Cygnet Health Care Limited

Cygnet Hospital Harrow

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our inspection of Cygnet Hospital Harrow took place between the 23 May and 11 June 2023. We completed full inspections of the four core services provided at the hospital. These services were the acute wards for adults of working age and psychiatric intensive care units (Byron ward) and the wards for people with autism (Springs Centre); forensic inpatient wards for autistic people (Springs unit); rehabilitation ward for autistic people (Springs Wing).

When we report on services for people with learning disabilities and autism, we refer to people who use services as 'people'. When we report on acute wards for adults of working age and psychiatric intensive care units, we refer to people who use services as 'patients'.

Our overall rating of this hospital went down. We had previously rated the service as good. At this inspection we rated it as **inadequate** because:

- The overall rating of inadequate was the combined ratings for the four services. Forensic inpatient wards for autistic people were rated inadequate across all five domains. Wards for autistic people were rated inadequate for safe, effective, caring and well led and requires improvement for responsive. Rehabilitation wards for autistic people were rated inadequate for effective, requires improvement for safe, caring and responsive. Acute wards for working age adults were rated inadequate for safe and well-led and requires improvement for effective, caring, responsive.
- The Springs Centre, Springs Unit and Springs Wing were described by the provider as delivering a specialist service for men with a diagnosis of autism spectrum disorder. However, our inspection found that this was not the case, and the service was not meeting the needs of autistic people using this service.
- Nursing and care staff who worked on Springs Unit, Springs Wing and Springs Centre which provided care and treatment for autistic people were not adequately trained to communicate effectively with people using the service. This impacted on how staff interacted and communicated with people. People told us that they did not feel they were treated with compassion and kindness.
- The environment of Springs Centre and Springs Unit was not suitable for autistic people. We found the environment to be institutional and noisy. There were no improvement plans in place on both wards with clear timescales to bring the environment to an adequate standard.
- Restrictions in place on Springs Wing, Springs Unit and Springs Centre were not always recognised or reviewed on a regular basis. Our inspection identified a person being taken to appointments wearing handcuffs (a mechanical restraint) and the restraint had not been reviewed by the clinical team. Other blanket restrictions such as access to hot drinks had not been kept under review.
- Springs Unit and Springs Centre were not kept adequately clean. One person on Springs Unit was in seclusion for 17 hours before smeared faeces was cleaned up.
- Some people on Springs Unit, Springs Centre and Springs Wing who may be in hospital for lengthy periods said the food was not always of good quality, could be too cold (when it was a hot meal), portions were too small and so they were eating snacks. Some carers told us that their relatives were gaining weight.
- People were living on the wards for autistic people for lengthy periods of time but were not having routine health checks such as appointments with the optician or dentist or an annual health check with the GP. Autistic people have a shorter life expectancy as their physical health needs are often not met and so it is important these health care appointments take place.

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- People were not being offered sufficient therapeutic activities that met their needs. We found that activities significantly reduced at the weekends on Springs Unit, Springs Wing and Spring Centre. This impacted on the need for autistic people to have structured activities in place. On Byron Ward some patients told us that they were dissatisfied with the activities available. Where patients had attended activities, this was not always reflected on their care records.
- The provider had not addressed all the previous breaches from the previous inspection report. We found ongoing issues across all wards inspected. For example, clinical and emergency equipment continued to not be routinely calibrated and checked it was in working order. This meant that in the event of an emergency the equipment might not work.
- On Byron ward, staff continued from the previous inspection to not always receive regular supervision. Group supervision was not always of a high quality. However, supervision on the wards for autistic people had improved.
- The provider did not take sufficient precautions to ensure patients' safety across all wards inspected. We found staff did not complete records to confirm physical health monitoring after rapid tranquilisation medicines were administered. This treatment can result in serious side effects including death, so it is imperative monitoring is carried out.
- On Byron ward, despite the ward having blind spots, there was no clear plan in place to mitigate the risk and staff did not observe patients in all parts of the ward in order to keep patients safe.
- Staff who worked on all wards across the hospital did not always treat patients with compassion or respect their dignity. On Byron ward we found that some patients had complained but their concerns had not been acknowledged or addressed by staff. Patients did not always receive visits from their families and carers because staff were unclear about the ward's rules on visitors.
- Across all wards inspected, there was a culture of patients eating meals in their bedrooms rather than in a more social environment.
- The care record systems on Springs Unit, Springs Centre and Springs Wing were poorly organised, and staff struggled at times to find important information.
- On Byron ward not all patients were given person-centred care. Patients did not always receive a one-to-one session with their named nurse, not all patients were given advice about their medicines or side effects, and nursing staff did not provide patients with a copy of their care plans.
- Carers were not adequately informed of the operation of the service. Some carers told us that they did not feel included in their relative's care, and they did not know how to complain. The provider recognised that carer engagement required improvement and had plans in place to provide face to face meetings with carers.
- Incidents that took place across the hospital were not always reported so there was not sufficient management oversight and lessons could not be learnt to improve the safety of the services.
- The hospital's governance systems and processes were not robust. The processes in place had not identified many of the issues found in our inspection.

However:

- The ward teams across the hospital included or had access to the full range of professional staff required. Some person-centred work was taking place on Springs Unit, Springs Wing and Springs centre by the allied health professionals and psychologists to promote positive care and recovery.
- People on Springs Unit, Springs Wing and Springs centre had access to a range of therapeutic activities during the week including some community-based activities that met their needs.
- Staff had a good understanding of safeguarding processes.
- Staff worked well with external stakeholders and professionals to support people's discharge plans. The ward manager of Springs Unit was involved in the North London forensic provider collaborative which was an opportunity for providers in the collaborative to provide updates about their services and learn from best practice guidance. On Byron ward patients were discharged promptly.

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- Staff completed a comprehensive assessment when patients arrived on the ward and records were usually holistic. Staff understood the individual risks for people using the service and ensured there were thorough handovers between shifts.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Managers met regularly to discuss staffing to ensure there were always enough staff on shift. Staff felt managers were supportive and approachable.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement because: • Springs Wing is described as being a specialised service for men with a diagnosis of autism spectrum disorder. Whilst our inspection found that the service was generally meeting people's day to day care needs, staff did not receive specialist communication training to be able to effectively communicate with autistic people who used the service. Staff only had access to basic awareness training which meant they would not be appropriately trained in how to communicate with people using the service and how to use a range of communication aids. • Restrictions were not always recognised or reviewed on a regular basis. The provider was unable to evidence that restrictions on the ward was routinely reviewed in between the hospital's restriction audit that took place every 6 months. • The ward had not ensured that they had become fully compliant with the requirement notice that the CQC issued following our most recent inspection in 2018 that related to the calibration of physical health equipment. During our latest inspection in May 2023, we identified physical health equipment that had not been appropriately calibrated, increasing the risks to people's health and wellbeing. • The hospital induction checklist record did not include a prompt to ensure the staff member was shown the ward ligature points and how they were managed. At the time of inspection, a few members of staff we spoke with were not aware of the environmental risks and management plan in place. • People were living on the rehabilitation ward for autistic people for lengthy periods of time but were not having routine health checks such as appointments with the optician or

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dentist or an annual health check with the GP. Autistic people have a shorter life expectancy as their physical health needs are often not met and so it is important these health care appointments take place. Some carers said people were gaining weight and they did not feel as though the service was supporting them to reduce it.

- Governance processes were not sufficiently robust and had not identified some of the issues found in the inspection.
- People did not always receive a copy of their care plan.
- The care record system in place was not easy to follow. Information and people's care and treatment was stored across two separate electronic care record systems as well as in paper folders.
- Carers were not adequately informed and engaged in the operation of the service.

However:

- Person-centred work was taking placed by the allied health professionals and psychologists to promote positive care.
- People were encouraged to attend therapeutic activities and leave the ward to visit the community. Some people took part in community-based activities such as swimming and voluntary work.
- Staff had a good understanding of safeguarding processes.
- Staff supervision had improved since the previous inspection.
- Staff understood the risks for people using the service and carried out thorough handovers between shifts.
- Staff worked well with external stakeholders and professionals to support people's discharge plans.
- The provider had improved the level of mandatory training compliance since our most recent inspection.

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Forensic inpatient or secure wards

Inadequate

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

- Springs Unit is described as being a specialised service for men with a diagnosis of autism spectrum disorder. However, our inspection found that the service was not meeting the needs of autistic people using this service.
- Nursing and care staff were not adequately trained to communicate effectively with people using the service. This meant that while people felt safe, they did not feel treated with compassion and kindness. Some people said they did not have a positive rapport with the staff. The approach of the nursing and care staff was at times custodial and threatening rather than supportive. Staff did not communicate consistently with the people which caused them to be distressed.
- The environment was not suitable for autistic people. The environment was institutional, noisy with alarms ringing, the lighting was too harsh. There were no plans in place with clear timescales for improvements to take place.
- Restrictions were not always recognised or reviewed on a regular basis. One person was wearing handcuffs (a mechanical restraint) when travelling to appointments at the acute hospital and this restraint had not been reviewed by the clinical team.
- People were living on the units for lengthy periods of time but were not having health checks such as appointments with the optician or dentist or an annual health check with their GP.
- People were not being offered sufficient therapeutic activities at the weekend which meant they did not have a structure which met their individual needs.
- Some basic safety measures were not in place. Checks of equipment used for resuscitation were not taking place regularly which was outstanding from the previous inspection. People were not recorded as having the correct monitoring after receiving rapid tranquilisation. Controlled drugs were not always being administered correctly.

Summary of findings

- The ward was not kept adequately clean. One person was in seclusion for 17 hours before smeared faeces was cleaned up.
- Incidents were not always reported so there was not sufficient management oversight.
- Care records including seclusion records were poorly organised and badly filed.
- The provider recognised that the food was not always of good quality. Some relatives said people were gaining weight.
- Governance processes were not sufficiently robust and had not identified many of the issues found in the inspection.
- Carers were not adequately informed and engaged in the operation of the service.

However:

- Some person-centred work was taking placed by the allied health professionals and psychologists to promote positive care.
- Therapeutic activities took place during the week including some community-based activities.
- Staff had a good understanding of safeguarding processes.
- Staff supervision had improved since the previous inspection.
- Staff understood the risks for people using the service and carried out thorough handovers between shifts.
- Staff worked well with external stakeholders and professionals to support people's discharge plans.
- The provider had improved the level of mandatory training compliance since our most recent inspection.

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

Inadequate

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

- The provider had not addressed all the previous breaches from the previous inspection report. We found ongoing issues with clinical equipment to monitor physical health not being calibrated. This included life saving equipment such as the ward's defibrillator. However, since the inspection

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the provider confirmed all equipment had been calibrated. We also found ongoing issues with supervision; not all staff received supervision, and group supervision was not always of a high quality.

- The safe domain was rated as inadequate as there were several areas for improvement which impacted on patient safety. We found staff did not complete records to confirm physical health monitoring after rapid tranquilisation medicines were administered. This treatment can result in serious side effects including death, so it is imperative monitoring is carried out.
- Staff did not always record incidents on the electronic incident reporting system. Some incidents of restraint that had been recorded on the system did not contain sufficient levels of detail. This meant that incidents were not always appropriately reviewed and investigated.
- Despite the ward being large and having blind spots, there was no blind spot audit and staff did not observe patients in all parts of the ward in order to keep patients safe.
- Not all care was person-centred. We found not all patients had one-to-one sessions with their named nurse, not all patients were given advice about their medicines or side effects, and not all felt involved with their care. Staff did not provide patients with copied of their care plans.
- Where patients had attended activities, this was not always reflected on their care records which meant it was unclear how often patients engaged with meaningful activities. Some patients we spoke with said they were dissatisfied with the activities.
- Not all ward staff had access to ward team meetings, and some said communication could be improved. However, the ward manager started to arrange these following our inspection.
- Staff did not always treat patients with compassion or respect their dignity. We found that some patients did not have access

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to personal hygiene products, some patients had complained but their concerns had not been acknowledged or addressed by staff, and most patients ate meals in their bedrooms rather than in a more social environment. Staff were unclear about the ward's rules on visitors which meant not all patients received visits from families and carers.

- Not all concerns and complaints raised by patients to staff were responded to or addressed in a timely manner. Most patients and carers we spoke with did not know how to complain.
- Our inspection findings across the key questions demonstrate that while the hospital had governance systems and processes in place, these did not always operate effectively. We identified that areas of practice were not being closely assessed and monitored which affected the quality of care delivered.

However:

- The ward environment was clean. The ward had enough nurses and doctors. Patients were offered regular physical health checks. They minimised the use of restrictive practices, managed medicines safely, and followed good practice with respect to safeguarding.
- Staff completed a comprehensive assessment when patients arrived on the ward and records were usually holistic. The service 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. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.

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- Most patients we spoke with said staff treated them well and with kindness. Staff actively involved patients and families and carers in care decisions.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- Managers met regularly to discuss staffing to ensure there were always enough staff on shift. Staff felt managers were supportive and approachable.

Wards for people with learning disabilities or autism

Inadequate

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

- Springs Centre is described as being a specialised service for men with a diagnosis of autism spectrum disorder. However, our inspection found that the service was not meeting the needs of autistic people using this service.
- Nursing and care staff were not adequately trained to communicate effectively with people using the service. This meant that while people felt safe, they did not feel treated with compassion and kindness. Some people said they did not have a positive rapport with the staff and that staff sometimes laughed and mimicked them.
- The environment was not suitable for autistic people. The environment was institutional, noisy with alarms ringing, the lighting was too harsh. Ward leaders had some plans to make improvements but not all actions identified had clear timescales in place.
- Restrictions were not always recognised or reviewed on a regular basis. The provider was unable to evidence that restrictions on the ward was routinely reviewed in between the

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hospital's restriction audit that took place every 6 months. People on the ward did not understand why there were restrictions in place.

- People said the food was not always of good quality, portions were too small and so they were eating snacks, some relatives said people were gaining weight. People were regularly eating in their bedrooms rather than using the dining area.
- People were not being offered sufficient therapeutic activities at the weekend which meant they did not have a structure which met their individual needs.
- People were not recorded as having the correct monitoring after receiving rapid tranquilisation. Staff had not ensured that they signed for medicines that had been administered.
- The ward was not kept adequately clean. The ward environment was visibly dirty.
- Care records were poorly organised, and staff struggled at times to find basic information.
- Governance processes were not sufficiently robust and had not identified some of the issues found in the inspection.
- Carers were not adequately informed and engaged in the operation of the service.

However:

- Some person-centred work was taking placed by the allied health professionals and psychologists to promote positive care.
- Therapeutic activities took place during the week including some community-based activities.
- Staff had a good understanding of safeguarding processes.
- Staff supervision had improved since the previous inspection.
- Staff understood the risks for people using the service and carried out thorough handovers between shifts.

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- The ward had implemented emergency simulations that provided staff with an opportunity to practice how to respond in a variety of emergency situations.
- Staff worked well with external stakeholders and professionals to support people's discharge plans.
- The provider had improved the level of mandatory training compliance since our most recent inspection.

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Background to Cygnet Hospital Harrow

Cygnet Hospital Harrow was registered with the CQC on 15 November 2010. The hospital is made up of 4 wards across 4 core services which include acute wards for adults of working age and psychiatric intensive care units, a low secure forensic ward for people with autism, a ward for people with learning disabilities or autism and a long stay rehabilitation ward for people with autism.

- Byron ward is an acute service for men of working age. The ward can accommodate up to 20 patients. The beds are commissioned by 2 London based NHS trusts.
- Spring Unit is a specialist low-secure forensic ward for up to 12 male patients with autistic spectrum disorders and who also present with mental health needs.
- Springs Wing is a specialist rehabilitation ward for up to 10 male patients with autistic spectrum disorders.
- Springs Centre is a specialist ward for up to 14 male patients with a diagnosis of autism and who also present with mental health needs. This ward opened in January 2018.

We have inspected Cygnet Hospital Harrow 3 times since October and November 2018. Our most recent comprehensive inspection of Cygnet Hospital Harrow took place in October and November 2018. Following this inspection, the hospital achieved an overall rating of good. The hospital was rated as requires improvement for safe and good for effective, caring, responsive and well-led. We issued requirement notices for four separate breaches of regulation in relation to regulation 12 (safe care and treatment), regulation 15 (premises and equipment), and regulation 18 (staffing), and made recommendations to the provider to improve in a few areas.

Since then, we have carried out a focused inspection of the acute ward in August 2020 and of the ward for people with autism in November 2020, following a number of concerns raised about the care people had received. We did not re rate the service at these inspections. We did not identify any breaches of regulation for the specialist autism wards. We found one breach of regulation related to the use of personal protective equipment during COVID-19.

We undertook an unannounced comprehensive inspection in May and June 2023 to find out whether the quality of services at Cygnet Hospital Harrow had changed since our previous comprehensive inspection in October and November 2018.

Cygnet Hospital Harrow is registered to provide the treatment of disease, disorder or injury and assessment or medical treatment of persons detained under the Mental Health Act 1983. There was a registered manager in place at the time of our inspection.

What people who use the service say

We spoke with 1 person on Springs Wing, the rehabilitation ward for people with autism who was positive about their overall experience on the ward. The person told us that they felt listened to and that staff supported them. We offered to speak with more people on the ward but they either declined or was off of the ward at the time of our inspection.

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On Byron ward, the acute wards for adults of working age, we spoke with 7 patients who spoke positively about staff attitudes overall. Patients liked the food. However, not all patients said they were involved in their care and treatment.

We spoke with 7 people from Springs Centre, the ward for people with a learning disability or autism. They had mixed views about the ward they were living in. Three people raised their concerns about how staff treated them. Three people said that staff mimicked them and laughed at them. Some people told us that there were not enough activities especially at the weekends.

On Springs Unit, the low secure forensic ward, we spoke with 5 people. Three out of 5 people told us that they felt ignored during periods of seclusion and that staff were unable to meet their needs. A small number of people had said that they felt safe on the wards.

