Kibo Hospital Services Limited

Pine House Rehabilitation Unit

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Inadequate
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

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

- Wards were not always safe, clean or well maintained. Repairs did not happen quickly and the environment was not therapeutic.
- Staff did not assess and manage risks well. Risk assessments and management plans did not address the needs of all patients. Some opportunities to prevent or minimise harm were missed.
- Information relating to patient care and treatment was not kept up to date or easy for staff to find.
- Staff had not always completed training to meet the specific needs of patients.
- Incidents, including the use of restrictive interventions were not well recorded. Lessons learnt were not always identified and shared with the whole team. Managers could not be assured physical restraint was being carried out in line with guidance.
- Managers had not ensured staff had received training necessary for their roles.
- The service was not well-led at all levels. Governance processes did not ensure that ward procedures ran smoothly. Some audits to evaluate the quality of care provided were not completed.
- The approach to service delivery and improvement had sometimes been reactive. This meant risks and improvements were not always managed appropriately or rectified quickly enough.

However:

- Staff were respectful to patients and were caring in their approach.
- Staff we spoke to were enthusiastic about the service and most felt supported in their role.
- Some improvements had been made following our previous inspection. Leaders had an action plan for future improvements and needed time for changes to be embedded.

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	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Pine House Rehabilitation Unit

Pine House is a mental health inpatient rehabilitation hospital in Bacup, Lancashire. The registered provider who runs this service is Kibo Hospital Services Limited who are part of the Krinvest Limited group. The hospital provides inpatient rehabilitation care and treatment to males with an acquired brain injury (ABI) or mental health needs. The service has been registered since November 2021. There are 3 wards on site.

- Pine ward, a 4-bed ward on the ground floor.
- Lyme ward, a 8-bed ward based on the first floor.
- Aspen ward, a 8-bed ward based on the second floor.

At the time of our inspection there were 15 patients staying at the hospital.

The provider had reconfigured the wards since our last visit. There were 4 patients receiving care for an ABI, who were now accommodated on the same wards as people receiving care for mental health needs. Pine ward was now a pre-discharge ward.

We decided to re-inspect this service following concerns being raised to us about the safety and leadership of the hospital.

A registered manager was in post at the time of our inspection.

We last inspected this service in October 2022 and rated it as 'good' overall. However, we rated 'safe' as 'requires improvement' following concerns in relation to staff training. We also highlighted other areas for improvement including the layout of wards, governance systems and opportunities for patients to access the local community.

What people who use the service say

We spoke with 3 patients using the service and reviewed other information, including minutes from patient community meetings.

Patients said the ward environment was not always kept clean and repairs were not made in a timely manner. They also stated that the environment could be very noisy and that doors could regularly be heard banging.

Patients generally described positive relationships with staff but reported that there were not always enough of them to meet everyone's needs.

Patients felt safe but found the ward could become very unsettled when other patients became distressed or aggressive. Patients had reported feeling bored at times. They also stated that opportunities to have trips off the ward were limited.

One patient said access to therapy could be inconsistent and that they didn't feel clear about their path to discharge.

Summary of this inspection

Patients generally described the food as good but stated that variety could be limited and that sometimes the food ran out.

How we carried out this inspection

We carried out this inspection because we had received information of concern that may affect the care and safety of patients. During this unannounced, focused, inspection we only looked at how 'safe' and 'well led' the service was. We did not review all our key lines of enquiries.

During the inspection we:

- visited the service and observed how staff were caring for patients
- spoke with the Hospital Manager (who was the registered manager) and the regional Director of Operations
- spoke with 8 other staff members delivering care and treatment
- looked at care and treatment records relating to 6 patients
- spoke with 3 patients using the service
- looked at a range of other information and data about the service

The main service provided was mental health, long-stay rehabilitation for adults. The acquired brain injury service was a smaller proportion of the hospital's activity. Although there were some slight differences in the professionals involved in the different care pathways, the two services were not delivered separately. We have reported findings for both care pathways under our mental health, long-stay rehabilitation service framework.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure records of each patient are reviewed, reflect the patient's current needs and are easily available to the appropriate staff. This includes records relating to the use of restrictive practices and risk management plans. (Regulation 12 Safe care and treatment)

