Aspen

Quality Report

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

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

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

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

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

Overall summary

We rated Aspen as good because:

- The hospital was clean, well maintained and had good furnishings. Patients had access to good facilities and took part in meetings and activities including at weekends. Staff updated risk assessments frequently and patients told us they felt safe in the hospital.
- There were enough suitably qualified staff so the provider did not have to use agency staff. Patients reported the staff were caring, approachable and skilled. Staff were well trained and they had access to supervision, appraisal and team meetings.
- Patient care plans were holistic and contained personalised recovery goals. Staff used a range of tools to assess and monitor patient outcomes. They involved patients in their treatment and empowered them to make decisions about their care. Staff involved patients' carers where appropriate.
- Staff encouraged patients to become involved in activities aimed at maintaining their independence and preparation for discharge. Patients could choose activities on the timetable and had a say in some of the hospital's routines.
- The hospital had few complaints and patients and their carers knew how to access advocacy support. Staff regularly carried out patient and carer surveys and responded to feedback.

Summary of findings

- There was an open culture where patients and staff could report concerns and share lessons learned from incidents. Staff surveys showed high levels of job satisfaction and staff were motivated to deliver high quality patient care.

However:

- Staff did not always take proper steps to control the spread of infection when administering medication.
- Staff did not always ensure the safe management of medicines. They did not record the current temperature of the medications fridge and did not always store controlled drugs correctly prior to disposal.
- Staff did not store emergency drugs together with other emergency equipment.
- Staff did not always administer patients' medication in a way that ensured their privacy and did not always encourage patients to carry out medical self-testing in a private area.

Summary of findings

Contents

Good

Aspen

Services we looked at:

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Aspen

Aspen is a 16 bed locked rehabilitation service providing assessment, treatment and rehabilitation for women with personality disorder and complex needs. At the time of our inspection, there were 14 patients staying in the hospital.

Aspen has been registered with the Care Quality Commission since 17 November 2010 and is registered to provide the following regulated activities; Assessment or medical treatment for persons detained under the Mental Health Act 1983, treatment of disease, disorder or injury. The hospital provides care and treatment to informal and detained patients. There was a registered manager in place who was also the Controlled Drugs Accountable Officer. This is the person responsible for all aspects of controlled drugs management in the hospital.

There have been a total of 19 inspections carried out at Aspen. At the time of all our previous inspections, Aspen was registered with another independent mental health hospital as one location. The last time the Care Quality Commission inspected Aspen was in April, 2015 when we rated the service as good overall. We rated all of the five key domains as good.

We told the provider they should take the following actions;

Ensure that patients are fully involved in discussions with regard to their care, treatment and discharge-planning options in ward round and this should be clearly recorded.

Ensure that a central risk register is held to detail all risks identified with clear actions and timeframes. This should be reviewed and updated on a regular basis.

Ensure that fridges that contain medication are kept securely locked and under the supervision of a registered nurse.

Consider making adjustments to the environment to mitigate the ligature risks posed by taps used in areas open to patients

Ensure that the controlled drug storage key is not held on the same key ring as other medication

Ensure that all staff receive an annual appraisal

Ensure that all clinical staff are in receipt of regular managerial and clinical supervision..

At this inspection, we found the provider had carried out all the above actions.

Our inspection team

Team leader: Liz Mather, Care Quality Commission inspector. The team that inspected the service comprised of two Care Quality Commission inspectors including the team leader, a specialist adviser who was a registered mental health nurse and an expert by experience.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked another organisation for information. The inspection was announced which meant the provider know we were coming to inspect the service.

During the inspection visit, the inspection team:

- toured the ward, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with nine patients who were using the service
- spoke with the registered manager, the head of care at the hospital and the regional operations director
- spoke with 11 other staff members; including doctors, nurses, an occupational therapist, a psychologist, an assistant psychologist, and support workers
- received feedback from an independent advocate
- attended and observed a hand-over meeting, a multi-disciplinary meeting and a community meeting
- collected feedback from one patient using a comment card
- looked at the care and treatment records for six current patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Overall patients said they liked the staff and that they were approachable, kind and genuinely cared about them. Two patients commented that sometimes staff had been rude but mostly they were polite and respectful. Carers said the staff were friendly and caring and they felt listened to.

Patients told us the hospital was clean and had good furnishings with enough suitable space for therapies and activities. One patient commented that there was no child-friendly visiting space on the ward. Three patients made comments about the lack of activities at weekends.

Most patients said they were making good progress with their treatment and that staff were well trained and skilled at their job. Patients said they were encouraged to keep in touch with their families and most carers said that staff had involved them in the patient's treatment plan. One carer told us they trusted staff to take care of their relative.

Both patients and carers reported they had good access to information about advocacy services and how to complain if they needed to.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because,

- Staff did not always take proper steps to control the spread of infection when administering medication.
- Staff did not record the current medications fridge temperature and did not always ensure the medications fridge was in good working order.
- Staff did not always record the date when they opened medication and did not always store it correctly prior to disposal.
- Staff did not store emergency drugs together with other emergency equipment.

However,

- The hospital was clean, had good furnishings and equipment that was well maintained. Part of the hospital was undergoing refurbishment to provide better medical treatment facilities.
- There were enough suitably qualified staff on duty and managers could adjust staffing levels to meet the needs of patients. The hospital only used bank staff so patients were familiar with the people caring for them.
- Staff were up-to-date with their mandatory training. They knew how to safeguard patients and reported concerns to the relevant authorities.
- Staff updated patient risk assessments daily and the hospital had robust assessment procedures to ensure only patients who could be safely managed were admitted. Patients and staff told us they felt safe in the hospital.
- Blanket restrictions were used only when staff could justify them and restraint was used only after verbal de-escalation had not proved effective.

Are services effective?

Good

We rated effective as good because,

- All the records we looked at demonstrated that staff carried out a timely and comprehensive assessment on each patient, which included a self-assessment using mental and physical symptoms relevant to the individual patient.

Summary of this inspection

- Each patient had a health improvement profile, which staff monitored and used as the basis for treatment decisions. Staff ran an in-house well women clinic and ensured patients engaged with local primary care services.
- Patients had a holistic care plan with personal recovery orientated goals. Staff updated patients care plans with patients frequently.
- Staff carried out occupational functioning assessments and each patient had a personalised activity plan and behaviour support plan in place.
- Staff used a range of recognised tools to assess and monitor patient outcomes. Each patient had a personal portfolio, which staff had developed with them to support their discharge and recovery.
- Patients were cared for by a multidisciplinary team who were skilled and experienced in working with people with a personality disorder. Staff compliance with role specific training was high and managers provided them with regular supervision and appraisal. Staff had access to multidisciplinary meetings including team meetings and reflective supervision.