On Springs Wing we spoke with 3 carers. All carers said that their relative felt safe on the ward and felt comfortable to raise concerns. Two carers told us that they were concerned that their relative had gained a lot of weight since being in hospital and that they did not feel involved in their relative's care. One carer told us that they felt that the ward was dirty.

On Byron ward we spoke with 5 carers. Overall, carers were positive about staff on the ward. They said staff involved them with care if the patient had consented to this. However, some carers had not been informed about visiting times which had resulted in long waits or being turned away.

Most patients and carers from Byron ward did not know how to complain.

On Springs Unit, we spoke with 2 carers. Both carers we spoke with told us that they felt communication from the ward could be improved. One of the 2 carers we spoke with told us that the service had never contacted them to inform them of when their relative had been involved in an incident. One carer told us that staff were not supporting their relative to manage their oral hygiene and since being in the hospital it had worsened. Most carers understood how to raise concerns and felt comfortable to do so.

During our inspection we spoke with 4 carers from Springs Centre. Three out of the 4 carers we spoke with told us that they felt that staff communicated with them. One carer told us that they felt that there was an unreasonable limitation on their visits to the ward and they were unable to visit as often as they would like.

How we carried out this inspection

During this inspection, we carried out the following activities:

- We visited all wards in the hospital and conducted an inspection of the ward environment and clinic room.
- We spoke with 4 ward managers across 4 of the wards.
- We spoke with 35 other ward staff including registered nurses, healthcare support workers, clinical team leaders, a consultant psychiatrist, a ward doctor, an activities coordinator and staff members from the individual therapy's teams.
- We spoke with 20 patients.

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- We spoke with 14 carers.
- We reviewed 22 patient care records.
- We spoke with senior leaders including the hospital director, clinical lead (who is also the designated safeguarding lead), head of psychology, quality and compliance lead and therapy services manager.
- We attended a handover meeting, a daily situation report meeting, ward round, and observed 3 lunch services. We also visited two of the wards out of hours on a weekend.
- CQC's mental health act (MHA) reviewers carried out a MHA monitoring visit that specifically looked at the use of seclusion. This visit took place shortly after our on-site inspection in May 2023.
- We carried out a short observational framework for inspection (SOFI) which is a tool developed and used by inspection teams to capture the experiences of people who use services who may not be able to express this for themselves.
- We reviewed documents and policies relating to the running of the service.

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.

Outstanding practice

During this inspection we did not find any areas of outstanding practice.

Areas for improvement

Action the provider 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 Springs Unit, the forensic inpatient ward for autistic people:

- The provider must ensure that patients' physical health is checked appropriately and recorded consistently after they have received medicines via rapid tranquilisation, in line with national good practice guidelines and the provider's own policy. Regulation 12 Safe care and treatment
- The provider must ensure equipment used to monitor patients' physical health is properly maintained and calibrated. This was required at the previous inspection. Regulation 12 Safe care and treatment
- The provider must ensure staff complete weekly checks of resuscitation equipment in line with national good practice guidelines. Regulation 12 Safe care and treatment
- The provider must ensure that restrictive practices such as the use of handcuffs are appropriately recognised, reported, and reviewed to ensure they are only used if absolutely needed. Regulation 13 Safeguarding people from improper treatment
- The provider must ensure people have access to regular physical health checks including dental and chiropody. Regulation 12 Safe care and treatment

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- The provider must ensure that staff working on all wards for autistic people are adequately trained and skilled to make sure that they can meet the care and treatment needs of autistic people. This must be in line with good practice and support the staff to communicate effectively with people using the service. Regulation 18 Staffing
- The provider must ensure the wards fire alarms do not go off unnecessarily to avoid distress for the patients and to also prevent people from becoming accustomed to alarms sounding and therefore not responding in the event of a real fire. Regulation 12 Safe care and treatment
- The provider must ensure that the environment for autistic people including the seclusion room is clean to ensure infection control principles are maintained. Regulation 12 Safe care and treatment
- The provider must ensure that people using the service have access throughout the week including the weekend to therapeutic activities which provide structure and meet their individual needs. Regulation 9 Person centred care
- The provider must ensure that people using the service are supported by staff in an appropriate and supportive manner, treat them with kindness and understand their individual needs. Regulation 9 Person centred care
- The provider must ensure that people have access to healthy food of a high quality and sufficient quantity. Regulation 14 Meeting nutritional needs
- The provider must ensure that the wards for autistic people provide an environment that meets their sensory needs. Regulation 9 Person Centred Care
- The provider must ensure that the number of paper and electronic record systems that are used in practice are organised and easily accessible so staff can find essential information. Regulation 12 Safe Care and Treatment
- The provider must ensure that staff correctly sign and witness the administration of controlled drugs (CDs). Regulation 12 Safe care and treatment
- The provider must ensure that people's treatment records are completed accurately so that they can be checked to ensure people are receiving safe treatment in line with best practice. Regulation 12 Safe care and treatment
- The provider must ensure that all incidents are recorded and that these are reviewed and where needed measures taken to address patient safety. Regulation 12 Safe care and treatment
- The provider must ensure governance processes operate effectively and that local procedures and policies are met. This includes having the processes in place to monitor whether patients are having their physical health monitored following rapid tranquilisation; whether staff are routinely reading patients their section 132 rights; whether equipment is being regularly checked; restrictions are recognised and regularly reviewed; whether information from completed audits is being used to improve services, It also includes ensuring managers have access to accurate data about incidents and other operational matters to enable them to have effective oversight of the hospital. Regulation 17 Good governance

Action the service MUST take to improve Springs Centre, the ward for autistic people:

- The provider must ensure that patients' physical health is checked appropriately and recorded consistently after they have received medicines via rapid tranquilisation, in line with national good practice guidelines and the provider's own policy. Regulation 12 Safe care and treatment
- The provider must ensure that restrictive practices are appropriately recognised, reported, and reviewed to ensure they are only used if absolutely needed. Regulation 13 Safeguarding people from improper treatment
- The provider must ensure that staff on all wards for autistic people are adequately trained and skilled to make sure that they can meet the care and treatment needs of autistic people. This must be in line with good practice and support the staff to communicate effectively with people using the service. Regulation 18 Staffing
- The provider must ensure the wards fire alarms do not go off unnecessarily to avoid distress for the patients and to also prevent people from becoming accustomed to alarms sounding and therefore not responding in the event of a real fire. Regulation 12 Safe care and treatment
- The provider must ensure that the environment for autistic people is clean to ensure infection control principles are maintained. Regulation 12 Safe care and treatment

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- The provider must ensure that people using the service have access throughout the week including the weekend to therapeutic activities which provide structure and meet their individual needs. Regulation 9 Person centred care
- The provider must ensure that people using the service are supported by staff in an appropriate and supportive manner, treat them with kindness and understand their individual needs. Regulation 9 Person centred care
- The provider must ensure that people have access to healthy food of a high quality and sufficient quantity. Regulation 14 Meeting nutritional needs
- The provider must ensure that the wards for autistic people provide an environment that meets their sensory needs. Regulation 9 Person Centred Care
- The provider must ensure that the number of paper and electronic record systems that are used in practice are organised and easily accessible so staff can find essential information. Regulation 12 Safe Care and Treatment
- The provider must ensure that people's treatment records are completed accurately so that they can be checked to ensure people are receiving safe treatment in line with best practice. Regulation 12 Safe care and treatment
- The provider must ensure that all incidents are recorded and that these are reviewed and where needed measures taken to address patient safety. Regulation 12 Safe care and treatment
- The provider must ensure governance processes operate effectively and that local procedures and policies are met. This includes having the processes in place to monitor whether patients are having their physical health monitored following rapid tranquilisation; whether staff are routinely reading patients their section 132 rights; whether equipment is being regularly checked; restrictions are recognised and regularly reviewed; whether information from completed audits is being used to improve services, It also includes ensuring managers have access to accurate data about incidents and other operational matters to enable them to have effective oversight of the hospital. Regulation 17 Good governance

Action the service MUST take to improve Springs Wing, the rehabilitation ward for autistic people:

- The provider must ensure that restrictive practices are appropriately recognised, reported, and reviewed to ensure they are only used if absolutely needed. Regulation 13 Safeguarding people from improper treatment
- The provider must ensure equipment used to monitor patients' physical health is properly maintained and calibrated. This was required at the previous inspection. Regulation 12 Safe care and treatment
- The provider must ensure people have access to regular physical health checks including dental and chiropody. Regulation 12 Safe care and treatment
- The provider must ensure that staff on all wards for autistic people are adequately trained and skilled to make sure that they can meet the care and treatment needs of autistic people. This must be in line with good practice and support the staff to communicate effectively with people using the service. Regulation 18 Staffing
- The provider must ensure that people have appropriate personalised care plans in place to support their behaviour and ensure they receive a copy. Regulation 9 Person Centred Care
- The provider must ensure the wards fire alarms do not go off unnecessarily to avoid distress for the patients and to also prevent people from becoming accustomed to alarms sounding and therefore not responding in the event of a real fire. Regulation 12 Safe care and treatment
- The provider must ensure that the number of paper and electronic record systems that are used in practice are organised and easily accessible so staff can find essential information. Regulation 12 Safe Care and Treatment
- The provider must ensure governance processes operate effectively and that local procedures and policies are met. This includes having the processes in place to monitor whether patients are having their physical health monitored; whether equipment is being regularly checked; restrictions are recognised and regularly reviewed. Regulation 17 Good governance

Action the service MUST take to improve Byron ward, acute services for adults of working age:

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- The provider must ensure that patients' physical health is checked appropriately and recorded consistently after they have received medicines via rapid tranquilisation, in line with national good practice guidelines and the provider's own policy. Regulation 12 Safe care and treatment
- The provider must ensure equipment used to monitor patients' physical health is properly maintained and calibrated. This was required at the previous inspection. Regulation 12 Safe care and treatment
- The provider must ensure staff complete weekly checks of resuscitation equipment in line with national good practice guidelines. Regulation 12 Safe care and treatment
- The provider must ensure that staff understand how they will manage blind spots on the ward and maintain oversight of the patients across the whole environment in order to keep them safe. Regulation 12 Safe care and treatment
- The provider must ensure that patients have regular one-to-one sessions with their named nurse to ensure they can develop therapeutic relationships and express any individual needs they may have. Regulation 9 Person centred care
- The provider must ensure patients are provided with information about their medicines and possible side effects. Staff must ensure patients are also involved with their care plans and provided with copies of these if requested. Regulation 9 Person centred care
- The provider must ensure all patients risk assessed as safe to have visitors are allowed visits from families, friends and/or carers, whether on or off the ward. Staff must be clear on the provider's protocol on visits. Regulation 10 Dignity and respect
- The provider must ensure it supports patients to eat meals off the ward where risk allows. Where meals must be eaten in patients' bedrooms, they must be delivered from the kitchen to the ward via a method in line with the provider's policy so that the meals are the correct temperature. Regulation 10 Dignity and respect
- The provider must ensure that all incidents are recorded and that these are reviewed and where needed measures taken to address patient safety. Regulation 12 Safe care and treatment
- The provider must ensure that all staff have access to regular good quality supervision. Improvements to supervision was required at the last comprehensive inspection of the hospital. Regulation 18 Staffing
- The provider must ensure all patients are given access to personal hygiene products. Regulation 10 Dignity and respect
- The provider must ensure all patients and carers on Byron Ward are provided with information about how to make a complaint, and that staff respond to complaints in line with the provider's policy. Regulation 16 Receiving and acting on complaints
- The provider must ensure governance processes operate effectively and that local procedures and policies are met. This includes having the processes in place to monitor whether patients are having their physical health monitored following rapid tranquilisation; whether equipment is being regularly checked and calibrated; staff are receiving regular good quality supervision; and whether information from completed audits is being used to improve services. It also includes ensuring managers have access to accurate data about incidents and other operational matters to enable them to have effective oversight of the hospital. Regulation 17Good governance

Action the service SHOULD take to improve

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

Springs Unit, the forensic inpatient ward for autistic people:

- The provider should ensure that the new staff induction checklist for people working on the wards for autistic people, includes a prompt to show them the environmental risks such as ligature points.
- The provider should ensure that leaders of the wards for autistic people record post incident debriefs.

Summary of this inspection

- The provider should ensure that the compliance rate for the mandatory virtual safeguarding training session is above 75%.
- The provider should ensure that all carers are adequately involved in providing feedback to the ward, and signpost them to support such as how to access a carer's assessment where needed.
- The provider should ensure that specialist low secure forensic ward takes part in opportunities to improve the quality of care for people such as involvement in quality improvement projects and accreditation schemes.
- The provider should ensure that staff working on the wards for autistic people monitor that people are being read their Section 132 rights on a regular basis.
- The provider should ensure that people on the ward are aware of the action the service has taken as a result of their feedback. This includes ensuring the 'you said, we did board' is up to date.

Springs Centre, the ward for autistic people:

- The provider should ensure that the new staff induction checklist for people working on the wards for autistic people, includes a prompt to show them the environmental risks such as ligature points.
- The provider should ensure that leaders of the wards for autistic people record post incident debriefs.
- The provider should ensure that all carers are adequately involved in providing feedback to the ward, and signpost them to support such as how to access a carer's assessment where needed.
- The provider should ensure that the wards for people with learning disabilities or autism takes part in opportunities to improve the quality of care for people such as involvement in quality improvement projects and accreditation schemes.

Springs Wing, the rehabilitation ward for autistic people:

- The provider should ensure that the new staff induction checklist for people working on the wards for autistic people, includes a prompt to show them the environmental risks such as ligature points.
- The provider should ensure that leaders of the wards for autistic people record post incident debriefs.
- The provider should ensure that the ward emergency bag is sealed.
- The provider should ensure that all carers are adequately involved in providing feedback to the ward, and signpost them to support such as how to access a carer's assessment where needed.
- The provider should ensure that the rehabilitation ward for autistic people takes part in opportunities to improve the quality of care for people such as involvement in quality improvement projects and accreditation schemes.
- The provider should ensure that people's consent to treatment is assessed and recorded at regular intervals.
- The provider should ensure that the compliance rate for the mandatory virtual safeguarding training session is above 75%.
- The provider should continue to ensure they improve people's access to healthy food of a high quality and sufficient quantity.

Byron Ward, the acute services for adults of working age:

- The provider should ensure that patients' blood samples are not stored alongside vaccines or other medicines.
- The provider should ensure medicines are stored in the correct storage facilities so nurses can access them promptly.
- The provider should ensure fire alarms do not go off unnecessarily to avoid distress for the patients.
- The provider should ensure it addresses ways to help patients quit smoking on the ward.
- The provider should consider refurbishing the ward's kitchenette and ensure foul smells are eradicated.
- The provider should continue its work to ensure that historical patient risk informs current risk management plans and that these plans are kept updated to reflect new risks.

Summary of this inspection

- The provider should ensure that care plans are completed within the timescales set by the service and that these are recovery orientated and updated as needed.
- The provider should continue its work to ensure all patients have access to meaningful activities, and that these are recorded in such a way that leaders can monitor.
- The provider should review its arrangements for team meetings to ensure that all staff have access to up-to-date information.
- The provider should ensure that carers are adequately involved in providing feedback about the ward and signpost them to support such as how to access a carer's assessment where needed.
- The provider should consider reviewing their local procedure on managing patients' money and financial affairs to ensure staff are clear about the expectations and processes.
- The provider should ensure it has access to information leaflets in other languages to ensure all patients have fair access to information about treatment and care.
- The provider should work to improve the visibility of the ward manager and other members of the hospital leadership team.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Wards for people with learning disabilities or autism	Inadequate	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe	Requires Improvement
Effective	Inadequate
Caring	Requires Improvement
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

The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. The fire alarm was ringing frequently in error which meant that people would be distressed by the noise and potentially not follow evacuation procedures. The equipment used to check people's diabetes blood sugar readings had not been routinely serviced which meant it may not give accurate readings.

Safety of the ward layout

People were cared for in a ward where staff had completed risk assessments of the environment and removed or reduced any identified risks. We reviewed the environmental risk assessments for Springs Wing which included an assessment for blind spots and ligature points. Environmental risks were managed by the use of convex mirrors, closed circuit television (CCTV) and regular eyesight observations.

Whilst the hospital ensured they carried out routine fire checks and fire drills, people and staff experienced frequent false alarms. During our inspection, we observed the fire alarm go off twice in one day. The fire alarm issue had been reported to the hospital maintenance team. The frequency of false alarms increased the risk of people not responding and evacuating the building in the event of a real fire as well as causing distress to people using the service.

People had easy access to nurse call systems and staff had easy access to alarms. A call bell was available in each bedroom and in various places across each ward. All staff were given personal alarms to wear in the event they needed to raise the alarm. Each ward alarm system was linked together, and an alert was sent to all wards when an alarm had been raised.

Maintenance, cleanliness and infection control

Springs Wing was clean and well maintained. The ward was visibly clean, and the ward furniture was well kept. Communal areas were tidy. During the week the hospital cleaners attended the ward, and, on the weekends, people were encouraged to clean their own bedrooms. Despite our findings at the time of inspection, a carer we spoke with told us that they were concerned that their relative's bedroom on the ward was very dirty.

Clinic room and equipment

Whilst the ward had a fully equipped clinic room, which was clean, well-organised and with handwashing facilities, equipment was not always checked, calibrated and recorded. At our previous inspection in 2018, we told the provider that they must ensure that equipment used to monitor patients' physical health is calibrated and maintained in line with the manufacturer's guidance. During our recent inspection in May and June 2023 we found continued issues with the way in which equipment was calibrated and maintained. We identified that most physical health equipment had been appropriately serviced apart from the blood monitoring (BM) machine. The emergency bag was not sealed which meant that staff could not be assured the bag was complete. The lack of routine servicing of the BM machine increased the risk of the machine not being in working order and providing an incorrect reading. This could have a negative impact on a diabetic person's health and wellbeing.

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

Ward leaders used a staffing matrix that was designed to increase and decrease the numbers of staff in order to meet the needs of people using the service. In addition to the core nursing team, additional agency and bank staff were deployed to support the team in carrying out eyesight observations and facilitate external community outings and appointments. People who were able to leave the ward told us that they regularly went out and engaged in community activities.