Summary of this inspection

- The provider must ensure that staff understand and follow local guidance about delivering safe care and treatment. This includes checking of emergency equipment, monitoring of fridge temperatures used to store medicines, use of personal alarms and completing observations. (Regulation 12 Safe care and treatment)

- The provider must assess and manage all areas of the hospital environment to ensure risks to the health and safety of patients and staff are mitigated wherever reasonably possible. This includes ensuring maintenance to the environment is carried out in a timely way. (Regulation 15 Premises and equipment)

- The provider must ensure governance systems and process are implemented effectively and consistently across the service to ensure issues are identified and rectified in a timely way. This includes processes relating to, incident reporting, management of patient finances, medication management and quality assurance. (Regulation 17 Good governance)

- The provider must ensure the number and skill mix of staff on each shift meets the needs of patients. Staff providing care must also have access to training and support to meet specific patients' needs safely and competently. (Regulation 18 Staffing)

Action the service SHOULD take to improve:

- The provider should consider how to develop and strengthen leadership provided by staff at ward level.

- The provider should evaluate how well it uses feedback from different sources to improve the service and take action where needed. This includes feedback regarding the provision of food and organisation of meetings.

- The provider should ensure patients are able to access meaningful activities and opportunities outside the service to promote their recovery.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe	Inadequate
Well-led	Requires Improvement

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate. Following our inspection we issued a warning notice to the provider telling them to improve specific areas of the service by 26 January 2024.

Safe and clean care environments

Wards were not always safe, clean or well maintained. Areas of Aspen and Lyme ward had been damaged and repairs had not happened quickly. This had put patients at risk and did not promote a positive recovery environment.

Safety of the ward layout

Staff had not completed and regularly updated thorough environmental risk assessments of all ward areas. For example, there were potential ligature anchor points in the service. We found cables from the TV and games console in some lounges were not encased behind the TV. This had not been identified in the ligature risk assessment.

A ligature risk assessment was completed for each floor of the building. However, the risk scoring did not reflect up to date guidance. For example, ligature points of any height, in any room in which patients spend time in private' should be considered as 'high risk'.

Some windows had been damaged following incidents. One had been broken and used by a patient to self-harm. The provider had replaced these windows with glass that was less likely to shatter. However, there had been no risk assessment completed to assess if all windows required replacement or to consider other mitigative actions to limit the likelihood of future incidents.

Potential fire risks were not always mitigated. Fire extinguishers had been removed to prevent patients removing them from the wall. This was not reflected in the fire risk assessment, and it was unclear what mitigative action the provider had considered.

Some aspects of the ward layout did not meet the needs of the patient group and were not safe. Some patient doors opened into other corridor doors causing an obstruction. It also impaired staff member's line of sight in parts of the wards. We raised this as a concern at our last inspection in October 2022. The provider said they were getting quotes for new magnetic fittings to ensure corridor doors stayed open. They said they had been delayed in replacing the doors due to fire regulations.

Wards were sometimes noisy and did not promote a therapeutic recovery environment. Patients raised concerns about the noise levels on the wards, particularly banging sounds of doors opening and closing. Some patients had specific sensory needs and were distressed by loud noises. The provider had not taken enough action to mitigate noise levels on the ward. Banging caused by doors had been a contributory factor to some incidents.

Staff did not always complete daily security checks of the wards. This included checking personal alarms and radios. This issue had been identified by the provider before our inspection but had not been rectified.

Staff did not always carry alarms or radios. On the day of our inspection 3 members of staff were not carrying alarms in case of an emergency. We also observed some staff without a radio and that some radios had run out of battery so staff could not respond when called.

There was no mixed sex accommodation.

Maintenance, cleanliness and infection control

Ward areas were not well maintained. There was extensive damage to the environment on Aspen and Lyme ward. For example, there were multiple holes in walls where the plaster board had been damaged. Areas across both wards needed re-decorating and some flooring required replacing.

Some damage put patients and staff at increased risk of avoidable harm. The nursing office door on Lyme ward was damaged and did not always close properly. On Aspen ward the TV had been damaged and was not correctly mounted. The viewing panes on the lounge door on Lyme ward had been removed and had left a hole in the door. On the day of our inspection, we saw a patient lean through the door and swing themselves.