Are services caring?

Good

We rated caring as good because,

- There was a strong person centred culture where staff took into account patient's individual needs and preferences.
- Patients thought staff were caring, respectful and approachable. Staff respected patient confidentiality but worked to involve families in treatment.
- Staff demonstrated a collaborative approach and empowered patients to make decisions about their care and about their surroundings. Patients told us they felt involved in their treatment and had a say in the hospital's routines.
- Staff encouraged patients to maintain their independence through completing their own portfolio of work. Some patients were actively involved in the local community, for example by attending college.
- Staff carried out regular surveys with patients and carers including whether patients were satisfied with local primary care services.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- Patients had access to a range of facilities including an enclosed garden, a modulation room, an art therapy area, a computer room, a well-equipped kitchen and a small on-site gym. The hospital was undergoing some refurbishment to create a new treatment room with a treatment couch.
- The hospital had a full activity timetable including some activities at weekends. Patients could choose which activities they wanted through a daily planning meeting.
- Patient and their carers had access to information about their rights and they knew how to complain. The hospital had few formal complaints and patients told us they could resolve issues quickly and informally. We saw evidence of changes made following a formal patient complaint.

However,

- We observed that staff sometimes dispensed medication to patients so that it could be seen by other patients.
- Staff did not always encourage patients to carry out medical self-testing in a private area.

Are services well-led?

Good

We rated well-led as good because:

- The hospital had strong positive values and we could see these in the way staff behaved and in their attitude to caring for patients
- The hospital had systems in place to effectively recruit, train, and support staff effectively so they spent a lot of their time involved in directly caring for patients.
- There was an open culture where staff and patients could raise concerns where necessary. Staff reported incidents and shared lessons when things went wrong.
- Staff surveys showed high levels of job satisfaction. Staff were happy and motivated to deliver high quality patient care.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Most were detained and receiving treatment under the Mental Health Act. The provider had trained 100% of staff in the Mental Health Act and staff had access to a trained Mental Health Act administrator on site who provided administrative support and legal advice on the implementation of the Act and the Code of Practice.

Staff informed all patients of their rights on admission to the ward and gave them a welcome pack that contained information about the ward, the complaints procedure and about their detention under the Act.

Overall, we found that Mental Health Act detention papers and transfer documentation was completed and in good order. The service was compliant with regard to procedures for admission, renewal of detention, patient's rights and consent to treatment.

Mental Capacity Act and Deprivation of Liberty Safeguards

Managers told us that all staff had participated in training about the Mental Capacity Act and the Deprivation of Liberty Safeguards and when we spoke with staff, they confirmed they had received training, which was updated annually.

Staff provided information to patients to enable them to make informed choices and were aware that patients had the right to make unwise choices.

The hospital had not made any Deprivation of Liberty Safeguards applications in the six months prior to 20 September 2017.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Requires improvement

Safe and clean environment

The ward had two levels, a first floor and a ground floor. The design of the hospital corridors incorporated wall mounted curved mirrors and clear safety glass panel doors or windows in communal areas to allow staff to observe patients in most parts of the hospital. Staff told us the patient group was particularly vulnerable to self-harming including self-strangulation so they monitored the risks to individual patients on a daily basis and changed risk management plans as needed. There were enough suitably trained staff on duty to be available to observe patients in communal areas

The provider carried out a thorough ligature risk audit in July 2017 and staff were aware of those parts of the hospital that contained ligature anchor points. A ligature anchor point is something which can be used for the purpose of hanging or strangulation. The hospital had ensured patient rooms contained many anti-ligature fixtures, for example, shower fittings, door handles and furniture. The sink taps in patient bedrooms were standard taps and presented potential ligature points but the provider had robust risk assessment arrangements in place for individual patients, which meant that, staff, where necessary could increase observations of patients and/or allow controlled access to the patient's bathroom. The provider told us they had a plan to replace the taps in patient bedrooms with anti-ligature fittings. This was documented on the location's risk register but staff were awaiting information from the maintenance team regarding the timescales. Staff also had access to ligature cutters, which were in specific locations throughout the hospital, they knew where they were and could access them quickly when needed.

The hospital only accepted female patients so fully complied with guidance on mixed sex accommodation. The hospital did not have seclusion facilities but patients had access to a tranquillity room overlooking the garden where they could choose to take time-out if they wanted. It was not locked so they were free to leave the room at any time.

Staff carried personal alarms linked to a system allowing them to identify which part of the building an alarm had been triggered. This meant staff could summon immediate assistance when required. There was also a nurse call system for patients located in their bedrooms and communal bathrooms. We saw how staff responded swiftly and appropriately when they heard an alarm activated. The staff and patients we spoke with told us they felt safe in the service.

The clinic room had emergency equipment, including a defibrillator which staff had been trained to use. However, we found that emergency drugs were stored with other medication and not kept together with other emergency equipment. This meant staff might be delayed locating all the medicine they required quickly in an emergency. We pointed this out to the registered manager at the end of our inspection and they told us they would rectify this immediately. The clinic room did not have an examination couch but the provider was re-organising the ward to create a new treatment room separate from the medication room where an examination couch would be located.

Long stay/rehabilitation mental health wards for working age adults

Good

Safety equipment, such as firefighting equipment was in date and there was evidence that portable electrical appliances had been checked and labelled with a re-check date. To ensure that medicines were stored at the correct temperature, staff checked the medications fridge daily. However, staff recorded only the maximum and minimum temperature ranges not the actual temperature in line with good practice. Without the current temperature reading available, it can be more difficult to make a clinical judgement on the stability of the stored medicines to ensure they are safe and effective for use. When we spoke with the provider about this, they said they would amend their monitoring procedures immediately. Following the inspection, they confirmed they had revised their policy to include fixed point in time temperature checks.

The medications fridge was not in good working order. It had a build-up of water in the drain and so was damp inside. When we pointed this out to staff, they told us they had reported the issue to the maintenance team. We also raised this with the registered manager, who subsequently reported the fridge drain had been cleared and it was working properly again.

