Elysium Healthcare Limited

The Woodmill

Inspection report

Exeter Road
Cullompton
EX15 1EA
Tel:
www.elysiumhealthcare.co.uk

Date of inspection visit: 21 June 2023
Date of publication: 20/09/2023

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

Ratings

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

Summary of findings

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	Good 	We carried out a comprehensive inspection of The Woodmill Hospital as the service has not previously been inspected. The Woodmill Hospital is in Cullompton and is a rehabilitation service for women with complex emotional and mental health needs who may have a secondary diagnosis of autism and/or mild learning disability and/or disordered eating. We rated this service as good because: • The service had enough nursing and medical staff who knew the patients well and received training to keep patients safe. While there were some staff vacancies, all shifts had been covered by either bank or agency staff. Staff understood how to protect patients from abuse, and the service worked well with other agencies to do so. • Patients were supported by staff who managed risks well. Staff followed best practice in anticipating, de-escalating, and manages behaviours where patients' place themselves or others at risk of harm. They minimised the risk of restrictive practices and managed medicines safely. • Staff developed holistic, recovery-orientated care plans informed by a comprehensive assessment. These were reviewed and updated as needed. Patients were supported in a range of treatments suitable to their needs and cared for in line with best practice and national guidance. Staff engaged in clinical audits to evaluate the quality of care provided. • The ward team included or had access to the full range of specialists required to meet the needs of patients. • The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Summary of findings

- Managers ensured they had staff with the range of skills needed to provide high quality care. They supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them. Staff helped patients with communication, advocacy, cultural and spiritual support.
- Patients were treated with compassion and kindness. Staff respected patients' privacy and dignity. They understood patients' individual needs and supported them to understand and manage their care, treatment, or condition. Staff planned and managed discharges. They liaised well with services that would provide aftercare. Staff did not discharge patients before they were ready and ensured they did not stay longer than needed.Leaders had the skills, knowledge, and experience to perform their roles. They understood the service they managed well and were visible and approachable for patients and staff.Staff felt respected, supported, and valued. They said the service promoted equality and diversity and provided opportunities for development and career progression. They could raise any concerns without fear of retribution.

However:
Checks were not always carried out in the activities of daily living kitchen area to ensure its cleanliness was being monitored.

Summary of findings

Contents

Summary of this inspection — Page

Background to The Woodmill — 6

Our findings from this inspection

Overview of ratings — 7

Our findings by main service — 8

Summary of this inspection

Background to The Woodmill

The Woodmill Hospital is part of Elysium Healthcare and has been open since 2022. The 18 bed unit creates a pathway for patients to step down through their recovery. Ivy is a 6 bed admission area and Rose is a 12 bed rehabilitation area.

The aim of the service is to support women to improve their self-worth, build a better quality of life for themselves and to equip them with the skills needed for community living and increased independence.

At the time of the inspection there were 10 patients using the service, all using Rose ward.

The service is registered for the following activities:

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

There was a registered manager in post at the time of this inspection.

What people who use the service say

Patients who use the service stated they feel treated with kindness, compassion, dignity and respect. Patients felt staff supported them and felt listened to.

One patient stated, “They couldn’t ask for a better ward to be on”.

Patients stated they liked the large bedrooms with double beds; some patients had personalised their bedrooms with support from staff.

Patients said they felt involved in their care plans and staff informed them of their legal position as well as having access to regular advocacy services.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that appropriate checks are conducted, recorded, and actioned within the activities of daily living area.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Good

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

Is the service safe?

Good

We rated it as good.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We saw up to date environmental, fire, health and safety and infection control risk assessments.

The wards were well ventilated, and patients had access to the kitchen, occupational therapy room and dining area. Patients had access to multiple garden areas through communal and activity rooms. One garden area had a large shelter with seating for patients who smoked or used vapes.

There was no mixed sex accommodation. This was a female only hospital. All patients had bedrooms with en-suite facilities and storage for patients' personal possessions.

Patients could make phone calls in private.

The service had mitigated the risks of potential ligature points throughout the wards to keep patients safe. Staff completed environmental risk assessments that identified ligature risks. Staff had access to ligature cutters.

There were lounges and dining areas where patients could meet and chat. Staff undertook observations on corridors to ensure they minimised risks where they could not easily observe patients.

