the ward at any time.
- Mental Health Act paperwork was all securely stored and correctly completed. Staff had clearly completed capacity to consent to treatment documentation in all patient files.
- Staff had links with the local authority approved mental health professional service and knew the process for requesting a Mental Health Act assessment.
- Advocacy was available to all patients and we saw evidence of staff requesting advocacy for detained patients.

Good practice in applying the Mental Capacity Act

- Staff completed Mental Capacity Act training as part of their mandatory training. Staff training rates were 94% compliant.
- At the time of the inspection no patients were subject to an authorised Deprivation of Liberty Safeguard, although staff knew when this would be appropriate.
- Staff would not ask a patient who they assessed as lacking capacity through intoxication to sign a consent to treatment form as they would not understand what they were agreeing to. Staff showed an understanding of the principles of capacity and consent, and always presumed capacity unless they had reason to question this, in accordance with the Mental Capacity Act.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, dignity, respect and support

- Patients were very complimentary about the care they received. They told us that staff treated them with kindness, dignity and respect. Patients felt safe on the ward.
- Patients reported that staff always had time for them and activities or leave were rarely cancelled. Staff showed a genuine interest in the patients and concern for their wellbeing.
- Staff were responsive to individual patient needs. Patients told us that staff were courteous when completing observation checks and would increase the checks to suit the patient, if this gave them a greater sense of security.
- Staff had time to support patients with activities outside the ward. We were told of a healthcare assistant who had been able to support a patient make travel arrangements, such as visits to travel agents, to receive follow up care abroad.

The involvement of people in the care they receive

- We reviewed five patient care records which all showed evidence of patient involvement in care planning. Patients had copies of their care plan.
- Patients could attend a weekly community meeting chaired by the hospital director to raise any issues or concerns they had. Staff took minutes at this meeting which also showed a record of actions taken as a result of patients' comments.
- Consultants on the ward held twice weekly ward rounds which patients were invited to attend. Patients were given the opportunity to discuss their on-going care and treatment at the hospital. Carers were also invited to these ward rounds. This gave carers the opportunity to ask how to support the patient when they were discharged and have involvement in care planning.
- Staff gave patients an induction pack on admission to the ward. This gave the patients information on mealtimes, ward routines, available therapy groups, details of advocacy and how to make a complaint.
- Patients could see who their named nurse was for the shift on a board outside the nursing station. Nurses could also use this board to alert patients of messages or correspondence.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

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

Good

- The hospital was registered for 18 patient beds. At the time of our inspection there were eight patients on the ward. The patient numbers changed frequently; during our inspection one patient was discharged and there was an admission planned.
- The average length of stay during the previous six months was 18 days.
- Patients could self refer to the hospital. The hospital also received referrals from GPs, NHS trusts (the local trust and also out of area placements) and internal referrals through the consultant's out-patient appointments.
- Staff allocated bedrooms based on gender and risk. Staff informed patients when they were admitted that they may have to move rooms during their admission, although staff avoided this if possible. Patients were not moved unless on grounds of risk or to maintain the appropriate gender zoning.
- Admissions were managed at an appropriate time of day. Patients were required to present for admission before 2pm, unless otherwise planned and staff were aware of the admission. Staff liaised with external support agencies and families to ensure patients were discharged in an appropriate manner.
- Staff had no issues with delayed discharges and there had been none in the previous six months.

The facilities promote recovery, comfort and dignity and confidentiality

- The ward had a full range of rooms suitable for patient use, including a well-equipped clinic room, an art room, female only lounge, communal areas and rooms that could be used for patients to have individual time with their named nurse to maintain confidentiality.
- All patient bedrooms had a safe for patients to store items. There was also a safe in the nurses office if patients would rather staff held on to any valuable items. Staff had a system in place for patients and staff to sign if these items were removed. All patients on the addictions treatment programme had to give in their mobile phone when they were admitted and these were kept in the ward safe. Patients signed to say they consented to this.
- There was a ward telephone, although this was not in a private space. Staff reported that patients who had access to their own phone used these, and patients without access to their phone could use the staff phone if appropriate.
- Patients were able personalise their bedrooms if they wished. All bedrooms were well decorated and had paintings on the wall. The ward was well maintained and decorated with paintings and photographs of the local area hung on the walls.
- The communal lounge had a drinks machine which patients could use to get a hot drink at any time of day or night. The ward also had a kitchen for patient use to make snacks.
- Patients had access to an outside space on the ground floor and a first floor outside terrace.
- The therapy team ran a full programme of therapy and groups during the day. There were some weekend activities, although some patients told us that there was often not much to do at weekends. Patients also told us they would like some form of exercise equipment to be available for use as there was little in the way of physical exercise offered.