We observed that some staff did not take all practicable steps to control the spread of infection when administering medication consecutively to patients in the clinic room as they did not wash their hands. According to the World Health Organisation, hand hygiene is the most important measure to avoid the transmission of harmful germs and prevent health care-associated infections but we did not see any hand washing instructions in areas where staff carried out clinical procedures. Following the inspection, the provider told us they had implemented a new hand-washing protocol and placed clear signs for staff in clinical areas.

The hospital employed two full-time cleaning staff who covered for each other during periods of absence. The environment was visibly clean and we checked staff maintained cleaning schedules with records of when and what had been cleaned. Staff identified hazardous cleaning substances labelling, storing, and disposing of them correctly. Patient bedrooms and communal areas had good furnishings which were well maintained. Patients and carers commented positively on the cleanliness of the environment.

Safe staffing

The provider had completed a risk assessment to determine minimum safe staffing levels, which they determined to be one qualified nurse and four other staff per shift, day and night. Managers told us they always tried to exceed minimum staffing levels and employed a team of 2 senior nurses, 6.9 whole time equivalent nurses plus a team of support workers to provide adequate cover for leave and sickness.

Aspen had a daily establishment level of two nurses plus five support workers on the day shift and two nurses plus four support workers on the night shift. In addition, during the day shift, Monday to Friday, the hospital employed two full-time occupational therapy assistants plus a ward manager and a head of care both of whom were registered nurses. There was also a full-time occupational therapist on duty during the day.

There were enough staff to carry out physical interventions and when we spoke with patients and staff, they confirmed there were enough staff to provide one-to-one support for patients and that activities were rarely cancelled because of short staffing levels. Managers told us they could increase staffing levels where there was a need, for example, where patients required additional observations. When we spoke with patients, they all told us they felt safe in the hospital and that daily routines and activities went ahead as planned. We looked at a sample of monthly audits carried out by managers and from January to October 2017 which showed the hospital did not cancel any escorted leave for patients due to staffing shortages.

The hospital did not use agency staff but had access to a bank of staff employed by the provider group. The provider did not report to us the number of shifts filled by bank staff to cover sickness absence or vacancies as they did not record this. They told us they tended to use the same pool of bank staff to provide cover because they were familiar with the patients and the hospital procedures. Managers told us bank staff participated in the same mandatory training programmes as regular staff and that they had a structured induction spending two days shadowing on the hospital ward before being put on shift. When we spoke with staff, they confirmed this.

The provider had recently recruited a new a full-time consultant psychiatrist. In the interim, a consultant psychiatrist from another independent mental health hospital provided cover on site each week and provided telephone support to the care team out of hours Monday to

Friday. However, where necessary the consultant would attend the service out-of-hours. Whilst on inspection, the consultant stayed at the hospital until late into the night to provide support to the team to manage a crisis affecting a number of patients. Managers were able to temporarily increase staffing by arranging for bank cover to help whilst they transferred a patient to a more appropriate facility.

In a medical emergency, the consultant psychiatrist directed staff to contact the appropriate emergency service or take the patient to the local emergency department. The hospital had access to two vehicles and a number of staff trained to drive and escort patients.

In the 12 months from September 2016 to August 2017, the provider reported the sickness rate for the hospital was 6.4% and eight staff had left out of a total staff team of 50. The provider told us turnover amongst support staff was low and we spoke with a number of staff that had been with the hospital for eight and nine years. Staff, told us the staff team was stable and they knew each other well. Patients also confirmed they knew staff individually and felt that staff also knew them well.

The provider had a number of mandatory training programmes for staff including managing aggression, Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards, first aid, suicide and risk and fire marshal training. Staff compliance with mandatory training was over 75%. The provider had trained 97% of staff in managing aggression and one member of the care team had beenaccredited to provide this training to ensure staff were always up-to-date with mandatory and refresher training in the hospital's approach for managing aggression.

Assessing and managing risk to patients and staff

The provider had admission assessment processes to ensure that only those patients who could safely be managed with these risks were accepted for admission. In the period 1 March 2017 -20 September 2017, the provider reported no incidents of seclusion or long-term segregation and no incidents of restraint in the prone position. The provider did not have a seclusion facility and we saw no evidence that patients had been secluded, held in long-term segregation or held in a prone restraint position. In the period 1 March 2017 -20 Sept 2017, the provider reported no incidents of rapid tranquillisation administration but had an up-to-date rapid tranquilisation policy written with reference to the guideline NG10, violence and aggression: short-term management in mental health, health and community settings produced by the National Institute for Health and Care Excellence.

In the period 1 March 2017 -20 September 2017, the provider reported 106 uses of restraint on 12 patients. The hospital had a policy and plan to reduce the use of restraint. Staff and managers had undertaken specialist training in the management of aggression. Clinical staff attended a four-day face-to-face training course and had their own workbook The techniques consisted of a set of ideas and skills to help people who were aggressive or violent to calm down. Staff told us they valued this approach because it supported them to use verbal de-escalation, which was in line with the ethos and the values of the hospital where restraint was the last resort.

Patients had access to a tranquillity room, which overlooked the garden and where they could spend quiet time if they wanted to. This room was not locked so patients were free to come and go. Staff knew patients well and could identify when they were becoming agitated or upset. We observed staff encouraging patients to speak with them in their rooms or in the tranquillity room when becoming agitated or in need of private space. All patients had a positive behaviour support plan in place which outlined what prevention and coping strategies they felt worked best for them and how they wished to be supported by staff, for example, when becoming upset or agitated.

Staff undertook a comprehensive risk assessment on every patient at admission. The assessment required the clinician to rate a variety of historical and current risks as low, medium or high and then to formulate a risk management plan appropriate to the risks identified. The multidisciplinary team reviewed baseline risk assessments and management plans every three months and the ward staff reviewed and updated risks assessment and risk management plans daily. We checked six current patient care records and confirmed they all contained a comprehensive risk assessment, which staff updated daily and when risks changed or new risks emerged. For example, we saw some patient assessments had been updated in response to identified concerns around suicide and self-harm. When documenting risk management plans, staff referred to protective and mitigating factors.

Long stay/rehabilitation mental health wards for working age adults

Good

Staff used an activity risk assessment-screening tool to identify each patient's risks to participate in a range of internal and external activities and used information from patient's daily risk assessment to update this. Each patient had a specific choking risk assessment, which staff updated at the daily handover meetings.

Patients were only allowed unsupervised access to knives and sharp implements after staff had carried out an individual risk assessment. This included knives in the patient kitchen, which staff kept unlocked unless they identified a specific risk to patients generally. Staff kept risk assessments under review and we saw evidence of this through daily risk monitoring. Informal patients had a fob to allow them free movement around patient areas and to exit the hospital.