Staff took steps to mitigate potential blind spots on the wards; this included the installation of convex mirrors. There was close circuit television (CCTV) in place. Staff informed us that the CCTV footage was only used to aid the investigation of specific incidents; only the hospital director and regional operations manager could access the footage.

Staff had easy access to alarms, and patients had easy access to nurse call systems. Alarms were tested on a regular basis.

Long stay or rehabilitation mental health wards for working age adults

Good

Maintenance, cleanliness and infection control

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

Cleaning records had been updated in line with the standards, and housekeeping staff made sure the premises were clean. Managers routinely monitored cleaning records to confirm they were up to date and regularly audited.

Staff followed infection control policy, including handwashing. Antibacterial hand gels were available in ward areas. Infection control audits were up to date and did not highlight any issues or concerns. However, the environmental checklist within the activities of daily living area was not regularly completed.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs. The clinic room contained all the necessary equipment required. All emergency drugs were in date and accounted for.

Staff checked, maintained, and cleaned equipment. All equipment had been calibrated and checked as per the manufacturer's instructions. Regular cleaning audits were in place for the clinic rooms and equipment, and there was evidence of actions being completed. However, the lock on the medication fridge was not functional, which meant it could still be opened when it was locked. This was highlighted to the registered manager, who ordered a new fridge as a replacement within 24hrs and we saw evidence this had arrived following the inspection.

Safe staffing

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

Nursing staff

The service used enough nursing and support staff to keep patients safe. Staffing levels were adjusted according to the needs of the patients. During our inspection, we saw additional staff on duty to facilitate enhanced observations for patients who needed it.

Managers accurately calculated and reviewed the number and grades of nurses, nursing assistants and healthcare assistants for each shift. Staffing rotas seen did not identify any gaps in staffing numbers. Agency staff familiar with the service were regularly required to fill gaps. The documentation we reviewed showed that the services safe staffing numbers had been consistently met during the previous 6 months.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We spoke with agency staff, who confirmed they had received an induction before starting their shift.

Managers supported staff who needed time off for ill health.

Levels of sickness were low. Patients had regular one to one sessions with their named nurse and psychologist.

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

Staff shared key information to keep patients safe when handing over their care to others. Risk assessment documents were updated following any incident. There were multidisciplinary team meetings and staff handovers where changes to risk were shared with staff. Handover documents we reviewed were comprehensive and clearly explained current risks, section status, leave arrangements and specific staffing arrangements.

Long stay or rehabilitation mental health wards for working age adults

Good

Medical staff

A doctor was available to go to the ward quickly in an emergency. The service had an on call rota for medical cover that worked across local Elysium hospitals.

The service had a consultant psychiatrist that worked three days a week. The wards had access to an associate specialist. GP's visited the service weekly to review physical health needs.

Medical staff had completed mandatory training and were up to date with their supervision and appraisals.

Managers could call locums when they needed additional medical cover and made sure they had an induction and understood the service before starting their shift.

Mandatory training

Staff completed and kept up to date with their mandatory training. It was noted there were training courses scheduled in the week following our inspection. Training was delivered through online and face to face sessions.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Across the service, over 90% of staff had completed their mandatory training, which included basic life support, immediate life support and prevention and management of violence and aggression (PMVA). Staff also completed Oliver McGowan training to enhance their understanding of working with people with a learning disability and Autism.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers could book and arrange training when required. Staff were aware of what training was required of them and were prompted to attend training when available.

Assessing and managing risk to patients and staff

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

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed three patients' records and found staff had completed the Short-Term Assessment of Risk and Treatability (START) assessment. This is a concise clinical guide used to evaluate a patient's level of risk for aggression and likelihood of responding well to treatment. We saw the START risk assessments were detailed and up to date.

Daily morning and evening handover meetings where all aspects of the patient's welfare and risks were discussed. Any changes were updated, which ensured staff had the most up to date information to support the needs of the patients.

Staff reviewed all new admissions and would only accept patients when safe to do so.

Staff were trained in managing conflict. Staff told us they knew the patients well and could intervene at the earliest point. The wards did not currently have a seclusion or de-escalation area. However, there is an 'extra support area'

comprising of a bedroom, ensuite and outdoor area that has not yet been used. This area has not had it's intended use defined within a policy yet; the manager stated she would like the area to be used instead of transferring patients to other another hospital more suited to managing patients more acutely unwell when theses presentations are only short term.

