Langford Clinic Limited

The Langford Centre

Inspection report

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Date of inspection visit: 1 and 2 March 2023
Date of publication: 07/06/2023

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

Summary of findings

Overall summary

The Langford Centre is an independent mental health hospital providing care and treatment to working-age adults with severe mental illness or a learning disability. The service provides one low secure forensic ward, two high-dependency mental health rehabilitation wards and three acute mental health wards for adults of working age.

The Care Quality Commission (CQC) conducted an unannounced inspection of The Langford Centre on the 1 and 2 March 2023. The inspection was carried out to check if the improvements required following the inspection in May 2022 and detailed in an action plan submitted by the provider in October 2022 had been made.

One of the acute mental health wards for adults of working age (Arlington ward) had recently opened in September 2022 and this was the first time we had inspected this ward.

Due to the concerns we identified during this inspection, the CQC used its urgent powers under section 31 of the Health and Social Care Act 2008 and issued the provider a Letter of Intent. The letter instructed the provider to provide assurance of its immediate action to improve the assessment and management of ligature risks. Subsequently, the provider supplied evidence of revised ligature audits which were an accurate reflection of ligature risks on the wards and the mitigation actions for these risks. The provider also acted promptly by removing or reducing identified ligature risks which had not previously been identified, supplied staff with appropriate ligature cutting equipment in line with their policy and rolled out additional ligature awareness training for all staff.

Our rating for The Langford Centre stayed the same. We rated it as requires improvement because:

- Each of the three core services were rated as requires improvement overall. Potential ligature anchor points still existed across the wards which had not been identified on the providers' ligature risk assessment document, despite the provider implementing a programme of works to minimise the presence of potential ligature risks after the last inspection in May 2022. A ligature anchor point is anything that could be used to attach a cord or other material for the purpose of hanging or strangulation.
- Equipment for managing ligature risk, such as wire cutters, were not available for staff to use in line with the provider's policy. Staff did not know how many ligature cutters should be available on the wards and ligature cutters which were present were not always in working order.
- We issued a Letter of Intent because the governance was not robust enough to ensure that ligature risks were assessed and managed well. The governance processes around how ligature risks were systematically reviewed, and actions carried out were not evident or documented effectively, and this had not been identified by the provider. Although immediate improvements were made in relation to the assessment and management of ligature risks, these improvements needed to be sustained and embedded.
- Staff did not always follow systems and processes to safely administer, record and store medicines and did not routinely check medical equipment.
- Whilst the provider had recruited additional occupational therapy assistants, there was only one qualified occupational therapist working across the hospital. This meant that there was limited occupational therapy support, particularly on the high-dependency rehabilitation wards where patients needed to be supported for discharge to community settings after long stays in hospital.
- Although the provider had plans to review the service model for the two high-dependency rehabilitation wards, this service did not adhere to the current model. Whilst there had been some improvement, the length of stay for patients on the rehabilitation wards was over two years, which was much longer than the anticipated maximum stay of one year for this type of service, as outlined in the CQC's brief guide for high-dependency unit specification.

Summary of findings

- There were limited activities of daily living during weekends and evenings which were basic and nurse led.
- The quality and detail of patient care plans was inconsistent across wards. Patient care plans on Seaford and Balmoral wards did not always capture patient views or goals. Positive Behaviour Support (PBS) plans on Pevensey ward were not always tailored to patient's needs and not updated regularly.
- Record keeping was inconsistent across wards. Staff recorded patient clinical information on both paper and electronic records, which posed a risk that all the information they needed to deliver safe care and treatment would not be accessible or up to date. Some staff reported that there was a lot of duplication and that documents were often disorganised and difficult to find.
- Patients' privacy and dignity was not maintained. On Arlington ward, staff searched patients returning from leave in an area which could be observed by others. On Seaford and Fairlight wards, staff did not routinely close the nursing office door which meant confidential discussions including patient identifying information could be overheard.
- A hospital wide systematic process for sharing lessons learned from incidents and complaints was inconsistent and not embedded.

However:

- Staff treated patients with compassion and kindness and understood the individual needs of patients. All patients we spoke with were positive about their experience using the service. Staff felt there was an inclusive culture and found their managers approachable.
- The provider had made progress with international nurse recruitment which had improved staffing levels and reduced the use of agency staff. Leaders ensured shifts had appropriate staff skill mix to ensure temporary staff had the right skills and experience to safely meet the needs of patients. Staff received support from ward managers and had access to clinical supervision and appraisals.
- Staff carried out comprehensive risk assessments for all patients. They understood their responsibilities in relation to safeguarding and knew how to identify issues of potential abuse and how to escalate these.
- The provider was taking proactive steps to enable patients to access Independent Mental Health Advocacy (IMHA) services on admission and routinely throughout their admission by referral, despite ongoing challenges regarding the IMHA service provision.
- Staff understood their roles in relation to the Mental Capacity Act 2005 and the Mental Health Act 1983 (MHA) and the application of the MHA was monitored closely by MHA administrators

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	Our rating of this service stayed the same. We rated it as requires improvement because: • The ward environments were not safely managed. The tools and audits used by staff did not adequately assess and manage potential ligature anchor points. A ligature point is anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. Some staff did not know how many ligature cutters were available on the ward. • The provider used both paper and electronic records. Clinical records such as the doctors initial clerking in documentations and patient risk screening were stored electronically. These were printed and subsequently stored in patients' files. This posed a risk that printed information could be old and not accurate if information had been updated in electronic format and not printed. • Patient privacy and dignity was compromised. The lobby area where patients were searched on their return from leave on Arlington ward had clear glass doors. This meant the people from outside the ward could see patients being searched by staff. On Fairlight ward, telephone conversations about patients could be heard outside the nursing office because staff did not routinely close the office door. • Controlled drugs were not safely managed. On Fairlight and Cooden ward, staff were not utilising the index in the controlled drug register. This posed a risk of controlled drug mismanagement. • The provider did not have appropriate local governance systems in place to effectively assess, monitor and improve the quality and safety of the service. Inaccuracy and inconsistencies between the way ligature risks had been assessed on each ward had not been identified by the provider.

Summary of findings

However,

- Staff observed patients safely. Patients were routinely observed by staff at different frequencies dependent on individual clinical risk. These observations were completed at intermittent times. This meant patients were unlikely able to predict when staff would observe them. Staff observed patients in bedrooms using door viewing panels which were closed when not in use.
- Staff assessed patient risk on admission. Initial risk screens were completed by the doctor on duty, these were accessible to staff. Records of the admission assessments were stored in electronic format and a paper copy was stored in patient's file. The minutes of handover meetings between staff, where they discussed how to manage patient risk, were accessible to staff.
- Staff involved patients in planning their care. Care records we reviewed demonstrated patient's involvement or staff attempts to involve patients in their care. These were updated regularly by staff with the involvement of patients, and patients were given copies of their care plans.
- Each patient had their own bedroom with an en-suite bathroom. Patients personalised their bedrooms with pictures and personal items. Patients had access to their bedroom key to lock their bedroom doors and there was no lockable space in patient bedrooms to secure personal items.
- Managers ensured there were enough staff with appropriate skills rostered to work on each shift to ensure that all patients` needs could be met. Training compliance was high for most of the mandatory training.
- The service had appropriate medical cover which included access to out of hours doctors. Each ward had a junior doctor located on the ward, working Monday to Friday to support patients and to manage new admissions.
- Although the lobby environment had clear glass which compromised patient's privacy, staff were trained to safely and effectively

Summary of findings

search patients for contraband items that may pose a risk of harm to patients using a handheld metal detector. Patients were searched on their return to the ward with their consent. When patients declined to be searched staff would risk assess the patient and observe the patient more frequently based on the risk.

- Each ward had safeguarding champions who met monthly with the senior leadership team to review all safeguarding issues across the wards.
- Patients could access independent mental health advocates (IMHAs). The advocate visited the wards on a referral basis. Posters were displayed to help patients who did not know the role of an IMHA or how to contact them.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Our rating of this service stayed the same. We rated it as requires improvement because:

- The ward environments were not safely managed. The ligature risk assessments were not robust enough and some staff told us the ligature maps were difficult to interpret.
- Staff did not always follow systems and processes to safely administer, record and store medicines and did not routinely check medical equipment. The blood glucose machines on both wards were not maintained as required by the manufacturer to ensure that they were working effectively. The fridge thermostat on Balmoral ward was faulty and a replacement had not been fitted. Staff did not keep accurate cleaning records.
- The service was currently designated as a high-dependency rehabilitation unit model, although the provider had plans to review this. Whilst there had been some improvement, patients continued to stay at the service for much longer than the anticipated maximum of one year for this type of service. Many patients were continuing to experience delayed discharges because the rehabilitation model was not clear enough.
- Patients did not have access to the appropriate amount of occupational therapy cover

Summary of findings

required by a high-dependency rehabilitation service, to meet the needs of patients. There were limited activities of daily living during weekends and evenings which were basic, and nurse led.

- Patient care plans did not always capture patient views or goals. Staff did not always record whether family or carers wanted to be involved in the patient's care.
- The provider used both paper and electronic records. Ward staff had to routinely access electronic records to print and store in patients' files. This posed a risk that printed information could be old and not accurate if information had been updated in electronic format but not printed.
- Patient privacy and dignity was compromised. On Seaford ward, telephone conversations about patients could be heard outside the nursing office because staff did not routinely close the office door.
- The provider did not have appropriate local governance systems in place to effectively assess, monitor and improve the quality and safety of the service. Ligature risks were not always assessed and managed appropriately to help manage the risk to patients, and this had not been identified by the provider's internal governance processes.
- A systematic process for sharing lessons learned from incidents and complaints with staff was not embedded.

However,

- Staff treated patients with compassion and kindness and understood the individual needs of patients. Patients reported that staff were genuinely kind, they made them feel safe and supported them emotionally.
- Patients could access independent mental health advocates (IMHAs) on a referral basis. Posters were displayed to help patients who did not know the role of an IMHA or how to contact them.

Summary of findings

- Staff assessed and managed risks to patients and themselves well. The service had improved their oversight of post rapid tranquilisation physical health monitoring.
- Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Each patient had their own bedroom with an en-suite bathroom which they could personalise. Patients had access to their bedroom key to lock their bedroom doors and were assigned a lockable space to secure personal items.
- Ward environments were well maintained, and staff followed good practice with respect to safeguarding.
- Both wards had a permanent ward manager. Staffing levels had improved leading to reduced rates of agency nursing staff being used. Both wards had registered nurses who were registered mental health nurses. Staff received appropriate mandatory training, supervision, and appraisal.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Forensic inpatient or secure wards

Requires Improvement

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always ensure that all potential ligature points were thoroughly risk assessed and that there were sufficient mitigations in place to reduce or remove such risks. There were potential ligature anchor points across the ward that had not been identified on the providers' ligature risk assessment document.
- The governance was not sufficiently robust enough to ensure that risks were managed well. Managers had not received training on how to complete a ligature risk assessment document. Staff were not always using the most up to date ligature policy document. Items for managing ligature risk such as wire cutters which were identified on the ligature risk assessment documents were not on the wards.

Summary of findings

- The service was not storing and recording medicines in line with best practice. There were different packages of methadone stored in the controlled drugs cupboard. Staff were also storing illicit substances, such as cannabis, which had been confiscated from patients in the controlled drugs cupboard. There were no audit trails or record of all items in the controlled drugs cupboard.
- The ward office was cluttered with paper files and disorganised. There were different versions of the same document which could be confusing for staff. Staff reported that there was a lot of duplication and documents were often difficult to find. Staff also reported that the ward office could be very hot. The clinic room door could be easily accessed by patients from outside putting the dispensing clinician at risk.
- Patients were bringing in illicit substances unto the wards. Although staff reported that they had received security training, it was not clear how patient were able to bring illicit substances unto the wards which could put patients and staff at risk.
- Not all staff had completed their training in managing patients with Autism & Learning Disability.
- There were concerns around restrictive practices which were not recognised as blanket restrictions and therefore regularly reviewed. For example, patients were not allowed into the kitchen to make snacks or hot drinks. However, the provider reported that this was for safety reasons.
- Some patients' positive behavioural support (PBS) plans were not tailored to their needs. For example, psychology had identified that a patient met the criteria for autism spectrum disorder (ASD), but there were no PBS plans to support them. In addition, there were no autism specific care plans for this patient. The PBS plans were not regularly updated.
- While we saw that new staff members were given an induction, managers did not ensure

Summary of findings

that staff had read and signed to show they understood the policies and procedures. In addition, the induction documents were not audited.

However,

- The ward was clean and well maintained. The wards had enough nurses and doctors. Staff followed good practice with respect to safeguarding.
- Staff carried out a comprehensive assessment of patient risk. Most patients had care plans that were tailored to their needs. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- Staff spoke very highly of their leaders. They felt there was opportunities for growth and career development.

Summary of findings

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Summary of this inspection

Background to The Langford Centre

The Langford Centre provides low secure forensic, high-dependency rehabilitation and acute inpatient mental health services to male and female working-age adults. Most patients are detained under the Mental Health Act (1983).

The service is provided by Bramley Health Limited.

The hospital is purpose built and provides seventy-six beds over six wards:

- Fairlight Ward (16 beds) is an inpatient acute ward for females,
- Cooden Ward (15 beds) is an inpatient acute ward for males,
- Arlington Ward (10 beds): is an inpatient acute ward for males,
- Seaford Ward (8 beds) is a high-dependency rehabilitation ward for males,
- Balmoral Ward (11 beds) is a high-dependency rehabilitation ward for females,
- Pevensey Ward (16 beds) is a low secure forensic ward for males,

The Langford Centre is registered to provide:

1. Treatment of disease, disorder or injury
2. Assessment or medical treatment for persons detained under the Mental Health Act 1983
3. Diagnostic and screening procedures

The hospital had a registered manager at the time of our inspection. The hospital director was fairly new in post, although the hospital was being overseen by other long standing senior managers whilst the new hospital director settled into their role.

The Langford Centre was last inspected in May 2022, when a comprehensive inspection was carried out of all the wards except Arlington ward which was non-operational at the time of the inspection. The hospital was rated requires improvement overall.