During our inspection, we reviewed a sample of rotas between December 2022 and May 2023 which showed that familiar agency and bank staff regularly worked at the service to cover shifts that were not fulfilled. The use of agency staff fluctuated between 30% in December 2022 to 7% in May 2023. The use of agency consistently decreased over the 6-month period. Over the same 6-month period the use of bank staff fluctuated between 34% in December 2022 to 27% in May 2023. At the time of our inspection, the ward had 2 registered nurse vacancies which included maternity cover and 3 care support worker vacancies. The ward manager was actively recruiting into vacant posts. The provider aimed to reduce the usage of agency and bank staff. This was a key risk on the hospitals risk register.

The ward had implemented a therapeutic engagement and support observation plan which was also known as a 'grab sheet'. The document provided important information such as a person's likes and dislikes, their level of eyesight observation and their key risks. New, agency or temporary members of staff were required to read the grab sheets and familiarise themselves with the information.

Whilst ward leaders made sure bank and agency staff had an induction before starting their shift, the hospital staff induction checklist record did not include a prompt to ensure the staff member was shown the ward ligature points and how they were managed. On the day of inspection, two staff members we spoke with were not aware of where the ligature anchor points were or how they were mitigated. Without a clear prompt on the induction checklist increased the risk of staff missing the opportunity to show a new member of staff the environmental risks and management plan in place.

The hospital had low turnover rates of nurses, but high rates of healthcare support worker turnover rates (HCSW). For example, over a period of 12-months the nurse turnover rate was 3.1%, whereas HCSW turnover was 24.7%.

Levels of sickness were low. The average sickness rate for the 12 months prior to our inspection for was 3.1%.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Medical staff

The service had enough daytime and night-time medical cover. The ward employed a consultant psychiatrist and a speciality doctor that was available during core work hours Monday to Friday. At the time of our inspection, the speciality doctor from Springs Centre was also providing support to the Springs Wing as the specialist doctor was on leave. Staff had access to the hospital medical cover out of hours.

Mandatory training

Staff had completed and kept up to date with their mandatory training. At our previous inspection in 2018, we told the provider that they must ensure that all staff are up to date with mandatory training. During this inspection, we identified that this had improved, and the average compliance rate was 93%.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. Staff followed best practice in de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward did not keep blanket restrictions under regular review, which meant that restrictions might remain in place for longer than needed. The care record system in place was not easy to follow which increased the risk of staff not being able to easily locate essential information.

Assessment of patient risk

When people were admitted to the ward, staff ensured they completed a risk assessment and reviewed it regularly including after an incident. During our inspection we reviewed 3 records in total. Of the 3 reviewed, we specifically inspected the records to assess people's individual risk assessments. We found that all of the people had been risk assessed and there was a clear record in place that was up to date. The MDT reviewed every person's risk at the ward round meetings that took place every 2 weeks.

Management of patient risk

Staff knew about any risks to each person and prevented or reduced risks. Each ward held a folder that included a summary document of each individual person on the ward. These were called therapeutic engagement and supportive observation plan also known as 'grab sheets'. The grab sheets were used to support all staff to briefly review a person and be aware of their presentation, risks and individual needs. We found that people's risk assessments had been updated following an incident and provided a clear rationale for why someone was deemed high risk.

Staff shared key information to keep people safe when handing over their care to others. We reviewed a sample of nursing handovers from Springs Wing from January 2023 and found that they covered key areas such as individual risks of people on the ward, mental health and physical health needs, section 17 leave status (permission to leave the hospital) and communication.

Use of restrictive interventions

Each person's care and support plan included ways to avoid or minimise the need for restricting their freedom. The responsible clinician reviewed individual restrictions placed on people at the regular ward round meetings. The doctors reviewed a person's rights to leave the hospital using Section 17 leave of the MHA and took into consideration their presenting risks. We found that most people regularly attended their ward rounds in person and were involved in treatment discussions.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Following our previous inspection in 2018, we told the provider that they must ensure that inappropriate blanket restrictions were not in place on ward. During our recent inspection in May and June 2023, we found that although blanket restrictions such as locking of communal toilets were not in place, we identified that ward leaders did not routinely review all blanket restrictions in order to reduce them or ensure they were the least restrictive.

We found that people on the ward did not have access to tea, coffee and sugar. During our inspection of Springs Wing, tea, coffee and sugar was mainly kept in the nurse's office. The service took the decision to remove access to these items for all people so that they could mitigate the risks that they posed to a small number of people. People were required to ask staff for access to the kitchen to make a hot drink. Following the inspection, we requested the provider to send us evidence that demonstrated blanket restrictions were routinely reviewed. The provider told us that the hospital did not formally monitor and review blanket restrictions in between the 6-monthly blanket restriction audit. However, going forward restrictions would be monitored at the monthly clinical governance meeting. The lack of system in place to ensure that blanket restrictions were closely monitored increased the risk of people living in an overly restricted environment which was not proportionate to the level of risk.

Staff made attempts to avoid using restraint by using verbal de-escalation techniques and restrained people only when these failed and when necessary to keep the person or others safe.

Staff reviewed restraint and used the examples as learning. The hospital had a dedicated Prevention and Management of Violence & Aggression (PMVA) trainer and health and safety manager who were responsible to review incidents of restraint and support staff to learn lessons and improve. During our inspection, we reviewed 2 incidents of restraint and found that staff had managed the incidents well. Staff recorded that they had attempted verbal de-escalation before moving to a form of restraint. Both restraints reviewed involved a person being put into forearm holds and guided to a seated position. The hospitals training records showed that 98% of staff were trained in the use of restrictive interventions, the training was certified as complying with the Restraint Reduction Network (RRN) Training standards. The provider showed us the training certificate in place that confirmed the training was approved by the RRN.

The ward manager told us that no restrictive interventions such as long-term segregation had been used on the ward.

Staff did not fully understand the provider's rapid tranquilisation (RT) policy and had incorrectly reported incidents of RT. During our inspection, we reviewed 2 separate incidences of where staff had administered oral medicines to people and believed that the administration was classed as RT. The provider's policy stated that oral medicines accepted by a person is to be recorded as 'as required' medicine not as RT. This was raised to the ward manager at the time of inspection who acknowledged that staff had misunderstood the policy.

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 understood how to protect people from abuse. Staff kept up to date with their intermediate e-learning safeguarding training and at the time of our inspection the completion rate was 100%. The compliance rate for the virtual classroom safeguarding training session was 75%.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff received group safeguarding supervision every six months. The provider's safeguarding lead told us that they facilitated sessions throughout the year to provide staff with an opportunity to learn about staff responsibility, how to report a safeguarding alert and reminding staff about the policies and procedures they can access to support them in their decision making. The provider's safeguarding policy provided a clear flowchart in how staff can report a safeguarding and highlights the importance of not finishing a shift without reporting their concerns.

Staff access to essential information

Staff had access to clinical information, but it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.

The electronic and paper-based recording systems used on the ward needed improving to ensure it was easy to follow. Information about each individual person was stored across a number of paper folders and on two separate electronic record programmes. The service did not have an electronic system or paper-based system in place that enabled staff to easily access a person's care and treatment record without delay. The way in which the care records were stored increased the risk of staff not being able to access important information when required.

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 ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. During our inspection we reviewed 5 medicine charts and found that medicines were prescribed appropriately and were not being used to control people's behaviour. High dose anti-psychotics were monitored by the medical staff and the external ward pharmacist. When required (PRN) medicines were prescribed on medicine charts for the management of agitation, insomnia and pain. We found that these medicines were administered appropriately and not overused.

People received support from staff to make their own decisions about medicines wherever possible. We saw that nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them.

People could take their medicines in private when appropriate and safe. The ward had access to an examination room off the ward that included an examination couch.

Staff made sure people received information about medicines in a way they could understand. We observed nursing staff introducing themselves to people before offering them medicines, they explained what they were giving, and observed the person to take them.

Staff followed national practice to check that people had the correct medicines. Medical staff followed national guidance to ensure patients were prescribed correct medicines. We found that medicines were prescribed appropriately meeting the Mental Health Act requirements. An external pharmacist visited the ward once a week to screen prescriptions and advise medical staff when doses needed to be revised.

People received their medicines from staff who administered, recorded and stored their medicines safely. Staff on Springs Wing ensured that medicine administration charts including the controlled drugs register were completed correctly. All medicine charts checked on the day of our inspection included people's allergy status, mental health act status and British National Formulary (BNF) limits.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service generally managed incidents affecting people's safety well. Staff recognised incidents and recorded them appropriately on the electronic incident reporting system. Staff discussed learning from incident in team meetings.

During our inspection, we reviewed 5 separate incidents that had been formally reported electronically. All of the incidents reviewed related to an episode of restraint. The incidents were clearly recorded and demonstrated how staff managed the restraint itself. The ward manager informed us that staff regularly report incidents that involve racial abuse from people on the ward. Staff were encouraged to discuss incidences of abuse with the ward psychology team and wider MDT. Staff were also supported to report racial abuse to the police. Lessons learnt were a standard agenda item during team meetings. We reviewed a sample of team meeting minutes from January 2023 and found that the team routinely discussed lessons identified following incidents. During one team meeting staff discussed lessons learnt following a recent TV documentary about wards for people with learning disabilities.

Ward leaders had not ensured that they had carried out a post incident debrief with a person following an episode of restraint. During our inspection, we found that staff had not ensured that a post incident debrief had taken place with the person involved in the incident. The record only showed that a debrief had taken place with the nursing team. The lack of recording meant that leaders could not be assured that a person was able to reflect on the incident.

Is the service effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected peoples assessed needs and were personalised and holistic. However, records did not clearly show that people had been given an easy read copy of their care plan.

Staff completed a comprehensive assessment of each person's physical and mental health either on admission and at routine intervals thereafter. During the inspection, we reviewed 3 records in total and found that everyone had received an initial assessment on admission and their mental health and physical health needs were reviewed at the fortnightly ward rounds. All disciplines were required to have input into each person's ward round. They recorded their feedback onto a centralised record that could be reviewed by the person and consultant psychiatrist.

All care records showed that people mostly had a variety of care plans in place to support their needs and identified risks such as self-harm, physical health, and mental health. However, one person did not have an appropriate care plan in place to manage their sexually inappropriate behaviour despite them being assessed as medium risk for this behaviour.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Therapy staff ensured people had up-to-date care and support assessments, including psychological, functional, communication, preferences and skills. The psychology team worked with people to develop positive behavioural support plans (PBS). A PBS plan is a person-centred framework for providing long-term support to people with a learning disability and/or autism, including those with mental health conditions, who have, or may be at risk of developing behaviours that challenge. During our inspection, we specifically 2 out of 3 records to assess whether each person had a PBS plan in place. We found that in both records reviewed a PBS plan was available and they were clear, accessible and of good quality.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Some people were not having their physical health checks such as dental, optical care and annual health checks and some carers said their relative's health had declined in hospital and they had gained weight. Staff used recognised rating scales to assess and record severity and outcomes. Whilst the provider carried out audits, these were not always completed to an appropriate standard.

Whilst the provider had guidelines in place to support people to live healthier lives and take an active role in maintaining their own physical health, there was an inconsistent approach to how well this was being implemented on the ward. Carers also had mixed views about the quality of care given to people's individual physical health needs. In all 3 care records reviewed, we found that staff did not ensure that all people received the right annual health checks. For example, in 1 record the person had not received a health check from either their dentist or optician. All 3 people had seen their GP within the past 12 months. Two out of 3 carers we spoke with raised concerns about their relative's overall decline in physical health whilst in hospital. Two carers told us that since being in hospital their relative had become severely overweight and they did not feel as though the service was supporting them to reduce it. One member of staff told us that they would like further training in physical health. Staff did not consistently ensure that they supported people to look after their physical health and attend their annual health checks. This increased the risk of people's overall health declining.

The psychology team had recently implemented ways for new staff to be able to improve their understanding and communication with people on the ward. Despite people having individual positive behavioural support plans in place these were sometimes lengthy and did not always enable a new member of staff to understand people's needs quickly. As a result of this, the psychology team created therapeutic engagement support plans also known as grab sheets. The grab sheets provided staff with an overview of people's key risks and needs.

Patients were supported and encouraged to plan their days during the week. Each person had a personalised timetable that included activities from Monday to Friday. We reviewed two people's activity records from Springs Wing and found that people were offered and attended a variety of groups that met their interests as well as voluntary work at the local charity shop and hospital tuck shop. The OT team monitored attendance at each group. Both people's records showed reduced activity in the evenings and weekends, however, both people were busy during the daytime and went home at the weekends.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Occupational therapists measured outcomes for patients using the model of human occupation (MOHO). However, there was a plan to implement a new model of care called The Vona du Toit Model of Creative Ability. Each

ward used The Global Assessment Progress (GAP) scoring to measure outcomes. This included looking at an assessment of progress for each person. The GAP data was monitored by the senior leaders and discussed clinical governance meetings. Leaders had recognised that there had been an issue with how staff were recording whether people had been offered and received a meaningful activity. Additional staff training had been provided to improve this.

Whilst ward staff and hospital leaders took part in clinical audits, some audits were not carried out often enough and they did not always generate improvements. For example, the provider carried out a blanket restriction audit every 6 months but in between this time ward leaders did not monitor the use of blanket restrictions on the ward. Following our inspection, senior leaders told us that this audit would be reviewed at the monthly governance meetings going forward.

Skilled staff to deliver care

Nursing and support worker staff members did not receive adequate training on how to support autistic people. This meant that there were aspects of people's care and treatment staff would be unable to support because they were not appropriately trained. Staff access to regular supervision had improved since the most recent inspection.

Autistic people were not supported by staff who had the right skills and training to ensure they were understood, and their individual needs were met. The hospital offered all staff including bank and agency staff, a basic level of training called autism awareness training and for permanent staff they also received positive behaviour support training. However, staff did not receive specialist training in communication. For example, staff were not trained in communication tools such as Talking Mats and therefore were unable to support people who used this way of communication or preferred it.

Following our most recent inspection in 2018 we told the provider that they must ensure staff receive regular supervision. At the time of our inspection May and June 2023, we found that this had improved. Clinical staff received supervision every 30 days. At the time of our inspection, the average supervision and appraisal rate was 85%. Medical staff and other members of the multi-disciplinary team carried out their yearly appraisal with a supervisor from their discipline. The head of psychology was also planning to reintroduce staff reflective practice meetings to provide staff with an opportunity to reflect and discuss their experiences.

Multi-disciplinary and interagency team work

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

People had access to speech and language therapy, occupational therapy and some psychological support. The psychology team were a new team and had been in place since March 2023. At the time of our inspection, the head of psychology told us that the team were aware that people on the ward had been unhappy with the lack of psychology input over the past few months and that they were looking to improve this soon. The team currently offered weekly drop-in sessions for people to attend and were mainly carrying out basic assessments of people to understand their motivation and individual needs. The team recognised that it was difficult to motivate people to engage in therapy.

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had consistent care. People were discussed at ward round meetings on a fortnightly basis and people were invited to attend. Records of MDT discussions were recorded within the persons individual care record.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The ward teams had effective working relationships with staff from services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge. The MDT also worked with community professionals such as GPs, community mental health teams and clinical commissioning groups.

Ward leaders were involved in interagency team working. Service leaders attended routine professionals meetings and worked with external agencies such as multi-agency public protection arrangements (MAPPA) to support people's discharges.

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 usually discharged these well. Managers made sure that staff could explain peoples' rights to them.

Staff received and kept up to date with training on the MHA and the Mental Health Act Code of Practice. The completion rate for staff for Mental Health Act awareness training was 100%. Staff had access to the provider's MHA administration team for support and advice when required.

Staff mostly ensured that they explained to each person their rights under the Mental Health Act in a way that they could understand, repeated it as necessary and recorded it clearly in the people's notes each time. During our inspection, we reviewed 3 records in total. Of the 3 reviewed we specifically checked 2 of them to assess whether staff routinely read people their rights. We found that in both records, staff had read people their rights within the most recent 3 months.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or the Ministry of Justice or both. People's individual care records showed that for people who were permitted to leave the ward they were supported to do so. People had a personalised daily timetable in place which showed that most people visited the community on a regular basis.

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

Staff had ensured that the appropriate MHA consent paperwork was in place for the prescribing of medicines. We reviewed 5 medicine charts and found that medicines were prescribed appropriately meeting the MHA.

Staff stored copies of people's detention papers and associated records correctly, and staff could access them when needed. The hospital's MHA administration team held detention paper records and could be accessed when required. Section 17 leave papers were kept on the ward, and we saw evidence that they had been completed correctly for 3 separate people.

Good practice in applying the Mental Capacity Act

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

Staff supported people to make decisions on their care for themselves. They assessed and recorded capacity to consent for most people who might lack the mental capacity to make certain decisions for themselves. Although during our inspection we found in 1 out of 3 records reviewed, that a person's capacity had not been reassessed since August 2022. We found that clinicians recorded people's capacity appropriately when they needed to make an important decision such as a medication change.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The provider had a policy on Mental Capacity Act and advance decisions or statements. Staff were able to access the policy electronically.

The provider monitored how well it adhered to the Mental Capacity Act and acted when they needed to make changes to improve. Managers completed Mental Capacity Act audits every 3 months. The most recent audit, completed in June 2023, achieved 100% compliance.

Is the service caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and listened to them. 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.

Staff were respectful and responsive when caring for people. We spoke with 1 person, and they told us that they felt safe on the ward, they felt listened to and they had a good rapport with the team. We observed positive interactions between staff and people on the ward. On the day of our inspection, people either declined to speak with us or they were off of the ward.

People were given opportunities to provide feedback about the service on a routine basis. The latest annual survey results showed that the food offered to people on the ward needed to improve to ensure it met their dietary requirements and preferences. As a result, 'meet the chef' meetings had been initiated which provided people with an opportunity to meet the catering team and provide feedback. The provider also invited people who used services to attend the clinical governance meeting with senior leaders and share their feedback. Although clinical governance meeting minutes showed that this was happening, people from Springs Wing rarely attended the meeting.