Staff only used blanket restrictions in response to identified concerns and reviewed these to ensure they were justified. For example, plastic carrier bags were not allowed in the hospital because of a recommendation from the coroner. Patients and staff were aware of this restriction and staff had documented it on the hospital's risk register. Some patients were not allowed sharp items in their rooms but staff had conducted a risk assessment to justify the reasons for this. When we looked at care records, we saw patients had a reducing restrictive practice plan which listed the items they could not have and the reasons why. Minutes of community meetings from November 2017 showed staff advised patients that restrictions were individually risk assessed and put in each patient's behaviour support plan.

The provider had appropriate safeguarding procedures in place and staff knew how to identify abuse and report safeguarding concerns. The hospital provided staff with annual safeguarding training and managers told us staff compliance with training was 100%. Managers provided all staff including bank staff with a safeguarding handbook on induction to the ward. The handbook provided staff with information about how to recognise abuse and what to do if they had concerns.

Managers had good communication with the local safeguarding adults' team and liaised as necessary regarding open referrals. Between the dates, 31 October 2016 and 31 October 2017, staff reported nine statutory notifications to CQC, which staff also reported to the local safeguarding authority.

We saw information for patients in ward areas about how to recognise abuse and who to report concerns to. On induction to the ward, staff provided patients with specific information about bullying including cyber bullying, how to recognise it and what to do if they experienced it or became aware of it. Staff informed patients about the hospital's safe procedures for their visitors including children. Visits took place in a designated room and the multidisciplinary team planned visits in advance following discussion with the relevant patient.

The provider had thorough medicines management arrangements in place including an up-to-date medicines management policy. At the last inspection in April 2015, we told the staff they should ensure that fridges containing medication should be kept locked and under the supervision of a registered nurse and that, the controlled drug storage key was not held on the same key ring as the keys for other medication. At this inspection, we found the provider had carried out these actions.

The hospital had a contract with a local pharmacy to carry out medication audits. At this inspection, we checked medication storage and dispensing arrangements including all patient medication records and audits carried out by managers in the service. We also looked at an audit carried out by the pharmacy on the provider's behalf and found staff had good medicines management practices in place. However, at inspection we saw that staff had not put the date they had opened a controlled drug on the container, which meant they would not be able to determine the use-by date. In addition, when they denatured this drug prior to disposal, they should have locked it away but we observed it had been left in the clinic room and not secured. Denaturing a drug is process staff use to destroy it once it is no longer required. It is good practice to ensure that once a controlled drug has been denatured, it is stored securely in a controlled drug cupboard before it is disposed of because it can take a while for the denaturing process to work and for the drug to become irretrievable. When we raised this with staff, they immediately locked the drug in their controlled drug cupboard.

Track record on safety

In the previous 12 months, the provider reported one serious incident, which involved an incident where one patient was violent towards another. Staff had reported this

to the appropriate authorities including the police and the local safeguarding team. They had carried out their own investigation, which was still on going at the time of our inspection.

Reporting incidents and learning from when things go wrong

All staff reported incidents directly to the nurse in charge and for serious incidents, the nurse in charge informed the hospital manager or head or care, using the out-of-hours on-call system where necessary. When we spoke with staff, they confirmed they knew how to report incidents and had received specific training at induction.

Staff told us they completed an incident report every time they had to use restraint and we saw examples of completed restraint report forms in care records. The forms we looked at confirmed that both staff and patients were offered the opportunity for de-brief following incidents.

At inspection, we observed managers providing de-brief to staff and patients following an incident on the ward. Staff also had access to a reflective forum facilitated by a member of the multidisciplinary team, which they could use to de-brief following incidents. Managers told us these meetings had been suspended due to the lack of a full-time psychologist but they would be resuming in January 2018 following the appointment of a new psychologist. Staff told us they valued these meetings as a way of reflecting on practice especially following incidents involving patients.

Staff communicated incidents and increases in risk to each other during morning and evening handover meetings and on weekdays, to the full multi-disciplinary team at morning meetings.

The team reviewed individual patient risk assessments and discussed further actions, which needed to take place. We saw managers kept a folder in the team office with notes of lessons learned from incidents. They encouraged staff to read the folder and discuss incidents at team meetings. We saw that managers had provided staff with further guidance and training following an incident of drug misuse on the ward.

Managers discussed all incidents including all safeguarding incidents at their bi-monthly clinical governance meetings. As part of the inspection we saw minutes from these meetings where they discussed safety incidents.

The provider had a duty of candour policy in place and staff could describe the hospital's duty to be open and honest with patients when things went wrong with their treatment and care. There were no incidents which happened at the hospital which met the threshold for the duty of candour.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We examined the care and treatment records of six current patients. All the records we reviewed demonstrated that nurses carried out a timely comprehensive assessment for each patient on admission to the hospital. The assessment included the presentation of the patient, their speech, and mood and thought content including abnormalities of perception.

Orientation to the ward was on an individual basis and patients acted to buddy newly admitted patients. As part of the assessment, staff encouraged patients to describe their main problems using their own words. This self-assessment included symptoms, thoughts, and feelings, which patients could underline if they felt they were relevant to them.

Each patient had a physical health check using a tool called a health improvement profile. The responsible clinician used the health profile to identify the frequency of patients' health observations, for example, their weight, blood pressure, body mass index, liver and renal function. We saw that each patient had a physical health profile, which clinicians tailored to their particular health needs. We saw evidence of on-going physical health monitoring and examples of where staff had changed a patient's medication because of abnormal electrocardiogram results.

The service encouraged women to attend an in-house well-women clinic for advice and referral about a range of women's health issues including cervical smear testing and mammogram screening. Staff connected all patients with

local primary care services including a local a G.P. dentist and optician and encouraged them to make appointments where needed. Staff offered patients healthier lifestyle information around diet, exercise, and smoking cessation.

All the records we looked at contained an up-to-date holistic care plan, which addressed the needs identified during the assessment. Care plans contained relapse prevention strategies and showed evidence of contingency planning. This meant patients would be better equipped to cope if their progress did not go according to the way they had planned it. Goals were person centred and recovery orientated, for example, we saw evidence in care plans of patients attending college courses and working on developing life skills. Staff reviewed care plans regularly and updated them as appropriate to patients' needs and preferences.