On 15 May 2022, a few days after the inspection, a patient sadly died after fixing a ligature to the sash-style window in their bedroom on Cooden ward, an acute mental health ward. Due to the concerns we identified during that inspection, we used our powers under section 31 of the Health and Social Care Act to take immediate enforcement action and placed a number of conditions on the provider's registration. This meant that the provider could not admit patients to Fairlight or Cooden wards, the two acute mental health wards for adults of working age, without seeking written permission from the CQC. The CQC also required the provider to make improvements to how ligature risks were identified and managed on Cooden and Fairlight wards, and to how individual patient risks were assessed on Fairlight ward. The urgent conditions were subsequently lifted and the provider was able to admit patients to Fairlight and Cooden wards from 9 June 2022. This was because the provider had taken prompt action to make improvements to keep patients safe. The provider worked in collaboration with the local mental health NHS trust to make some immediate improvements to the service.

At the previous inspection in May 2022, the provider had been issued with requirement notices. We told the provider to make the following improvements:

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

Summary of this inspection

- The provider must ensure improvements to how ligature risks are safely assessed and managed are sustained and embedded, and that ligature risk assessments continue to be developed by a suitably trained person. Regulation 12(2)(d)
- The provider must ensure patient observations are completed intermittently rather than at set times. Regulation 12(1)(2)(b)
- The provider must ensure nursing staff with the appropriate skills are rostered to work on each shift to safely meet the needs of patients, and that staff receive the necessary specialist training to ensure they are skilled and competent to carry out their roles. Regulation 18(1)
- The provider must ensure improvements to assessing patient risk in a comprehensive and timely manner are sustained and embedded. Regulation 12(2)(a)(b)
- The provider must ensure staff are trained to safety search patients to keep them safe from risks posed by contraband items. Regulation 12(1)(2)(b)
- The provider must ensure blanket restrictions are systematically reviewed and appropriate for patients based on clinical risk, and that patients can secure their personal items in a lockable space independently. Regulation 13(1)(4)(b)(c)(5)
- The provider must ensure all essential clinical information is appropriately managed and routinely accessible to staff. Regulation 17(1)(2)(c)
- The provider must ensure patients are involved in planning their care and treatment. Regulation 9(1)(c)(3)(a)(c)(d)(g)
- The provider must ensure that patients can access an appropriate amount of occupational therapy led therapeutic activities, including during evenings and at weekends. Regulation 9(1)(a)(b)
- The provider must ensure patients can easily access independent mental health advocates (IMHAs) on the wards. Regulation 9(1)(3)(c)(d)(f)
- The provider must ensure appropriate governance systems are in place to assess, monitor and improve the quality and safety of the service. Regulation 17(1)(2)(a)

Long stay or rehabilitation mental health wards for working age adults:

- The provider must ensure ligature risks are safely assessed and managed and that ligature risk assessments are developed by a suitably trained person. Regulation 12(2)(d)
- The provider must ensure clinical waste including used sharps are managed safely to minimise the risk of injury and infection. Regulation 12(1)(2)(h)
- The provider must ensure staff safely monitor the physical health of patients who have received medicine by intramuscular rapid tranquilisation to help identify significant potential physical health deterioration, and that staff have access to the necessary emergency medicines to manage a physical health emergency. Regulation 12(1)(2)(b)(f)
- The provider must ensure patients can easily access independent mental health advocates (IMHAs) on the wards. Regulation 9 (1)(3)(c)(d)(f)
- The provider must recruit to the ward manager posts on Seaford and Balmoral wards. Regulation 18(1)
- The provider must operate effective governance systems to enable the provider to assess, monitor and improve the quality and safety of the service. Regulation 17(1)(2)(a)
- The provider must adhere to an inpatient rehabilitation model and ensure the anticipated length of stay, patient discharge plans and multidisciplinary staffing provision, including occupational therapy and consultant psychiatry, align with this model. Regulation 9(1)(3)(a)
- The provider must ensure that each patient has a plan for their discharge from the service. Regulation 9(1)(3)(b)
- The provider must ensure patients have access to a key to their own bedroom where this is clinically appropriate. Regulation 13(1)(4)(b)(c)(5)
- The provider must ensure all essential clinical information is appropriately managed and routinely accessible to staff. Regulation 17(1)(2)(c)

Forensic wards:

Summary of this inspection

- The provider must ensure ligature risks are safely assessed and managed and that ligature risk assessments are developed by a suitably trained person. Regulation 12(2)(d)
- The provider must ensure patients have the appropriate support to develop their daily living skills, including the ability to cook and prepare meals with appropriate support from an occupational therapist. Regulation 9(1)(a)(b)(2)(3)(b)
- The provider must ensure patients can easily access independent mental health advocates (IMHAs) on the wards. Regulation 9(1)(3)(c)(d)(f)
- The provider must ensure all essential clinical information is appropriately managed and routinely accessible to staff. Regulation 17(1)(2)(c)

During this inspection we found some improvement and many of the requirement notices had been met. However, at the last inspection in May 2022 we highlighted the need for sustained improvement for how environmental ligature risks were safely assessed and managed. Furthermore, we identified the requirement for governance processes to be fully embedded and these had only been partially achieved. As a result, the CQC used its urgent powers under section 31 of the Health and Social Care Act 2008 and issued the provider the Letter of Intent. The letter instructed the provider to provide assurance of its immediate action to improve the assessment and management of ligature risks. In response, the provider supplied evidence of revised ligature audits which were an accurate reflection of ligature risks on the wards and the mitigation actions for these risks. The provider also acted promptly by removing or reducing identified ligature risks which had not previously been identified, supplied staff with appropriate ligature cutting equipment in line with their policy and rolled out additional ligature awareness training for all staff.

What people who use the service say

During this inspection we spoke with a total of 22 patients. We also undertook a short observational framework for inspection (SOFI) assessment on all wards to observe how staff were caring for patients. A SOFI is an observational tool used to help us collect evidence about the experiences of people who use the service, especially where people may not be able to fully describe this themselves because of cognitive or other problems. It enables inspectors to observe people's care or treatment looking particularly at staff interactions.

The feedback we received from these patients was positive. Patients told us that most staff were caring and treated them with respect and kindness. People we spoke with felt safe at the hospital and told us that staff were responsive to their needs.

During the SOFI assessments we observed that staff treated individual patients with respect, dignity, kindness and the staff team were caring and flexible with the individuals to meet their needs.

How we carried out this inspection

The team that inspected the hospital comprised of one CQC inspection manager, seven CQC inspectors, three specialist advisors and one expert by experience.

Before the inspection visit, we reviewed information that we held about the hospital and recent inspection reports.

During the inspection visit, we completed the following activity:

- Visited all wards and looked at the quality of the ward environments.
- Spoke with a total of 22 patients who were using the service

Summary of this inspection

- Undertook a short observational framework for inspection (SOFI) assessment on all wards to observe how staff were caring for patients.
- Spoke with 34 members of staff including senior leaders, ward managers, consultant psychiatrists, registered nurses, an occupational therapist, occupational therapy assistants, healthcare support workers and assistant psychologists. We also spoke with several agency staff.
- Reviewed 24 sets of care records including risk assessments across all wards
- Reviewed 35 prescription charts across all wards.
- Inspected the clinic rooms on all wards.
- Reviewed incident and safeguarding records across the hospital.
- Reviewed a range of documentation and policies relating to the running of the hospital.

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:

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

- The provider must ensure improvements to how ligature risks are safely assessed and managed are sustained and embedded, and that ligature risk assessments continue to be developed by a suitably trained person. Regulation 12(2)(d)
- The provider must ensure that controlled drugs are safely managed in line with national guidelines. Regulation 12(2)(g)
- The provider must ensure patients' privacy and dignity is always respected. Regulation 10(1)(2)
- The provider must operate effective governance systems to enable the provider to assess, monitor and improve the quality and safety of the service. The provider must ensure that there is a systematic review of the quality of audits, ensuring that actions are pulled through with clear ownership of who is completing the actions. Regulation 17(1)(2)(a)
- The provider must ensure that all incidents and complaints are systematically reviewed and shared with all staff. The provider and staff must be able to demonstrate how learning from incidents and complaints have led to improvement. Regulation 17(1)(2)(a)

Long stay or rehabilitation mental health wards for working age adults:

- The provider must ensure improvements to how ligature risks are safely assessed and managed are sustained and embedded, and that ligature risk assessments continue to be developed by a suitably trained person. Regulation 12(2)(d)
- The provider must ensure that medicines are stored safely. Regulation 12(2)(g)
- The provider must ensure that equipment used for physical health monitoring is checked regularly and maintained in line with manufacturer's requirements. Regulation 12(2)(e)
- The provider must ensure that care plans reflect patients' personal goals and that staff record patient and carer involvement in developing care plans where possible. Regulation 9(1)(c)(3)(a)(b)(d)

Summary of this inspection

- The provider must ensure that they complete their plans to review the inpatient rehabilitation model and ensure the service provision including anticipated length of stay, occupational therapy support and therapeutic activities align with this model. Regulation 9(1)(3)(a)
- The provider must ensure that all known risks are accounted for on the risk register and that governance processes are effective to enable the provider to maintain oversight of these risks, improve the quality and safety of the service. Regulation 17(1)(2)(e)
- The provider must ensure that all incidents and complaints are systematically reviewed and shared with all staff. The provider and staff must be able to demonstrate how learning from incidents and complaints have led to improvement. Regulation 17(1)(2)(a)

Forensic wards:

- The provider must ensure improvements to how ligature risks are safely assessed and managed are sustained and embedded, and that ligature risk assessments continue to be developed by a suitably trained person. Regulation 12(2)(d)
- The provider must ensure staff follow national best practice regarding the storage of controlled drugs. The provider must ensure that there is clear record log and audit trail for all medicines stored in the controlled drugs' cupboard. Regulation 12(2)(g)
- The provider must ensure that all patients have a positive behaviour support (PBS) plan which is personalised, tailored to meet the needs of the patient and reviewed regularly. The provider must ensure that all patients have appropriate care plans that met their needs. Regulation 9(1)(a)(b)
- The provider must operate effective governance systems to enable the provider to assess, monitor and improve the quality and safety of the service. The provider must ensure that there is a systematic review of the quality of audits, ensuring that actions are pulled through with clear ownership of who is completing the actions. Regulation 17(1)(2)(a)
- The provider must ensure that all incidents and complaints are systematically reviewed and shared with all staff. The provider and staff must be able to demonstrate how learning from incidents and complaints have led to improvement. Regulation 17(1)(2)(a)

Action the service SHOULD take to improve:

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

- The provider should ensure that they complete their planned project to prevent illicit substances from being brought onto the wards.
- The provider should ensure staff complete training in managing patients with autism and learning disability.
- The provider should ensure that agency staff are trained in Prevention and Management of Violence and Aggression (PMVA).
- The provider should ensure that restrictive practices should be reviewed regularly based on current inpatient group.
- The provider should ensure that patients' viewpoints and voices are captured and clearly documented in their care plans.

Long stay or rehabilitation mental health wards for working age adults:

- The provider should ensure that staff keeping cleaning records up to date.
- The provider should ensure that they complete their planned project to prevent illicit substances from being brought onto the wards.
- The provider should ensure staff complete training in caring for people with autism and learning disability.

Summary of this inspection

- The provider should take steps to address how paper records are stored to ensure they are organised, well catalogued and easily accessible to staff.

Forensic wards:

- The provider should ensure that they complete their planned project to prevent illicit substances from being brought onto the wards.
- The provider should ensure staff complete training in caring for people with autism and learning disability.
- The provider should take steps to address how paper records are stored to ensure they are organised, well catalogued and easily accessible to staff.
- The provider should ensure that latest versions of policies and procedures are easily accessible to staff. The provider should consider checking regularly with all staff including new inductees their understanding of the policies and procedures.
- The provider should consider taking steps to address issues around reducing restrictive practices with staff kept apprised of what constitutes a blanket restriction.
- The provider should take steps to ensure that the clinic room door is robust enough to assure the safety of the dispensing staff.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

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

Requires Improvement

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

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

The wards were clean, well equipped, well furnished, well maintained and fit for purpose. However, improvements were needed to the way that staff identified and managed ligature risks.

Safety of the ward layout

During the last inspection in May 2022, we identified that the ward environments were not safely managed. At this inspection, we identified some improvement although some concerns remained. On each ward, ligature risk assessments were in place. However, these were basic, inconsistent across the three wards and did not identify the primary ligature risk. A ligature point is anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. All ligature anchor points should be assessed as presenting a high risk. Although the provider had replaced all the windows in patient's bedrooms on the acute wards our concern relating to risk and risk management remained. On Fairlight ward, the risk rating for air conditioning units in the courtyard was rated as medium risk when it should have been rated as high risk due to the height. Similarly, on Cooden ward the risk rating for trunking for air conditioning pipes was rated as low whilst this was presenting a higher risk. We were told by a ward manager that the ligature risk assessments were completed by each individual ward manager with the support of the clinical service manager. However, they had not received specific training in how to assess ligature risks.

The CQC used its urgent powers under the Health and Social Care Act 2008 and issued the provider a Letter of Intent. The letter instructed the provider to provide evidence and assurance on its approach to assessing and managing ligature risks. Subsequently the provider had provided evidence of revised ligature audits which were accurate reflection of ligature risks on the ward and the mitigation actions for these risks. The provider also took action by moving air conditioning units to a higher height in line with its policy on Fairlight ward.

Staff could tell us how they were working to manage identified environmental risks through patient observation and patient risk assessments. Staff knew where to access ligature cutters to use in an emergency. However, there was a discrepancy on staff awareness of how many ligature cutters there were on Fairlight ward. Staff told us there were two ligature cutters on the ward whilst the ward manager told us there were five. This presented a risk of a delayed response if a patient tied a ligature and needed help, increasing the likelihood of them sustaining significant harm or death.

During the last inspection in May 2022, we identified that staff did not safely observe patients to ensure they were safe. At this inspection, we found that this had improved. Patients were observed by staff at different frequencies depending on their clinical risks. Staff completed enhanced patient observations intermittently.

Previously, we identified that patient's privacy and dignity was compromised because the spyholes which were installed on the bedroom doors could not be secured in the closed position by patients. At this inspection, we identified that this had improved. Staff could safely observe patients in their bedrooms through observation window panels on the bedroom doors and these were kept closed.