Staff understood and respected the individual needs of each patient and supported patients to manage their own care where appropriate. We observed patients being supported to attend regular activities in the community.

Staff ensured that people's information was kept confidential. Information about people was stored securely on an electronic system or in folders in the nursing office. The ward also had information about people kept on a whiteboard in the nursing office. The whiteboards could be covered over to ensure the information remained private.

Involvement in care

Staff generally involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had access to independent advocates. Staff did not always involve patients in care planning.

Involvement of patients

Whilst the care and treatment records created by the therapies teams showed that people were involved in the planning of their care, the nursing and medical records did not always demonstrate the same level of people involvement. We

reviewed care plans for 3 separate people and found that in 2 out of 3 records the nursing and medical staff had not clearly demonstrated that the person had been involved and had received a copy of their care plan. In one care plan there was a clear record of the MDT involving the person in discussions about their care and treatment. The lack of involvement in care planning was not person-centred and increased the risk of people receiving care that is not personalised.

Generally, people were supported to access independent, good quality advocacy. An independent mental health advocacy (IMHA) service visited the ward on a twice weekly basis to speak with people. The hospital advocate told us that they attended weekly ward rounds.

Involvement of families and carers

The hospital recognised that it did not sufficiently communicate with and involve carers.

Two out of three carers we spoke with told us that they felt that staff communication could be improved as they do not feel involved in their relative's care. All carers told us that they felt confident to raise concerns if required.

Hospital leaders recognised that ways for carers to feedback about the service needed to improve. There were plans to restart carer forums in August 2023 and surveys as well as offering carers a dedicated carers email address. The lack of family involvement meant that individual people could not receive support from people they know, and carers were unable to advocate for the person and share their views.

Is the service responsive?

Requires Improvement

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

Access and discharge

Staff managed beds well and worked with external stakeholders to facilitate discharge arrangements. Most people only stayed in the hospital for as long as needed although there were a few delayed discharges.

Staff planned and managed discharge well. During our inspection, Springs Wing was 80% full. The ward accepted people who lived outside of London. Service leads and the MDT regularly reviewed length of stay for people at the fortnightly ward rounds.

When people went on leave there was always a bed available when they returned. When a person's risk increased and the service was unable to support the person, they would refer the person to an appropriate setting.

People were moved between wards during their stay only when there were clear clinical reasons, or it was in their best interests. During our inspection, we found that one person spent time on the ward during the day due to them being at risk of harm from another person. The person told us that they enjoyed being on Springs Wing and felt safe there.

Staff supported patients when they were referred or transferred between services. This included patients who needed to attend external appointments.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Discharge and transfers of care

Staff regularly reviewed people's length of stay to ensure they did not stay longer than needed. This was dependent on the availability of appropriate discharge placements. At the time of our inspection, the ward manager told us that the average length of stay was 7 months. Although 1 person had been on the ward for 2 years due to ongoing issues with their discharge placement. The MDT was actively working with external professionals to agree a plan for discharge. There were 4 other people who were awaiting discharge, but this had been delayed also due to community placement issues. One person was aiming to be discharged in June 2023.

The ward liaised with services that would provide aftercare and escalated issues with people's discharges or transfers of care to community professionals and clinical commissioning groups. Breakdown in discharge placements meant that at times people stayed in hospital longer than needed.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Although people were not always able to make hot drinks when they wanted. 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 ward environment of Springs Wing was calm and welcoming. The ward layout supported people's privacy and dignity. Each person had their own bedroom with an en-suite bathroom and had storage facilities to keep their personal belongings safe. People were also able to store their valuables in the nursing office. People had access to their bedroom during the day, but most people spent their time off of the ward or attending activities. As part of rehabilitation programme, people were supported to change their own bed linen and assisted by staff to wash their own clothes.

The layout of the ward supported people's privacy and dignity. People on the ward were also able to store their personal belongings in the nurse's office. Each ward had a quiet room for privacy. People were able to meet visitors in a private room on the ward or in a room located within the hospital.

People had access to easy read information. On Springs Wing we observed there to be various signs and posters around the ward showing people what they could expect such as explaining a person's journey, information about the occupational therapy team and activity timetables.

People had access to full range of rooms and equipment to support treatment and care. For example, clinic rooms, a communal lounge, a quiet room and outdoor areas.

People were dependent on staff to make hot drinks. The service made the decision to remove access to tea, coffee and sugar for all people on the ward so that they could mitigate the risks that they posed to a small number of people. Leaders of the service acknowledged that these restrictions were not routinely reviewed, and this would be improved going forward. The service recognised that the food offered to people on the ward needed to improve to ensure it met their dietary requirements and preferences. As a result of the latest survey results, 'meet the chef' meetings had been initiated which provided people with an opportunity to meet the catering team and provide feedback. Hospital leaders recognised that there were still some improvements to be made to ensure staff supported people to choose food that met their needs.

People could make phone calls in private. People had access to the ward cordless phone.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients' engagement with the wider community

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

Activity and therapy staff supported people to take part in their chosen social and leisure activities on a regular basis. Most people were able to access different opportunities to try new experiences, develop new skills and gain independence. The therapies team ensured that people had a personalised timetable of activities Monday to Friday. People had access to a range of activities that would support them in their recovery and to live independently such as cooking, shopping to the local town centre and voluntary work.

People were supported by staff to try new things and to develop their skills as part of the occupational therapy programme. The hospital had set up a car wash so that people who were able to leave the hospital could earn their own money. The hospital had also set up a regular tuck shop that was led by the people from the wards from across the hospital and was a way to earn money and develop their social skills. Springs Wing used to offer pet therapy twice a week which included dogs and cats being brought onto the ward. However, this had not taken place for the past few months. Staff told us there was a plan to re start the pet therapy as it was a positive experience for people.

Staff enabled flexibility and helped people to have freedom of choice and control over what they did. The hospital had employed drivers who were able to transport people to their desired destination. This was a way of encouraging people to go out into the community.

Meeting the needs of all people who use the service

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

The therapy teams ensured people had individual communication plans that detailed effective and preferred methods of communication. People had pictured based timetables that provided a schedule of activities that met their needs. Pictured based information about what each person could expect from their experience was visible on the walls around the ward.

Staff made sure people could access information on treatment, local services, their rights and how to complain. Leaflets were not available on the ward, but staff told us that people could access the leaflets that were stored in the nursing office. Complaints information posters were visible around each ward.

People had access to spiritual, religious and cultural support. People on the ward routinely visited the community and were able to visit their preferred place to pray. One person on the ward had a visit to the local church included on their individual timetable.

Listening to and learning from concerns and complaints

People and those important to them could raise concerns and complaints easily, and staff supported them to do so.

All 3 carers we spoke with understood how to raise concerns and felt comfortable to do so.

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them. Over a 12-month period, the ward had received 1 complaint that related to quality of care. The complaint record showed that the provider investigated the concern and had addressed the concerns by a local resolution. The service had provided an outcome letter to the person within the timescale of 20 working days.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff knew how to acknowledge complaints, and people received feedback from managers after the investigation into their complaint.

The service clearly displayed information about how to raise a concern in areas used by people. Information about how to complain was visible on the walls around each ward.

Managers shared feedback from complaints with staff, and learning was used to improve the service. Lessons learnt were a standard agenda item during team meetings. Team meetings provided an opportunity to discuss lessons identified following complaint investigations and improve practice. Hospital leaders discussed complaints during clinical governance meetings.

Is the service well-led?

Requires Improvement

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

Leadership

Whilst the hospital leadership team at the hospital showed a commitment to deliver good quality care, they did not have the insight to recognise that the service was not meeting the needs of autistic people and that staff were not adequately trained to be able to meet the full needs of an autistic person.

Whilst the ward leader worked hard to manage the running of the ward, some aspects of care and treatment needed improvement. We identified blanket restrictions in place on the ward, but they were not being closely monitored to ensure they were the least restrictive measure. Whilst improvements had been made since our most recent inspection to ensure most physical health equipment had been calibrated and serviced appropriately, our inspection team found that one piece of equipment, the blood monitoring machine (BM) had not been calibrated. This increased the risk of the machine giving incorrect readings which could impact on a person's health and wellbeing.

The ward manager was visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. Staff we spoke with felt supported to be able to carry out their roles. During our inspection, we observed the ward manager to have a good rapport with people on the ward.

Vision and strategy

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

Staff worked with people to develop their independence and social skills. Staff supported people to use their leave independently and as a group. During our inspection of Springs Wing, we observed positive interactions between staff and people. Staff had built good relationships with people and during our inspection we observed this.

Culture

Staff felt respected and supported. They said the hospital provided opportunities for development. They could raise any concerns without fear.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

During our inspection we spoke with 5 members of staff who spoke positively about their place of work and their roles. Staff told us that the provider offered them opportunities for development and career progression, and they received regular supervision. We saw some evidence of the service promoting equality and diversity. For example, employing staff from diverse backgrounds and staff feeling listened to and included.

Staff felt able to speak up and raise any concerns without fear. During our inspection, we reviewed a sample of team meeting minutes and found that generally team meetings were well attended, and staff routinely discussed important matters with their peers.

The provider had implemented new ways of retaining and rewarding staff. Staff were entitled to receive support with costs for their health check-ups such as eye tests, an employee assistance programme for staff and their family members that included counselling and advice, free staff lunches and on-site parking.

Governance

Whilst governance systems and processes were in place, they did not enable the provider to identify, understand, monitor and address current risks relating to the quality and safety of care delivered to autistic people.

During the inspection, we identified a small number of concerns which had not been identified by the service. The governance systems were not tailored to assess and identify the individual needs of autistic people. The processes in place had not identified that the quality-of-care people received was at risk of being impacted by the lack of specialist training provided to the nursing staff. We found that staff did not have the skills to be able to communicate effectively with an autistic person that was non-verbal or preferred to communicate using communication aids such as talking mats. The governance systems had also not identified that blanket restrictions in place on the ward were not routinely reviewed to ensure they were the least restrictive.

Management of risk, issues and performance

Whilst senior leaders used a risk register to track and monitor risks related to the running of the hospital and individual ward, they were not sighted on some of the quality of care issues that we had identified during our inspection.

Information management

Staff had access to the information systems they needed to provide safe and effective care.

The ward manager had access to information to support them to do their role effectively. This included having access to management systems that provided information about people's care, staff training compliance and supervision completion rates.

All services registered with the Care Quality Commission (CQC) are required to notify the Commission of certain incidents, without delay. The service notified the Care Quality Commission of notifiable incidents.

Engagement

The service engaged with patients, carers and staff by providing up to date information about the ward and hospital. However, at the time of inspection the hospital leaders recognised they needed to improve their engagement with carers.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff, people and carers had access to up-to-date information about the work of the provider. The provider had a comprehensive website available to keep the public informed of the work they were undertaking to support people, their families and carers. At the time of our inspection, the service was not providing carers with an opportunity to meet face to face with leaders to share their feedback.

At the time of our inspection, the service was not providing carers with an opportunity to meet face to face with leaders to share their feedback.

Learning, continuous improvement and innovation

At the time of the inspection no research or quality improvement programmes were taking place on Springs Wing. The ward was not accredited by the National Autistic Society. For a provider to be accredited demonstrates that they are able to meet a strict criterion and provide evidence that they were meeting the National Autistic Society standards.

Inadequate

Forensic inpatient or secure wards

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

The ward where people were receiving care and treatment was dirty and poorly maintained. The fire alarm was ringing frequently in error which meant that people would be distressed by the noise and potentially not follow evacuation procedures. Some equipment to be used in the event of a clinical emergency was not regularly checked which meant there was a risk this might not work when needed.

Safety of the ward layout

People were cared for in a ward where staff had completed risk assessments of the environment and removed or reduced any identified risks. We reviewed the environmental risk assessments for Springs Unit which included an assessment for blind spots and ligature points. Whilst we found that most environmental risks were managed by the use of convex mirrors, closed circuit television (CCTV) and regular eyesight observations, we identified that the ligature risk assessment had not been updated to reflect how staff were managing the risk in practice. We identified a significant ligature risk in one room on the ward. The ward ligature risk assessment stated that the mitigation in place was for patients to be supervised at all times whilst using the room. However, during the inspection we observed a person using the room alone and unsupervised. A member of staff told us that for people who were assessed as being low risk they would be able to use the room unsupervised. Following the inspection, we escalated this to the provider to address. The provider recognised that the ward risk assessment had not been updated to reflect how staff were managing the risk on the ward. The provider promptly updated the risk assessment to ensure it reflected what staff had told us.

Whilst the hospital ensured they carried out routine fire checks and fire drills, people and staff experienced frequent false alarms. During our inspection, we observed the fire alarm go off twice in one day. The fire alarm issue had been reported to the hospital maintenance team. The frequency of false alarms increased the risk of people not responding and evacuating the building in the event of a real fire as well as the distress caused for people accessing the service.

People had easy access to nurse call systems and staff had easy access to alarms. A call bell was available in each bedroom and in various places across each ward. All staff were given personal alarms to wear in the event they needed to raise the alarm. Each ward alarm system was linked together, and an alert was sent to all wards when an alarm had been raised. The only room that did not have an alarm was the multi-faith room. A member of staff told us that people were supervised when using the room.

Maintenance, cleanliness and infection control

At the time of inspection, the ward was not clean and well maintained. The environment on Springs Unit was visibly dirty and the décor was tired. On Springs Unit the downstairs single toilet was visibly dirty, and the radiator was covered in rust. Although the hospital cleaners attended the ward twice weekly, the general cleanliness of the ward was poor. Chairs that were available for people to use were ripped.

Staff did not always ensure that if people were secluded, they were kept in a clean and safe environment and their basic needs were met. During our inspection, we identified one episode of seclusion where a person had smeared faeces over the walls. The person was left in the seclusion room for more than 17 hours without the environment being appropriately cleaned by staff members. Staff told us that seclusion was terminated the following morning to clean the room. However, there was no documentation of this within the seclusion records. Staff failed to provide care and treatment in a way that was safe, dignified, and upheld infection control principles.

Seclusion room

The seclusion room was located on Springs Unit. People who were secluded were able to communicate with staff. Staff were based in the de-escalation room which was adjoined to the seclusion room. Staff communicated with the person in seclusion via an intercom.

Clinic room and equipment

Whilst the ward had a fully equipped clinic room, which was clean, well-organised and with handwashing facilities, equipment and emergency medicines were not always checked, calibrated and recorded. At our previous inspection in 2018, we told the provider that they must ensure that equipment used to monitor patients' physical health is calibrated and maintained in line with the manufacturer's guidance. During our recent inspection in May and June 2023 we found continued concerns with the way in which equipment was calibrated or maintained. We identified that most physical health equipment had been appropriately serviced apart from the blood monitoring (BM) machine. We also identified that staff on Springs Unit did not carry out safety checks of emergency equipment and medicines. We found that there were no records to demonstrate the required checks had been carried out. The emergency bags were not sealed which meant that staff could not be assured the bag was complete. National Institute for Health and Care Excellence (NICE) guidance states that health providers are to ensure that resuscitation equipment is checked once a week if restrictive interventions are used. Overall, the lack of checking emergency equipment and medicines increased the risk of equipment not working correctly or items being out of stock in the event of an incident. The lack of routine servicing of the BM machine increased the risk of the machine not being in working order and providing an incorrect reading. This could have a negative impact on a diabetic person's health and wellbeing.

Safe staffing

Whilst there were enough staff working on the ward there was a high use of agency staff on Springs Unit although many of them knew the service. There was sufficient medical cover. Compliance with mandatory training had improved.

Inadequate

Forensic inpatient or secure wards

Nursing staff

Ward leaders used a staffing matrix that was designed to increase and decrease the numbers of staff in order to meet the needs of people using the service. In addition to the core nursing team, additional agency and bank staff were deployed to support the team in carrying out eyesight observations and facilitate external community outings and appointments. People who had section 17 leave (permission to leave the hospital) were able to leave the ward told us that they regularly went out and engaged in community activities.

During our inspection, we reviewed a sample of rotas for the ward between December 2022 and May 2023 which showed that familiar agency and bank staff regularly worked at the service to cover shifts that were not fulfilled. On average between December 2022 and May 2023 Springs Unit had deployed 45% of agency staff to available shifts. The high use of non-permanent staff was because of staff vacancies and the level of acuity of the ward. At the time of our inspection, there were 9 people needing 1:1 observation and 2 other people who required 1 or 2 members of staff to observe them whilst out in the community. The use of bank staff was significantly lower. The ward manager was actively recruiting permanent staff into vacant posts. The provider aimed to reduce the usage of agency and bank staff. This was a key risk on the hospitals risk register.

The ward had implemented a therapeutic engagement and support observation plan which was also known as a 'grab sheet'. The document provided important information such as a person's likes and dislikes, their level of eyesight observation and their key risks. New, agency or temporary members of staff were required to read the grab sheets and familiarise themselves with the information.

Whilst ward leaders made sure bank and agency staff had an induction before starting their shift, the staff induction checklist record did not include a prompt to ensure the staff member was shown the ward ligature points and how they were managed. Without a clear prompt on the induction checklist increased the risk of staff missing the opportunity to show a new member of staff the environmental risks and management plan in place.

The hospital had low turnover rates of nurses, but high rates of healthcare support worker turnover rates (HCSW). For example, over a period of 12-months the nurse turnover rate was 3.1%, whereas HCSW turnover was 24.7%. The ward manager was involved in interviewing on a regular basis week for vacant nursing roles.

Levels of sickness were low. The average sickness rate for the 12 months prior to our inspection for Springs Unit was 2.8%.

Medical staff

The ward had enough daytime and night-time medical cover. The ward employed a consultant psychiatrist and a speciality doctor that was available during core work hours Monday to Friday. Staff had access to the hospital medical cover out of hours.

Mandatory training

Staff had completed and kept up to date with their mandatory training. At our previous inspection in 2018, we told the provider that they must ensure that all staff are up to date with mandatory training. During this inspection, we identified that this had improved, and the average compliance rate for the ward was 93%.