Meeting the needs of all people who use the service

- The hospital was based in a Victorian grade II listed building and was not compliant with the Equality Act 2010 on accessibility. There was a working lift for patients with limited mobility, although the ward would not be able to accommodate wheelchair users.
- Staff gave patients information on local services, advocacy, how to make a complaint and treatment options and information when they were admitted to the ward. This could be provided in different formats including easy read if required.
- Patients had a choice of food options for all meals throughout the day. Patients reported that food was of good quality and varied. There was always a vegetarian option and dietary requirements could be catered for depending on spiritual or allergy needs. The hospital chef ensured they had an up to date list of all patient requirements.
- Staff could support patients to attend local religious centres if requested. At individual patients requests staff had also arranged for members of local religious groups to attend the hospital.
- Staff had access to interpreter services if needed.

Listening to and learning from complaints

- Patients we spoke with told us they knew how to make a complaint. Staff would try and resolve complaints as

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

Good

they came in so they would not need escalating. The hospital director chaired the weekly community meeting and would attempt to resolve any issues during this forum.

- At the time of the inspection there were no on-going complaints issues and no formal complaints had been raised in the previous six months.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Vision and values

- Staff reported that senior managers were a visible presence on the ward and they felt able to approach them if they had any issues. Staff felt valued by this, which contributed to the overall teamwork approach of the hospital.
- Staff were fully aware of the transition to Elysium Healthcare and knew the core values of the new provider. Staff felt informed during this transition phase and felt that senior management kept them up to date. Staff knew the values of the new organisation and this was reflected in the way they interacted with patients on the ward.

Good governance

- The hospital had good governance systems in place. This was reflected in the high rates of mandatory training, supervision and staff appraisals. Staff knew of the hospital's incident reporting process and any lessons learnt were shared with the wider staff team.
- Staffing rotas showed that there were always sufficient numbers of staff on each shift. The clinical services manager had flexibility in using healthcare assistants to ensure there were always appropriate numbers on duty.
- The ward had good administration support from the ward clerk, Mental Health Act and human resources administrator and from the reception team. The various support teams all worked collaboratively with the clinical staff.
- Staff could submit items to the hospital risk register if they felt appropriate. The clinical governance meeting would discuss the risk register and apply a risk rating to each item. This was shared in team meetings to ensure the wider staff team were aware of any potential risk within the hospital.

Leadership, morale and staff engagement

- Staff reported a high degree of job satisfaction and motivation. We observed a supportive staff culture and a real sense of team working.
- Staff had the opportunity for career progression and development, such as healthcare assistants spending time with the therapy team to develop skills and knowledge.
- Staff were passionate about their job and spoke highly of the management structure in place.
- Staff reported they had not much involvement in the transition to Elysium Healthcare, but felt that there was an opportunity for service development. Staff felt confident they would be involved in service developments.
- We observed an open culture in which staff reported they felt able to raise any concerns or issues without fear of recriminations or victimisation.

Commitment to quality improvement and innovation

- The clinical services manager had started to invite members of nursing staff to attend the monthly clinical governance meeting. This was to give members of the nursing staff an idea of how and why certain decisions were made, and gave the nursing staff a greater sense of involvement in the running of the hospital.
- Nursing staff along with the clinical services manager participated in the ligature and blind spot audit, which gave nursing staff the opportunity to learn more about ligature awareness and mitigation.
- The working relationship between the pharmacy and the ward continued to develop ensuring ward staff and the pharmacy team could hold real time conversations as they could both access patient information simultaneously. This system reduced the likelihood of medicines running out of stock or not being available to staff.
- The ward was not participating in any accreditation schemes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that nursing staff have paper copies of incident reporting forms in the event of the electronic reporting system not working, to ensure reports are written contemporaneously.
- The provider should ensure that there is a more structured programme of weekend activites for patients.
- The provider should ensure that staff on all wards have a clear understanding of defintions of restraint.