Staff could observe the communal areas of the ward from the nursing office. During this inspection we observed that there were several blind spots in the communal areas on Arlington ward and Cooden ward. We raised this with the managers during this inspection and were told that the risk of harm to patients due to these blind spots were mitigated by staff environmental observations and patient's risk assessments.

The ward complied with single sex accommodation guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

The wards were visibly clean in all areas. Cleaning schedules were in place and dedicated cleaning staff were allocated to each of the wards. Staff made sure cleaning records were up-to-date and the communal areas of the wards were visibly clean.

Infection, prevention and control processes were managed well in relation Covid-19 and protective equipment was available to staff.

Clinic room and equipment

During the last inspection we identified that staff did not routinely check that clinical equipment was in date, calibrated and safe to use. At this inspection, we found that this had improved. Equipment was in date, calibrated and safe to use. Out of date equipment was removed and disposed. The clinic room was fully equipped, and equipment was clean and checked regularly. Emergency drugs were available to the relevant registered staff, and staff checked and audited stock medicine weekly. Staff monitored room and fridge temperature daily and all medicines were labelled and were in date.

Safe staffing

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

Nursing staff

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

Requires Improvement

Managers used a formula to work out the number and grade of nurses, nursing assistants and healthcare assistants for each shift and this was dependent on the number of patients on enhanced observations. Rotas indicated that the service was always able to cover these numbers. Agency staff were used to fill vacant shifts. Nurses from the agency were familiar with the wards and knew the patients. When they started working on the wards, they completed a local induction. However, we reviewed 7 agency staff profiles which were brought to us from the compliance team. Three of the 5 files had a training log and 2 did not have a training log. The 5 agency staff files which had a training log did not complete PMVA training. The provider told us there was a plan to ensure that locum or regular agency staff were booked onto the hospital PMVA training program.

Across the wards, bank and agency staff was booked to cover staff shortage, sickness and annual leave. All the three acute inpatient wards continued to use bank and agency staff weekly. However, this had reduced significantly since our last inspection. For the months between December 2022 and February 2023, on average 28% of registered nurse shifts and 25% of support workers shifts were filled by agency staff on Arlington ward. On Cooden ward 25% of registered nurse shift and 7% of support worker shift were filled by agency for the same period. On Fairlight 38% of registered nurse shifts and 14 % of support worker shifts were filled by agency staff for the period of December 2022 and January 2023. Bank shift for the period of December 2022 to January 2023 was 2.3% for support worker shift for Arlington ward, 2.6% for Cooden ward and 4%. For Fairlight ward for support worker shifts and 0.3% for register nurse shift for the same period.

The staff turnover rate for the last 6 months across the acute inpatient wards was 7.21% and levels of staff sickness across the three wards was low at 4.09%. No shift was uncovered due to staff shortages.

During the last inspection in May 2022, we identified that leaders did not ensure staff with an appropriate skill mix were rostered to work on each shift. At this inspection, we identified that this had improved. The rota we reviewed across the three wards showed that the skill mix of staff was considered. Managers we spoke with told us that they ensured that there was always a member of staff whose first language was English to support international staff with communication skills.

Agency staff reported feeling well supported by ward managers.

Patients we spoke with told us they had regular one to one time with their primary nurse and could identify who their primary nurses were.

Medical staff

The service had appropriate medical cover which included access to out of hours doctors. Each ward had a junior doctor located on the ward, working Monday to Friday to support patients and to manage new admissions. Each ward had an allocated consultant psychiatrist available to act as responsible clinician and to oversee the patients' care. The staff teams felt this level of medical input was suitable and felt they could contact the consultants outside of their working hours if needed.

The service had a clear rota for cover for out of hours consultants and staff knew how to contact them when required.

Managers made sure that when locum medical staff were hired; they had a full induction and understood the service before starting their shift.

Mandatory training

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

Requires Improvement

Staff were mostly up to date with their mandatory training. Managers monitored mandatory training compliance and alerted staff when they needed to update their training. All training figures were above 85%, which was the provider's target except for Immediate Life Support (ILS) training which was at 55% and Safe Administration of Medicines which was at 80%. ILS training was mandatory for qualified nurses. All support staff were trained in Basic Life Support (BLS) which was 90% at the time of our inspection. The provider had plans to deliver ILS training face to face for nursing staff who were not compliant following the ease of Covid-19 restrictions.

Staff felt the mandatory training programme was comprehensive, these trainings were a combination of face to face and online trainings. During this inspection we found that Autism and Learning Disabilities training was not a mandatory training. We raised this with the senior managers. Subsequently all staff were booked for this training and the figure we received for compliance with this training following our inspection was 83% for the acute wards.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

During the last inspection in May 2022, we identified that the initial risk screen was completed by the doctor who oversaw each patient's admission and was not routinely accessible to staff. At this inspection, we found that this had improved. Patient's initial risk screen was stored on an electronic system and a printed copy was store in paper format in patient's file. Staff had access to both electronic copy and paper copy.

Management of patient risk

Patient risk was discussed in each handover meeting between shifts. Notes from these meetings were stored electronically and a printed copy was available to all staff.

Patient risk assessments and risk management plans were reviewed regularly in patient's ward round by the multi-disciplinary team. Staff told us that risk assessments were also reviewed when patient's risk had changed or following an incident. However, in one of the care records we reviewed for a patient on Fairlight ward, we saw that the risk assessment was not regularly reviewed after incidents.

Patients we spoke with reported they felt safe on the ward. There were processes for checking for contraband items. We checked this with the ward staff and reviewed their process for admission to the ward. There was a clear list of contraband items, and the staff used a metal detector to assist in searching.

Blanket restrictions were in place and were reviewed by the provider to ensure they were appropriate. However, there was restriction to access the garden for patients on Cooden ward. The manager of that ward told us that this blanket restriction was not based on individual patient risks but rather on environmental risk as the ward was located on the second floor. On Fairlight ward, patients did not have access to the kitchen. This was a blanket restriction and patients had to ask staff for access to this facility. Staff told us this was due to patients' risks.

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

Requires Improvement

Senior managers told us there was a reducing restrictive practices committee and we reviewed quarterly audits that had been completed as part of the quality assurance framework for the hospital. However, these audits showed little evidence of a review of restrictive practices and were generic for the acute wards.

Use of restrictive interventions

Episodes of physical restraint and rapid tranquilisation were low across the acute wards. 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.

Staff used de-escalation skills to manage conflict and normally de-escalated incidents of violence and aggression before the need for physical intervention. Use of physical restraint was low over six months prior to the inspection. Eleven episodes of physical restraint had taken place on Arlington ward, 31 episodes had taken place on Cooden ward, and 52 episodes had taken place on Fairlight ward. None of these restraints had used the prone position.

Rapid tranquillisation is the use of medicine to help calm a person who is extremely distressed and is at risk of harm to themselves, or possibly those around them. Use of rapid tranquillisation was low across the acute wards with staff on Fairlight ward using it 45 times, staff on Cooden ward using it 13 times and staff on Arlington ward using it five times in the six months prior to the inspection. Staff followed NICE guidance when using rapid tranquilisation.

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

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training and training compliance was overseen centrally by the rota manager to ensure all staff were booked onto training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them.

There were dedicated visiting rooms elsewhere in the hospital designated for children who visited, and the staff encouraged patients to go out with their family members as much as possible.

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

Each ward had safeguarding champions who met monthly with the senior leadership team to review all safeguarding issues across the wards and ensure actions were picked up and lessons were learned and fed back to the teams.

Staff access to essential information

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

Requires Improvement

Staff had access to clinical information. It was not easy for them to maintain high quality clinical records due to the risk of updated electronic copies of records not being printed and stored in paper file care records.

During the last inspection, we identified that staff did not always have easy access to clinical information. At this inspection we observed that this had improved. All staff had access to essential information such as risk assessments, care plans, handover documents.

Leaders reported they had plans to move all records to an electronic system although there were not yet timescales for this work to be completed.

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.

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.

We reviewed 21 sets of patient medicine records and saw that staff followed the correct procedure for prescribing and administering medicines.

An external pharmacy company completed regular audits for the use of medicines and how safely they were managed. Any actions suggested by the pharmacist were communicated with the nursing staff and the prescriber. The pharmacist visited the hospital weekly and checked that staff had acted on advice given and fed back to the senior management team.

Room temperatures and fridge temperatures were recorded and audited regularly. The clinic rooms all had labelled containers for the safe disposal of medications which was signed for securely by two nurses.

However, the management of controlled drugs was not safe and was not in line with national guidance. On Fairlight and Cooden wards, we saw that the index in the controlled drug register was not being used appropriately. Staff had started using the index and page for certain drugs but had not continued to use the index on the register. This posed a risk of controlled drug mismanagement or inaccurate recording of these 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.

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

Requires Improvement

Staff recognised incidents and reported them appropriately. Staff reported all incidents using a paper-based incident reporting system. Staff met to discuss the feedback and look at improvements to patient care.

Serious incidents were initially discussed at the morning managers handover meeting. From here it was decided what immediate action should be taken and a member of the clinical team was allocated to investigate the incident. The incident review then fed into the patient safety meeting, which was held monthly, where representatives from all the wards reviewed all serious incidents and lessons learned. Incidents were also discussed at clinical governance meetings.

Managers and members of the senior management team debriefed and supported staff and patients after serious incidents. Weekly multi-disciplinary team meetings also reviewed serious incidents for individual patients and showed evidence of discussion. However, staff we spoke to were not always clear how managers shared feedback from incidents with staff and how learning was used to improve the quality of care. Staff were not able to give examples of how local incidents or accidents across the hospital had affected the way they worked.

Is the service effective?

Good

Our rating of effective improved. 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.

Doctors assessed the physical and mental health of all patients on admission. They developed care plans which were reviewed and updated regularly by the multidisciplinary team.

Each patient had a care plan in place. Physical health care plans were individualised to the patients' health needs. Although, mental health care plans were generic and followed a standard format.

Ten patients we spoke with across the three wards told us that they felt involved in their care planning and had been given a copy of the plan.

On Fairlight ward we reviewed two patient care plans. These were not regularly reviewed or updated following a change in the patient's risk or presentation. Documentation of the care plans for these patients showed they had not been involved in developing their care plans and they refused to sign these. All patients on Fairlight ward had a psychology treatment plan. One of the patients we spoke with said how beneficial the mood chart created by psychology staff had been in helping her. Care plans for patients on Cooden and Arlington wards were of a higher quality. Staff had involved or attempted to involve patients in planning their own care and treatment. For example, patients' particular needs around wound care and managing their diabetes or alcohol withdrawal had been well documented.

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

Requires Improvement

The service benefitted from having junior doctors based on the wards throughout the week who were able to focus on physical health and we saw evidence of good physical health monitoring on Cooden ward. Staff made sure patients had access to external physical health care, including specialists as required.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

During the last inspection in May 2022, we identified that patients did not have appropriate access to occupational therapy support. At this inspection we saw that this had improved. On the acute wards the therapy programme was run by the occupational therapist, the therapy technicians, and assistant psychologists. The therapy programme was in line with National Institute for Health and Care Excellence (NICE) guidelines which recommend meaningful and culturally appropriate activities seven days a week and not limited to 9am to 5pm. Staff delivered an occupational therapy activity programme during the day from 9-5 and two evenings in the week. There was a timetable for planned weekend activities on Saturday or Sunday, but these were basic activities such as DVD nights and art. Activity timetables on the wards included a range of individual and group work.

Staff identified patients' physical health needs and recorded them in their care plans and made sure patients had access to physical health care, including specialists as required.

Managers took part in a programme of clinical audits which fed directly into the quality assurance framework of the hospital. These audits were monitored by the ward managers using a dashboard system which was reviewed regularly by the compliance team at the hospital. Managers used results from audits to make improvements.

Staff used clinical outcome measures such as HONOS (Health of the Nation Outcome Scales) to review improvement or progress patients have made whilst in the acute wards. HoNOS is a clinician rated instrument comprising 12 simple scales measuring behaviour, impairment, symptoms and social functioning.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). 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 a full range of specialists to meet the needs of the patients on the ward.

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

Managers gave each new member of staff a full induction to the service before they started work. Managers supported staff with appraisals, supervision, and opportunities to update and further develop their skills.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Staff also accessed regular clinical supervision of their work. Long-standing agency staff were not entitled to this same level of support.

Staff we spoke with told us that they had access to appropriate specialist training to equip them to meet the needs of the acute patient group. This included training on management of violence and aggression, and health and safety training.

Agency support workers staff we spoke with had experience of working on an acute ward. Managers booked agency staff who had worked on the wards previously and worked regularly at the hospital.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff from different disciplines worked together as a team to benefit patients. The ward teams had effective working relationships with other relevant teams within the hospital and with relevant services outside the hospital.

Staff held a weekly multidisciplinary ward meeting on each of the acute wards to discuss patients' care and develop multi-disciplinary care plans. We attend one of these meetings on Arlington ward. We observed staff collaborated in their approach to patient care.

Daily handover meetings were clear and structured. The senior management team also had a senior handover meeting each morning to review any risk or safeguarding activity across the hospital and to check staffing arrangements across the wards.

Ward teams had positive working relationships with external teams and organisations. The bed manager from the local mental health trust attended the weekly ward round meetings virtually to oversee the clinical management of patients.

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 (MHA) and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them. Informal patients were not all aware that they had the right to leave the ward. The provider did not ensure that patients had easy access to Independent Mental Health Act advocates (IMHAs).

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

During the last inspection in May 2022, we identified that informal patients were not aware they could leave the ward freely and were told by staff that if they tried to leave without staff support, they could be detained under the MHA. At this inspection, we found that this had improved. There were signs on the doors in the corridor on each of the acute wards informing informal patients they were able to leave the ward.

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

Requires Improvement

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who the Mental Health Act administrator was and when to ask them for support.

The wards had access to advocacy service, but this was on a referral basis. The advocate attended the ward and met with patients who had made an appointment. Patients we spoke with were aware of the process for accessing support from independent mental health advocacy. There was information in relation to accessing the advocate service on information boards on the wards.

Staff took time to speak with each detained patient about their rights under the MHA in a way that they could understand. They repeated this as necessary and recorded it in the patient's notes each time. There was a form that was completed for informal patients to record that a conversation had happened in relation to their rights.