Assessing and managing risk to patients and staff

The ward did not keep blanket restrictions under regular review, which meant that restrictions might remain in place for longer than needed. Whilst in most cases individual restrictions were kept to a minimum, we did

find one person on Springs Unit where handcuffs, a mechanical restraint, had been used twice during their transport to an acute hospital without all the necessary actions in place to ensure this level of restriction was needed. Records were not in place to confirm that people had received the necessary monitoring after they had received rapid tranquilisation. Some seclusion episodes had not been recorded correctly and in one case the seclusion episode had not been documented. People's records were poorly organised, and staff struggled to find essential information.

Management of peoples risk

When people were admitted to the ward, staff ensured they completed a risk assessment and reviewed it regularly including after an incident. During our inspection we reviewed 4 records in total. Of the 4 reviewed, we specifically inspected 3 of the records to assess people's individual risk assessments. We found that all of the 3 people had been risk assessed and there was a clear record in place that was up to date. The MDT reviewed every person's risk at the ward round meetings that took place every 2 weeks.

Staff knew about any risks to each person and prevented or reduced risks. Each ward held a folder that included a summary document of each individual person on the ward. These were called therapeutic engagement and supportive observation plan also known as 'grab sheets'. The grab sheets were used to support all staff to briefly review a person and be aware of their presentation, risks and individual needs.

Staff shared key information to keep people safe when handing over their care to others. We reviewed a sample of nursing handovers from Springs Unit from January 2023 and found that they covered key areas such as individual risks of people on the ward, mental health and physical health needs, section 17 leave status (permission to leave the hospital) and communication.

Use of restrictive interventions

Each person's care and support plan did not always include ways to avoid or minimise the need for restricting their freedom. The doctors reviewed a person's rights to leave the hospital using Section 17 leave of the MHA and took into consideration their presenting risks. The responsible clinician reviewed these at the regular ward round meetings. We found that most people regularly attended their ward rounds in person and were involved in treatment discussions. However, in one of the records we reviewed we identified that a person had been taken to A&E in secure transport and in mechanical restraint (handcuffs) on 2 separate occasions in early 2023. Despite the handcuffs being the property of the external secure transport company, the ward staff who accompanied the person to hospital failed to record the incidences of mechanical restraint in the person's care record. The MDT had also not reflected on the use of mechanical restraint and had not put a personalised support plan in place that aimed to reduce the use of mechanical restraint. Staff had failed to follow the providers' own restraint and violence reduction policy as well their general record keeping procedures. The provider's restraint policy stated that mechanical restraint is to be approved following an MDT consultation that includes an independent mental health advocate (IMHA), and the use of mechanical restraint is to be reviewed frequently in a medical review. We did not find recorded evidence that staff followed any of these guidelines.

Following our previous inspection in 2018, we told the provider that they must ensure that inappropriate blanket restrictions were not in place on ward. During our recent inspection in May and June 2023, although we did not find blanket restrictions such as locking of communal toilets in place, we did identify that ward leaders did not routinely review all blanket restrictions in order to reduce them or ensure they were the least restrictive.

However, we identified that ward leaders did not routinely review blanket restrictions in order to reduce them or ensure they were the least restrictive. We found that people on the ward did not have access to tea, coffee and sugar. The service took the decision to remove access to these items for all people so that they could mitigate the risks that they posed to a small number of people. People were required to ask staff for access to the kitchen to make a hot drink. Following the inspection, we requested the provider to send us evidence that demonstrated blanket restrictions were routinely reviewed. The provider told us that the hospital did not formally monitor and review blanket restrictions in between the 6-monthly blanket restriction audit. However, going forward restrictions would be monitored at the monthly clinical governance meeting. The lack of system in place to ensure that blanket restrictions were closely monitored increased the risk of people living in an overly restricted environment which was not proportionate to the level of risk.

When a person was placed in seclusion, staff did not always follow best practice guidelines when recording a period of seclusion. During our recent mental health act monitoring visit, we identified that staff had failed to appropriately record seclusion for 2 separate people. For one person there was no record of seclusion in place despite the person's care record stating that they had been placed in seclusion and seclusion was terminated by the duty doctor. The second person had been placed in seclusion and the records of their seclusion episode was poor in quality. The decision to terminate seclusion was not recorded and there was no multidisciplinary review within 8 hours. The poor recording of seclusion meant that staff were not adhering to the provider's own policies and the MHA Code's requirements.

The ward we inspected had not had any recent episodes of long-term segregation. The hospital did not have the facilities to support long-term segregation.

Staff reviewed restraint and used the examples as learning. The hospital had a dedicated Prevention and Management of Violence & Aggression (PMVA) trainer and health and safety manager who were responsible to review incidents of restraint and support staff to learn lessons and improve. The hospitals training records showed that 98% of staff were trained in the use of restrictive interventions, the training was certified as complying with the Restraint Reduction Network (RRN) Training standards. The provider showed us the training certificate in place that confirmed the training was approved by the RRN.

The hospital had implemented emergency simulations to ensure staff understood how to respond in a variety of emergency situations. Ward leaders on Springs Unit had carried out a simulation in June 2023, however, the outcome report had not been fully completed. This meant that staff would be unable to refer back to the report for their own learning and improvement.

Staff did not ensure that people on the ward received the appropriate physical health checks following rapid tranquilisation (RT). During our inspection, we identified 4 incidences of rapid tranquilisation without records in place to confirm any post physical health monitoring. This was not in accordance with NICE guidance and the provider's own 'rapid tranquilisation procedure'. The lack of physical health monitoring post RT increased the risk of a person developing adverse side effects and not being appropriately treated. This put people at risk of avoidable harm.

Safeguarding

Staff understood how to protect people from abuse. Staff we spoke with knew how to recognise adults 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. Staff kept up to date with their intermediate e-learning safeguarding training and at the time of our inspection the completion rate was 77%. However, the compliance rate for the virtual classroom safeguarding training session was 67%. The Springs Unit had the lowest safeguarding compliance rate compared to other wards in the hospital.

Staff received group safeguarding supervision every six months. The provider's safeguarding lead told us that they facilitated sessions throughout the year to provide staff with an opportunity to learn about staff responsibility, how to report a safeguarding alert and reminding staff about the policies and procedures they can access to support them in their decision making. The provider's safeguarding policy provided a clear flowchart in how staff can report a safeguarding and highlights the importance of not finishing a shift without reporting their concerns.

Staff access to essential information

The electronic and paper-based recording systems used on the ward was disorganised. The service did not have a system in place that enabled staff to access person's care and treatment record without delay. During the inspection, we identified that records of seclusion were not kept together and were badly filed. The way in which the care records were stored increased the risk of staff not being able to access important information when required.

Medicines management

Medicines were mostly managed well, although improvements were needed on Springs Unit with the administration of controlled medication.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. During our inspection we reviewed 3 medicine charts and found that medicines were prescribed and monitored appropriately and were not being used to control people's behaviour. High dose anti-psychotics were monitored by the medical staff and the external ward pharmacist. When required (PRN) medicines were prescribed on medicine charts for the management of agitation, insomnia and pain. We found that these medicines were administered appropriately and not overused.

People received support from staff to make their own decisions about medicines wherever possible. We saw that nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them.

People could take their medicines in private when appropriate and safe. The ward had access to an examination room off the ward that included an examination couch.

Staff made sure people received information about medicines in a way they could understand. We observed nursing staff introducing themselves to people before offering them medicines, they explained what they were giving, and observed the person to take them.

Staff followed national practice to check that people had the correct medicines. Medical staff followed national guidance to ensure patients were prescribed correct medicines. We found that medicines were prescribed appropriately meeting the Mental Health Act requirements. An external pharmacist visited the ward once a week to screen prescriptions and advise medical staff when doses needed to be revised.

Inadequate

Forensic inpatient or secure wards

Whilst people received their medicines from staff who mostly administered, recorded and stored their medicines safely, on the day of our inspection we identified that staff on Springs Unit had failed to ensure that they had correctly signed and witnessed the administration of controlled drugs (CDs) on 2 separate occasions. Controlled drugs are medicines that are subject to high levels of regulation and require specific secure storage and record keeping. We found the staff did not record the administration of controlled drugs as per the provider's own policy and national guidance.

Track record on safety

Staff did not always recognise incidents and record them appropriately on the electronic incident reporting system. This meant that senior leaders were unable to review and thoroughly investigate incidents to ensure that sufficient improvements were made.

During our inspection, we identified 5 separate incidents that had not been formally reported electronically. For example, we reviewed 2 separate incidents of where a person had been taken to hospital in secure transport and in a mechanical restraint. Provider staff who had escorted the person had failed to formally report the use of mechanical restraint. Staff had failed to follow the provider's own restraint and violence reduction policy which states that any form of restraint is to be reported on the electronic incident reporting system. We also identified that staff were not routinely reporting rapid tranquilisation (RT) as an incident. For example, we identified 3 incidences of RT that had not been recorded on the system. Overall, the lack of incident reporting meant that hospitals management team were unable to review and thoroughly investigate incidents to make sure that sufficient action is taken to prevent further occurrences and to make improvements as a result.

Reporting incidents and learning from when things go wrong

The service did not manage incidents affecting people's safety well. Debriefs were not recorded consistently after incidents so it was not possible to know if this had taken place to an appropriate standard.

Ward leaders did not always ensure that they consistently recorded post incident debriefs. Whilst staff we spoke with told us that a verbal debrief took place with both the person and staff involved, we did not find consistent evidence of this. During our inspection, we reviewed a sample of 3 incidents to assess whether the provider had recorded that a debrief had taken place. We found that a debrief had not taken place for 2 out of 3 incidents. The lack of recording meant that leaders could not be assured that staff and people involved were reflecting on incidents and learning from them. There was also no formal record for staff to refer back to at a later date.

Is the service effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected peoples assessed needs and were personalised and holistic. However, people's records did not always reflect decision making processes as was the case for the person on Springs Unit where mechanical restraint was being used.

Inadequate

Forensic inpatient or secure wards

Staff completed a comprehensive assessment of each person's physical and mental health either on admission and at routine intervals thereafter. During the inspection, we reviewed 7 records in total. Of the 7 reviewed, we specifically reviewed 3 to check people's admission paperwork. We found that everyone had received an initial assessment on admission and their mental health and physical health needs were reviewed at the fortnightly ward rounds. All disciplines were required to have input into each person's ward round. They recorded their feedback onto a centralised record that could be reviewed by the person and consultant psychiatrist.

We reviewed 7 care records and found that 6 people had care plans in place to support their needs and identified risks such as self-harm, physical health, and mental health. However, in 1 record the nursing and medical records did not reflect the decision-making process for the person on Springs unit who was subject to mechanical restraint.

Therapy staff ensured people had up-to-date care and support assessments, including psychological, functional, communication, preferences and skills. People had a variety of care plans in place that had been created by the speech and language therapy (SALT) team, the occupational therapy (OT) team and psychology team. During our inspection, we randomly sampled 3 therapy treatment records. All 3 records showed that people had individual communication passports that were used to support them to share important information about themselves in an accessible way.

The psychology team worked with people to develop positive behavioural support plans (PBS). A PBS plan is a person-centred framework for providing long-term support to autistic people, including those with mental health conditions, who have, or may be at risk of developing behaviours that challenge. During our inspection, we specifically checked 6 out of 7 records to assess whether each person had a PBS plan in place. We found that in all records reviewed a PBS plan was available and they were clear, accessible and of good quality. However, 1 PBS plan had not been signed or dated by a member of staff.

Best practice in treatment and care

Staff did not consistently provide a range of treatment and care for autistic people based on national guidance and best practice. Some people were not having their physical health checks such as dental, optical care and annual health checks and some carers said their relative's health had declined in hospital and they had gained weight. Whilst therapeutic activities were well structured during the week this was not the case at the weekend which was not autism focused or in line with NICE guidance. Staff used recognised rating scales to assess and record severity and outcomes. Whilst the provider carried out audits, these were not always completed to an appropriate standard.

Whilst the provider had guidelines in place to support people to live healthier lives and take an active role in maintaining their own physical health, there was an inconsistent approach to how well this was being implemented on Springs Unit. During the inspection, we reviewed 7 records in total. Of the 7 reviewed, we specifically reviewed 3 to check whether people were offered and attended annual health checks. In 3 out of the 3 care records reviewed, we found that staff did not ensure that they had received the right annual health checks. For example, in 2 records the people had not received a health check from either their dentist or optician. Both people had seen their GP within the past 12 months. In one other record the person's health checks were all overdue. The person had most recently attended for their annual health checks in early 2022. Two carers we spoke with raised concerns about their relative's overall decline in physical health whilst in hospital. The carers told us that since being in hospital their relative had become severely overweight and they did not feel as though the service was supporting them to reduce it. One of the carers also told us that staff were not supporting their relative to manage their oral hygiene and since being in the hospital it had worsened. Staff did not consistently ensure that they supported people to look after their physical health and attend their annual health checks. This increased the risk of people's overall health declining.

The psychology team had recently implemented ways for new staff to be able to improve their understanding and communication with people on the ward. Despite people having individual positive behavioural support plans in place these were sometimes lengthy and did not always enable a new member of staff to understand people's needs quickly. As a result of this, the psychology team created therapeutic engagement support plans also known as grab sheets. The grab sheets provided staff with an overview of people's key risks and needs.

Staff supported people with their dietary needs and promoted healthy eating. Occupational therapy staff cooked meals in the kitchen as part of their care plan and led a healthy eating group once a week to provide education. Some people and staff told us that the meal portions were small in size, and this meant that people snacked more often.

Patients were supported and encouraged to plan their days during the week. Each person had a personalised timetable that included activities from Monday to Friday. We reviewed 4 people's activity records from Springs Unit and found that people were offered and attended a variety of groups that met their interests as well as voluntary work at the local charity shop and hospital tuck shop. The OT team monitored attendance at each group.

However, at the weekends people's activity significantly reduced. People's individual timetables stated that the activities on the weekends were nurse led. We identified that on some weekends staff took groups of people on outings, however, when these trips did not take place individual care records showed that activities were limited. During our inspection, we carried out an out of hours visit and visited Springs Unit. We observed 4 people to be visible on the ward and other people were in their bedroom. Staff and a person we spoke with told us that movie evening was the main activity that took place over the weekend. Staff told us that there were no activity coordinators or OT assistant's available on the weekends. We found that there had been no activities allocated to any one member of staff. We observed in the gym there to be a broken table tennis table. The people found the weekends boring and wanted more things to do. The lack of nurse led activities meant that people who were unable to leave the ward did not have any meaningful activities to do or clear structure to their day which was not autism focused and not in accordance with NICE guidance.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Occupational therapists measured outcomes for patients using the model of human occupation (MOHO). However, there was a plan to implement a new model of care called The Vona du Toit Model of Creative Ability. Each ward used The Global Assessment Progress (GAP) scoring to measure outcomes. This included looking at an assessment of progress for each person. The GAP data was monitored by the senior leaders and discussed clinical governance meetings. Leaders had recognised that there had been an issue with how staff were recording whether people had been offered and received a meaningful activity. Additional staff training had been provided to improve this.

Whilst ward staff and hospital leaders took part in clinical audits, some audits were not carried out often enough and they did not always generate improvements. For example, despite the provider carrying out their own seclusion audits, our MHA seclusion review identified a number of shortfalls care and treatment that dated back to January 2023. The provider also carried out a blanket restriction audit every 6 months and in between this time ward leaders did not monitor the use of blanket restrictions on the ward. Following our inspection, senior leaders told us that this audit would be reviewed at the monthly governance meetings going forward.

Skilled staff to deliver care

Nursing and support worker staff members did not receive adequate training on how to support autistic people. This was particularly reflected in the observations of staff failing to communicate effectively with the people using the service. Staff access to regular supervision had improved since the most recent inspection.

Autistic people were not supported by staff who had the right skills and training to ensure they were understood, and their individual needs were met. The hospital offered all staff including bank and agency staff, a basic level of training called autism awareness training and for permanent staff they also received positive behaviour support training. The compliance rates for both of these courses were 100%. However, staff did not receive specialist training in communication. During our inspection we identified that specialist care and treatment could not always be offered due to the lack of skilled nursing staff.

We found staff were not trained in picture-based communication tools and therefore were unable to support people who used this way of communication or preferred it. We identified in the records of 3 people on Springs Unit that a communication tool called Talking Mats would be beneficial, as the people found visual communication helpful. However, the nursing staff were unable to support the people to communicate in this way as they were not trained to use this method of communication. In 1 out of the 3 records we reviewed, we identified that a person's communication care plan included the use of Talking Mats. A member of staff told us that Talking Mats was not used with the person as they 'can verbalise.' Another member of staff told us that they had received autism training, but they did not practice it on the ward as the people did not present with autism.

Staff also lacked the skills to be able to effectively deescalate and understand the triggers of people on the ward. During the CQC's recent MHA seclusion review visit, we spoke with 4 people who had used seclusion since January 2023. One person told us that when they head banged this was their way of communicating to staff that they needed support. However, staff responded to tell them to 'stop' which triggered them to continue head banging. Three other people told us that there were occasions when alternative methods of de-escalation were not offered by staff, they had never been given the opportunity to discuss triggers and how best to de-escalate behaviour when expressing heightened emotions. Overall, staff lacked the understanding and the skills to be able to meet the care and treatment needs of a person with autism. This impacted on how staff interacted with people and how people felt they were treated.

Following our most recent inspection in 2018 we told the provider that they must ensure staff receive regular supervision. At the time of our inspection May and June 2023, we found that this had improved. Clinical staff received supervision every 30 days. At the time of our inspection, the supervision and appraisal compliance figure was 76%. This was due to 4 members of staff being overdue for their clinical supervision due to the ward manager being on leave. Medical staff and other members of the multi-disciplinary team carried out their yearly appraisal with a supervisor from their discipline. The head of psychology was also planning to reintroduce staff reflective practice meetings to provide staff with an opportunity to reflect and discuss their experiences. However, this was not in place at the time of our inspection.