Management of patient risk

Staff knew each patient's risks and acted to prevent or reduce risks. Care records identified each patients' risk, and staff we spoke with knew the patients well.

Patients were individually assessed to see if they required enhanced observation from staff to help keep them safe. The service reviewed its enhanced observation process at daily morning meetings.

Staff followed organisational policies and procedures when searching patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were generally low.

Staff participated in the provider's restrictive intervention reduction programme, meeting best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We reviewed the service's records for restraint and found no issues or concerns.

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

Staff followed the National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We reviewed documentation of patients who had received rapid tranquillisation and found all observations, times, and patient's general mood states were noted with no discrepancies.

The service did not use long term segregation or seclusion.

Where restrictions were in place, the provider attempted to mitigate the impact on patients. For example, patients were asked not to use their mobile phones in communal areas around other patients. Staff said this prevented escalation of agitation when patients suffered from heightened states of paranoia.

Safeguarding

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

Staff received training on how to recognise and report abuse appropriate for their role. Staff had received safeguarding level 3 training for adults and children; compliance was 91% across all staff groups. The registered manager and social worker had effective oversight of safeguarding issues.

Staff could give clear examples of protecting patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood what would be classified as a safeguarding concern. Staff had access to a safeguarding policy to follow for guidance.

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

There was a separate visiting room available off the main wards and the team worked with families when arranging visits.

The registered manager and social worker reviewed all safeguarding concerns and ensured these were discussed with staff to ensure lessons were learnt. The regional operations manager had oversight of all safeguarding concerns and confirmed that staff reported safeguarding concerns appropriately.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Information relating to patient care was stored across multiple electronic record keeping systems. During the inspection, we reviewed three care records. Information was easy to access and relevant to patient care, such as risk assessments, care plans, and patients' physical health were available.

Consent to share information was sought on admission and was well documented in patient records. We saw examples of staff revisiting this with patients.

The psychologist would upload relevant information onto the patient's electronic record system and give verbal handovers to nurses on patients where psychology sessions had been difficult.

Patient record audits were conducted. Leaders undertook documentation checks and, where required, could request that changes be made.

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

Records were stored securely

Medicines management

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

Staff kept clear records in relation to each patient's medicines. Medicine administration records were in good order. Stock levels were good, with no over ordering. Controlled drug recordings were all up to date and signed with no omissions. There were both doctor's and nurses signature lists.

Consent and capacity forms were clearly written and in the medicine folder.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed the medicines administration records for five patients and found medicines had been administered in line with individual care plans. Patient's prescriptions were within British National Formulary (BNF) limits.

Staff reviewed each patient's medicines regularly and advised patients and carers about their medicines. Staff reviewed the effects of each patient's medicines on their physical health in line with NICE guidance.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff learned from safety alerts and incidents to improve practice.

The external pharmacist visited weekly. During their visits, the pharmacist checked that the drug charts were completed where applicable, controlled drugs audits, and reported any incidences found.

The service carried out weekly audits of stock. Patients' Mental Health Act (MHA) status had been correctly updated. We found no issues with the T2 (treatment requiring consent or a second opinion) or the T3 (treatment where the patient lacks the mental capacity to consent or the responsible clinician believes the patient has capacity to consent but is refusing) documentation. All records were up to date and easily accessible.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff could highlight any concerns with drowsiness or other side-effects to the consultant during their visits or at the daily morning meeting.

During our inspection, we saw the lock on the clinic fridge did not work; we escalated this to leaders. They responded to this by ordering a new fridge as a replacement within 24hrs. This fridge did not contain controlled drugs.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

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

Incident reports were thorough and well written. Managers shared learning in staff meetings and minutes were available for people who could not attend.

The service recorded all incidents using an electronic incident management system. For example, the incident management system we reviewed evidenced that lessons were learned and shared with following a documented incident. CCTV was used to review this incident where restraint occurred, and guidance was given to staff to ensure overuse of restraint was not applied in similar situations.

Patients were given information and feedback regarding any concerns where their views, wishes and beliefs were respected. All patients had access to an advocate who supported them weekly on site or remotely by phone.

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

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff followed a clear process for reporting and investigating incidents. There was a daily review of incidents. Incidents were also discussed at the monthly local clinical governance meetings.