Staff received and kept up to date with mandatory training on the Mental Health Act and the Mental Health Act Code of Practice and established staff could describe the Code of Practice guiding principles.

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 trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Nurses and managers understood the provider's policy on the Mental Capacity Act 2005 and the multi-disciplinary team reviewed capacity to consent to treatment in ward rounds. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. There was a policy on Mental Capacity Act and deprivation of liberty safeguards, which staff knew how to access. Staff received and kept up to date with mandatory training in the Mental Capacity Act and understood the five basic principles.

Paper records had evidence that assessment of capacity to consent to treatment had happened and was reviewed when necessary.

Is the service caring?

Requires Improvement

Our rating of caring stayed the same. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However, they did not respected patients' privacy and dignity.

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

Requires Improvement

During the last inspection in May 2022, we identified that staff did not always respect patients' dignity and some patients reported that communicating with staff was sometimes a challenge. At this inspection we observed that this had improved.

Staff attitudes and behaviours when interacting with patients showed that they were positive, calm, respectful and responsive to the needs of patients. Staff knew patients well and provided the right kind of support based on their individual needs. Staff provided patients with help, emotional support, and advice at the time they needed it.

We spoke with 10 patients. The feedback we received from patients was positive. Patients said that their thoughts and views were sought, considered, and addressed. Patients described staff as approachable, polite, kind, and helpful.

Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment, or condition. Upon admission, staff discussed patients' cultural, religious, and social needs and documented these to provide effective care. They also helped patients access different services such as advocacy and specialist health services.

Patients we spoke with said they felt able to raise concerns and that staff worked to resolve the issue quickly. Staff said they could raise concerns about disrespectful, discriminatory, or abusive behaviour towards patients without fear of the consequences as there was an open culture.

During the last inspection in May 2022, we identified that some bedroom doors had spy holes for staff to observe patients in their bedrooms, which could be operated by anyone using the bedroom corridor. Other bedroom doors had staff-operated vision panels to provide staff with clear visibility into patient bedrooms when they needed to undertake observations. Previously patients told us that their vision panels were left open by staff, and we observed that all the vision panels on bedroom doors were left in the open position. At this inspection we observed that all doors were fitted with vision panels, and these were closed when not in use to protect patient`s privacy and dignity.

During the last inspection patients told us that they did not feel involved in their care planning and had not been given a copy of the plan after admission or after it had been reviewed in the ward round. At this inspection we reviewed 13 care records. Documentation of these care records demonstrated that staff involved or attempted to involve patient in their care plans and a copy of this was offered to them.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients.

Staff told us they made every effort to keep patient information confidential, patient information folders were kept in the staff office. However, we observed staff discussing patient information on the phone whilst the office door was open on Fairlight Ward. This meant that the patient's personal information could be heard by people outside the office. This was a breach of patient confidentially.

Patient privacy and dignity was also compromised on Arlington ward. Patients returning to the ward were searched in a lobby. Staff searched what items were brought back and patients were searched using a metal detector. This lobby area where patients were searched on their return from leave on Arlington ward had clear glass doors. Although no body searches were carried out at the lobby, this meant people from outside the ward could see patients being searched by staff.

Involvement in care

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

Requires Improvement

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.

During the last inspection we identified that staff did not routinely involve patients in care planning and risk assessments and did not always actively seek their feedback on the quality of care provided. At this inspection we saw that this had improved.

Involvement of patients

Patients were involved in their care on the acute wards. We spoke with 10 patients across the three wards. They told us they knew who their named nurse was and had regular one to one meeting with their named nurse. Care records we reviewed demonstrated that staff involved or attempted to involve patients in their care plans. Patients were offered a copy of their care plan and where patients refused to participate or accept these, it was documented that the patient had refused.

During the last inspection patients told us that they did not feel involved in their care planning and had not been given a copy of the plan after admission or after it had been reviewed in the ward round. At this inspection we reviewed 13 care records. Eleven out of the 13 care records demonstrated that staff involved or attempted to involve patients in their care plans and a copy of this was offered to them.

On Arlington and Cooden wards we identified better examples of patients being involved in their care planning and that patients were having regular discussion about support for autism, physical health care planning and alcohol consumption or withdrawal plan were in place where necessary.

Staff used the admission process to welcome patients to the ward and introduce them to the service. Patients could give feedback on the service and their treatment and staff supported them to do this through regular weekly community meetings and monthly peoples' council meetings which were attended by representatives from each ward. This meant for the acute wards the action required in relation to acting on patients' feedback was being met.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff told us that they had regular contact with families and carers. We could see from the patient ward round records that family members were invited if patients gave consent. This was facilitated mostly via teleconference.

Staff sought patient consent to share information with relatives before doing so. The ward manager on Cooden ward told us the service had plans to introduce a carers forum to support carers and to strengthen the working relationship with carers.

Is the service responsive?

Good

Our rating of responsive improved. We rated it as good.

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

Requires Improvement

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Patients were not discharged before they were ready. Staff did not move or discharge patients at night or very early in the morning. All admissions were planned and coordinated with the local mental health NHS trust who block booked the beds.

When patients went on leave there was always a bed available when they returned. During the inspection there were patients on community leave and their beds were available for when they returned.

Managers worked with discharge planners from the local mental health NHS trust and regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to.

Staff liaised with colleagues at the local mental health NHS trust to ensure that in the event of a patient requiring a more enhanced level of care, such as care in a psychiatric intensive care unit (PICU), they were able to move the patient to the appropriate setting promptly.

Discharge and transfers of care

The multi-disciplinary teams reviewed the discharge arrangements for the patients who were ready to leave hospital and had oversight of these patients' discharge plans. We reviewed the records for one patient who was being discharged on the day of the inspection and observed that their primary nurse had recorded one-to-one sessions where they had made post discharge plans with the patient and discussed what support the patient required.

In ward rounds the multi-disciplinary teams monitored the number of patients whose discharge was delayed, they knew which ward had the most delays, and took action to reduce them.

Patients did not have to stay in hospital when they were well enough to leave.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

During the last inspection in May 2022, we identified that patients were not able to lock their bedroom doors without assistance from staff and patients did not have a lockable space in their bedrooms to store personal items. At this inspection, we found that this had improved. We saw patients had access to the key to their bedrooms. The managers we spoke with told us that patients could have the key to their rooms, but some chose not to. Patients also had a lockable cabinet in their bedroom to store any valuable belongings.

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

Requires Improvement

Patients on Fairlight and Arlington wards had access to a ward garden that they could access easily. The door to this garden was kept open so patients could walk in and out freely when they wanted fresh air. On Cooden ward, as it was on the second floor, patients could not access an outside space freely and required staff escort to enable them to use the stairs to access the garden. This was recorded as a restrictive practice on the ward audit, but the audit showed no plans on how to review this restriction.

Each patient had their own bedroom with an en-suite bathroom. Patients personalised their bedrooms with pictures and personal items.

Patients on the acute wards always had access to drinks and snacks.

Patients were able to use their own personal mobile phones if this had been risk assessed by the clinical team and most patients we spoke with had their own phones with them on the wards. If patients did not have a suitable mobile phone, they were able to use the ward phone to take incoming calls.

Patients' engagement with the wider community

Staff supported patients with activities outside the service and family relationships.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community such at local gymnasium, library, and shops.

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.

During the last inspection in May 2022, patients told us that the food available did not always meet their dietary needs. Patients with specific religious needs for foods were not being met, other patients told us vegetarian options were poor. At this inspection we observed that this had improved. Leaders had identified this as an issue and had arranged for the head chef to attend some of the community meetings to discuss this with the patients. Out of the 10 patients we spoke with, two reported they were not happy with the quality food they received.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us that they could access translation services when needed.

Patients could make phone calls in private. Patients also had access to their own mobile phones, which was risk assessed on an individual basis.

The ward had personal emergency evacuation plans in place for patients with mobility needs who required them. We identified two patients who had clear plans in place to ensure staff supported them to leave the building promptly in an emergency.

Listening to and learning from concerns and complaints

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

Requires Improvement

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.

Patients and staff understood how to use the provider's formal complaints process. Patients knew how to complain or raise concerns. Posters detailing how to follow the complaints process were displayed on both wards. Complaints and compliments were routinely discussed monthly during clinical governance meetings.

Ward managers we spoke with told us they responded to complaints within the five-day target. The service had oversight of complaints. Complaint which could not be resolved immediately and needed further investigation were conducted by another ward manager.

Staff understood the policy on complaints and knew how to handle them. Agency staff we spoke with would refer patients to the nurse in charge or manager in the first instance to report a complaint.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

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

Ward managers had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The service had recently appointed a hospital director. The senior managers and ward managers had a good understanding of the services and their challenges. The senior management team were visible and accessible to staff and patients. They demonstrated effective leadership skills, were role models, and had developed an inclusive culture. They empowered staff to develop ideas to improve the care of patients.

The ward managers on the acute wards had a good understanding of the services they managed and a clear focus on providing high quality care. Staff were positive about their managers and felt well supported and listened to. Staff said the managers had an 'open door' policy, were very visible on the wards and helped support staff on the wards in practical ways. All staff felt comfortable raising issues directly with senior colleagues and were confident these would be addressed.

Leadership development opportunities were available, and staff were encouraged to develop skills and competencies. There were also opportunities for staff below this level to develop.

The ward managers knew the training and development needs of their staff and supported them to attend training to develop skills and competencies. For example, further training was provided to support staff in managing violence and aggression.

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

Requires Improvement

Vision and strategy

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

During the last inspection in May 2022, we identified that the senior leadership team had not communicated the organisations vision and values effectively and staff were not able to inform us of the provider's vision or describe how these should be applied in the process of their work. At this inspection we observed that this had improved.

Staff on the acute wards knew the organisation mission and felt that these were reflected by their team and the service they provided. Managers ensured team objectives reflected those of the organisation through team meetings, supervision, and appraisals.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff we spoke with talked positively about their roles and were passionate about the service developing. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. Staff members at all levels told us they felt valued, had input into the service, and were consulted and involved in service quality development.

Staff felt they had suitable levels of supervision and felt that ward managers were approachable and available for ad-hoc supervision.

Staff were aware of the provider's whistleblowing policy and knew how to use the whistleblowing process. However, all staff we spoke to said they would raise concerns directly with management and described the culture as being very open and honest. They felt confident that their concerns would be acted upon without recourse to the whistleblowing procedure.

At the time of the inspection, managers told us no grievance procedures were being pursued within the acute wards and there were no allegations of bullying or harassment.

The provider carried out an annual staff survey which was last completed in February 2023. Sixty-one staff completed the survey across the hospital. The themes that were identified from the survey were "does your manager or team leader assist you with managing stress levels at work, do you feel recognised, respected and motivated by your manager and are you aware of Bramley Health's Employee Assistance Programme". The provider had developed an action plan to address these areas.

Governance

Our findings from the other key questions demonstrated that governance processes were not robust enough to enable the provider to assess, monitor and improve the quality and safety of the service.

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

Requires Improvement

During the last inspection in May 2022, we found that the provider did not have robust internal assurance processes which meant that many of the issues identified during the inspection were unknown to senior leaders. At this inspection we saw that some improvement had been made.

There was a clear governance structure in place with routes of escalation, reporting and decision making. Ward managers and the senior management team had access to data relating to the quality and safety of the care delivered through attendance at monthly hospital-wide clinical governance meetings. These meetings ensured that standard agenda items such as staffing, complaints, safeguarding, incidents, outcomes of audits, medicines management and service level risks were routinely reviewed and discussed.

Managers had been proactive in successfully implementing an international recruitment campaign which had improved staffing levels across wards. All staff received appropriate levels of mandatory training for their role and there was an effective system in place to ensure that this training was kept up to date. Managers had oversight of training needs via a central electronic mandatory training compliance system.

However, we remained concerned that the governance processes around how ligature risks were systematically reviewed, and actions carried out were not evident or documented effectively, and that this had not been identified by the provider. Furthermore, a systematic process for sharing lessons learned from incidents and complaints was not embedded.

Staff took part in a programme of clinical audits which fed directly into the quality assurance framework for the hospital, although some of the concerns identified during our inspection had not been flagged through this process.

Management of risk, issues and performance

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

There was a system in place to identify, monitor and address risks at the hospital. Staff maintained and had access to the risk register at hospital level. Ward managers could escalate concerns when required. Managers told us the risks listed on the register were discussed at the clinical governance meeting. This ensured that risks were continually monitored and minimised where possible.

Information management

During the last inspection, the provider told us that they planned to develop an electronic care records system. At this inspection, leaders told us that plans to implement the chosen system in November 2022 had been halted due to technical issues with the system and that the system was no longer available. Managers told us that alternative electronic systems had been considered, in liaison with the local NHS trust, to identify a suitable electronic system, although discussions were ongoing.

The ward managers and the quality team had dashboards in place to support them in their role. This included information on staffing, supervision and appraisals, training, and hospital performance data.

Staff were aware of the requirements to refer to external bodies such as the CQC when required, to report incidents and safeguarding issues.

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

Requires Improvement

Staff collected data about outcomes and performance.

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 had the opportunity to give feedback about the service via the patient weekly community meetings which happened on all the acute wards. Items from these meetings were populated on a "You said, we did" board where patients could see what actions had been taken.

The service had a carer's annual survey. The last carer's survey was completed in June 2022. Eight carers took part in this survey. Feedback from the survey was positive to all 11 questions, with answers ranging between 'satisfied, very satisfied or extremely satisfied'.

The acute wards regularly met with external stakeholders and commissioners of the service through engagement meetings. Staff told us that the provider had received positive feedback from one of the local trusts who was positive about the care delivered to their patients.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

Improvements were needed to the way that staff identified and managed environmental ligature risks. However, the wards were visibly clean, well furnished, well maintained and fit for purpose.

Safety of the ward layout

During the last inspection in May 2022, we identified that the ward environments were not safely managed. At this inspection, we identified some improvement although some concerns remained. Potential ligature anchor points were not always assessed and managed appropriately to help manage the risk to patients. For example, environmental ligature risks were not always identified on the corresponding ligature risk assessments.Two service user bedrooms on Balmoral ward had their own lockable medicines safe attached to the wall for service users who had been appropriately risk assessed to store their own medications. A ligature could potentially be tied around these, and this risk had not been identified in the ligature risk assessment. A ligature point is anything which could be used to attach a cord, a rope or other material for the purpose of hanging or strangulation.