Multi-disciplinary and interagency team work

People had access to a range of specialists although the psychology team were only recently appointed and were just starting to carry out their role. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

People had access to speech and language therapy, occupational therapy and some psychological support. The hospital's psychology team were a new team and had been in place since March 2023. At the time of our inspection, the head of psychology told us that the team were aware that people on the ward had been unhappy with the lack of psychology input over the previous few months and that they were looking to improve this soon. The team currently offered weekly drop-in sessions for people to attend and were mainly carrying out basic assessments of people to understand their motivation and individual needs. The team recognised that it was difficult to motivate people to engage in therapy.

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had consistent care. People were discussed at ward round meetings on a fortnightly basis and people were invited to attend. Records of MDT discussions were recorded within the persons individual care record.

The ward teams had effective working relationships with staff from services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge.

Ward leaders were involved in interagency team working. The ward manager was part of the North London forensic provider collaborative which commissions and delivers low secure male low and medium secure learning and autism services. The regular meetings were an opportunity for providers in the collaborative to provide updates about their services and learn from best practice.

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 usually discharged these well. Managers made sure that staff could explain peoples' rights to them. However, where shortfalls were identified during audits, actions to address issues were not always carried out.

Staff received and kept up to date with training on the MHA and the Mental Health Act Code of Practice. The completion rate for staff for Mental Health Act awareness training was 100%. Staff had access to the provider's MHA administration team for support and advice when required.

Staff mostly ensured that they explained to each person their rights under the Mental Health Act in a way that they could understand, repeated it as necessary and recorded it clearly in the people's notes each time. During our inspection, we reviewed 7 records in total. Of the 7 reviewed we specifically checked 3 of them to assess whether staff routinely read people their rights. We found that 2 of the 3 people had not been read their rights since April 2021. This meant there was a risk that they were not always fully informed of their MHA right. A senior leader told us that there was a plan for Springs Unit to implement a system that would monitor for when people needed staff to read them their rights.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or the Ministry of Justice or both. People's individual care records showed that for people who were permitted to leave the ward they were supported to do so. The daily planning meetings were an opportunity for people to plan their days and for people to inform staff that they would like to take their leave. The ward had allocated staff to accompany people during their leave.

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

Staff had ensured that the appropriate MHA consent paperwork was in place for the prescribing of medicines. We reviewed 3 medicine charts and found that medicines were prescribed appropriately meeting the MHA. We reviewed 3 medicine charts and found most T2's and T3's was correctly in place.

Staff stored copies of people's detention papers and associated records correctly, and staff could access them when needed. The hospital's MHA administration team held detention paper records and could be accessed when required.

Inadequate

Forensic inpatient or secure wards

Whilst the managers and staff carried out frequent audits to ensure they applied the Mental Health Act correctly; improvements were not always made as a result. During our inspection, we reviewed the ward December 2022 MHA audit and found there were a small number of gaps in how often staff were reading people's rights to them. There was no action plan in place to address the issues. During our recent inspection in May and June 2023, we identified that practice on Springs Unit had not improved.

Good practice in applying the Mental Capacity Act

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

Staff supported people to make decisions on their care for themselves. They assessed and recorded capacity to consent for people who might lack the mental capacity to make certain decisions for themselves. We found that clinicians recorded people's capacity appropriately when they needed to make an important decision such as a medication change.

The provider had a policy on Mental Capacity Act and advance decisions or statements. Staff were able to access the policy electronically.

The provider monitored how well it adhered to the Mental Capacity Act and acted when they needed to make changes to improve. Managers completed Mental Capacity Act audits every 3 months. The most recent audit, completed in June 2023, achieved 100% compliance.

Is the service caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff who lacked autism specific training did not know how to interact appropriately with the people they were supporting. This meant that while people felt safe, they did not feel treated with compassion and kindness. Some people said they did not have a positive rapport with the staff. The approach of the nursing and care staff was at times custodial and threatening rather than supportive. Staff did not communicate consistently with the people which caused them to be distressed.

The lack of specialist training to support autistic people impacted on how the nursing staff interacted with people on the ward. Staff lacked the awareness and understanding of how their behaviours could be perceived by an autistic person. For example, during our inspection we carried out a short observational framework for inspection (SOFI) which is a tool developed and used by inspection teams to capture the experiences of people who use services who may not be able to express this for themselves. We observed during a period of 10 minutes, a person had asked a member of staff for a change of clothes and in response 9 members of staff were observed to talk to the person at the same time. We observed that the number of staff trying to engage with the person was disproportionate to the person's need. We observed the interaction to be intimidating and could be perceived as threatening.

Inadequate

Forensic inpatient or secure wards

Staff did not always show compassion and respect when interacting with people. During our inspection we observed staff standing for long periods observing people but not interacting with them. The approach felt custodial rather than supportive. One member of staff said they were 'guarding' the patients'. During our on-site inspection we spoke with 11 people and 3 of those people raised their concerns about how staff treated them. One person told us they felt that staff were not meeting their needs. One other person told us they felt ignored by staff. All three people told us that staff needed additional training.

People did not always feel valued by staff or showed genuine interest in their well-being and quality of life. During our recent MHA seclusion review, we spoke to 5 people who had used seclusion since January 2023. Two of the people told us that they felt staff had ignored them during a period of seclusion which had escalated their behaviour, another person told us that a member of staff told them they would keep them in seclusion 'for days', and one other person told us that staff stood and smiled at them whilst in seclusion. We also identified a recent incident of when a person had smeared faeces around the seclusion room and staff had left them in the room for over 17 hours without cleaning it up. Staff had failed to behave in a caring way that upheld people's rights.

People did not always feel that staff took the time to understand and develop a rapport with them. One person from Springs Unit told us that they liked to play board games, but staff did not want to play. The February 2023 clinical governance meeting minutes also showed that 2 other people from Springs Unit raised similar concerns to the senior leadership team.

People from Springs Unit were asked to share their experiences. People were able to provide feedback about their experience through various ways such as the weekly community meetings, the hospital survey that took place twice per year as well as opportunities to attend the clinical governance meeting minutes to share their feedback. People had fed back that the meals available on the ward needed to improve and as a result the catering team were visiting the ward to meet with people to discuss their feedback. The ward also used a 'you said, we did' board, which is an initiative used to demonstrate how a service or organisation has listened to user feedback and publicly shows how the service has responded. However, at the time of our inspection the board had not been updated for 2 weeks. This meant that people on the ward were unable to see what action the service had taken as a result of their feedback.

Staff ensured that people's information was kept confidential. Information about people was stored securely on an electronic system or in folders in the nursing office. The ward also had information about people kept on a whiteboard in the nursing office. The whiteboards could be covered over to ensure the information remained private.

Involvement of patients

Staff actively sought patients' feedback on the quality of care provided. They ensured that most patients had access to independent advocates. However, staff did not always involve patients in care planning. The hospital recognised that it did not sufficiently communicate with and involve carers.

Whilst the care and treatment records created by the therapies teams showed that people were involved in the planning of their care, the nursing and medical records did not always demonstrate the same level of people involvement. We reviewed 3 individual care plans and found that in 2 care plans the nursing and medical staff had not clearly demonstrated that the person had been involved and had received a copy of their care plan. A person who had been taken to hospital in a mechanical restraint and their views had not been considered or documented. The lack of involvement in care planning was not person-centred and increased the risk of people receiving care that is not personalised.

Inadequate

Forensic inpatient or secure wards

Generally, people were supported to access independent, good quality advocacy. An independent mental health advocacy (IMHA) service visited the ward on a twice weekly basis to speak with people. The hospital advocate told us that they attended weekly ward rounds. However, during our recent MHA seclusion review we identified that an IMHA was not informed of episodes of seclusion or involved in multidisciplinary reviews of seclusion. One person told us that they could not access an IMHA in seclusion and we found no record of IMHA involvement in independent reviews after 8 hours of seclusion. The lack of IMHA involvement for a person in seclusion meant that staff had not adhered to the MHA code of practice and had not followed the provider's own policy.

People were involved and supported to make decisions about the service when appropriate and felt confident to feed back on their care and support. People from Springs Unit had been involved in early conversations relating to the renovation of the old dining room space. People had requested for half of the room to be a sensory room and the other half to be a new OT kitchen. Within the past 12 months, 7 people had independently raised a formal complaint with the hospital director.

Involvement of families and carers

Two carers we spoke with told us that they did not feel that staff communicated with them or that staff attitude was sometimes an issue. One carer told us that they had experienced some staff being abrupt to their relative and on one occasion witnessed a member of staffing shouting at them. Another carer told us that they have only been invited to one ward round and does not feel that they are kept up to date.

There was a lack of carer involvement and feedback. Families and carers were not always informed of when their relative had been taken to seclusion. During our MHA seclusion review, we reviewed 16 episodes of seclusion for 6 separate people and found that the records did not demonstrate that families and carers had been notified of the seclusion episode. The lack of family involvement meant that individual people could not receive support from people they know, and carers were unable to advocate for the person and share their views. Staff did not adhere to the Code of Practice. One of the 2 carers we spoke with told us that the service had never contacted them to inform them of when their relative had been involved in an incident.

Hospital leaders recognised that ways for carers to feedback about the service needed to improve. There were plans to restart carer forums in August 2023 and surveys as well as offering carers a dedicated carers email address.

Is the service responsive?

Inadequate

Our rating of responsive went down. We rated it as inadequate.

Access and discharge

Staff managed beds well and worked with external stakeholders to facilitate discharge arrangements. Most people only stayed in the hospital for as long as needed although there were a few delayed discharges.

Inadequate

Forensic inpatient or secure wards

Staff regularly reviewed people's length of stay to ensure they did not stay longer than needed. The average length of stay was different between each ward. Springs Unit, which was a low secure service had the longest length of stay which was between 2 and 5 years. However, this was dependent on the availability of appropriate discharge placements. During our inspection, the ward was at full capacity. Springs Unit was a low secure service which was nationally commissioned and accepted people who lived outside of London.

Bed management

When people went on leave there was always a bed available when they returned. When a person's risk increased and the service was unable to support the person, they would refer the person to an appropriate setting. During our inspection, we identified one person who had been referred to a number of medium secure units due to the escalation in their behaviour.

People were moved between wards during their stay only when there were clear clinical reasons, or it was in their best interests. During our inspection, we found that one person spent time on Springs Wing during the day due to them being at risk of harm from another person. The person told us that they enjoyed being on Springs Wing and felt safe there.

Discharge and transfers of care

Discharge plans were discussed and recorded during ward round meetings.

The ward liaised with services that would provide aftercare and escalated issues with people's discharges or transfers of care to community professionals and clinical commissioning groups. Breakdown in discharge placements meant that at times people stayed in hospital longer than needed.

Facilities that promote comfort, dignity and privacy

The ward environment did not meet the sensory needs of autistic people. There were no clear plans in place with timescales for improvements to take place. Several people said the food needed to improve and it was poor quality and small portion sizes.

The ward environment of Springs Unit was not autism friendly, did not meet people's sensory needs and did not follow the principles of CQC's right support, right care, right culture guidance. The specialist low secure ward felt impersonal and institutional due to the unwelcoming and clinical atmosphere. During our inspection in 2018, we recommended to the provider that they should improve the ward environment including a sensory room. During our recent inspection in May and June 2023 we found that whilst Springs Unit had installed a sensory room, the room was basic. The sensory room consisted of bean bags and a light feature on the wall. The ward manager said that a new sensory room would be installed in late 2024 due to funding. Two people told us that the ward was noisy and that the ward lighting affected them. One person had covered their windows with paper to prevent the light coming in. Another person told us that they would like sensory lights of blue and red in their room as they find it relaxing. We also observed several people wearing ear defenders because of the level of noise and alarms sounding. Springs Unit had not formally assessed the environment and did not have a formal action plan in place that they were working toward. During the inspection, the ward manager had told us that an external person had assessed the ward environment but there was no action plan created as a result. The provider had not done everything reasonably practicable to make sure that people who use the service receive person-centred care that met their needs.

Inadequate

Forensic inpatient or secure wards

Whilst the ward regularly employed a large nursing team to support the needs of people, this impacted on the ward environment being overcrowded. During our inspection we observed Springs Unit to deploy a high number of additional staff. For example, there were 16 additional members of staff to the core nursing team plus the 12 people. Due to the ward corridors being narrow and small in size, staff were unable to spread out. We observed that the high numbers of staff on the ward at times created an atmosphere that did not support a person with sensory differences. This increased the risk of people feeling overwhelmed and causing an escalation in their behaviour.

People had access to full range of rooms and equipment to support treatment and care. For example, clinic rooms, a multifaith room, a quiet room, gym facilities and outdoor areas.

Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. People on the ward were also able to store their personal belongings in the nurse's office. Each ward had a quiet room for privacy. People were able to meet visitors in a private room on the ward or in a room located within the hospital.

The service recognised that the food offered to people on the ward needed to improve to ensure it met their dietary requirements and preferences. As a result of the latest survey results, 'meet the chef' meetings had been initiated which provided people with an opportunity to meet the catering team and provide feedback. Hospital leaders recognised that there were still some improvements to be made to ensure staff supported people to choose food that met their needs.

People could make phone calls in private. People had access to the ward cordless phone. People on Springs Unit were given a basic mobile phone that did not have a camera or provide access to the internet. The hospital had experienced issues with the internet and some people had reported that they were unable to use the computer as a result. During our inspection, the registered manager told us that this had been reviewed by the IT team. The IT team had plans to speak with people who were unhappy with their access to the internet and assess whether it could be fixed.

Patients' engagement with the wider community

The service supported people during the week to access a range of activities supporting their rehabilitation and, in some cases, accessing opportunities in the community.

Activity and therapy staff supported people to take part in their chosen social and leisure activities on a regular basis. Most people were able to access different opportunities to try new experiences, develop new skills and gain independence. The therapies team ensured that people had a personalised timetable of activities Monday to Friday. People had access to a range of activities that would support them in their recovery and to live independently such as cooking, shopping to the local town centre and voluntary work.

People were supported by staff to try new things and to develop their skills as part of the occupational therapy programme. The hospital had set up a car wash so that people who were able to leave the hospital could earn their own money. The hospital had also set up a regular tuck shop that was led by the people from the wards across the hospital and was a way to earn money and develop their social skills.

Staff enabled flexibility and helped people to have freedom of choice and control over what they did. The hospital had employed drivers who were able to transport people to their desired destination. This was a way of encouraging people to go out into the community.

Meeting the needs of all people who use the service

Inadequate

Forensic inpatient or secure wards

The service met the needs of most people – including those with a protected characteristic. Staff helped people with advocacy and cultural and spiritual support.

The service was working to improve the support for people with their sexual, religious, ethnic, gender identity without feeling discriminated against. The ward manager had carried out a learning event with the North London Forensic Consortium provider collaborative relating to safe sexual expressions. As a result of this learning event, a drop-in group led by male members of staff was to be implemented on the ward to enable people to express their thoughts and feelings.

The therapy teams ensured people had individual communication plans that detailed effective and preferred methods of communication. People had pictured based timetables that provided a schedule of activities that met their needs. Pictured based information about what each person could expect from their experience was visible on the walls around the ward.

Staff made sure people could access information on treatment, local services, their rights and how to complain. Leaflets were not available on the ward, but staff told us that people could access the leaflets that were stored in the nursing office. Complaints information posters were visible around each ward.

People's access to easy read information was limited. The ward had some easy read information located on the walls, but this was minimal. There was no easy read information about people being able to leave the ward.

People had some access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

People and those important to them could raise concerns and complaints easily, and staff supported them to do so.

Two carers we spoke with understood how to raise concerns and felt comfortable to do so. One carer told us that although they had complained but they had not received a response.

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them. Over a 12-month period, the ward had received 13 separate complaints. Out of the 13 received, 7 complaints were from individual people and 4 complaints were from family members or carers. The complaints related to therapeutic interventions, a lack of information, quality of care and attitude of staff. One person we spoke with told us that they had made several complaints about the ward and how they had been treated by staff.

Staff knew how to acknowledge complaints, and people received feedback from managers after the investigation into their complaint. During the inspection, we reviewed a sample of 2 complaints that the hospital had received in the past 12 months. We found that the provider's complaints response timescales had been adhered to and acknowledgement letters had been sent on the same day as the complaint had been received. The provider had appropriately investigated each concern and had provided an outcome letter to the person within the timescale of 20 working days.

The service clearly displayed information about how to raise a concern in areas used by people. Information about how to complain was visible on the walls around each ward.

Inadequate

Forensic inpatient or secure wards

Managers shared feedback from complaints with staff, and learning was used to improve the service. Lessons learnt were a standard agenda item during team meetings. Team meetings provided an opportunity to discuss lessons identified following complaint investigations and improve practice. Hospital leaders discussed complaints during clinical governance meetings.

Is the service well-led?

Inadequate

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

Leadership

Whilst the hospital leadership team at the hospital showed a commitment to deliver good quality care, they did not have the insight to recognise that the service was not meeting the needs of autistic people, that staff were not adequately trained leading to a variable quality of interactions with people using the service and that the environment was not meeting people's needs.

Whilst most leaders worked hard to manage the running of each ward, the oversight of the quality of care given to people needed significant improvement. During our inspection, we identified two separate incidents where two people had received poor quality care. For example, one person had been left in the seclusion room surrounded by faeces for more than 17 hours without the environment being cleaned. Another person had been put in a mechanical restraint whilst being transported to hospital, but the ward leaders had failed to ensure that the use of mechanical restraint had been appropriately care planned and reported as a formal incident. Staff did not adhere to the provider's own restraint and violence reduction policy. We also identified blanket restrictions in place that were not being closely monitored to ensure they were the least restrictive measure.

Ward managers were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. All staff we spoke with felt supported to be able to carry out their roles. During our inspection, we observed ward managers to have a good rapport with people on the ward. We observed them to be directly involved in coordinating people's care.

Vision and strategy

Whilst staff knew and understood the provider's vision and values, some staff did not always act in line with them.