The provider had not been quick to repair the damage caused. For example, the fire door on the patient kitchen on Aspen Ward had been removed and had not been replaced. The system of reporting damage and scheduling repairs was not effective. A paper maintenance book kept on site was not being completed after every incident of damage. Some damage went unreported and had not been scheduled for repairs.

Wards were not always clean. Patients had raised cleanliness of ward areas as an issue to staff. Daily checks on patient kitchens were not being recorded and it was unclear who was responsible for these additional checks. Audits of infection prevention and control did not take place regularly. The domestic team did visit once a day during the week and kept records to say where they had cleaned. However, this had not been sufficient to ensure all ward areas remained tidy.

Good food hygiene was not always followed. For example, patient food was not stored appropriately in ward fridges. The temperatures of patient fridges were not always recorded. The kitchen hobs were not clean. There were half empty packets of cereal in one kitchen.

Some hand soap and sanitiser dispensers were not always re-filled in good time. On the day of our inspection, we found two dispensers were empty and one had been removed due to patient damage.

However, the provider had made some improvements since our last visit. For example, they had allocated the second dining room on Lyme and Aspen ward as a dining area. They also ordered some new furniture to replace damaged furniture.

Managers said most of the damage on wards had been caused by a small number of patients, some of whom had left the service. There had also been a period where there had been no onsite maintenance staff in post. They were aware improvements needed to be made and had tried to prioritise more urgent jobs such as repairing broken windows. Pine ward had been recently re-decorated, and leaders planned to decorate the other wards.

Clinic room and equipment

Clinic rooms were equipped with accessible resuscitation equipment.

Staff locked the clinic room when it wasn't in use.

Although the rooms were too small to have examination couches for patients, staff would use patient bedrooms or work with the local GP surgery to complete any physical examination.

Ligature cutters were accessible for staff on wards.

An external pharmacy service visited the hospital to complete regular audits in clinic rooms and review medication management.

However, daily checks in clinic rooms and on equipment were not carried out to avoid potential risks to patients. The temperature of the clinic rooms and fridges used to store medication were not being monitored. The issue had been previously highlighted to the provider by audits completed by the external pharmacy. Staff did not always complete daily checks of the emergency equipment.

Safe staffing

Nursing Staff

The service did not always have enough nursing staff to keep patients safe or ensure their needs were met.

The service had struggled to recruit nursing staff. At the time of our inspection 70% of nursing posts were vacant.

On the day of our inspection there was one agency nurse covering all three wards. There were supposed to be two nursing staff. The other nurse had cancelled their shift at short notice and the provider had been unable to find cover. Managers said this did not happen very often. We reviewed recent staff rotas and found there had not been other recent incidents of this.

To cover registered nursing vacancies the provider had been using agency nursing staff. There were some shifts where all nurses on duty were agency staff. Where possible managers limited their use of agency staff and requested staff familiar with the service. For example, the agency nurse on shift at the time of our visit had worked at the service before and was familiar with the hospital.

Patients described positive relationships with staff but reported that there were sometimes not enough of them to meet everyone's needs.

Records did not show that patients had regular one to one time with a named nurse. Some staff said that shifts weren't well organised, and that activities and staff breaks didn't happen on time or as planned.

Some of the challenges the provider faced in recruiting registered nurses were reflective of the national nursing shortages.

To try and alleviate this the service had focused on the recruitment of recovery workers (non-registered nursing staff). Use of agency recovery workers had started to decline as a result.

This meant a lot of new staff had joined the service in the last 6 months. Over 50% of the workforce had not worked in the service for more than 6 months at the time of our visit. This created a potential risk to patients as a newer staff did not have experience of mental health rehabilitation services.

Managers had tried to mitigate the potential risks of having a relatively new workforce by bringing in senior recovery staff from other services to support newer staff. They also planned shifts so experienced members of staff were available to provide support. Managers also ensured all new staff had completed an induction.

Managers did review staffing levels on each shift and would bring in additional staff when needed.

Managers supported staff who needed time off for ill health.