Ligature cutters were not systematically checked to ensure they were accessible and safe to use. One of the ligature cutters on Seaford ward appeared rusted. This posed a risk that it might not be effective if staff needed to use it in the future. The provider's ligature policy stated that ligature cutters should be checked after every use, and where necessary be sharpened or replaced after each use. However, staff could not tell us whether the ligature cutter had been used previously and kept no record of this.

Staff did not complete or regularly update thorough risk assessments of all ward areas to remove or reduce any risks they identified. For example, the ligature risk assessment for Balmoral ward, dated 12 September 2022, rated bedside cabinets and beds as a medium residual risk, with actions for them to be fixed to the floor, in all bedrooms. We saw that this had not been done. There were no dates recorded for the actions to be completed by. This meant that the people

identified to complete this work would not be held to account, which may cause unnecessary delay and an unnecessary increased risk of harm to patients for longer. Furthermore, staff did not know when ligature risk assessments should be reviewed and by who. This posed a risk that staff would not identify when these could become outdated and inaccurate for staff.

Staff did not always know how to use the ligature 'heat maps', which were designed to aid their awareness and understanding of how to manage ligature risks. Some staff on Balmoral ward reported that they found the ligature heat map difficult to interpret.

On Balmoral ward, we observed that the ward manager's office door was not locked when vacant. Staff told us that they did not routinely lock the room which contained ligature risks.

Following the inspection visit, the CQC used its urgent powers under the Health and Social Care Act 2008 and issued the provider a Letter of Intent. The letter instructed the provider to provide evidence and assurance on its approach to assessing and managing ligature risks. Subsequently, the provider supplied evidence of revised ligature audits which were an accurate reflection of ligature risks on the wards and the mitigation actions for these risks. The provider also acted by promptly removing the medicines safes from bedrooms and ensuring bedside cabinets were fixed to the wall. The provider also took swift action to supply staff with appropriate ligature cutting equipment in line with their policy, and additional training in ligature awareness.

Due to the layout of the building staff could not always observe patients in all parts of the wards. There were closed circuit television (CCTV) cameras that operated across both wards to mitigate this, although this was only reviewed post incident. Most patients on Seaford and Balmoral wards were assessed as low risk of self-harm and/or suicidality. Managers told us that in the event of the risk increasing, appropriate enhanced observations would be put in place.

The service complied with the Department of Health and Social Care guidance on eliminating mixed-sex accommodation in hospitals. Balmoral ward was a female only ward and Seaford ward was a male ward.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were well maintained, well-furnished and fit for purpose, although staff did not always clearly record why patient bedrooms had not been cleaned. For example, on Balmoral ward, during the four weeks preceding our inspection, there was not one day in any week where all bedrooms had been cleaned with no explanation recorded. On Seaford ward, there were records left blank which meant that staff did not know whether areas had been cleaned or not.

Clinic room and equipment

Equipment was not always checked to ensure that it was working effectively. For example, the blood glucose machine on Balmoral ward was last calibrated in 2021. The blood glucose machine on Seaford ward had also not been recently calibrated and a staff member we spoke with did not know that this was required by the manufacturer to ensure quality control. There were patients across both wards who were diabetic and prediabetic which meant that staff monitoring these conditions could not rely on these machines for accurate readings.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

During the last inspection we found that improvements needed to be made to ensure clinical waste was managed safely. At this inspection we found that clinical waste bins were properly used and maintained. This had been added to the daily clinic room audit to ensure staff were checking clinical waste bins routinely.

Clinic rooms were clean and fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. Since the last inspection, the provider had taken steps to recruit international nurses following the introduction of overseas nursing programme by the UK government. Many were working towards gaining their registration with the Nursing and Midwifery Council (NMC) to become registered nurses in the UK. All the staff we spoke with felt that the staffing levels had improved.

The service had no nurse or support worker vacancies. At the time of our inspection, six nurses and 14 support workers were going through pre-employment checks and were yet to start.

One registered nurse worked on each ward during each shift. If the nurse needed to leave the ward for any reason for example, ward rounds, this left the wards without a registered nurse. However, staff told us they could call on a nurse from another ward when required, to assist when the registered nurse was absent. The ward manager, who was a registered mental health nurse, was also available across both wards Monday to Friday 9am to 5pm, to support the nurse in charge.

Managers calculated the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager told us that they could adjust staffing levels according to the needs of the patients. For example, on Seaford ward they had a patient on one-to-one observations during the day and the ward manager had been able to allocate an additional staff member for each shift so that the staffing levels were not negatively impacted.

Both Seaford and Balmoral wards continued to use bank and agency staff weekly. However, this had reduced significantly since our last inspection. For the months between September 2022 and February 2023, on average just under 49% of registered nurse shifts were filled by agency staff and just under 4% were filled by bank staff on Seaford ward, and just under 46% were filled by agency staff and just under 1% were filled by bank staff on Balmoral ward. For support worker shifts, just over 14% and 21% were filled by agency staff, and just under 7% and just under 8% were filled by bank staff on Seaford and Balmoral wards respectively. Both wards used regular agency nurses who knew the patients well. The service had enough staff on each shift to carry out any physical interventions safely.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff shared key information to keep patients safe when handing over their care to others. Handover meetings were held at the start of both day and night shifts to ensure that necessary information about patients was shared.

The staff turnover rate for the last 6 months across both wards was 6.85%

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Levels of staff sickness across both wards was low at 3.88%.

Medical staff

The service had appropriate medical cover and a doctor available to go to the ward quickly in an emergency. Each patient was registered with a local GP.

Both wards had their own locum consultant psychiatrist who worked two days per week, to act as responsible clinician and to oversee patients' care. Each ward also had an associate specialist doctor who worked full-time for the service.

Staff had access to an on-call consultant psychiatrist out of hours during evenings and weekends and knew how to contact them when required.

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

Mandatory training

Staff had completed and kept up to date with their mandatory training. All training figures were above 85%, which was the provider's target. Managers monitored mandatory training and alerted permanent staff when they needed to update their training.

Staff felt the mandatory training programme was comprehensive and met the needs of patients and staff. The training was a combination of face-to-face and online training. During this inspection we found that training for managing people with autism and learning disabilities was not included in the provider's mandatory training schedule, in line with legislation. We raised this with senior managers who told us that this was an administrative error due to their training provider having stopped providing this training and it being removed from the system. During the inspection, managers showed us evidence that all staff had been booked onto the training for the weeks following our visit. Data received from the provider following the inspection showed that 100% of staff across both Seaford and Balmoral wards had completed this training.

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.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. All patients received a short-term assessment of risk and treatability (START) assessment on admission. Risk assessments were updated every three months unless there was an identified change in risk.

Where appropriate some patients had a Historical Clinical Risk Management (HCR20) in place. This is a structured tool for assessing the risk to others for individuals with a forensic history, and to monitor their response to treatment and interventions.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patient risks were discussed regularly during ward rounds, with input from the multi-disciplinary team (MDT). Specific patient risks were also discussed during shift handover meetings which were recorded and accessible to staff.

Management of patient risk

During the last inspection we found staff did not always robustly monitor the physical health of patients who received medicines via rapid tranquilisation, who were at a heightened risk of significant physical health deterioration. At this inspection we found that this had improved, and staff followed NICE guidance when using rapid tranquilisation. Records showed the use of intra-muscular rapid tranquilisation was rare on the wards. Seaford ward reported no uses of rapid tranquilisation over the past six months and Balmoral reported seven uses. Staff explained how de-escalation methods would be made prior to the use of rapid tranquilisation. The service had improved their oversight of post-dose physical health monitoring. Instances of rapid tranquilisation were routinely discussed during morning handovers and daily leader's meetings attended by members of the multi-disciplinary team (MDT). This assured the provider that staff were adhering to the process for physical health monitoring post rapid tranquilisation.

Staff knew about any risks to each patient and acted to prevent or reduce risks. For example, one patient on Balmoral ward was prescribed high dose antipsychotic therapy (HDAT) which is an antipsychotic drug prescribed at a daily dose above the maximum recommended limit in the British National Formulary (BNF). This patient had a clear care plan recorded for how staff would monitor and manage the patient's physical health risks associated with their medicine.

Staff complied with protocols to manage the risk to a patient of childbearing age who was prescribed sodium valproate. National standards require that a woman of childbearing age should not be considered for this medication except in special cases because of the effects on any new-born child. Part of the requirement is to discuss the risks with the patient and with their consent carry out regular pregnancy tests. These requirements were met by the medic for this patient on Balmoral ward, who was also prescribed contraceptive medicine, and we saw clear recording of staff monitoring in the patient's care plan.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff followed procedures to minimise these risks and where they could not easily observe patients, staff used enhanced observations where clinically appropriate.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

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

Levels of restrictive interventions were low and /or reducing and staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The service recorded 17 restraints across both wards over the past six months. None of these restraints had used the prone position.

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. Prevention Management of Violence and Aggression (PMVA) training was mandatory for all staff who worked with patients. At the time of our inspection, across both wards 88% of staff had completed their PMVA training.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff monitored and regularly reviewed any blanket restrictions, and restrictions were specific for each patient and were in the patient's best interest. Senior managers told us there was a reducing restrictive practices committee and undertook quarterly audits as part of the quality assurance framework for the hospital.

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 and kept up to date with training on how to recognise and report abuse, appropriate for their role. One hundred percent of staff across both wards had completed their adult safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding records showed that appropriate referrals were made, investigated and lessons learned.

Staff followed clear procedures to keep children visiting the ward safe. There was a visitor's room next to reception away from the wards where patients could meet with their visitors including children.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff access to essential information

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

During the last inspection in May 2022, we identified that the initial clerking in documents completed by the doctor on admission were stored electronically and not routinely accessed by staff. At this inspection we observed that this had improved. To mitigate this, the provider had implemented an audit to ensure all clerking in documents were printed and placed in patient folders within 24 hours. However, the continued use of both paper and electronic records posed a risk of duplication, and that staff would not be up to date with essential clinical information.

Senior leaders reported that they had plans to move all records to an electronic system which aligned with the local NHS trust, although there were not yet timescales for this work to be completed.

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

Paper records were stored securely in individual folders in the nurse's office and medicine records were stored in the clinic room.

Medicines management

Staff did not always follow systems and processes to safely store medicines. However, staff recorded and administered medicines safely, and regularly reviewed the effects of medications on each patient's mental and physical health.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff followed systems and processes to record and administer medicines safely.

The thermostat for the medical fridge on Balmoral ward was faulty. A new one had not been installed despite staff telling us they had reported this two weeks before the inspection. There were no medications currently required to be stored in the fridge. However, if the ward had a new admission and/or a patient's medication changed, there was the potential that medicines would not be stored safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed each patient's medicines regularly, including the effects of each patient's medicines on their physical health and provided information and advice to patients about their medicines.

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 when things went wrong, staff apologised and gave patients honest information and suitable support. However, a systematic process for sharing lessons learned with the whole team and wider service was not embedded.

Staff knew what incidents to report and how to report them. Staff made appropriate notifications to external agencies such as the CQC and the local authority when required.

Staff knew what incidents met the serious incident criteria and how to report them in line with the provider's policy. There was a process to ensure staff and patients received a debrief after any serious incident.

The service had no never events on either ward. Never events are serious incidents that are preventable.

Staff understood the duty of candour. Staff told us it was about being open and honest, and giving patients and families a full explanation when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

A systematic process for sharing lessons learned with staff was not embedded. Whilst incidents were discussed at monthly clinical governance meetings, staff meeting and morning handover minutes showed that learning was not being routinely discussed at team level. However, staff we spoke with told us that learning and feedback was shared on an informal basis. We fed this back to managers during the inspection, who updated the team meeting agenda template to include standing agenda items which covered 'lessons learnt from incidents on the ward' and 'lessons learnt from incidents in the hospital', however this needed embedding.

Is the service effective?

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Care plans did not always reflect patients' voices. However, patients were offered a copy of their care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Staff assessed the physical and mental health of all patients on admission.

During the last inspection we found that staff did not always record whether patients were offered copies of their care plans. At this inspection we found that this had improved. However, patient care plans did not always capture patient views or goals. Across both wards we looked at eight out of 15 patient's care records. Whilst we saw that patients had been involved in care planning, in six out of eight records looked at most of the interventions were prescribed by professionals and patient views, opinions, voices or statements were not evidenced or documented. Staff informed us that often patients did not wish to be actively involved in their care plans and chose not to engage with staff completing them. However, staff were not recording this in care plans when patients had chosen not to take part in planning their own care.

Staff did not always record whether family or carers wanted to be involved in the patient's care. Five out of eight care records looked at had minimal or no evidence recorded of family or carer involvement. The Royal College of Psychiatry Standards for Inpatient Mental Health Rehabilitation Services 2020 3.3 recommends that staff must develop the care plan collaboratively with the patient and their carer (with patient consent).

Patient care plans were reviewed and updated following ward rounds which took place every two weeks. Most patients had positive behaviour support (PBS) plans and any psychology or occupational therapy interventions were detailed in patient care plans. The psychological interventions included strategies for crisis management and relapse prevention.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Each patient had a short-term assessment of risk and treatability (START) assessment on admission which identified potential risks such as risk of violence, self-harm, and substance use.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the wards which was clearly documented in the care plans we looked at. Staff reported that the doctors were required to carry out weekly physical health monitoring for patients.

Best practice in treatment and care

Staff provided a range of treatment and care for patients, although this was not enough to meet the needs of patients requiring treatment at a high-dependency rehabilitation unit. However, access to specialist multi-disciplinary team members including occupational therapy had improved.