During our inspection, people told us that staff did not always show compassion and respect when interacting with people. We spoke with 3 people who raised concerns about how staff treated them. Some people told us that staff did not meet their needs and at times felt ignored. During our MHA monitoring visit, we spoke with 5 people who told us that they had negative experiences of seclusion partly because of how staff behaved towards them. The behaviours displayed by some members of staff meant that the general culture of the ward was at risk of decline.

Culture

Staff felt respected and supported. They said the hospital provided opportunities for development. They could raise any concerns without fear.

Inadequate

Forensic inpatient or secure wards

Governance

Whilst governance systems and processes were in place, they did not enable the provider to identify, understand, monitor and address current risks relating to the quality and safety of care delivered to autistic people.

During the inspection, we identified the following concerns, which had not been identified by the service. The governance systems were not tailored to assess and identify the individual needs of autistic people. The processes in place had not identified that the quality-of-care people received was being impacted by the lack of specialist training provided to the nursing staff. We found several examples of staff behaving in a way that was not effective and lacked compassion.

The systems in place had not identified that the physical health monitoring of people after they had received rapid tranquilisation did not consistently take place. Several incidents had not been reported in practice. For example, incidents of rapid tranquilisation and restraint were not routinely reported on the electronic incident reporting system. This meant that the hospital management team could not monitor the incidents for appropriate action to take place to ensure the patients received safe care and treatment. It also meant impacted on the ability to learn and make improvements to the service. Learning from audits were not being followed through to ensure that improvements were made such as people not being read their MHA rights on a regular basis. During our inspection, we identified that this had not improved on Springs Unit.

Management of risk, issues and performance

Whilst senior leaders used a risk register to track and monitor risks related to the running of the hospital and individual ward, they were not sighted on some of the quality of care issues that we had identified during our inspection.

Information management

Staff collected and analysed data about outcomes and performance although some aspects of the data could not be relied upon.

Leaders recognised that the quality of data was not always accurate because staff were not routinely reporting incidents via the electronic reporting system.

All services registered with the Care Quality Commission (CQC) are required to notify the Commission of certain incidents, without delay. The service notified the Care Quality Commission of notifiable incidents.

Engagement

Managers engaged and participated in meetings with local health and social care systems.

The ward manager for met on a regular basis with system partners that provide forensic services in North London. The meeting was an opportunity for providers to share best practice and learn from similar services.

At the time of our inspection, the service was not providing carers with an opportunity to meet face to face with leaders to share their feedback.

Inadequate

Forensic inpatient or secure wards

Learning, continuous improvement and innovation

At the time of our inspection, the ward for autistic people were not accredited or participating in any nationally recognised improvement projects. Springs Unit was not accredited by the National Autistic Society. For a provider to be accredited demonstrates that they are able to meet a strict criterion and provide evidence that they were meeting the National Autistic Society standards.

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

Inadequate

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

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

The ward had a few blind spots, but staff were unable to clearly articulate how this was managed to ensure patients were appropriately observed. Some medical equipment was not calibrated at the correct frequency, and this was outstanding from the previous inspection. Resuscitation equipment was not being checked as regularly as it should be. The provider's food safety policy was not always followed, which meant there were risks of food not reaching patients at the correct temperature. However, the ward was well equipped, and well furnished.

Safety of the ward layout

Byron Ward is comprised of 20 en-suite bedrooms spread out across one floor. The ward had changed from a mixed sex ward to an all-male ward at the start of 2023. Other rooms on the ward included a patient lounge, a therapy room, a gym, a kitchenette, and two outside areas. A room previously used as the female lounge was being turned into a multifaith room. If assessed as safe to do so, some patients could access rooms off the ward such as the occupational therapy room and visitor rooms.

Staff completed and regularly updated health and safety risk assessments of ward areas, and removed or reduced any risks they identified. Maintenance issues were discussed during the daily weekday situation report meeting attended by hospital managers, maintenance, and the multidisciplinary team. Staff told us most maintenance issues were addressed promptly. During our inspection, a patient told us they had received a shock from touching their light switch that morning. We informed the provider who investigated but could not find any issues. The service had requested the installation of sensors to replace switches on the ward. This was ongoing at the time of reporting.

The ward had experienced an increase in patients going absent without leave (AWOL) after jumping over the fence. In response, a 3-meter-high replacement fence was installed. At the time of our inspection, part of this fence was broken so the garden was closed to patients while it awaited repair.

The ward had a number of blind spots within the communal spaces and patient bedrooms. Staff said they mitigated risks with increased levels of observation if needed. However, there was no blind spot audit, staff did not clearly describe how they kept all areas of the ward under observation, and we did not see staff deployed across the ward. For example, there was a long corridor with patient bedrooms off it that led to the ward's entrance and exit. At one end was a small nursing station, and there were CCTV cameras on the corridor. However, we did not see a staff member on the smaller nursing station during our inspection, and the live view of CCTV was turned off in the office following learning from another hospital.

Unannounced fire drills took place and debriefs were held to share concerns and recommendations with staff. The most recent fire risk assessment was completed in January 2023 and actions had been addressed within target timeframes. During our first 2 days on site, the fire alarm went off 3 times. Some staff and patients told us this happened very often.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The most recent annual ligature anchor point risk assessment was completed in December 2022 and a heat map showing risk points was displayed on the wall. Staff knew where the ligature cutters were stored. Improvements to the ward environment was in progress to reduce ligature points. For example, some bedrooms had been renovated so beds were fixed to the floor and headrests were flush to the wall. These renovations were ongoing.

The ward complied with guidance and there was no mixed sex accommodation. The provider had started a contract with a London based NHS trust in January 2023 which changed the ward from a mixed sex ward to an all-male ward. At the time of our inspection managers did not know if the ward would return to a mixed sex ward or not. At our most recent comprehensive inspection of the hospital in 2018, we said the provider should ensure that planned building works on Byron Ward were completed to ensure the ward fully complied with the guidance. During this inspection we found the building works had not been completed. The hospital director said they had improved signage to clarify which corridors were for each sex. They said if the ward returned to mixed sex accommodation, they would use additional staff to manage the risks. The layout of the building still meant that, if females returned to the ward, patients would have to walk along corridors of the opposite sex to access lounges, therapy rooms and to exit the ward.

Staff had easy access to alarms and patients had easy access to nurse call systems. All patient bedrooms and en-suite bathrooms had nurse call alarms. Staff checked their personal alarms worked at the start of each shift. They also carried radios if they needed to call for back-up. Staff we spoke with said alarm systems were effective.

Maintenance, cleanliness and infection control

Ward areas were well furnished. The ward has recently been painted, some carpets had been replaced for vinyl flooring, and new artwork was displayed.

Staff made sure cleaning records were up-to-date and the premises were clean. Daily cleaning records were completed for the ward, examination room and recovery college room. Cleaners offered to clean patients' bedrooms daily and changed their bedding at least twice a week. However, the lounge carpet was stained, the patio area was closed due to the broken fence, and the kitchenette was in a poor condition. There was a foul smell, possibly from the drains, in the kitchenette. Staff said the kitchenette had been this way for some time. Furthermore, although we did not find any sour milk at the time of inspection, staff did not monitor the temperature of the fridge patients' milk was stored in. We raised our concerns with the manager and during our next onsite visit we saw evidence that fridge temperature monitoring had started. Managers had plans to improve the kitchenette, flooring and fence issues.

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

Inadequate

Improvements were required to ensure staff always followed infection control (IPC), dress code, and food safety policies. We observed that staff were not always bare below the elbow. We saw some staff wore watches and long-sleeved tops. Managers had previously reminded staff of this requirement, but improvements remained ongoing.

An IPC audit completed in April 2023 scored the ward 100% for compliance. However, the audit did not identify the absence of kitchen fridge temperature checks.

Staff did not always follow the provider's policy on food safety and management. We observed most patients ate their meals on the ward. Meals were brought up from the hospital's kitchen on an unheated trolley and covered with cling film. This was not in line with the provider's policy which states hot food should be placed onto a pre-heated hot holding unit immediately after cooking. Furthermore, all hot food should be kept at 63°c or above. We did not see any evidence that ward staff checked food temperatures before handing hot meals to patients. Some patients we spoke with said their food was sometimes cold.

Seclusion room

The ward did not have a seclusion room. There was a seclusion room on another ward that patients could be escorted to if needed. No patients from Byron Ward had used this room for at least 12 months.

Clinic room and equipment

The ward had a clinic room which was kept clean and tidy. There was also an examination room off the ward which served all wards across the hospital. This contained items such as an examination couch, fridge, medical paraphernalia, and an electrocardiogram (ECG) machine. There was a non-wipeable pillow with an old blood stain on the examination couch. We made the provider aware of this and they replaced this immediately. The room contained a fridge used to store blood samples from patients, and vaccines belonging to an external occupational health professional. A courier came daily to transport blood samples to a laboratory. This contravened NHS England guidance which states specimens should never be stored alongside vaccines. We asked several staff who had responsibility for this room and were provided with different answers. Managers said equipment and vaccines were owned and overseen by an external occupational health nurse, other staff said it was the responsibility of the doctor or the clinical lead.

At our previous comprehensive inspection of this hospital in 2018, we said the provider must ensure that equipment used to monitor patients' physical health is calibrated and maintained in line with the manufacturer's guidance. We found ongoing issues with calibration during this inspection. Some medical equipment on Byron ward had not been calibrated in January 2023 as required. This included the blood pressure monitor, oximeter and ECG machine. We saw evidence that a manager had been alerted to the overdue calibration, but they accepted they had failed to follow this up. Neglecting calibration meant staff and managers could not be assured results from physical health monitoring tests were accurate. Furthermore, the defibrillator had not been calibrated which meant staff could not be assured they would be able to provide the necessary lifesaving treatment if required. We raised this with the provider during our inspection and they immediately arranged for all equipment to be calibrated.

We also found staff did not complete daily checks of the glucose machines as expected. During a 34-day period (30 March to 2 May 2023), these checks were not completed on 15 days.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. Staff usually checked first aid and resuscitation equipment weekly, although between January and May 2023, staff missed 4 weekly checks. This was not in line with NICE guidance which states providers should maintain and check resuscitation equipment every week. Given the service was administering rapid tranquilisation medicines which have potentially high-risk side effects, it is essential staff are assured resuscitation equipment is in working order.

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. However, patients did not receive dedicated one-to-one time with their named nurse.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Byron Ward admitted up to 20 patients. During the day and night shifts, a minimum of 2 registered nurses and 4 healthcare support workers (HCSW) were assigned to the ward. Rotas showed this was usually met. We reviewed day and night shift rotas across 6 weeks (84 shifts in total). We found 4 shifts where there was only one nurse on duty, but the number of HCSWs were increased.

The ward manager could adjust staffing levels according to the needs of the patients, for example, if additional staff were needed to facilitate leisure trips or the acuity on the ward increased. We saw extra staff were often used. Patients rarely had their escorted leave or activities cancelled. The service had a system in place to book bank and agency staff and staff said they could get extra staff quickly. This system allowed managers to check necessary training was up to date, and prevented agency staff booking shifts if their training had lapsed.

The service had low vacancy rates. The ward manager said they had 1 nurse vacancy, 3 HCSW vacancies, and 1 psychotherapist vacancy.

The service had low rates of bank nurses and bank HCSWs, but the ward still used quite a high number of agency nursing staff to support with extra needs of the ward. Between December 2022 and May 2023, the proportion of shifts where agency staff were used each month fluctuated between 12.7% to 33.1%. There were always several permanent staff on shift at the same time. Managers said they tried to limit their use of bank and agency staff and requested agency staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We were informed the health, safety and security lead provided a security induction which included topics such as alarms, fire procedures and a tour of the ward. New agency staff attended handovers and shadowed an experienced staff member.

The hospital had low turnover rates of nurses, but comparatively high rates of healthcare support worker turnover rates. For example, over a 12-month period the nurse turnover rate was 3.1%, whereas HCSW turnover was 24.7%. Managers attempted to overcome this by interviewing twice a week for these roles. They also recently created a new senior HCSW role with the aim of developing and retaining staff. In general, staff we spoke with said staffing levels were good.

Levels of sickness were low. The average sickness rate for the 12 months prior to our inspection was for Byron Ward was 5.2%.

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

Inadequate

The service had enough staff on each shift to carry out any physical interventions safely. Staff could also request assistance from staff on other wards if an emergency intervention was needed.

Staff shared key information to keep patients safe when handing over their care to others. For example, community mental health teams were invited to meetings before the service discharged patients.

However, despite good staffing levels, patients did not have regular one-to-one sessions with their named nurse. We asked 4 patients if they had these one-to-one sessions and they all told us they did not. Patient care records supported this. This meant patients were not given dedicated time from nursing staff to develop therapeutic relationships and express any individual needs they may have. This was not in line with NICE guidance which states patients should be offered daily one-to-one sessions with a healthcare professional familiar to them. Some of the multidisciplinary team requested nurses provide a more accurate representation of patients' presentations on the ward during ward round handovers. The ward manager had reminded staff to complete one-to-one sessions during 2 group supervision sessions, but improvements were required.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. An on-call duty doctor was available for out of hours cover.

Byron ward had 2 ward doctors and 2 consultant psychiatrists dedicated to it.

Mandatory training

At our previous comprehensive inspection of this hospital in 2018, we said the provider must ensure all staff were up to date with mandatory training. During this inspection we found improvements.

Most staff had completed and kept up to date with their mandatory training. 93.5% of staff had completed their mandatory training courses. However, 2 out of 28 courses fell below the provider's target of 80%. These were appraisals (73.5%) and medication competency for nursing services (77.8%).

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

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had employed a training coordinator who monitored training compliance data and shared these with managers each week. Staff said managers ensured they had time during shifts to complete their training where risk levels allowed, or they were offered overtime to complete training outside their shift.

Assessing and managing risk to patients and staff

Staff did not complete physical health monitoring following rapid tranquilisation in line with the provider's policy and national guidance. Risk assessments and management plans were not always completed thoroughly or updated after incidents. However, the staff team held detailed handovers which enabled them to manage risks to patients. Staff used restraint only after attempts at de-escalation had failed. The ward kept restrictive practices under review although there were concerns about restrictions for visitors to patients. Staff carried out therapeutic observations in line with the providers guidance.

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

Inadequate

Assessment of patient risk

Staff usually completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly. The service had exclusion criteria, which included not accepting people with a high risk of self-harm, significant physical health needs, or drug induced psychosis as a primary diagnosis. Two NHS trusts block booked all the beds on Byron ward which meant staff could view their medical records and liaise with the trust's liaison nurse to discuss risks. Observation levels were agreed based on levels of risk and regularly reviewed.

We reviewed 8 patient care records. Of these, 3 showed delays with risk assessment completion ranging between 5 days and 2 weeks. The service's target was for this to be completed within 72 hours. We also found that some potential risks from the patient's history, such as previous physical aggression, was not making its way into the risk assessments and management plans, which meant staff might not have an awareness of these potential risks.

Management of patient risk

Staff discussed individual risks to patients during multidisciplinary meetings, handover meetings and daily situation report meetings and considered ways to prevent or reduce risks. We observed a handover meeting and saw staff shared information such as physical health needs of patients, their current presentations and medicine needs. They also shared tips on how to work with specific patients in ways they would respond positively to.

However, as outlined above, documentation was not always completed promptly and did not always consider how individual risks would be managed. Furthermore, staff did not always review and update documentation such as risk assessments and management plans after any incident. For example, 2 care records we reviewed noted incidents where staff had been threatened by patients, but neither risk assessment was updated following these incidents.

Staff understood how to complete different levels of therapeutic observations in line with the provider's policy. For example, they knew that intermittent observations, checks which are completed at least 4 times per hour, should be timed in a randomised manner. This was so patients could not predict times of checks, with the aim of reducing the likelihood of harm to themselves or others.

Staff completed risk assessments for patients granted leave from the ward to ensure it was safe to do so.

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

Use of restrictive interventions

Staff did not follow NICE guidance when using rapid tranquilisation (RT) and leaders did not address this. We looked at 4 separate incidents of RT on Byron Ward and found that 3 did not show evidence that any physical health monitoring happened after the medication was administered. The other record showed only 1 set of physical health monitoring had taken place following RT. This was not in accordance with national guidance or the provider's own 'rapid tranquilisation procedure.' The lack of physical health monitoring post RT increased the risk of a person developing adverse side effects and not being appropriately treated. This put people at risk of avoidable harm. Managers monitored the use of RT during monthly clinical governance meetings, although figures were not reliable due to some missed reporting. Between January and March 2023, managers recorded that staff had completed the physical health monitoring after only 3 out of 8 incidents. There was no narrative around this shortfall and no action plan to ensure improvements were made.

Some staff told us different things about visitors being able to come onto the ward or not. For example, one relative who wanted to visit a patient at risk of absconding from the ward was refused their visit. We did not see evidence that staff considered an alternative method, such as staff supervising a visit off the ward, to allow this visit to happen.

Not all managers we spoke with were familiar with the restrictive interventions reduction programme. Furthermore, 2 staff we spoke with said the hospital did not have a reducing restrictive practice lead, which contradicted what senior leaders informed us. Leaders reviewed blanket restrictions on the wards every 6 months in accordance with the provider's expectations. Managers told us they had recognised more oversight of blanket restrictions was required and that ward manager reports on restrictive practices had lapsed. Following the inspection, senior leaders planned to review restrictive practices at monthly clinical governance meetings.

We saw evidence staff reviewed restrictive interventions on the ward. For example, patients complained to staff that they had to ask for tea and coffee because it was kept in the nursing office. The decision was reviewed and removed, which gave patients unrestricted access to making hot drinks in the ward's kitchenette.

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 were trained in the use of restrictive interventions and the training was certified as complying with the Restraint Reduction Network (RRN) Training standards. Levels of restrictive interventions were reported to be quite low. Over a 6-month period, 62 incidents on the ward were categorised as violence and aggression. Of these, 17 resulted in staff restraining patients. However, we found evidence during our inspection that not all instances of restraint were uploaded to the provider's incident recording system, which meant these figures were unreliable.

The security lead reviewed CCTV following incidents where restraint was used to ensure good practice was followed. We reviewed CCTV of one incident that resulted in the eventual restraint of a patient, and saw that staff used de-escalation techniques first.