Long stay or rehabilitation mental health wards for working age adults

Good

Is the service effective?

Good

We rated it as good.

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Staff involved patients or documented when patients would not engage.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Medical staff on site dealt with all physical illness and requirements. This ensured that patient's physical reviews were up to date.

We saw that all National Early Warning Scores (NEWS2) forms were accurately recorded to ensure the welfare of the patient's physical health.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans. All care plans were reviewed frequently following any significant incident or change.

Care plans were personalised, holistic, and recovery orientated. There was evidence of patient input into the care plans. The patient's voice had been included regarding their views and wishes. Care plans covered all areas of care and treatment as well as social care concerns. The service offered patients a copy of their care plan, but this wasn't always accepted.

Care plans focused on short term and long-term goals with the emphasis on rehabilitation and independence. Care plans were reviewed with each patient.

Staff were aware of what triggers patients may have that led to challenging behaviours and what individualised interventions were successful to use to support patients effectively.

Best practice in treatment and care

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

Long stay or rehabilitation mental health wards for working age adults

Good

Staff provided a range of care and treatment suitable for the patients in the service. Patients had access to occupational therapy and psychological therapy treatments. Patients we spoke with told us that many therapies were available, and 4 patients told us how they had found these helpful. The local allotment society also attended weekly to work with patients utilising an onsite polytunnel and raised plant beds. We saw fresh herbs, fruit and vegetables being grown that were also being utilised by the service.

The patients' timetable included both group and 1:1 sessions. Staff had created individual assessments to understand their needs and goals. During our visit a patient went out with the occupational therapist (OT) into the community and one patient was due to take part in cooking activities in the afternoon. One patient told us they were receiving psychology and 1:1 sessions twice daily.

Occupational therapy was accessible for all patients to assess and treat their needs such as personal care, domestic skills, work, and education. We saw that most patients were accessing meaningful activities throughout the week.

Staff identified and recorded patients' physical health needs in their care plans. Staff ensured physical health care was monitored on an on-going basis. Patient records demonstrated this, Staff made sure patients had access to physical health care, such as regular GP visits to the service. We saw comprehensive care plans for patients on Clozapine and Lithium, which monitored administration, titration and outcomes.

Staff took patients to appointments and accessed emergency care where appropriate.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff ensured care plans and strategies were in place to address these.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff provided smoking cessation support and advice to patients.

The service used outcome measures to evaluate the patient's progress. Such as Recovery Star, this is a tool for supporting and measuring change when working with adults of working age experiencing mental health problems. Other outcome measures included the 'quality of life tool' EQOL and the Health of Nation Outcome Scale (HoNOS), which measures the health and social functioning of people with severe mental illness.

Skilled staff to deliver care

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

The service had good access to a full range of specialists to meet the needs of the patients on the ward. This included a psychologist, a consultant psychiatrist, and occupational therapist and occupational therapy assistants. Staff could also access specialist input from other sites when required.

The service had a vacancy for an assistant psychologist at the time of the inspection. However, due to Ivy not yet admitting patients, the lead psychologist was able to cover the current number of patients appropriately.

Managers made sure they had staff with the range of skills needed to provide high quality care. Managers supported staff through regular, constructive supervision of their work.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers ensured staff, including agency staff, had the right skills, qualifications, and experience to meet the needs of the patients in their care.

Managers gave each new staff member a full induction to the service before they started work. As part of their induction, staff were provided with a variety of training courses to prepare them for their role.

Managers supported all staff through regular, constructive supervision and appraisal of their work. Managers continued to complete appraisals as and when they were due. Medical staff were supported to develop through constructive appraisals of their work. Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Managers and the medical director supported medical staff through regular, constructive clinical supervision of their work. Figures seen showed that staff received regular supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Minutes of meetings were emailed to staff who were unable to attend. Information relating to the running of the service was exchanged.

Managers identified their staff's training needs and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff received relevant and specialist training as part of their induction, including fire safety, Oliver McGowan, PMVA, national early warning score, and conflict resolution.

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

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Meetings were attended by the consultant psychiatrist, the psychologist, occupational therapist, and members of the nursing team.

The consultant provided learning and support to staff. These ensured staff had a better understanding of patients' needs and how to recognise helpful strategies they could utilise when responding to difficult behaviour.