Previously we raised concerns around the provision of activities being delivered on the high-dependency rehabilitation wards, and patients not having appropriate access to occupational therapy support. During this inspection the service had made improvements to the provision of occupational therapy staff. The provider had recruited additional

occupational therapy assistants (OTA), one of which was dedicated to the two rehabilitation wards. However, there was still only one occupational therapist (OT) across the whole hospital. This meant that the OT may not have sufficient capacity to provide OTAs with the required support to deliver therapeutic activities to patients in a rehabilitation setting. The Royal College of Psychiatry Standards for Inpatient Mental Health Rehabilitation Services 2020 5.5(e) recommends that a high dependency unit that admits detained patients with up to 16 beds has one whole time equivalent occupational therapist as part of the multi-disciplinary team (MDT).

We reviewed activity timetables on the wards which included a range of individual and group work, including horticulture and garden maintenance, health walks, pool, arts and crafts, one-to-one cooking sessions, one-to-one shopping, and yoga. Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Occupational therapy staff used the model of human occupation screening tool (MOHOST) to develop an individualised activity plan for each patient. This is an assessment tool used to gain an overview of patients' occupational functioning including self-care, productivity, leisure, and motivation. However, there were still limited activities of daily living (ADL) during weekends and evenings, and activities during these times were basic activities such as board games and art which were nurse led. The National Institute for Health and Care Excellence (NICE) guidelines recommend meaningful and culturally appropriate activities seven days a week, not limited to 9am to 5pm.

Staff ensured patients had access to regular physical health care, including specialists as required, and recorded them in their care plans. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff used technology to support patients. For example, patients had access to their mobile phones and could access computers with staff support.

Staff took part in a programme of clinical audits which fed directly into the quality assurance framework for the hospital. These audits were monitored by the ward manager using a dashboard system which was reviewed regularly by the hospital's compliance team.

Skilled staff to deliver care

Managers made sure the service 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.

At the time of the last inspection neither rehab ward had a permanent ward manager in post, and staff were being supported by ward managers from the acute and low secure forensic wards. At this inspection the service had appointed a permanent ward manager who managed both Seaford and Balmoral wards.

Managers ensured staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. Each new member of staff received a full induction to the service before they started work. However, the OT provision dedicated to the two rehabilitation wards was provided by an occupational therapy assistant (OTA), with support from the only qualified OT who supported the whole hospital and therefore quite stretched. Senior leaders told us that two additional OTs had been recruited, who were going through pre-employment checks.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers supported permanent staff to develop through yearly, constructive appraisals of their work. Across both wards over 96% of staff had an annual appraisal.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. The qualified nurses were responsible for the clinical supervision the senior support workers, who were in turn responsible for the supervision of the other health care support workers. Across both wards, on average 96% of staff supervision sessions went ahead as planned in the last 12 months.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

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

Multi-disciplinary and interagency teamwork

Staff worked together to benefit patients and 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. The service held a ward round fortnightly for each patient where the team formally reviewed patients' care and treatment with them, including their MHA status and rights, medicines, and discharge plans. Patients were always invited to these meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Shift handover meetings were comprehensive and detailed, and included information about each patient's mental and physical health, including current risks.

Ward teams had effective working relationships with other teams in the organisation. Staff told us they could get support from other teams when required.

Ward teams had effective working relationships with external teams and organisations including commissioners, care co-ordinators, local authority safeguarding teams and the police.

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.

At the time of the last inspection, patients told us that they could not always access an independent mental health advocate (IMHA) and did not know how to contact an IMHA if they needed one. Whilst the IMHA service continued to experience staffing issues impacting on their ability to routinely attend the wards for regular clinics, leaders had made improvements to their process for ensuring all patients had access to advocacy services on a referral basis. Senior managers told us that all patients were referred to the service on admission and at regular periods thereafter. Some

patients we spoke to told us that they were aware of the process for accessing IMHA services and that they had received IMHA support during ward round and tribunals. There was information available for patients about accessing the advocate service clearly displayed on information boards on both wards, and patient community meeting minutes showed that advocacy issues were a standing agenda item.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Across both wards, 92% of staff had completed their training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were 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 stored copies of patients' detention papers and associated records correctly and staff could access them when needed. 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 care records each time.

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 of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Informal patients knew that they could leave the ward freely and the service displayed posters on notice boards near exits on each ward to tell them this.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff understood the trust 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 five principles. Across both wards, 100% of staff had completed their training.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards when required.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff assessed and recorded capacity to consent clearly in patient care records, each time a patient needed to make an important decision. T2 and T3 paperwork was clear and evident in patient records.

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

Our rating of caring stayed the same. 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.

We spoke with eight patients across both wards who felt staff were respectful and caring, treated them well and were kind. Patients told us staff gave them help, emotional support and advice when they needed it. We observed staff giving time to patients for them to ask questions and requests and were compassionate with their responses.

Staff supported patients to understand and manage their own care, treatment or condition and directed and supported patients to access other services such as mental health support charities and peer support groups.

Staff knew patients well and understood the individual needs of each patient. We observed that individuals were encouraged to express their individuality where they wanted to. For example, on Balmoral ward a patient was empowered to express themselves through art and staff had created a designated area for them to use for this.

Staff followed policy to keep patient information confidential. Paper records were kept securely in folders and the electronic systems were password protected.

Patients we spoke with said they felt able to raise concerns without fear. Staff said they could raise concerns about disrespectful, discriminatory, or abusive behaviour towards patients without fear of the consequences.

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 patients to the wards and the service as part of their admission.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff offered patients a copy of their care plan and risk assessments, which was an improvement following our last inspection.

Whilst patient care plans did not always reflect the patients' voice, most patients felt staff supported them to make decisions on their care. Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Most patients we spoke with were aware of their stage of rehabilitation and knew how to support their own progress.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Both wards held weekly community meetings and monthly peoples' council meetings which were attended by representatives from each ward.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported families or carers and helped them to give feedback on the service. The provider had an annual carer's survey, which was last undertaken in June 2022. Eight carers took part in the survey. Feedback was positive to all eleven questions asked. For the question 'how satisfied are you that you received information about the service when your friend/relative was admitted, or shortly afterwards?', 33% answered extremely satisfied and 67% answered very satisfied.

Staff told us that they had regular contact with families and carers. The service had introduced carer's leads for each ward to improve the opportunities for communication and feedback. A carer's event had been planned for the end of the month following our inspection, to support and strengthen working relationships with carers.

Whilst staff recorded minimal carer involvement in care planning records, we could see from the patient ward round records that family members were invited if patients gave consent. Furthermore, for the question, 'how satisfied are you that the care team have listened to you in the role of carer/friend/family member?', 100% of participants answered very satisfied. For the question, 'how satisfied are you that the care plans and medication management plans of your friend/relative have been explained to you?', 67% answered very satisfied, and 33% answered somewhat satisfied.

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

Is the service responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service provision did not align with the hospital's current high-dependency rehabilitation model. However, staff worked well with services providing aftercare to progress patients towards discharge.

Previously we found that the service provision including client group, staffing requirements, length of stay and recovery goals were not aligned to the service specification, which was designated as a high-dependency rehabilitation unit. During this inspection we saw some improvement regarding patient acuity, occupational therapy input and the service continuing to work to identify suitable placements for patients who had been at the service for a significant period of time. One patient on Balmoral ward had been at the service for over 10 years. Senior managers told us that Seaford ward provided an internal recovery pathway for people transitioning from the hospital's secure ward, which was clearer. However, they acknowledged that some patients on both Balmoral and Seaford wards had long-term complex needs that may require alternative treatment by a service providing a different rehabilitation model.

We reviewed the length of stay for patients using the service. Out of 15 patients across both wards, 11 of them had been at the service for over two years. This meant that many patients had continued to stay on the ward for extended periods of time. The high-dependency unit specification as outlined in the CQC's brief guide states that the length of stay should be up to one year, which the service was currently commissioned for. Staff told us that some of the patients admitted to the wards had complex needs which made it difficult to find appropriate placements in community rehabilitation units or supported living accommodation. However, all patients had an individualised discharge plan and the service was continuing to work with care co-ordinators to try and secure appropriate placements. Most patients we spoke with knew who their care co-ordinator was and reported being in regular contact with them.

Senior managers were aware of these issues and told us that they had plans to re-identify the service model specifically for Balmoral ward and reassess their admissions criteria across both wards. However, this work was not embedded and the current lack of a clear rehabilitation model increased the risk that patients might be inappropriately admitted to the service and their needs not adequately met.

Facilities that promote comfort, dignity, and privacy

The design, layout and furnishings of the wards supported patients' treatment, privacy, and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. However, Seaford ward did not have kitchen facilities for all patients to learn to self-cater.

Each patient had their own bedroom with an en-suite bathroom and shower, which they could personalise. During the last inspection, some patients reported that they did not have keys to their bedrooms and staff had not clearly documented the reason for this. At this inspection we found that all patients were individually risk assessed and where appropriate, had access to their own bedroom key.

Patients had a secure place to store personal possessions.

Due to COVID-19, visitors were not allowed on the wards. Staff told us patients could meet with friends and family off the ward in the general visitor's room next to reception. Both wards had a quiet area, although Seaford ward communal areas were quite small, and only had one additional room which was multi-functional. The room had a pool table for patients to use and was also used for one-to-one sessions and quiet time. This meant that if the room was already in use, patients would have to use their bedrooms if they wanted some privacy.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

We observed that staff did not always close the door to the nursing office on Seaford ward. This was partly due to the nursing office being small and not allowing for more than two members of staff comfortably. This meant that patients could overhear staff conversations which could include patient identifiable information which compromised patients' privacy and dignity.

Some aspects of the environment still required improvement to meet the needs of people using the service. For example, most patients on Seaford ward had no direct access to cooking facilities. One bedroom had kitchen facilities, which meant that only one patient at any time could learn to self-cater. Staff told us that therapy staff could facilitate cooking sessions by either bringing a hot plate to the ward or taking patients to the therapeutic garden to cook outside. However, the lack of a cooker on the ward did not support preparation for discharge from hospital and most patients on Seaford ward were unable to develop their daily living skills in relation to preparing and cooking meals.

Patients could make phone calls in private. We saw that patients were in possession of their own mobile phones, unless staff had identified risks relating to a patient having a mobile phone following a risk assessment. Patients also had access to the ward phone. Patients reported that they could make phone calls privately in their bedroom.

Each ward had its own outside space, although patients could not access this freely due to being located on the first and second floors. Staff escorted patients to the garden areas. Whilst this was recorded as a restrictive practice on the ward audits, the service had implemented the measure to mitigate the risk of patients coming into contact without staff supervision in the stairwells which were shared.

Patients could make their own hot drinks and snacks and were not dependent on staff.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work and supported patients. The provider advertised paid and volunteer opportunities for patients. Staff supported patients to write CVs and to apply for these roles.

Staff helped patients to stay in contact with families and carers and encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities and those with communication needs or other specific needs. For example, lifts were available for patients to access who had reduced mobility and we observed staff assisting a patient with paperwork who had a sight impairment.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients, such as Halal options.

Patients had access to spiritual, religious, and cultural support. We saw that patients were granted hospital leave to routinely attend their chosen place of worship.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, a systematic process for sharing learning with the whole team and wider service was not embedded.

Patients and staff understood how to use the provider's formal complaints process. Patients knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern, on notice boards in patient areas.

Managers investigated complaints and identified themes. Complaints and compliments were routinely discussed during monthly clinical governance meetings and forums were available to staff to receive feedback. For example, daily handover meetings, monthly patient safety meetings, senior support worker meetings and safeguarding champion meetings. However, staff we spoke to were not always clear how managers shared feedback from complaints with staff and how learning was used to improve the quality of care.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Complaints which could not be resolved immediately and needed further investigation were conducted by another ward manager.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

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

At the time of the last inspection neither rehab ward had a permanent ward manager in post, and staff were being supported by ward managers from the acute and low secure forensic wards. At this inspection the service had appointed a ward manager who managed both Seaford and Balmoral wards.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The ward manager had a good understanding of the service they managed and were visible on the wards. They undertook additional shifts to maintain clinical practice. Staff and patients described them as approachable and supportive.

The hospital had recently appointed a new hospital director who had started only a week prior to our inspection. However, other senior managers and ward managers had a good understanding of the services and their challenges and were supporting the new hospital director whilst they settled into their role. Staff and patients felt the senior management team were visible and could access them when they needed to.

There was an emphasis on leadership development opportunities and staff were encouraged to develop these skills and competencies.

Vision and strategy

The provider's vision and values for the service were not clearly defined.

At the time of the last inspection, staff were not able to inform us of the provider's vision or describe how these should be applied in the process of their work. Furthermore, the service provision for the rehab wards including client group, staffing requirements, length of stay and recovery goals were not aligned to the service specification, which was advertised as a high dependency rehabilitation unit. During this inspection we saw that some improvement had been made and most staff spoke enthusiastically about these improvements with the service. However, the vision and strategy for Seaford and Balmoral wards were still not clearly defined. Senior leaders told us that future visions for the service included exploration of the rehabilitation model to ensure there was a forward focus on recovery and the journey to discharge.

Culture

Staff felt respected, supported, and valued by the ward manager who oversaw the two wards. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise concerns without fear.

Staff spoke positively about their roles and were passionate about developing the service model. Staff felt there was an inclusive culture and found their managers approachable.

The provider was also working towards developing and supporting its own staff to take on more senior leadership roles, and staff felt very positive about the opportunities for growth and career progression.

An annual staff survey carried out in February 2023 was completed by 61 staff members ranging from those in management positions, to support workers and registered nurses, to administration and operations staff. Seventy-seven percent of all participants said that they would recommend the provider as a place to work to their family and friends. Other feedback collected as part of the survey included responses to the questions, 'how often does your manager or team leader assist you with managing stress levels at work?', 'do you feel recognised, respected and motivated by your manager?', and 'are you aware of Bramley Health's Employee Assistance Programme?'. The provider had developed an action plan based on the questions with the poorest responses, to improve these areas for staff.

One hundred percent of staff who took part in the annual survey were aware of the provider's whistleblowing policy.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Governance

Our findings from the other key questions demonstrated that governance processes were not robust enough to enable the provider to assess, monitor and improve the quality and safety of the service.

During the last inspection in May 2022, we found that the provider did not have robust internal assurance processes which meant that many of the issues identified during the inspection were unknown to senior leaders. At this inspection we saw that some improvement had been made.