Levels of sickness were low.

Medical Staff

The service had enough medical staff.

There were 3 consultant doctors based off site who visited the hospital to see patients under their care. They visited the hospital at least weekly to review patient care.

A doctor was available to go to the ward in an emergency and staff knew when to contact emergency services.

We did receive some feedback that the multiple meetings that took place with different consultants weren't well organised. Concerns were raised that meetings between patients and their responsible clinician (consultant) could change without notice and that meetings were sometimes delayed which caused distress to some patients.

Mandatory training

At least 75% of staff had completed and kept up to date with their mandatory training. New staff were enrolled onto training. Managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training programme had improved since our last inspection and staff had now completed training in the use of physical intervention and life support appropriate to their role. A training manager had been introduced to deliver and organise training for staff.

However, further work was needed to ensure the training available to staff was comprehensive and met the needs of current patients. For example, staff had not completed training in Epilepsy, Diabetes or Stoma care despite having patients with some of those needs. Following our inspection, the provider confirmed they had sourced additional training in these areas and all nursing staff had been enrolled.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff access to essential information

Staff did not have easy access to clinical information.

The record keeping system on site was disorganised and made it difficult for staff to access and maintain. Records had become split between paper and electronic documents. Some recovery workers could not access the electronic records. Staff that could access the electronic folders were unsure where some information had been saved.

Nursing staff told us that some members of the multidisciplinary team kept separate records and were unsure where to find these.

Daily records were not maintained to ensure staff knew if the specific needs and risks of some patients had been managed. For example, fluid and nutrition charts were incomplete. Daily notes for individual patients were not detailed.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour. The provider had not outlined a clear restrictive interventions reduction programme.

Assessment of patient risk

Staff did have access to a risk assessment tool and had completed some assessments for patients.

However, staff did not always assess and develop specific plans to support patients' individual risks and needs. Risk assessments and management plans were not kept up to date. For example, up to date assessments considering specific risks such as choking, self-harm and violence and aggression were not always in place . Some risk assessments were not reviewed, even after an incident.

This put patients at potential risk of harm because staff may not have identified and responded to any changes in risks to, or posed by, patients.

Following incidents where patients had acted aggressively, we had received concern from anonymous whistleblowers about how the service risk assessed new patient referrals.

During our inspection we were told changes had been made to the pre-admission assessment process and at least two staff including the hospital manager and operations director would be required to complete the assessment. Prior to our visit pre-admission assessments had been completed by one consultant. Although referrals were discussed at team meetings, the provider had recognised more than one member of staff should have been involved in these assessments.

Management of patient risk

Staff did not always act effectively to prevent or reduce risks to patients.

For example, staff did not follow procedures to minimise risks where they could not easily observe patients. We reviewed records for observations completed by staff to ensure patients were safe and found gaps. Observations were not completed in line with best practice. Some staff completed observations at set time intervals which made them predictable and less effective in managing patient risks.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The communication of risk at handovers between shifts was not consistent. Information about patient risks, including what observation level they were on, were inconsistently recorded in handovers.

Prior to our inspection concerns were raised about how safely staff supported patients to manage their individual risks. There had been a number of incidents of violence and aggression in the service in the six months prior to our visit. Although the number of these incidents had started to reduce there were still gaps in how well the service supported some patients to manage violence or aggression.

For example, the service had not fully assessed and managed the ward environment in terms of patient risk. Some patients had sensory needs and were sensitive to noise and light. Noise had been highlighted as a potential trigger for them. We found the wards were noisy and concerns had been raised to the provider about this. Patients reported that the environment could be very noisy and that doors could regularly be heard banging. The service had failed to assess and manage these potential risks to patients which may have contributed to, or lead to, some incidents of aggression or violence. We also found examples where risk management plans and assessments had not been completed or reviewed following an incident.

This did not follow best practice guidelines around supportive management of violence and aggression and did not follow the provider's own policy on 'prevention of aggressive and violent (crisis) incidents'.

Patients said they felt safe but found the ward could become very unsettled when other patients became distressed or aggressive.

To help staff understand individual patient risks and reflect on their practice the provider had started 'staff support sessions' led by a clinical neuropsychologist. However, these sessions were not held routinely, did not get shared with all staff and did not always feed into the risk management plans.

However, staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Managers were able to describe some examples where they had worked with some patients to reduce risks posed to themselves and others.

Use of restrictive interventions

The use of restrictive interventions was not always well managed, recorded or avoided.

A clear restrictive interventions reduction programme or strategy was not in place for the service. Although the provider had a policy in place there was no clear plan in how the service was monitoring and planning the reduction in restrictive practices. For example, there was no specific audit in place to look at the use of restrictive practice.

Positive Behavioural Support (PBS) plans were not kept up to date for patients. We found one patient did not have a PBS plan in place at all. A PBS plan is created with patients to help manage behaviours and reduce the likelihood of certain behaviours happening.

The use of restrictive interventions was poorly recorded. When staff used restrictive interventions such as physical restraint and rapid tranquilisation, they did not always record it well. We found examples where physical restraint had been used but there was no record of; why it had been used, what specific holds had been used and which staff had been involved as well as other important details. This did not meet standards set out in legislation such as The Mental Health Units (Use of Force) Act 2018.

For example, body maps were not routinely completed despite the local providers stating this was a requirement. The date, dose and time of incidents where rapid tranquilisation was used were not always clear. This meant the provider could not be assured that restrictive interventions were being used safely, effectively and in line with national guidance. The lack of detail on incident reports meant less information may have been available to managers when reviewing these incidents.

The service had not considered the use of some models such as 'Safewards'. This may have reduced levels of violence and aggression and subsequent use of some restrictive practices.

However, we did find some examples where staff had tried to avoid using physical restraint by using de-escalation techniques.

Staff told us they avoided restraint whenever possible and had completed training in how to do this safely.

An up-to-date blanket restriction register was in place that staff reviewed to avoid unnecessary blanket restrictions within the service.

Safeguarding

Some aspects of safeguarding were not well managed. Systems and processes to ensure managers had full oversight of safeguarding were not in place.

Some aspects of safeguarding were not well managed. For example, some patients were at risk of financial abuse. But processes in place to manage patient finances on wards were not always carried out effectively. This increased the potential risk of financial abuse for some patients.

There was some confusion about how money was being managed at ward level. We were told by a manager that recent changes meant patient money was now managed and handled by the senior recovery workers and occupational therapy team. However, during our visit we saw patient money still being accessed by recovery workers on each ward. This was not in line with the changes.

However, staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. Staff knew who to inform if they had concerns.

Procedures were in place to keep children visiting the ward safe.

Managers took part in serious case reviews.

Medicines management

We found some issues with the way medicines were managed.

Systems and processes in place did not ensure medicines were stored correctly at all times. Medicine fridge temperatures were not monitored well. In some audits they had been reported to go above 8ºC. This may have affected some medicines like antibiotic liquids, injections, eye drops and some creams that must be stored between 2ºC and 8ºC. We found gaps where fridge temperatures had not been recorded.

Medicines were not always ordered on time or disposed of when they expired. We found 2 packets of out-of-date medicine in the clinic room on Lyme ward. These were disposed of whilst we were on site. Audits completed by an external pharmacy found multiple incidents where medicines had been 'unsuccessfully administered' to patients as they had not been in stock.

Records about the administration of medicines with a PRN (pro re nata) or 'when required' dose were not detailed or accurate. Some examples of this are detailed in our above findings about the use of rapid tranquilisation where electronic records about specific doses administered to patients did not match paper-based incident reports.

Recovery workers were asked to counter sign paper records to detail administration of Drugs liable for misuse (DLMs). However, they had not been given training to ensure they were able to carry out this responsibility safely.

Despite some of these issues having been raised in medication audits there was no specific action plan, at the time of our inspection, that detailed what staff were doing to rectify these issues.

Reporting incidents and learning from when things go wrong

Incidents were not always reported, investigated thoroughly and lessons learnt shared with the whole team.

Staff said they knew what incidents to report and how to report them. However, the paper-based incident reporting system did not ensure all incidents were reported and investigated.