Staff carried out assessments of patients' occupational functioning and each patient had a personalised activity timetable and a positive behaviour support plan in place. The behaviour support plans we looked at contained clear information for staff about the factors influencing each patient's behaviour and personalised strategies to prevent behaviour from escalating to crisis level. We saw examples of staff using distraction and diversion techniques with patients when they became, for example, highly agitated or anxious.

Some parts of patient files were electronic and some elements were paper based but staff had printed all the information and organised it into a well-structured paper file for each patient. When we spoke with staff, they told us that all the information needed to deliver patient care was available in one place and clear to understand. Files were stored securely in the staff office and were accessible to all the care team including support workers and bank staff.

Best practice in treatment and care

The provider had a clinical operating model in place, which was underpinned by guidance issued by the National Institute for Health and Care Excellence, the Royal College of Psychiatrist's Centre for Quality Improvement, the Department of Health, and the National Institute of Mental Health. Patients attended therapeutic interventions including psychosocial groups delivered in collaboration with the occupational therapy team and the wider multidisciplinary team. The patient care pathway was divided into three distinct phases; assessment and stabilisation, social learning and core treatment and resocialisation and transition. Each phase identified specific interventions aimed at moving the patient through the treatment and rehabilitation pathway.

Staff told us they aimed to build trusting relationships with patients and work in an open, engaging, and non-judgemental way. Patients had access to individual and group therapy underpinned by cognitive and dialectical behaviour therapy principles. Cognitive behaviour therapy is a talking therapy aimed at helping patients change their thinking and behaviour. Patients had access to mindfulness, which is a simple form of meditation which can be a helpful tool for patients with a mental health problem.

Staff used a range of recognised tools to assess and monitor patient outcomes, for example, they used Health of The Nation Outcome Scales, (HoNOS), which is a tool to measure the health and social functioning of people with severe mental illness. The occupational therapy team used the Model of Occupational Functioning Tool, (MoHOST) to assess patient motivation, communication, and interaction to gain an overview of each patient's occupational functioning.

Each patient had a dietary assessment, which contained recommendations about nutrition and fluid intake as well as details about allergies personal likes and dislikes. Staff encouraged patients to access specialist physical healthcare and we saw how one patient had specialist medical attention for a specific physical health problem.

Each patient had a personal portfolio, which they developed whilst in the hospital and took with them following discharge. The portfolio was a toolkit developed as a joint initiative between patients and the psychology and occupational therapy team. Patients had access to a workbook of transitional skills, which they themselves developed through a mixture of attendance at educational sessions, and exposure to the community. The lead occupational therapist at the hospital was due to present the work at a national conference and had been contacted by other providers to share good practice. One patient we spoke with told us they found their portfolio invaluable and used it to identify triggers and coping skills.

Staff used the "Recovery Star" to measure patients' progress with their recovery goals. The

star contained ten areas covering the main aspects of patients' lives including living skills, relationships, work, identity and self-esteem and social networks. Patients set their own goals and measured over time how far they had progressed towards these goals.

Staff were involved in physical health care audits and medication audits. Clinical staff had identified that some of the hospital's prescribing for anti-psychotic medication was outside of guidance issued by the National Institute for Health and Care Excellence. They had a longer-term plan to ensure they reduced patient's medication appropriately and had discussed this with the newly appointed consultant due to start at the hospital in December 2017.

The provider's approach to clinical and quality audit was under development as they had a newly formed quality team who would be providing direction and guidance to staff engaged in future clinical audit.

Skilled staff to deliver care

The hospital had a range of mental health professionals providing input into patient care including a consultant psychiatrist, a clinical psychologist, an assistant psychologist, an occupational therapist, occupational therapy assistants, nursing staff and support workers. Staff were experienced in working with patients with personality disorder and were motivated to provide high quality care and treatment. When we spoke with patients, they told us the therapy team were highly skilled but that they wanted more access to one-to-one psychological therapy. The hospital told us they had been without a full-time psychologist for several months but that a new one had been recruited to start in December 2017 and that access for patients would improve following that. In the interim, a clinical psychologist from another independent mental health hospital visited each week and an assistant psychologist worked full time at the service.

Staff were able to show they had expertise to support patient's recovery and address patients' complex and diverse needs including patient physical health monitoring, assessing self-harm risk, psychosocial interventions, art therapies, self-care, everyday living skills, and support with meaningful occupation. Staff had access to support from a pharmacy technician contracted from a local service who carried out audits on the providers behalf. Whilst inspecting the service, we observed care staff seeking advice from pharmacy staff concerning medication storage arrangements.

All staff received a structured induction with access to on-line training and two days supernumerary on the hospital ward before managers put them on shift. Support staff undertook appropriate training towards the care certificate with 23 out of 24 staff having completed this. Staff had a workbook and access to on-line training based on the care certificate standards. When we spoke with support staff, they told us they had access to specialist training to work with the patient group. Managers provided us with data to show that support staff had received training in working with patients with personality disorder and other appropriate therapeutic skills training.

Staff told us they discussed training needs in individual supervision and had access to further training appropriate to their role. Some support staff had been trained to take blood and monitor physical healthcare. Some therapy staff had identified training in post-traumatic stress disorder because that reflected the needs of some of the current patients. Managers supported staff to learn new skills and share best practice through meetings discussions and attendance at training events. We saw how some staff had been accredited to provide training in managing aggression for immediate colleagues and staff across the wider organisation.

Managers on site provided individual line management supervision to staff as a minimum once every three months though the staff we spoke with had participated in supervision more frequently than this. Managers confirmed they provided individual supervision every four to six weeks. Clinical staff had access to clinical supervision provided by an off-site clinical supervisor from their own particular discipline, for example, nursing. Staff had access to group reflective supervision facilitated by a member of the multidisciplinary team. Staff told us they valued this but it had not happened recently due to the absence of a full-time psychologist. When we raised this with managers, they told us these sessions would be re-instated in January 2018 when the new psychologist was in post.

Managers told us that 88% of nursing and other staff providing direct care had undergone an appraisal in the previous 12 months and when we spoke with staff, they confirmed they had undergone a recent performance

appraisal. Appraisals were structured and contained performance objectives, which managers reviewed regularly through supervision with staff. Staff had access to regular team meetings, which we confirmed when we saw copies of team meeting minutes.

Managers told us they had support from the organisation's human resources department to deal with any performance issues including long-term illness in the team. Managers also had access to management development training where they felt that would be useful.

Multi-disciplinary and inter-agency team work

The multidisciplinary team working with patients consisted of a consultant psychiatrist, an occupational therapist, a clinical psychologist, an assistant psychologist and two therapy assistants. Nursing and support staff also supported patients and took part in twice-daily handover meetings and, as part of the inspection, we observed a multidisciplinary meeting and a handover meeting.