Staff shared information about patients during daily meetings. We reviewed minutes from daily meetings and saw information was shared about the patient's recent well-being and progress. This included mental health, physical health, activities of daily living, diet, weight, leave arrangements, risks, medicines, and observation levels.

Ward teams had effective working relationships with external teams and organisations. The service had links with a local GP practice that was working well. The service liaised with the GP practice to discuss any issues.

Staff said they had good relationships with the local safeguarding teams and felt safe and comfortable in raising concerns.

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Staff received and kept up to date with training on the Mental Health Act and could describe the Code of Practice guiding principles. Staff we spoke with said they had a good understanding of the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. There was a Mental Health Act administrator available to staff to assist with any queries relating to the Mental Health Act.

Staff knew who their Mental Health Act administrator was and when to ask them for support.

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff could access a copy of the Mental Health Act Code of Practice when they needed to.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There was an advocacy service that visited regularly. There were notices in communal ward areas about the advocacy service together with contact details.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We reviewed Mental Health Act paperwork for five patients and found the records to be in good order. Patients' rights were included within the records seen.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the ministry Staff spoke favourably about patients being able to take section 17 leave when required. This included both escorted and unescorted leave.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Mental Health Act paperwork was easily accessible to staff. This included T2 and T3 forms.

At the time of our inspection, it was noted that no notices were visible to inform informal patient's they could leave the ward freely. However, there was one informal patient at the time of our visit, and they were clear about their rights as an informal patient and managers attached relevant posters about informal patient's rights in communal areas before the end of our inspection activity.

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

Good practice in applying the Mental Capacity Act

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

Long stay or rehabilitation mental health wards for working age adults

Good

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of the 5 key principles. A Mental Capacity Act policy was in place for staff to refer to.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff said they could seek advice about capacity issues by speaking to the consultant psychiatrist for support with any issues.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff said they assumed patients had capacity unless they felt cause for concern related to an unwise decision.

Staff told us that should they assess a patient as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

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

Is the service caring?

Good

We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Patients we spoke to during the inspection stated they liked the staff and felt they helped them. This was also reflected in compliments written by family members at a recent 12 month anniversary celebration of the service. Staff understood and respected the individual needs of each patient. Staff displayed a good knowledge and understanding of each patients needs and personalities.

Staff were discreet, respectful, and responsive when caring for patients. We noted that staff knocked on bedroom doors prior to entering.

Following a recent survey, seven out of eight patients said they felt they were treated with compassion, dignity and respect, the other response neither agreed or dis-agreed

Staff gave patients help, emotional support and advice when they needed it. Staff signposted patients to where activities were delivered so they could attend.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. Staff supported patients to access the advocacy service when required. Patient records demonstrated staff supported patients as and when required.

Staff felt they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients. Staff stated they trusted the management team to address any concerns raised relating to abuse towards patients.

Staff followed policy to keep patient information confidential. Patient records and documents were stored electronically within the provider's secure electronic system.

Involvement in care

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

Involvement of patients

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

Staff involved patients and gave them access to their care planning and risk assessments. Copies of care plans seen identified patient involvement. The patients voice had been included in respect to their views and wishes. The records identified that patients were asked if they would like to receive copies of their plan. All plans were kept in their files.

Following a recent survey, six out of eight patients agreed they felt involved in their care, the other two responses neither agreed or dis-agreed

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Staff told us how they supported patients with their care plans and options for treatment. However, at the time of our inspection, there was no 'easy read' documentation for patients in communal areas for patients with a learning difficulty or disabilities. However, Managers made this available before the end of our inspection, easy read information made available to patients included the use of force leaflet, information about being detained under the MHA, your treatment and care plan and keeping safe from abuse book.

Staff involved patients in decisions about the service when appropriate. Minutes of patient meetings showed that staff asked patients for their views about the service and ideas for improvement. The service had a 'you said, we did' board where patients could make suggestions and the service explained what they had or had not been able to do in response. For example, patients expressed an interest in watching a specific movie at the cinema, which then took place with staff support.

Staff made sure patients could access advocacy services. We saw advocacy posters displayed within communal areas of the wards.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff supported, informed, and involved families or carers. Although some patients within the service lived out of the area, we saw evidence that family or carers were invited to attending meetings in person, via telephone or electronically.