There was a clear governance structure in place with routes of escalation, reporting and decision making. Ward managers and the senior management team had access to data relating to the quality and safety of the care delivered through attendance at monthly hospital-wide clinical governance meetings. These meetings ensured that standard agenda items such as staffing, complaints, safeguarding, incidents, outcomes of audits, medicines management and service level risks were routinely reviewed and discussed.

Managers had been proactive in successfully implementing an international recruitment campaign which had improved staffing levels across wards. All staff received appropriate levels of mandatory training for their role and there was an effective system in place to ensure that this training was kept up to date. Managers had oversight of training needs via a central electronic mandatory training compliance system.

However, we remained concerned that the governance processes around how ligature risks were systematically reviewed, and actions carried out were not evident or documented effectively, and that this had not been identified by the provider. Furthermore, a systematic process for sharing lessons learned from incidents and complaints was not embedded.

Staff took part in a programme of clinical audits which fed directly into the quality assurance framework for the hospital, although some of the concerns identified during our inspection had not been flagged through this process.

Management of risk, issues, and performance

The hospital had an up-to-date corporate risk register in place.

The risk register included two identified risks which were the financial and reputational risk associated with the rating from the regulator, and COVID-19. Senior managers also recognised that the hospital had historically had a high turnover of senior management staff, and the ongoing impact of this for both patients and staff, although this was not yet highlighted as a risk on the risk register.

The high use of agency staff due to staff vacancies had recently been removed from the risk register following the provider's successful international recruitment drive.

There was a system in place to identify, monitor and address risks at the hospital. Staff told us that service level risks were escalated to managers who in turn informed the senior leadership team. Managers told us the risks listed on the register were discussed at the local and corporate clinical governance meetings. This ensured that risks were continually monitored and minimised where possible. However, the provider had not added the ongoing hospital-wide risks associated with ligature management to the risk register, despite this being identified at the last inspection in May 2022.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had a business continuity plan for emergencies.

Information management

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

During the last inspection, senior leaders reported that they had plans to move all records to an electronic system which aligned with the local NHS trust. At this inspection, leaders told us that plans to implement the chosen system in November 2022 had been halted due to technical issues with the system and that the system was no longer available. Managers told us that alternative electronic systems had been considered, in liaison with the local NHS trust to identify a suitable electronic system, although discussions were ongoing. This meant that staff continued to use a combination of electronic and paper records which increased the risk of duplication or information being missed.

The service used systems to collect data from wards. The ward manager had access to a dashboard which was also access by the hospital's compliance team. This included information on staffing, supervision and appraisals, training, and hospital performance data.

Staff had their own personal log in credentials to ensure patient information was kept confidential. Each staff member an email address where they received updates from the provider.

Staff were aware of the requirements to refer to external bodies such as the CQC when required to report incidents and safeguarding issues.

Engagement

Managers engaged actively with 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.

Senior leaders had taken steps to improve communication with staff at the hospital since the last inspection and this was reflected in the staff feedback. Hospital managers told us that encouraging staff to speak up was a priority and that human resources staff held regular drop-in clinics for staff to access a safe environment for feedback.

Leaders visibly encouraged continuous improvement with regular quality walkarounds when members of the senior management team visited all areas of the hospital, talked to staff and patients, and checked documentation.

Patients had the opportunity to give feedback about the service via the patient weekly community meetings.

Learning, continuous improvement and innovation

Senior managers told us that they had plans to review the service specification and rehabilitation model. This included reviewing the inclusion and exclusion criteria for the service and barriers to discharge, with the aim of improving care for patients requiring a rehabilitation setting.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Leaders told us they were working towards attaining a national accreditation for rehabilitation services for people recovering from mental health issues. This network would provide opportunities for the service to be reviewed by peers and to share good practice and innovation across similar services.

Requires Improvement

Forensic inpatient or secure wards

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

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

Safety of the ward layout

Staff did not always ensure that all potential ligature points were thoroughly risk assessed and that there were sufficient mitigations in place to reduce or remove such risks. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.

We saw safes in patients' bedrooms on Pevensey ward that were attached to the walls which could be potential fixed ligature anchor points, but this had not been identified and recorded in the provider's ligature risk assessment.

The provider had identified the de-escalation room as a possible high-risk area for ligatures, but staff were not adhering to the mitigations which were put in place. For example, the de-escalation room had a sash-style window which was a potential fixed ligature anchor point. Staff were to ensure that the de-escalation was locked when not in use. However, we saw on inspection that the de-escalation was unlocked, and patients could access the room freely and unsupervised. We also saw a ladder which was left unattended in the de-escalation room. In addition, the de-escalation room had a blind spot from the office with a wall hiding potential access to the room. Although there were parabolic mirrors in place, this was not sufficient to mitigate the risk.

The provider reported in its ligature risks assessment that there were closed circuit television cameras (CCTV) in place to manage ligature risks. However, the CCTV was not monitored in real-time and was only used to review incidents.

We raised our concerns during the inspection to the provider, and they took immediate action to remove the ladder. However, the de-escalation room remained unlocked. Staff and patients reported that the de-escalation room was always left opened for patients 24 hours of the day.

Patient risk items were stored in a locked room in individual lockers. Staff had easy access to alarms and patients had easy access to nurse call systems.

Requires Improvement

Forensic inpatient or secure wards

Pevensey ward was a male only ward and complied with mixed sex guidance.

Maintenance, cleanliness and infection control

Patient accessible areas were generally clean, well maintained, well-furnished and fit for purpose. Fire exit signs were clearly displayed, and exits were free of clutter.

Staff made sure cleaning records were up to date. Staff followed infection control policy, including handwashing. Staff completed daily fridge temperature checks. Cutleries were checked in and out and signed for.

The ward had a quiet room which was also used as a group room which was locked when not in use.

The hospital had an onsite maintenance team, and staff reported that they were very responsive. All maintenance issues were logged in the maintenance book and maintenance issues reported were attended to daily.

While staff completed daily checks and signed them, we saw there were different versions of the checks documents which could be confusing for staff. In addition, we saw that the ward office was cluttered with piles of paperwork across all desks. The ward office was also very hot, and staff complained that it was difficult to work while it was hot.

The office had no “at a glance” board to show staff easily what patients were admitted to the ward and what their risks were.

Seclusion room (if present)

The service did not have a seclusion room. There was a de-escalation room that was furnished for the purpose of de-escalation.

Clinic room and equipment

The clinic room had accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff ensured that equipment were checked, maintained and cleaned. However, staff did not always attach a sticker to indicate when the equipment was cleaned.

The clinic room was small; however, it was fully airconditioned. The clinic room had a stable door with an easily accessible handle on the inside and a turn style lock. If a patient wanted to access the clinic, they could place the hand over and unlock the door which could pose a risk to the dispensing staff. Staff informed us that when they dispensed medication, there was usually a member of staff outside the clinic to ensure safety. However, we saw on inspection that when a patient attended for their PRN medication, there was no supporting staff member to ensure the nurse’s safety and none was requested.

The clinic room did not have an examination couch. Staff informed us that certain medication, for example, depo injections, were administered in patients’ bedrooms.

Physical health monitoring equipment was stored in the nursing office including the emergency bag and oxygen. Staff told us that this was so that it could be accessed easily by all staff as only trained nurses can access the clinic room.

Staff checked the emergency bags and resuscitation equipment was checked regularly. Emergency drugs were kept separately to the emergency bag in a sealed bag in the clinic. Medicines were all in date, and all stock on the list was present.

Safe staffing

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

Nursing staff

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The staffing included two registered nurses in the day and one at night.

The service had enough nursing and support staff to keep patients safe. Patients reported there was always enough staff and they were well trained. The provider had successfully recruited some international nurses to fill the vacant posts.

Managers ensured there were always enough staff on a shift to keep people safe. Staffing data in the last three months showed that all shifts were filled. There was an activity board completed for the day, with staff on duty identified, with each patient allocated a nurse.

The ward manager could adjust staffing levels according to the needs of the patients.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service had reducing rates of bank and agency nurse and nursing assistants' usage in the last three months.

Staff and patients reported that they could speak to staff if they had any concerns and staff ensured that their needs were met.

While patients reported they did not always have regular one to one session with their named nurse, they reported they rarely had their escorted leave or activities cancelled.

Although the service had not reported any physical intervention on the ward in the last three months, managers ensured that there were enough staff to carry out any physical interventions safely if the need arose.

Staff shared key information to keep patients safe when handing over their care to others.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

The service had reducing turnover rates. The turnover rate in the last three months was 7%.

Managers supported staff who needed time off for ill health. Levels of sickness were low at 4%.

Medical staff

Requires Improvement

Forensic inpatient or secure wards

The ward had a responsible clinician who worked one and a half days a week. There was a ward doctor who worked 9am to 5pm Monday to Friday. There was an out of hours responsible clinician and a manager cover. There was a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Staff mostly completed and kept up to date with their mandatory training. However, not all staff had completed the training in the management of learning disability and autism.

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff were required to complete 29 mandatory and statutory training modules both face to face and online. The mandatory training included safeguarding adults and children, data protection and confidentiality, Mental Health Act, basic and intermediate life support training and Prevention and management of violence and aggression (PMVA).

Managers monitored mandatory training and alerted staff when they needed to update their training.

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 support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and 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. Staff completed a Short-Term Assessment of Risk and Treatability (START). START is a concise, clinical guide used to evaluate a patient's level of risk for aggression and likelihood of responding well to treatment.

Staff also completed the Historical Clinical Risk Management–20 (HCR–20) for all patients. HCR-20 is a clinical risk measure that provides a 'guided clinical approach' to risk assessment. The HCR–20 is used for the assessment of general violence in forensic-psychiatric patients.

Management of patient risk

Staff we spoke to knew the patients on the wards and what their risks were.

Requires Improvement

Forensic inpatient or secure wards

Staff identified and responded to any changes in risks to, or posed by, patients. We reviewed observation records for patients on level 2 intermittent observations and records showed that observations were being completed at random within the observing period in line with guidance.

Staff followed procedures to minimise risks where they could not easily observe patients. For example, when patients were in the privacy of their bathroom staff would knock on their doors to check that they were fine and responsive.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patients who were coming back from leave were searched in the de-escalation room. The ward manager informed us that patients were searched at random except those with known risks who were searched regularly. However, staff expressed concerns that there were high levels of illicit substances being used by patients on the ward, and they were not always aware how these substances got onto the ward.

Use of restrictive interventions

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. Patients reported that staff hardly used restraint and where there was an incident staff responded quickly to deescalate the situation.

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

Patients had keys to their bedrooms when clinically assessed and safe to do so.

There ward did not have a dedicated search area. Patients coming back from leave were searched in the de-escalation room at random unless there was a cause for concern or increased risk.

The ward carried out annual reducing restrictive intervention (RRI) audit. Staff told us there were no blanket restrictions, however, we saw that the kitchen area was locked and only accessible by staff. Staff recorded in the RRI audit that this was not a blanket restriction.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Requires Improvement

Forensic inpatient or secure wards

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw an example of staff making a safeguarding referral for a patient who was assaulted by another patient. Staff told us that they would normally discuss all safeguarding concerns with the safeguarding lead depending on the risks. On this occasion, to safeguard patients, a referral was made by staff directly to the local authority safeguarding team.

Staff access to essential information

Staff did not ensure that paper records were well-maintained. Staff did not always have access to the most up to date information.

Paper records were disorganised across the office desks with multiple files for different documents. Staff reported that there was a lot of duplication of paperwork. For example, paper-based records and incident reports were duplicated in multiple locations. Staff reported that because of this, documents could be difficult to find.

Staff did not always have the latest version of documents available. For example, staff on the wards were using an older version of the ligature risk assessment.

Medicines management

Staff did not always follow national best practice for the management and storage of medicines. While reviewing ward medicines, we saw eight different sizes and designs of methadone packaging stored in the controlled drugs (CD) cupboard which consisted of both see-through and opaque packaging. There was a risk that patients may be administered the wrong medicine.

Staff were storing illicit substances and its paraphernalia confiscated from patient in the CD cupboard. The items included a glass pipe, a small amount of substance that looked like cannabis in a clear packet. There was also a small amount of material in a black plastic bag that staff described as 'Crack Cocaine'. There was also a lighter and metal, which staff reported as items patients used to heat drugs before smoking them.

We saw other items in packets and envelopes which were sealed, and one package had "THC" written on the package. We were concerned that there were unidentified substances stored in the controlled drugs cupboard without an inventory or clear records in the CD register. Staff were not aware of why these substances were stored in the controlled drugs cupboard. There were no audit trails for these items in case they went missing.

Staff followed systems and processes to prescribe and administer medicines safely. The service used an electronic system for medicines prescribing provided by a third-party pharmacy. Staff reported that the system was very effective, and the numbers of medication errors had reduced since the system was implemented in November 2022.

The service carried out regular medication audits to ensure that medicines are used appropriately. Staff reported that the audit picked up themes and trends and audit showed that PRN medication was not being used excessively.

While we saw that for two patients' high dose antipsychotic therapy (HDAT) medication were above BNF limit, staff clearly recorded their rationale. Staff ensured that HDAT monitoring were recorded and completed comprehensively. Any issue identified from the monitoring of the use of HDAT was raised with the patient's GP.

Staff ensured that patient allergies were clearly recorded in line with best practice.

Requires Improvement

Forensic inpatient or secure wards

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

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 at clinical governance. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Staff reported serious incidents clearly and in line with incident reporting policy.

The service had no never events.

Staff understood the duty of candour. Staff informed us it was about being open and transparent, and giving patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents and involved patients and their families in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented. However, not all patients had positive behavioural support plans that met their needs.

Requires Improvement

Forensic inpatient or secure wards

All patients had a positive behaviour support (PBS) plan in place. However, we saw that one patient's PBS plan had not been updates since 2019 and another patient's PBS plan did not have interventions specifically tailored to a person with autism. The patient had a psychology care plan present and the teams had identified that the patient met the criteria for a diagnosis of autism spectrum disorder (ASD). However, care plans did not include or consider this.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. For example, we saw the doctors had seen a patient and managed their physical health needs before they were handed over to paramedics following an incident where a peer physically assaulted the patient.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. All patients had a multidisciplinary care plan in place which included the mental health recovery, behaviours and risk, staying healthy, life skills, relationships and legal needs. Some patients had a care plan for other needs such as how they would manage their drug and alcohol problems.