Staff held a multidisciplinary meeting every morning to review risk plans, observation levels, medication concerns, and other matters, which had arisen over the preceding 24-hour period. This meant they were informed and up-to-date with patients' treatment and could share information and ideas with different members of the team. Nursing and support staff held meetings twice per day so that each shift could handover to the other. In both meetings, we observed how staff from different disciplines worked together effectively to discuss significant events and issues affecting patients. Handover meetings were thorough and included in-depth discussion about how each patient presented including any incidents, which staff on the next shift needed to be aware of. We saw how staff used the information to update treatment plans and risk management plans. The systems in place allowed staff to share real-time information including to external agencies where patients were transferred or discharged.

We were not able to observe a care programme approach meeting but we saw evidence in patient files that external care coordinators were present at such meetings or were involved at a distance with decisions affecting patient care. For example, we saw how staff worked together with one patient's care coordinator to find an appropriate alternative placement because they were not making progress at the hospital. Staff escorted patients to visit the local GP, which was a few minutes' walk from the hospital. The local surgery staff insisted that patients were accompanied on all GP visits but the hospital told us this was not always appropriate for patients. Staff had put this issue on the hospital's risk register and managers were meeting with staff at the local surgery to try to resolve the matter.

Adherence to the MHA and the MHA Code of Practice

Most patients in the hospital were detained and receiving treatment under the Mental Health Act. The provider had trained 100% of staff in the Mental Health Act and staff had access to a trained Mental Health Act administrator on site who supplied administrative support and legal advice on the implementation of the Act and the Code of Practice. As part of our inspection, we interviewed the responsible clinician at the service and looked at detention records for five patients. We also reviewed the latest Mental Health Act monitoring report carried out by CQC in January 2017.

All patients were informed of their rights on admission to the ward and were given a welcome pack that contained information about the ward, the complaints procedure and about their detention under the Act. This included information about their right of appeal and about their right to be supported by an independent mental health advocate. An independent mental health advocate visited the ward weekly and routinely spoke to all new patients. There was also contact information available freely on the ward that allowed patients to contact the independent mental health advocate directly.

Prior to this inspection with spoke with the advocacy service who told us they had positive dealings with the hospital and that staff provided strong support to patients to access the service. The advocate had the use of a private room in which to speak with patients and staff were approachable and helpful in facilitating advocacy visits.

We saw evidence in patient files that patient's capacity and consent to treatment was sought in line with the Mental Capacity Act and Code of Practice. Where required, we saw evidence that second opinion appointed doctors were involved. Informal patients were free to leave and were not subject to restrictions.

Overall, we found that Mental Health Act detention papers and transfer documentation completed and in good order. The service was compliant with regard to procedures for admission, renewal of detention, patient's rights and consent to treatment.

Long stay/rehabilitation mental health wards for working age adults

Good

Good practice in applying the MCA

Managers told us that all staff had participated in training about the Mental Capacity Act and the Deprivation of Liberty Safeguards and when we spoke with staff, they confirmed they had received training, which was updated annually. The Mental Capacity Act is legislation designed to protect and empower patients who may lack the capacity to make decisions about their care and treatment. The Deprivation of Liberty Safeguards are part of the Mental Capacity Act and aim to make sure that patients' freedoms are not inappropriately restricted. The hospital had a policy and clear guidance for staff in how to apply the principles of the legislation and how to make best interest decisions. When we spoke with staff, they could describe some of the principles of the Act and knew how the legislation applied to their day-to-day work with patients.

Staff provided information to patients to enable them to make informed choices and were aware that patients had the right to make unwise choices. The staff we spoke with knew to refer to the nurse in charge or members of the multidisciplinary team where they had concerns about a patient's capacity to consent or make specific decisions. Nursing staff told us they had been involved in mental capacity assessments with the responsible clinician.

The hospital had not made any Deprivation of Liberty Safeguards applications in the six months prior to 20 September 2017.

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

Good

Kindness, dignity, respect and support

Staff interacted with patients frequently in the communal areas especially in the garden area where patients tended to congregate. We observed how staff spoke with patients in a respectful and caring way. On one occasion, we saw a patient become verbally agitated but staff were able to de-escalate the situation in a calm manner and with considerable skill. Staff knew the patients well and this was evident in the quality of their interactions. There was a strong, visible person-centred culture where staff went beyond their minimum duties to care for patients. We saw that managers thanked the staff team when they had stayed late to support patients.

When we spoke with patients and carers, most told us they liked the staff and that they were approachable, kind and genuinely cared about the patients. Two patients commented that sometimes staff had been rude but mostly they were polite and respectful. We saw how staff provided appropriate emotional support to patients when they were upset or anxious and how they provided practical support, for example, by attending hospital appointments with patients. We saw how staff took account of individual preferences when they supported patients who were visibly distressed and how patients' emotional and social needs were embedded into their treatment.

The provider had updated the welcome board so patients knew all the names and job titles of the staff who worked in the hospital. Managers had provided interpersonal skills training for staff to remind them to be respectful and polite with patients. The hospital had appropriate information sharing policies in place and we saw how staff protected patient information by having agreements in place with patients about who they wanted staff to share their information with. Staff also protected patient information by having secure procedures for the access and storage of confidential information.

We saw in handover and multidisciplinary meetings how staff understood the needs of individual patients and supported them to connect with local support networks and advocacy services. We attended a community meeting and a patient activity-planning meeting where we observed positive interactions between staff and patients. Staff demonstrated a collaborative approach by empowering patients to facilitate meetings and make decisions. Patients were active partners in their care and had a stake in the running of the ward. One carer we spoke with told us they trusted staff to take good care of their relative.

The involvement of people in the care they receive

The hospital produced a guide to help orient patients to the environment and the routines. The guide was detailed and contained information about staff, the therapy on offer,

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Good

the facilities, activities, and meetings that patients could attend. During the admissions process, patients were given the opportunity to talk about what specific kind of help they wanted from the hospital.

Patients and carers we spoke with told us they had access to good quality information about the hospital, the local area and advocacy arrangements. When we spoke with the local advocacy service, they told us staff actively encouraged patients to engage with them. A carer we spoke with told us staff had involved them in the patient's treatment plan and provided them with appropriate information and support. In a survey carried out by the hospital in December 2016, most patients who commented confirmed they were able to keep in touch with family and friends but one patient said they were unable to invite family or friends to meetings. Staff told us that relatives could attend ward rounds or care programme approach meetings at any time with the patient's consent. One relative in the carer survey said they thought that having to seek patient consent was a barrier to carer involvement.