The quality of hand-written incident reports varied. We found examples where specific details of incidents had not been recorded on paper forms. Some reports were not clearly legible. We received feedback prior to our inspection that staff were not reporting some incidents. We found one example of this where a patient had damaged a bathroom, and this had not been reported or recorded elsewhere.

There were practical issues with the paper forms that may have also affected the recording of incidents. For example, some staff were not sure where to print new copies of the form when they had run out on the ward. Staff had raised concerns that paper incident forms were being left in the filing trays. We found another example where an incident of rapid tranquilisation had been recorded twice by different staff members and the details did not match.

It was unclear how confident staff were in using the reporting system. We found examples where staff had emailed managers directly about incidents.

The manager had also introduced a notebook for staff to detail concerns. Only one copy of this notebook was put on Lyme ward for staff from all three wards to use. One staff member had reported an incident in the book, but it was unclear if they had also completed an incident report form and whether this had been investigated.

Managers did not always complete paper incident reports to show they had been reviewed.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

We requested investigation reports from the provider for review. We received the incident report, MDT review of the patients' care following the incident and an incident debrief. These did not show how patients, their families or their advocates were involved in these investigations. It was also unclear how lesson learnt had been shared with staff members not involved in the incident.

Whilst on site we had found multiple incidents where there was no follow up investigation documented in the patient's folder.

Lessons learnt were not always shared with the whole team.

Managers completed an incident analysis to categorise the number and type of incidents that happened in the service. This was shared at team meetings. However, meeting minutes did not show staff received feedback from investigation of incidents, both internal and external to the service.

When we discussed with the manager how lessons learnt following an incident were shared with staff, they told us this was all done through team meetings. It was unclear how staff who were unable to attend these meetings were informed of investigations and lessons learnt. The meeting minutes were not circulated, were not on clear display in staff only areas and there were no other alerts of bulletins sent to staff.

Some staff had attended 'staff support sessions' to discuss specific incidents and look at improvements to patient care. But this had only happened on two occasions in since January 2023 and all staff had not been able to attend.

However, managers debriefed, and staff said they were supported after an incident.

For staff who had attended, senior staff had shared learning at team meetings about incidents that happened elsewhere.

Is the service well-led?

Requires Improvement

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

Leadership

The Hospital Manager was responsible for the day-to-day leadership of the service and was the registered manager. A regional Director of Operations also provided leadership and support and visited the service on a weekly basis. Both had a good understanding of the service model and what it was trying to achieve for patients.

Most staff felt senior managers were visible in the service and approachable for patients and staff.

However, leadership capacity at ward level required improvement. We found quality issues that indicated tasks were not always completed during shifts. For example, regular supervision of staff did not always happen. Patients did not have regular one to one time with a named nurse or allocated recovery worker. Some quality audits did not take place. Care records were not kept up to date.

Some staff raised concerns that the lack of permanent nurses had led to gaps in ward level leadership. We found some inconsistencies in service quality that may have been linked to this. This included the ordering of medication and regular review of patient care.

There was no additional leadership training available for nursing staff.

The provider recognised that leadership capacity needed some improvement. Two senior recovery workers (that worked in another hospital ran by the provider) also visited the service two days a week to offer additional support. The provider was also considering recruiting a deputy manager to provide extra support to staff working on the wards.

'Champion' roles were also being introduced for specific areas such as dignity, physical activity and staff well-being to upskill nursing staff and give them responsibility for certain areas of quality at ward level.

Culture

Most staff felt they could raise concerns without fear, but it was not always clear what action had been taken in response.

Prior to our visit, several whistle blowers contacted us to raise concerns about the service. They did not feel their concerns had been taken seriously by the provider. On site we also received feedback from one staff member that they did not always feel respected by other members of the team.

A paper notebook had been left on each ward for staff to write their concerns in. However, staff on Aspen ward did not know about this book and we only found one notebook on Lyme ward. Although concerns had been raised in this book it was unclear what response had been provided to staff and how the manager had investigated these concerns.

However, we did find examples where managers had acted on staff concerns, this included the purchasing of comfier furniture in the staff room and the adjustment of staffing levels on night shifts. Staff we spoke to were enthusiastic about the service and most felt supported in their role. Most felt respected and valued.