Care plans included information provided by families and carers about the patient. As the service had only been running for 12 months, family and carers feedback on the service had not yet been sufficient to understand trends or themes that could be used to improve the service.

Is the service responsive?

Good

We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers followed a clear admission policy. The service had a rehabilitation model of care that included a therapeutic timetable for each patient, learning psychological skills, Cognitive behaviour therapy (CBT) and Dialectical behaviour therapy (DBT). Managers told us they refused patients who did not meet the admission criteria and required care and treatment that the service could not fully meet.

The service had a mix of out of area and local patients. Patients had discharge plans in place, and there was evidence of close working with patients care coordinators. There were no pressures on bed occupancy.

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

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

Patients could be moved between wards during their stay only when there were clear clinical reasons or it was in the patient's best interest. Managers told us an example of this could be a patient requiring a further 'step down' approach to their care in preparation for discharge. The service configured the ward to align with the patient's rehabilitation journey. This allowed staff to deliver more focused activities to the patient groups.

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

Discharge and transfers of care

At the time of the inspection, the service had no patients whose discharge was delayed.

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

Staff regularly reviewed patients' progress to see where they were in the rehabilitation pathway. Staff actively worked with commissioners to plan discharges and patient records demonstrated this.

Long stay or rehabilitation mental health wards for working age adults

Good

Suitable plans and arrangements were in place that meant patients did not stay in hospital longer than needed. However, plans were reliant on available social care options, which was outside of the service's control. The service kept in contact with care coordinators to ensure plans were followed.

Staff supported patients when they were referred or transferred between services. For example, we saw a patient being transferred to another health care facility to receive a treatment that The Woodmill could not provide; they were then transferred back with the assistance of staff.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, 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. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Patients were encouraged to take pride in their bedrooms and add their own decorations.

Patients had a secure place to store personal possessions. Patients had lockers with their own key to keep personal possessions safe and access them when they wished.

Staff used a full range of rooms and equipment to support treatment and care. Patients had access to the kitchen and activity rooms.

The service had quiet areas and a room where patients could meet with visitors in private. Patients had access to their own bedrooms if they wanted to spend time alone.

Patients could make phone calls in private. The service had multiple access to outside spaces that patients could easily use.

Patients could make their own hot drinks and snacks and were not dependent on staff. Some patients had made their own meals in the activities of daily living area.

The service offered a variety of good quality food. Staff told us patients were able to request specific food which were provided.

Patients' engagement with the wider community

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

Staff said they encouraged patients to access meaningful activities outside the service, such as work and education.

Staff helped patients to stay in contact with families and carers. Families and/or carers were invited to attend virtual care review meetings. Patients had mobile phones so they could contact families at any time.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. This supported patients and the community team to establish community placements such as alternative and appropriate accommodation. For example, we saw evidence of staff supporting a patient with enrolment to further education at university level.

Meeting the needs of all people who use the service

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

Staff could adapt service delivery to meet the needs of for disabled people and those with communication needs or other specific needs. Resources were made available to make information more accessible. Communication information cards could be provided when required. Staff told us they used picture cards (PECS) to describe things that some patients did not understand when verbalised.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. We saw patient's rights were documented in their care records.

The service could provide information leaflets in languages spoken by the patients and information about the local community.

Managers made sure staff and patients could get help from interpreters or signers when needed. The service had not needed to use signers or interpreters. However, they would use a suitable agency to provide this should the need arise.

The service provided a variety of food to meet individual patients' dietary and cultural needs. Menus could be tailored to meet individual needs such as religion or to support medical conditions such as diabetes.

Patients had access to spiritual, religious, and cultural support. Staff said they would support patients with this if required.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

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

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

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw feedback from complaints in weekly and staff meeting minutes. Two complaints we reviewed showed evidence that thorough investigations had taken place and satisfactory outcomes had been achieved.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff confirmed that managers shared outcomes of any investigation with them. Staff were able to describe the incident in detail and action taken during the investigation process.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good

We rated it as good.

Leadership

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

The registered manger had a good understanding of the service they managed and was being supported by the regional operations manager. They had a clear focus on what they wanted to achieve and how they proposed to deliver and motivate staff to succeed. They knew how the teams worked together to provide high quality care.