Staff encouraged patients to be involved in their own care and to identify recovery goals through joint work with staff on the recovery star. When we inspected the hospital in April 2015, we told staff they should ensure patients were involved in discussions about their treatment and that this should be clearly evidenced. When we inspected the service this time, we found that patients signed their care plans and most had been written in the first person and all had been recently reviewed. Some staff told us the care plan template in use did not lend itself well to demonstrating patient involvement but patients preferred working with their individual portfolios towards their treatment goals. The service encouraged patients to comment on their risk assessments and suggest activities they would like to participate in. Staff incorporated patient suggestions into the weekly activity calendar.

When we spoke with patients, they told us they felt involved in their treatment and we could see this clearly, when we attended a community meeting and an activity planning meeting, which the majority of patients attended. Staff interacted with patients to empower them to facilitate the meetings and make decisions about the service. For example, staff asked patients about the best way to remind everyone about a matter connected with the laundry facility. Patients read out the notes from previous meetings and held staff to account for updating actions. They colour coded actions according to whether they had been resolved and discussed issues important to patients like restrictive practices and patient choice. At the meeting we attended, staff asked patients if they would like to be involved in staff recruitment and we saw examples of questions that patients had asked previous job candidates. Patients were involved in choosing some of the décor for the hospital and had created a collage for the wall.

Staff encouraged patients to maintain their independence through completing their own portfolio of work. Some patients attended a local college and staff told us they encouraged patients to participate in some staff training courses. For example, staff told us that a few patients had completed the first aid course and care certificate training, which they had recorded in their portfolios.

Both staff and patients could provide feedback to staff through meetings and regular surveys. The results of the last survey carried out the provider in December 2016 were mainly positive and the staff produced a short action plan to address some negative comments made by a small number of patients. Staff also carried out an annual survey to assess patients' satisfaction with the local GP service.

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

Good

Access and discharge

The provider told us the average occupancy over the six months prior to September 2017 was 88% and most of the current patients were from outside the local area. Staff liaised with NHS commissioning bodies to coordinate the transfer of patients from acute mental health wards and secure care, including transferring patients who were already detained under the Mental Health Act. At the time of our inspection, fourteen out of sixteen beds were occupied but one patient was discharged to another facility whilst we were there. We saw how staff liaised with a patient's external care coordinator to find a more suitable placement and once one had been identified, they acted swiftly to ensure they transferred the patient in an appropriate and timely way.

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Good

Each patient had a personal portfolio, which they took with them when they left the hospital. The portfolio contained information about the patient's coping skills and relapse strategies and was designed to help patients prepare for discharge. Patients themselves had the main input into the portfolios, which meant the information in them was specific to their individual recovery. Patients we spoke with said the portfolio helped them identify how to cope with certain triggers when they left the hospital.

The hospital told us the average length of stay for patients was eighteen months. Commissioning guidance produced by The Joint Commissioning Panel for Mental Health suggests an admission period of between 1-3 years is appropriate for rehabilitation services for people with complex mental health issues. From 1 January 2016 to 31 October 2017, the hospital reported no delayed discharges.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a range of rooms to support treatment and care and staff were in the process of creating a clinic room separate to the medication room so patients could have access to an examination couch. The provider was refurbishing a sensory modulation room with each patient having a sensory profile put together by the occupational therapist. The hospital had a computer room, an arts and crafts room and a small gym with a running machine. There were quiet areas where patients could spend time and two lounge areas with a television and media players. Patients confirmed that facilities were available to meet visitors but one patient commented that the meeting room was not child friendly and therefore not suitable for children who might wish to visit patients. Managers reported they would identify if there was anything they could do to improve this.

Whilst we were there, we observed two patients in a queue at the clinic room door to accept medication and one patient conducting a self-diagnostic test in a communal area. The hospital's patient handbook stated that no consultation or treatment should be carried out in a public area but staff were aware that some patients could observe procedures, which should have been conducted in a private area. Staff did not always encourage patients to carry out medical tests on themselves in private areas. Following the inspection, the provider told us they had implemented a new system when dispensing medication to patients.

Patients had access to a communal garden where they could smoke. Staff told us they were purchasing a static lighter so patients who did not have access to lighters could light their own cigarettes. Following an individual risk assessment, informal patients had a key fob to leave and enter the hospital freely. Patients had access to a well-equipped kitchen and laundry facilities and could make hot drinks and snacks at any time of the day We saw a range of menus on the wall which were colour coded according to their nutritional content. Most patients we spoke with thought the food was of good quality and there was enough choice.

Patients could lock their own bedrooms and could store personal possessions in there. We saw that patients could personalise their rooms with pictures, ornaments, and furniture if they wanted. They had access to their own mobile phones including smart phones with internet access but they could use the ward cordless phone when they wished.

The hospital had a full activity timetable and links with local services to provide patients with opportunities to network and socialise. Activities included cooking skills, arts crafts and animal therapy, visits to local places of interest. Patients could suggest activities and visits through the weekly planning meetings. Whilst we were there, we saw patients engaged in a session run by a qualified beauty therapist. Most of the patients we spoke with though there was a good range of activities but some said they got bored at the weekend. When we looked at the activity timetable, we could see patients had access to pre-planned activities during the day and evening and on Saturdays and Sundays. One patient said activities were often cancelled at the weekend but other patients did not confirm this.

Meeting the needs of all people who use the service

The hospital had a lift for patients with reduced mobility and staff made reasonable adjustments for patients with physical health conditions. For example, we saw how staff enlarged risk assessment paperwork for a patient with reduced sight and they had purchased some equipment for a patient with a back complaint. We saw that kitchen staff prepared meals for patients with particular dietary requirements and patients could speak with kitchen staff directly if they had any special requests. Staff were respectful of patients' cultural and spiritual needs and had arranged for a local pastor to visit the ward regularly. The

Long stay/rehabilitation mental health wards for working age adults

Good

manager confirmed staff had access to translation services for patients whose first language was not English. Therapy staff confirmed that information would be made available in patient's own language where required.

We saw that patients had access to a variety of information on notice boards around the hospital and in patient leaflets. We saw information about how to make a complaint, access advocacy, healthy eating and menu information, ward round dates, community meeting dates and information about local services.