Leaders were keen to find new ways to improve and sustain staff morale. For example, the manager had brought in thank you gift bags for staff. The provider had also negotiated a pay increase for staff where possible.

The provider was also considering team building activities to help build relationships between new staff members.

The service had tried to introduce staff support sessions. However, these were focused on specific incidents and risk formulation and had only taken place twice. They did not focus on individual staff wellbeing or facilitate peer support.

Management of risk, issues and performance

The approach to service delivery and improvement had sometimes been reactive and focused on more immediate challenges such as recruitment of new staff. This meant other areas of service performance had been overlooked. For example, at ward level, daily security checks were not always completed, and observations were not always used effectively. Emergency equipment in the 'grab-bag' was not checked in line with local guidance.

The provider had not been pro-active in the way it responded to issues. For example, a patient had damaged a window and used the glass to self-harm. The window had been replaced but the provider had not completed a further

assessment to consider if all windows needed replacing or assess if other changes could be introduced to mitigate future risks. A quarterly environmental risk assessment had not been completed. We found examples of where damage to the environment had not been reported through the maintenance report book and there was no exact schedule for repairs. There had been a vacant post in the onsite maintenance team and the provider had not organised alternative arrangements during this period which had led to a delay and accumulation of some jobs and repairs.

Managers had not embedded systems to ensure they assessed training needs to training provision in a pro-active way. For example, they completed a training needs analysis specific to restrictive interventions after organising the restrictive intervention training. Since our last visit the provider had introduced some new training but there were still gaps. This meant staff did not always have access to training that matched individual patient's needs.

Leaders were aware that parts of the service required improvement and some governance and risk management processes had not been completed. They had formulated a service improvement and action plan and said they needed further time to embed new systems and processes to improve service quality.

A risk register was in place and was updated.

Governance

Our findings demonstrated that governance processes did not operate effectively. This had affected safety and meant regulations were not always met.

Some checks were not carried out and meant managers did not have full oversight of service quality. An audit schedule was in place, but some audits had not been completed. This included audits on physical health, environmental cleaning and psychology provision.

Assurance processes in relation to Safeguarding across the service were not effective. A safeguarding awareness audit was supposed to take place every month to check staff had the right knowledge but had only taken place in January and June 2023. Safeguarding audits did not show how managers had checked to see if a safeguarding referral had been made when needed and what the outcomes of these referrals were.

Where issues were identified, action was not always taken to rectify them in a timely way. For example, a care record audit found issues found in April 2023 that had not been rectified by June 2023. We also found some risk assessments for one patient had not been updated since May 2023, despite multiple incidents occurring since then. The care audit completed in June 2023 for this patient stated all risks assessments were up to date. This gave the provider false assurance.

Some patients did not have care plans in place to address all their needs. For example, when the service received advice from external professionals these were not always translated into meaningful care plans that staff could follow. This put patients at risk as it meant staff may not have had the right information to support them in a safe and effective way.

The provider told us that following our inspection they reviewed all care plans and made sure up to date paper copies were available on all wards. The provider had been aware of some issues and was looking to move to a new electronic record keeping system in the future.

Further work was needed to ensure colleagues understood their roles and responsibilities in relation to governance processes and systems. Over half of the workforce had not worked in the service more than 6 months at the time of our visit. In the recent staff survey 4 out of 9 disagreed with the statements 'team members understand each other's roles'.

There was a framework of what must be discussed at team or governance meetings. However, these meetings did not always take place and information was not always shared with staff who were unable to attend.

Information management

Information used to monitor service performance was not always accurate or kept up to date. This limited how useful it was to leaders in ensuring the service was safe and effective.

Systems to collect data from wards were not consistent and required manual input from staff. For example, we reviewed data relating to the training and supervision of staff and found some staff were missing from the data sent.

The manager completed a monthly incident analysis but the issues we found with the paper-based reporting system undermined the reliability of this data.

Staff did not always have access to the equipment and information technology needed to do their work. For example, we found staff did not always have access to essential information and patient care records had become disorganised across a paper based and electronic system.

Engagement

Internal communication and engagement with staff required some improvement.

For example, the manager had been encouraging staff to attend team meetings and this had improved. But we also found that team meeting minutes were not readily shared with staff members who could not attend.