Leaders were visible and approachable for patients and staff, they confirmed an open-door policy for informal discussions, advice and support when required. Staff we spoke confirmed the registered manager was always present during agreed work hours and they felt supported, comfortable, and confident in approaching them if they had any concerns

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The aim of the service is to support women to improve their self-worth, build a better quality of life for themselves and to equip them with the skills needed for community living, supportive relationships, and increased independence.

All staff we spoke with knew the providers' vision and values, they were able to tell us the values were Kindness, Integrity, Teamwork and Excellence (KITE).

The registered manager told us they were hoping to work to towards the accreditation for inpatient mental health services (AIMS). However, they acknowledged the infancy of the service and understood the importance of building and maintaining stability prior to undertaking of quality improvement projects.

Culture

Staff felt respected, supported and valued. They said the organisation promoted equality and diversity in daily work and provided opportunities for development and career progression. This included apprenticeships, leadership courses and additional training to support the needs of patients.

Long stay or rehabilitation mental health wards for working age adults

Good

All staff said they felt supported by the leadership team and others within the service. Staff felt respected and valued at ward level. Staff felt they were treated fairly.

Staff worked well together and where there were difficulties, they were supported by the leadership team who dealt with them appropriately.

Staff told us there was a positive culture and they could share their views without fear of reprisals. The leadership team said they knew the importance of embedding a positive culture within a service in its infancy and were committed to doing this, we noted morale across the staff team was good.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

We saw that the registered manger had oversight of the service and could identify any gaps in governance. This included a range of audits and other quality checks that were completed regularly and fed up and shared with the senior management team.

The manager completed weekly key performance indicator reports containing information about occupancy levels, incidents and safeguarding, staffing and complaints.

Governance reports completed by the registered manager contained data and analysis relating to the running of the service.

The service had policies in place for staff to refer to that were in date and contained relevant information.

Ward managers said they were included in the decisions about referrals for placements, and their views were considered.

There was a series of meetings where information could be shared and escalated. These included daily meetings, monthly staff meetings, clinical reviews, and referral meetings. There was evidence of common themes being identified and shared learning.

Management of risk, issues and performance

Staff had access to the information they needed to provide safe and effective care and used that information to good effect.

The provider had systems and processes in place to monitor risk and performance. The service held daily meetings to review each patient, staffing levels, incidents, and any issues of concern. The leadership team formed plans and actions to address these.

Staff had access to electronic records for each individual patient. Staff said they had all the relevant information to support each patient's individual needs.

The service had an up-to-date risk register which the registered manager maintained. This explained current risks in relation to, for example, staffing and training. Where required, there were action plans to manage risk. Ward managers could escalate concerns when required. We saw the concerns listed matched those on the risk register.

Long stay or rehabilitation mental health wards for working age adults

Good

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service collected information and integrated and secure information systems. 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.

The registered manager had access to information relating to the operational performance of the service and used it to support them with their management role. This included staffing and discharges. They reviewed this information at monthly governance meetings with senior provider team members.

Information governance systems included confidentiality of patient records. There was a clear policy regarding the use of CCTV that respected patient's dignity. Staff working within the service were unable to view this footage freely and was only accessible by the registered manager and regional operations manager.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Patients were provided with up-to-date information about the service they used. Patients were given the opportunity to provide feedback on the service and identify areas of concern or

need. Actions were discussed and recorded, enabling patients to see how the service responded and resolved their concerns using the 'You said We did' community board.

The registered manager said they were due to undertake a survey to gather family and carers' feedback, this had not yet happened due to the infancy of the service.

The registered manager confirmed they linked with external coordinators to ensure they were kept up to date with each patient under their care. The service linked with police, undertaking sessions on living together and Royal Devon and Exeter hospital to ensure 'fast track into A&E.

There were good links with patient's home care teams. Managers and staff actively sought to forge links to support patients' discharge home.

Learning, continuous improvement and innovation

All staff we spoke to were committed to making improvements. The registered manager and operations manager had recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service.

Staff worked together in the running of the service. The service held regular meetings where learning was discussed. For example, team meetings and managers meetings.

Incidents and shared learning were discussed with staff. This provided an opportunity for discussion on safety. The leadership team were responsive to concerns raised and sought to learn from them to improve services.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff said they were given the time and opportunity to learn.