Some care plans were personalised, holistic and recovery orientated. All care plans showed evidence of the patient voice and appropriate interventions. Staff ensured patients signed and offered copies of their care plans.

Staff ensured that patients had a discharge plan which was reviewed regularly.

Best practice in treatment and care

Staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the patients in the service. There were several areas on the ward for patients to spend time including a TV/games room with a pool table.

Staff identified patients' physical health needs and recorded them in their care plans. For example, one patient's staying healthy care plan referred to the use of a walking stick and how staff would support them, and this had a separate risk assessment. The patient was also provided with lots of guidance on how to manage their diabetes.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There was specific care plan for patients on how they would manage issues with drug and alcohol. Patients reported that staff kept them busy and helped them get well. Staff encouraged patients to get a lot of exercise and fresh air.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes such as the Health of the Nation Outcome Scales (HoNOS). HoNOS is a clinician rated instrument comprising 12 simple scales measuring behaviour, impairment, symptoms and social functioning.

Staff took part in clinical audits such as medication audits. Managers used results from audits to make improvements.

Requires Improvement

Forensic inpatient or secure wards

Staff delivered care in line with best practice and national guidance. Patients had individual weekly activity schedule which included gardening, karaoke, photography and creative writing. Staff ensured that patients who could not participate in OT activities due to their physical health or other reasons were able to engage in regular community activities. There were activities on the weekends which were nurse led including board games and current affairs groups. There was good evidence of weekly sessions with primary nurse and key worker in patient notes.

Skilled staff to deliver care

While we saw that the there was an induction programme for new staff including agency staff, managers were not consistently checking staff understanding and awareness of risks. The ward induction forms did not have a section for staff to sign to say they understood their requirements.

The service had a full range of specialists to meet the needs of the patients on the ward. The team consisted of doctors, nurses, psychologists and psychology assistants, occupational therapist and occupational therapy assistants.

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

Managers supported staff through regular, constructive appraisals of their work.

Managers supported staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

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

Staff told us that they received specialist training for their role including security training which included searching. However, there were still concerns about the number of illicit substances on the ward and how they got into the hospital.

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

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Requires Improvement

Forensic inpatient or secure wards

Ward teams had effective working relationships with external teams and organisations. The team held regular meetings with the Kent, Surrey and Sussex provider collaborative.

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 (MHA) and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were 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 ensured that all MHA documentation were completed and kept up to date. Staff explained patients Section 132 rights to them regularly and these were clearly documented.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Information about the independent mental health advocacy service was displayed on a noticeboard.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. All section 17 leave forms were completed and signed by the ward doctor and patient.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Good practice in applying the Mental Capacity Act

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

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles.

Requires Improvement

Forensic inpatient or secure wards

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions about their care before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw examples of staff completing mental capacity assessment for a patient in relation to taking medication and treatment.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Is the service caring?

Good

Our rating of caring stayed the same. 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.

All four patients on we spoke with on Pevensey ward reported that staff were caring and compassionate. Patients said staff treated them well and behaved kindly.

Patients reported that staff were discreet, respectful, and responsive when caring for them.

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

Staff supported patients to understand and manage their own care treatment or condition. For example, one patient felt they were taking positive steps toward recovery because staff were very friendly, and that staff empowered them and supported them in their recovery journey.

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

Staff understood and respected the individual needs of each patient. Patients told us that staff always try to help to ensure their needs were met. Community meeting minutes showed that when patients made requests or raised concerns, staff ensured something was done about it. If the request was not possible, staff tried to find an alternative.

Requires Improvement

Forensic inpatient or secure wards

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

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 patients to the ward and the services as part of their admission. Although, there was very limited information about treatment on the ward.

Staff involved patients and gave them access to their care planning and risk assessments.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. The service had access to interpreters and signers through a third party.

Staff involved patients in decisions about the service, when appropriate. There was a weekly community meeting where patients could give feedback about the service and suggests ways to improve the ward.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff made sure patients could access advocacy services. The patient advocates name was displayed on the notice board. However, staff reported that there had been issues with accessibility to the advocates due to staff shortage by the Independent Mental Health Advocacy Services (IMHA).

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers.

Staff helped families to give feedback on the service. The provider carried out annual Carer's survey which allowed carers and family members to feedback about the care and support the patient was receiving. Results from the last Carer's survey conducted in June 2022 showed that carers were satisfied that staff informed and involved them in decision making, catered to any specific of cultural needs, felt listened to and staff were polite and approachable.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Requires Improvement

Forensic inpatient or secure wards

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

The beds were full at the time of our inspection. One patient had been on extended long-term leave, although the bed was kept for them in case they returned to hospital

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. They made sure patients were not moved or discharged at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharge were delayed. While some patients had been at the service for a while, staff informed us that three patients were now ready for discharge.

Staff told us that the reason for the delays were partly due to finding appropriate placement, and careful planning of patient discharges to reduce the chances of readmission. Staff informed us they were working with care managers and coordinators to make sure the discharge went well.

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.

Each patient had their own bedroom, which they could personalise. We reviewed one patient bedroom and saw that they had many items including fishing equipment. The ward manager informed us that the patient had been risk assessed as safe to store these items.

Patients could store their personal possessions in a secure locker.

The service had a full range of rooms and equipment to support treatment and care including a quiet room and a games room, which were easily accessible to patients.

The ward had no visitation room, however, there was a dedicated family room where patients could meet with their visitors next to hospital reception.

Patients could make phone calls in the privacy of their bedrooms as most patients were allowed to have their mobile phones following a risk assessment.

The service had an outside space that patients could access easily. We saw that most of the patients on the ward had approved section 17 leave.

The service offered a variety of good quality food that met people's religious and cultural needs. Patients and staff reported that the food was of good quality and tasteful.

Patients' engagement with the wider community

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

Staff encouraged patients to take opportunities for paid work such as brick laying and gardening. Staff supported patients to with outdoor activities such as nature walks on the beach, the local swimming pool and group visits to the local shops. Patients usually went out on trips to the cinema, although we saw that the cinema trip in February 2023 was cancelled because the driver was off sick.

Staff helped patients to stay in contact with families and carers. They reminded patients to contact their families and friends.

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

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The ward had personal emergency evacuation plans in place for patients who required them, which meant that staff knew how to safely evacuate patients with mobility needs in an emergency.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. There were a range of information leaflets available to patients at reception including complaints forms.

The provider displayed information about services, including advocacy, clearly on noticeboard on all the ward. Although staff reported that the independent mental health advocates have been short-staffed and would only see patients on referral basis.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary, religious and cultural needs of individual patients. Staff informed us there were halal meals available.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

Requires Improvement

Forensic inpatient or secure wards

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.

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

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

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

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.

Managers shared feedback from complaints with staff and learning was used to improve the service.

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

Is the service well-led?

Requires Improvement

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

Leadership

Leaders including the ward manager 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.

Staff spoke very highly of the ward manager. Staff felt the ward manager and senior leaders were kind and supportive. Although some staff felt that the way information was communicated from senior leaders to the wards could be better.

Vision and strategy

The provider described the model of care as least restrictive practice principles which focussed on enablement, positive risk-taking, therapeutic optimism, relapse prevention and reducing episodes of challenging behaviour while preparing individuals to transition into step-down or community settings.

The ward manager had worked at the service for a long time and knew the patients well. The ward manager described the ward strategy as being inclusive, with good collaborative working relationships to ensure good positive outcomes for patients.

Requires Improvement

Forensic inpatient or secure wards

Staff knew and understood the provider's vision and values and we saw that staff worked to build good therapeutic relationships with service users.

Culture

Staff felt respected, supported and valued. They felt that leaders promoted equality and diversity in daily work and provided opportunities for development and career progression.

Staff felt comfortable to raise concerns without fear of retribution. Staff knew and understood their duty under the whistleblowing policy.

Governance

The provider's system and process around the management of ligature risks were not robust enough to sufficiently remove or mitigate against such risks. Ligature risks were not systematically reviewed, and actions were not always clearly documented.

Staff were not recording patients risks appropriately in line with the provider's policy. For example, from speaking with staff and reviewing patient care records on Pevensey ward, we saw that some patients had a history of depression, previous suicidality, chaotic behaviour and co-morbid substance misuse. The provider's policy stated that patients with these current or historic needs/ behaviours should be rated as high. However, the profile ratings for these patients was medium on the ligature risk assessment (LRA).

Ward managers were not always aware of when the ligature risk assessment should be reviewed and by who. Ward managers informed us that they had not received specific training around assessing ligature risks.

The provider had visual 'heat maps' to identify ligature risk areas. However, staff had not understood the available 'heat maps' which were difficult to understand. Three members of staff we spoke to were unable to interpret this tool and could not explain how it should be used. The ligature heat map does not correspond to the ligature risks identified on the LRA and could be misleading to staff.

The ward induction programme was not effective enough to provide new staff with skills and awareness to manage ligature risks. Induction for new staff was carried out by senior healthcare support workers who signed off the induction booklet. It was not clear who was checking the competence of new and existing staff regarding levels of awareness of the policy and understanding of ligature risks, after their initial ward induction. In addition, the induction pack was missing the form which the inductee was required to sign to say that they understood the policies and procedures.

The provider did not ensure that staff were accessing the most up to date information and policy documents. For example, the ligature risk assessment which was printed and available to staff on Pevensey ward was out of date (May 2022). There was a newer electronic version dated December 2022. The newer version contained key additional information around the need to have certain ligature cutters such as Fish safety knife, Res-Q-Hook, and wire cutter. None of these items were available on the ward. None of the staff member we spoke to had seen the new policy document.

The way the service categorised risks was not always consistent. For example, the service had documented on the ligature risk documents risks such sink push button, sink plugs, bathroom door masking plate. However, staff we spoke with did not know how these items posed a risk. The ligature risk documents referred to an area where there were

potential ligature risks but was not always specific. For example, the document referred to the ceiling fitting vent as a risk. However, we saw that it was the gaps around the vent the posed potential risk and not the vent itself. In addition, we also saw ligature risk points on inspection which had not been identified on the ligature risk documents such as loose anti-ligature door handles and doorknobs.

Management of risk, issues and performance

The provider did not ensure that the risk management strategies which was in place was effective enough to reduce risks.

We saw that the provider maintained a register of risks. However, this did not include all identified risks. There were risks around ligature risk management and ward safety which had not been identified as a risk. Patients had brought illicit substances onto the ward which staff told us they believed to be cannabis and crack cocaine. It was not always clear how patients were able to bring these items through security on their return from leave.

Patient risk levels were not adequately categorised in line with the provider's policies; however, this had not been identified through a systematic review or audits. For example, on the ligature audit all patients were coded as level 2 which was not in line with their own policy which stated that patients with severe depression, unpredictable behaviour, recent history of suicidal ideation should be considered level 3.

Managers had not received awareness training around understanding and completing a ligature risk assessment and training around ligature risk had not been provided to staff. They were not always sure how to interpret ligature risk documents.

Staff and managers were not aware of or using up to date polices and there was key information missing in induction forms. There were not wire cutters on the ward and staff were not aware of this. Ligature cutters on Pevensey ward appeared well used and needed replacement, but there were no records of this. It was not clear if this had been reported and actions taken to replace them.

Information management

Staff collected analysed data about outcomes and performance.

The ward manager reported they had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Ward manager received information from the central administrative team who monitored mandatory training and alerted the staff when they needed to update their training.

Staff had access to equipment and technology needed to do their work.

Staff knew the process for sending notifications to outside bodies, such as the CQC and the local authority safeguarding team.

Engagement

Requires Improvement

Forensic inpatient or secure wards

Staff could give feedback about the service through the annual staff survey.

Patients and their carers could give feedback through patient satisfaction surveys and carer surveys.

The provider informed us that they have restarted the Patient council meetings with an external expert by experience chairing the meetings. They have also produced a Carer's handbook and there were carers leads allocated for each ward. A carer's event was planned for end of March 2023.

Learning, continuous improvement and innovation

Staff informed us that there were debriefs after major incidents.

While we saw that lessons learnt were discussed in clinical governance, staff informed us that there is not a clear system for sharing lessons learned, such as through letters or bulletins. The provider informed us that staff meeting templates have been updated to include lessons learned.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must ensure that care plans reflect patients' personal goals and that staff record patient and carer involvement in developing care plans where possible. Regulation 9(1)(c)(3)(a)(b)(d) The provider must ensure that they complete their plans to review the inpatient rehabilitation model and ensure the service provision including anticipated length of stay, occupational therapy support and therapeutic activities align with this model. Regulation 9(1)(3)(a) The provider must ensure that all patients have a positive behaviour support (PBS) plan which is personalised, tailored to meet the needs of the patient and reviewed regularly. The provider must ensure that all patients have appropriate care plans that met their needs. Regulation 9(1)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must operate effective governance systems to enable the provider to assess, monitor and improve the quality and safety of the service. The provider must ensure that there is a systematic review of the quality of audits, ensuring that actions are pulled through with clear ownership of who is completing the actions. Regulation 17(1)(2)(a)

This section is primarily information for the provider

Requirement notices

The provider must ensure that all incidents and complaints are systematically reviewed and shared with all staff. The provider and staff must be able to demonstrate how learning from incidents and complaints have led to improvement. Regulation 17(1)(2)(a)

The provider must ensure that all known risks are accounted for on the risk register and that governance processes are effective to enable the provider to maintain oversight of these risks, improve the quality and safety of the service. Regulation 17(1)(2)(e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure improvements to how ligature risks are safely assessed and managed are sustained and embedded, and that ligature risk assessments continue to be developed by a suitably trained person. Regulation 12(2)(d) The provider must ensure that controlled drugs are safely managed in line with national guidelines. Regulation 12(2)(g) The provider must ensure that medicines are administered and stored safely. Regulation 12(2)(g) The provider must ensure that equipment used for physical health monitoring is checked regularly and maintained in line with manufacturer's requirements. Regulation 12(2)(e) The provider must ensure staff follow national best practice regarding the storage of controlled drugs. The provider must ensure that there is clear record log and audit trail for all medicines stored in the controlled drugs' cupboard. Regulation 12(2)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

The provider must ensure patients' privacy and dignity is always respected. Regulation 10(1)(2)