The provider had completed a staff survey in June but only 34% of staff responded.

Patients had opportunities to give feedback on the service they received at regular community meetings. But the service was not always quick to act on this feedback and make improvements. For example, patients raised concerns that wards were noisy and not always kept clean. We found these issues were ongoing and had not been resolved.

We also found examples where the service had not learnt from concerns raised by staff and patients regarding food provision. Both staff and patients had stated that enough food was not always available for patients when the main kitchen was closed. On the day of our inspection, we found that basic provisions such as bread had run out on Aspen ward. We were told this was due to the food delivery not arriving the day before. A member of staff was sent to the nearby supermarket in response.

However, staff understood arrangements for working with other organisations to meet the needs of the patients. The local authority safeguarding team had attended site to review specific concerns. Staff had built relationships with the local GP practice to improve information sharing and the organisation of patient reviews.

The provider had completed a patient survey in July 2023 and the results had been shared with staff. They were in the process of reviewing the feedback with patients and creating an action plan at the time of our inspection.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The provider had a family and friends satisfaction survey in place but had not had many responses. Unfortunately, we did not speak to any family members or carers during this inspection so were unable to make further observations about the provider's engagement with them.

Learning, continuous improvement and innovation

Leaders had focused on trying to address immediate issues with service delivery which had inhibited wider quality improvement activities. For example, staff had not participated in research to improve the service and innovations were not taking place.

Due to some vacancies in the multi-disciplinary team, there had been a lack of checks completed to measure specific outcomes and clinical effectiveness of the service. For example, patients did not always engage in meaningful activity as part of their planned rehabilitation journey. Patients reported at times feeling bored as there were not enough activities available on the ward and in the community. Some patients did not have individual activity timetables in place. A new occupational therapist had recently joined the service and had started work to review individual patient activity.

At our last inspection we suggested the service should continue to consider improving opportunities for patients to access community activities and education. However, we found that this had not improved significantly. Patient feedback in meetings still indicated there was a lack of activities going on outside of the service. No patients at the time of our inspection were engaging with external education or work opportunities.

Staff did not participate in accreditation schemes relevant to the service. This included Standards for Inpatient Mental Health Rehabilitation Services set by the Royal College of Psychiatrists.

Staff did not receive training in quality improvement methods.

Leaders had done some self-assessment of service quality and visited other locations ran by the provider to consider areas for improvement. However, the service may have benefited from completing further benchmarking exercises and gaining feedback from external sources.

Despite the challenges the service had faced, most staff we spoke to onsite were enthusiastic about improving the service and felt positive about the future. Leaders were confident that they could focus on improving the service and sustaining any improvement now that they had recruited more staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider had not assessed managed all areas of the hospital environment to ensure risks to the health and safety of patients and staff were mitigated wherever reasonably possible. This included ensuring maintenance to the environment had been carried out in a timely way.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not ensured governance systems and process were implemented effectively and consistently across the service to ensure issues were identified and rectified in a timely way. This included processes relating to, incident reporting, management of patient finances, medication management and quality assurance.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not ensured the number and skill mix of staff on each shift met the needs of patients. Staff providing care did not have access to training and support to meet specific patients' needs safely and competently.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not ensured records of each patient were reviewed, reflected patients' current needs and were easily available to the appropriate staff. This included records relating to the use of restrictive practices and risk management plans. • The provider had not ensured that staff understood and followed local guidance about delivering safe care and treatment. This included checking of emergency equipment, monitoring of fridge temperatures used to store medicines, use of personal alarms and completing observations.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Following our inspection we issued a warning notice to the provider telling them to improve by 26 January 2024. The warning notice was issued due to breaches of Regulation 12, Safe Care and Treatment which are detailed in this report including; • Failures to identify, assess and take consistent actions to mitigate and manage risks in relation to the environment. • Repairs and maintenance to the ward areas did not take place in a timely way. Damage to the environment posed risks to service users and staff. • Failures to identify, record and take consistent actions to mitigate and safely manage specific risks to individual service users. • Incidents of restrictive interventions were not well recorded. • Staff did not always carry personal attack alarms when they should have been.