Listening to and learning from concerns and complaints

All the patients and carers we spoke with at inspection told us they had seen information on the ward and knew how to make a complaint**.** In the 12 months prior to inspection, the provider had received seven complaints. Four complaints were upheld and none were referred to the Ombudsman. The hospital received six compliments in the 12 months prior to inspection.

Staff knew how to respond to complaints and most issues were resolved through community meetings and informal conversations with staff. We saw that managers kept a record of formal complaints and conducted investigations where required. They provided feedback to patients on the outcome of their complaint and shared their findings where appropriate with staff through team meetings. We saw evidence in team meeting notes where managers had discussed a recent patient complaint in order to ensure staff were aware of the outcome. Staff made changes to the service as a result of complaints, for example, we saw how staff made changes to a patient's care plan and medication regime following a complaint.

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

Good

Vision and values

At the time of our inspection, the provider was going through a merger with another company so staff expected that some of their vision and values would change because of this. However, staff told is that the current organisation's aim was "to make a positive difference" and the organisations core values were fairness, respect, equality, dignity and autonomy. We could see the values of the organisation in the way staff behaved and in their attitude to caring for patients. The service had a set of objectives consistent with the organisations values and strategic vision, which was to be recognised as a centre of excellence in treating patients with personality disorder.

Staff had met the organisations senior managers and when we inspected, we saw the regional operations director had called in on his way to a local meeting. Staff told us the chief executive of the organisation had visited the ward and spent time with staff and patients.

Good governance

Overall, the hospital had good systems in place to ensure staff received timely access to the right training to perform their role and that they were supported through supervision, appraisal and continuous professional processes. Staff on the ward spent the majority of their time on shift involved in directly caring for patients and systems were in place to ensure sufficient numbers of experienced staff were available to cover shifts. Managers had the autonomy to request additional staffing resources and we saw evidence that they increased staffing in response to the needs of patients. Staff followed correct procedures and the hospital had appropriate policies concerning safeguarding, mental capacity and the Mental Health Act. Managers participated in a variety of local and regional governance meetings aimed at improving quality and responding to concerns. Minutes of clinical governance meetings showed that higher managers provided oversight of incidents and would identify where incidents required further monitoring.

Staff participated in some clinical audit, for example, around medication prescribing but they told us they would have a consistent clinical audit schedule once the new consultant psychiatrist and psychologist had commenced in their roles. Senior managers confirmed that clinical audit was under development and the provider had created a quality team who would oversee audit processes. Managers had a number of operational audits in place, for example, case file audits, environmental audits and medication audits that they carried out on a monthly basis. Following each audit, they completed an action plan with timescales.

Long stay/rehabilitation mental health wards for working age adults

Good

Staff reported incidents including all incidents of restraint and managers kept a log of lessons learned in the staff office. We saw meeting minutes where managers reminded staff to refer to this log. We confirmed through team meeting minutes that staff had responded to patient feedback regarding staff behaviour on the ward.

The provider had key performance indicators in place which managers monitored on a weekly basis. They told us the indicators covered a range of measures including staffing and training and were discussed at board level. Local managers met with other operational managers from across the organisation to share practice and discuss quality initiatives and managers confirmed they could influence decision making regarding their individual services. Senior managers had oversight of the incidents affecting the hospital because we saw in meeting notes that they monitored incident outcomes at their quarterly regional operational governance meetings.

When we last inspected the hospital in April 2015, we told the provider they should have a central risk register in place, which they should keep updated. At this inspection, we found managers had established a central risk register with clear actions, which they updated regularly. The register reflected the current concerns of staff including potential ligature risks in communal bathroom areas. Managers put measures in place to reduce the risks, recorded these on the register and discussed them with staff at team meetings.

Leadership, morale and staff engagement

The provider carried out an annual survey of staff satisfaction and prior to this inspection, we looked at the latest survey carried out in December 2016. Almost 90% of staff said they felt supported in their work and 87% described the provider as a good or excellent place to work. The staff we spoke with at inspection told us there was a strong sense of teamwork at the hospital and we confirmed this when we looked at the latest staff survey. The survey described high levels of job satisfaction and staff told us they were happy and motivated to provide high quality patient care. Morale in the team was high despite the stresses of working with patients with complex mental health problems.

When we spoke with staff, they told us there was an open culture in the service where concerns could be reported to managers without fear of victimisation. The provider did not report any cases of staff bullying or harassment and staff we spoke with knew about the whistleblowing policy. Staff knew about the hospital's duty to be open and honest when things went wrong and managers confirmed staff had been informed about the hospital's duty of candour policy.

The provider had introduced a staff magazine which they circulated by email to all staff. Staff could nominate colleagues for acts of kindness and these would be published. Managers had the option to participate in leadership development programmes and there were some opportunities for promotion. We saw examples where support staff and nursing staff had been promoted to leadership roles.

Commitment to quality improvement and innovation.

The provider told us they did not participate in any accreditation schemes or national quality improvement programmes. However, managers told us the provider had recently created a quality team to oversee the development of quality improvement initiatives. The hospital had developed a transitional skills portfolio with patients, which they were presenting at a national conference.

Outstanding practice and areas for improvement

Outstanding practice

There was a strong person centred culture where staff took into account patient's individual needs and preferences. Staff demonstrated a collaborative approach and empowered patients to make decisions about their care and about their surroundings. Community meetings and activity planning meetings were well-attended by patients and they felt involved in the running of the ward.

The psychologist and occupational therapist worked co-productively with patients to develop a personalised portfolio to support each patient to prepare for discharge and build up skills for independent living. Staff carried out detailed individual risk assessments and risk management plans, which they developed with input from patients and updated on a daily basis.

Areas for improvement

Action the provider MUST take to improve

- Staff must ensure they record the current temperature of the medication fridge, not just the maximum and minimum temperatures
- Staff must ensure they practice good infection control precautions when carrying out clinical procedures
- Staff must ensure they store controlled drugs securely prior to disposal

Action the provider SHOULD take to improve

• The provider should ensure that emergency drugs and equipment are easily accessible so that staff are not delayed when responding to an emergency.

• Staff should ensure they record the date when they open medication so they can establish the use-by date.

• Staff should ensure they administer patients' medication in a way which ensures their privacy

• Staff should encourage patients to carry out medical tests on themselves in a private area

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not ensure the safe management of medicines. They did not always store controlled drugs securely prior to disposal. They did not record current medication fridge temperatures. Patients and others were not always protected against the spread of infections when staff carried out medication administration. This was a breach of regulation 12 (1) (2) (g) (h)