Safeguarding

Staff generally 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 usually knew how to apply it.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff received training on how to recognise and report abuse, appropriate for their role. Most staff kept up to date with their safeguarding training. 81.8% of staff had completed their mandatory safeguarding training. The hospital had a safeguarding lead, and the ward had a dedicated social worker. The safeguarding lead had delivered additional training for staff to ensure they understood their responsibilities.

Staff could give examples of how to protect patients from harassment and discrimination, for example, by raising safeguarding concerns after observing certain behaviours between patients.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff reported good working relationships with the local authority safeguarding team. Managers discussed safeguarding matters during the daily weekday situation report meetings. The hospital notified the Care Quality Commission of any abuse, or allegations of abuse, in relation to a patient.

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

Inadequate

Staff followed clear procedures to keep children visiting the hospital safe. Children under the age of 18 were not permitted on the ward. Staff assigned rooms away from the ward for visits to take place if risk assessed as safe to do so.

Staff access to essential information

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

Although the service used a combination of electronic and paper records, staff did not report any concerns in relation to accessing information.

Patient notes were comprehensive and usually up to date.

Records were stored securely, either as hardcopies within the nursing office or on the electric patient record.

Senior leaders we spoke with said the hospital planned to introduce a new version of their existing system, resulting in more electronic documents.

Medicines management

The service generally 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, although did not always discuss these with patients.

During our most recent comprehensive inspection of this hospital, we said the provider must ensure that controlled drugs on Byron ward are safely stored, in line with national guidance. They should also ensure that effective systems are in place to monitor stocks of medicines to prevent overstocking. During this inspection we found the provider had made improvements.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 9 medicine charts and found staff completed medicines records accurately and kept them up to date. The charts included any known allergies. An external pharmacist completed weekly reviews and provided feedback to the ward on their findings. Managers discussed the results and improvements during monthly clinical governance meetings.

Staff reviewed each patient's medicines regularly in ward rounds, but most patients we spoke with said staff did not give them advice about their medicines or possible side effects. A doctor we spoke with said they did not complete side effect monitoring forms. They said this was covered by the physical health checks and discussions during MDT ward rounds. We looked at notes following 4 multidisciplinary (MDT) meetings for 1 patient where different medicines were noted. Only 1 of 4 contained evidence that effects of medication were discussed. Three other records of patients prescribed medicines contained no evidence that medicines or side effects were discussed. This meant patients were not always able to discuss the balance of risks and benefits to treatment choices with clinical staff.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in alphabetised storage boxes, but we found medicines that did not match their labelled boxes. For example, we found Ibuprofen in the U – W storage box, and Salbutamol in the H storage box. This meant staff might be delayed in finding medicines required by patients.

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

Inadequate

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The ward's external pharmacist was also involved in these reviews.

Staff learned from safety alerts and incidents to improve practice. Staff recorded medicines errors on the provider's incident management system, and these were discussed during the daily situation report meeting and clinical governance meetings.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. All medicine charts we looked at showed prescribed drugs were within the recommended doses. Oral medication was offered before staff administered intramuscular rapid tranquilisation.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Patients were offered regular physical health checks.

Track record on safety

The service had a good track record on safety. No serious incidents were reported for the 3 months prior to our inspection.

Reporting incidents and learning from when things go wrong

Staff did not always recognise incidents or report them appropriately. Managers investigated incidents, but there were sometimes delays with reviewing them. However, the service managed patient safety incidents well. Managers shared lessons learned with some staff. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not always raise concerns and report incidents and near misses in line with the provider's policy. For example, 2 out of the 4 instances of rapid tranquilisation we reviewed had not been uploaded to the provider's reporting system. This was not in line with the provider's own restraint and violence reduction policy or the Mental Health Unit (Use of Force) Act 2018 which both state that any form of restraint should be recorded on the provider's electronic reporting system. The ward manager repeatedly reminded staff to record incidents, restraints or injuries but the issue remained ongoing. Furthermore, some recorded incidents of restraint did not contain sufficient detail on the system or patient care records. For example, two incidents did not contain a detailed description after a prone restraint was noted to have taken place. Two incidents did not include the names of staff involved in the restraints. The Mental Health Unit (Use of Force) Act 2018 states records should contain details including the name and job title of any member of staff who used force on the patient and a description of how force was used. Taken together, this indicated staff did not always know what incidents to report and how to report them. It also meant managers could not be assured they were sufficiently monitoring the use of restraint or reporting on accurate data.

However, managers discussed incidents during the daily situation report meeting and staff raised incidents during handover meetings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, the service had apologised to a family member following poor communication and explained how they planned to make improvements. Staff offered a debriefing for patients involved in incidents.

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

Inadequate

Managers debriefed and supported staff after any serious incident. The new head of psychology planned to introduce reflective practice sessions for staff in the future.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers were notified each time an incident was recorded on the system. However, we found some delays with ward managers reviewing and approving incidents. For example, 6 incidents which concerned 1 patient between 26 April 2023 and 25 May 2023 had not been reviewed. The ward manager admitted it was hard to keep on top of incident reviews due to the volume of them. At the time of our inspection, we saw 6 incidents were "in progress," 34 were "being reviewed," and 8 were "awaiting review". This contravened the provider's policy which stated managers should aim to review and manage incidents daily and approve and close incidents within 5 working days. Such delays could result in delays to sharing lessons learnt and improved practices with staff, and in reporting incidents to internal and external teams.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, following an incident where a taxi took a patient from another ward to the wrong address, staff were reminded to speak to reception before patients boarded taxis.

Staff met to discuss the feedback and look at improvements to patient care, although at the time of our inspection, there was no team meeting for all ward staff in place. We saw managers spoke to some staff about improvements to patient care during brief meetings following handovers. The ward manager also emailed staff an update on Fridays. We were told team meeting minutes were stored on the shared drive for staff who were not present to access. However, we viewed the ward's shared drive and the meeting minutes had not been uploaded to it. Two staff members we spoke with said lessons were only shared if staff attended handovers from the shift before.

There was evidence that changes had been made as a result of feedback. For example, during our inspection we found staff had tried to use a patient's debit card to buy them cigarettes. The patient consented to this because they did not have Section 17 leave (permission to leave the hospital) from the ward. The patient and staff had signed a proforma about this. Staff confirmed the PIN was not disclosed or shared. Staff had tried to use the contactless method, but this did not work so no purchases were made. The provider's policy stated PIN numbers are not to be disclosed but did not mention contactless payments. It also stated staff needed to send a letter to the Head Office if patients wanted staff to assist them in managing their finances. We did not see evidence of this letter, or that there was a care plan/financial support plan in place for the patient. We informed senior leaders of our concerns during our inspection. They did not appear aware of the proforma but promptly investigated the matter and raised a safeguarding alert with the local authority. The local authority closed the safeguarding based on the actions the provider had taken since, but warned the provider it was not good practice for staff to use patients' bank cards. The actions leaders took included ending the agreement immediately and planning to review their local procedure for managing patient finances.

Is the service effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

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

Inadequate

Staff assessed the physical and mental health of all patients on admission. They usually developed individual personalised care plans for some patients and reviewed these regularly through multidisciplinary discussions. However, not all patients had care plans, and of the patients who did have care plans, these were not always recovery-orientated.

We reviewed 8 patient care records.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Where patients had care plans, these were regularly reviewed and updated when patients' needs changed. Care plans we saw were reviewed every 2 weeks following multidisciplinary ward round meetings. The ward manager said these should be reviewed weekly, more often if the person was involved with an incident. Care plan and risk assessment compliance data was sent to the ward manager weekly.

However, of the 8 records we looked at, only 5 had care plans. Of the 3 patients that did not have care plans, 2 patients had been on the ward longer than the 72-hour target for completing these. Their records contained presenting issues and risk management plans, for example observation levels and medication.

Of the records that did have care plans, they were personalised. Most care plans identified each patient's mental and physical health needs but were not always recovery orientated. Care plans did not always detail how patients' needs would be addressed. Two care plans referenced the patients attending the hospital dining room for mealtimes when ready, but there were no plans around how to achieve this. During our inspection we saw that most patients ate their meals in their bedrooms. Managers were aware that quality of care plans needed improvement. The service had allocated a staff member to monitor the systems from late 2022. The ward doctor and a manager had delivered training to staff in an effort to improve the quality of care records.

Best practice in treatment and care

Staff did not use recognised rating scales to assess and record severity and outcomes, and results from audits were not always used to make improvements. Staff did not always provide a range of treatment and care for patients based on national guidance and best practice, and some patients felt dissatisfied with the activities. However, staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. They also participated in benchmarking and quality improvement initiatives.

Managers did not always use results from audits to make improvements. For example, a Mental Health Act audit from April 2023 identified shortfalls, but there was no narrative to explain these shortfalls and no action plan with how the service planned to improve.

Byron ward staff did not use recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. This was confirmed by 2 medical staff. This meant staff could not measure how effective treatment was for a patient, and that patients may not recognise their own improvements.

Staff provided a range of care and treatment suitable for the patients in the service, although therapy options were limited. Patients were admitted to Byron ward for treatment of an acute episode of mental illness such as psychosis,

schizophrenia, and bi-polar disorder. Treatment involved taking medicines and engaging in activities. The ward did not have a dedicated psychologist or occupational therapist, but staff could make referrals if required. A bank psychotherapist attended the ward twice a week and offered group sessions on dealing with emotions and mind relaxation. The ward's previous psychotherapist had recently left so there was a vacancy for this post.

Staff sometimes delivered care in line with best practice and national guidance from relevant bodies such as the National Institute for Health and Care Excellence (NICE). For example, patients had regular contact with the MDT, and staff gave patients the opportunity to provide feedback. However, patients did not have daily one-to-one sessions with their named nurse, and most patients we spoke with did not feel involved in their care plan or receive a copy.

The ward had a full-time activities coordinator and staff were often allocated to facilitate activities over the weekend. Patients who had section 17 leave from the ward were able to attend community leisure activities and access the occupational therapy room based off the ward. We saw evidence that some patients took part in activities over the weekend. The ward had a gym, a TV lounge, and a garden which patients without leave could use. However, some patients we spoke with told us they felt bored and/or there were no activities. One patient told us he did nothing during his first 3 weeks on the ward and "begged" staff for 30 minutes of an activity. Patient care records did not record meaningful activities within the activities tab, so it was unclear what activities patients engaged with. Managers said activities were happening, but that staff had not recorded them correctly which meant data was not captured. Managers provided training but our findings suggested the learning still required embedding.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. For example, a patient at risk of choking had a comprehensive care plan completed by a speech and language therapist from the local acute hospital. A fitness instructor visited the ward each week.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. For example, the patient at risk of choking had a soft food diet.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. We saw examples of staff encouraging physical activity and offering nicotine replacement therapy. However, patients used the ward's garden to smoke. We were told this had happened during the COVID-19 pandemic. This was not in line with national guidance that states mental health services should be smoke free. The ward planned to reintroduce e-cigarettes and regular smoking awareness groups.

Staff used technology to support patients. For example, facilitating video calls and meetings from the ward laptop.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. A recent quality improvement project looked at whether meaningful activity attendance increased if patients were involved in choosing them. Since becoming a male ward, staff found patients were more interested in attending physical activities. As a result, the hospital had purchased a pool table and table tennis. Patients with section 17 leave from the ward could join group trips to the swimming pool, local park and leisure centre.

Skilled staff to deliver care

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

Inadequate

Nursing staff, support workers and bank staff did not all receive regular, high-quality supervision. Staff were not invited to attend regular team meetings. However, the ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Staff were not always supported through regular constructive clinical supervision or appraisals of their work. At the time of our inspection, only 73% of ward staff and 25% of bank staff were up to date with their supervision and appraisals. 100% of ward managers, senior leaders, and staff from the occupational therapy, psychology and social work departments had completed their supervision. It was the nursing, HCSW and bank staff where supervision levels needed to improve.

Managers informed us there had been issues with the system that recorded supervision and had reported this to the provider. However, 6 staff we spoke with said they either had not had supervision, were overdue supervision, or had only had informal conversations. At our previous comprehensive inspection of this hospital, we said the provider must ensure that staff received regular supervision. Managers had attempted to make improvements, for example, by introducing a supervision structure detailing staff responsibilities and by monitoring compliance during meetings. Quality and topics discussed during individual supervision covered a range of topics and actions from previous supervisions were reviewed. We also reviewed 9 group supervision records; 6 completed during day shifts and 3 from night shifts. These usually happened monthly, but only staff on shift that day could attend. We found the quality of group supervision needed to be improved. Many conversations seemed more suitable to managerial supervision. For example, staff discussed breaks, staff toilets, upcoming training, and maintenance issues. We did not see any discussions around specific patient case studies and reflections on how clinical practice could be improved. Safeguarding matters were not discussed. Actions and outcomes for 4 out of 6 group supervision records was for staff to ensure they returned promptly from breaks to relieve other staff. However, we did see reminders to staff about the importance of meaningful one-to-one sessions with patients, some lessons learnt were shared, and managers outlined expectations around staff conduct.

We found that managers did not make sure all staff attended regular team meetings. Most staff we spoke with said they did not have team meetings. Two staff said communication needed to be improved. The ward manager usually sent weekly email updates to staff. Over a 4-month period, 3 brief meetings with staff happened after morning handover and minutes were taken for those who could not attend. However, these meetings did not follow a set agenda and only staff present at the morning handovers could attend. Furthermore, the meeting minutes had not been uploaded onto the ward's shared drive for staff who were not present to review. This meant staff who could not attend would not be able to get important and up to date information about the running of the ward. Staff informed the ward manager they would benefit from team meetings. In response, we saw evidence that all ward staff had been invited to a team meeting shortly after our inspection.

The service had access to a full range of specialists to meet the needs of the patients on the ward, with the exception of a psychotherapist who recently left. It had dedicated nurses, HCSWs, doctors, psychiatrists, an activities coordinator, and a social worker. It did not have a dedicated psychologist or occupational therapist, but staff could make referrals to these departments if required.

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. The hospital employed a training coordinator who informed staff when training was due to lapse. The system used to book bank and agency staff blocked individuals from booking shifts if their training had lapsed.

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

Inadequate

Managers gave each new member of staff a full induction to the service before they started work. This included information about security, fire, and medical matters, such as where emergency equipment was located. Two members of staff we spoke with said the induction could be more structured. They said after the initial information was given, they shadowed more experienced staff, but this meant they were not exposed to all parts of the role. Staff had fed this back to the ward manager and at the time of inspection, the service was in the process of creating a more formalised induction for all staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, medical staff planned to deliver training to staff to improve quality of documentation on patient care records. In addition, regular unannounced emergency simulation scenarios were carried out by the managers. A recent scenario was cardiac arrest and managers assessed how staff responded. Reports which detailed shortfalls and actions were developed to reduce chances of errors happening if a real emergency incident occurred.

Managers made sure staff received any specialist training for their role. In addition to the mandatory training, hospital staff delivered training on specific topics. For example, side effects of medicines, and positive communication with patients.

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

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. However, care records were not always updated to reflect patients' changing needs.

Staff held regular multidisciplinary meetings to discuss patients and improve their care, but patient records were not always updated. The ward's 2 consultant psychiatrists each completed one ward round a week and all patients had the opportunity to attend. We attended a ward round for one patient and saw that staff worked together to discuss their individual needs and actions required. Notes from ward rounds were comprehensive and reflected on patient care records. However, ward round discussions did not follow a structured agenda which meant conversations were not consistent across patients, and that updates from all professionals involved in the patient's care were not always included. We also found evidence that risk assessments and care plans were not always aligned. For example, a risk assessment for a patient completed on admission showed risks of sexually inappropriate behaviour. During a multidisciplinary team (MDT) meeting two days later, risks of high vulnerability and drug use were also identified. The patient's risk assessment was not updated after this MDT meeting and the patient did not have a care plan.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Nursing staff held handover meetings twice a day before each shift change. We attended a handover and observed a nurse explain the individual needs of the patients to staff. The handover covered all patients, their current presentation, and any risks.

Ward teams had effective working relationships with other teams in the organisation. Managers from different wards, senior leaders, and other heads of departments such as security and maintenance met daily to share risks and information.

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

Inadequate

Ward teams had effective working relationships with external teams and organisations. Records showed information from ward rounds was often shared with care coordinators and bed managers. A liaison nurse from one of the commissioning NHS trusts worked on Byron ward 2 days a week. They attended weekly ward rounds, ensured admissions were appropriate and supported with discharges from the ward. Staff reported a positive relationship and improved efficiency at sharing information.

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 usually discharged these well. Managers made sure that staff could explain patients' rights to them. However, where shortfalls were identified during audits, actions plans to address issues were not always created.

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. The completion rate for Mental Health Act Awareness training was 97.4%.

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. Mental Health Act administrators provided drop-in sessions for staff. Staff could access out of hours advice if required. The service planned to introduce a weekly slot during situation report meetings so Mental Health Act related matters could be routinely discussed.

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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The advocate we spoke with was positive about the service, and patients knew to access them if 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 notes each time.

Staff made sure patients could take section 17 leave when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff said leave was rarely cancelled because staffing was adjusted to facilitate this.

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

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Due to the higher turnover of patients on Byron Ward compared to the other wards within the hospital, detention papers were stored in the nursing office for ease of access. Mental Health Act administrators planned to attend the situation report meetings once a week to inform managers of upcoming detention expiry dates and to ensure treatment was delivered under the correct authority.

Informal patients knew that they could leave the ward freely and the service displayed posters 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.

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

Inadequate

The audit process and oversight required improvements so managers and staff could make sure the service applied the Mental Health Act correctly and discuss the findings. For example, the Mental Health Act audit for April 2023 identified some shortfalls, but there was no narrative to explain the shortfall and no action plan to explain how the service planned to improve.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the 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 at least the five principles. The completion rate for Mental Capacity Act and Deprivation of Liberty Safeguards training was 97.4%.

Staff had not made any deprivations of liberty safeguards applications made in the most recent 12 months.

There was a policy on Mental Capacity Act and deprivation of liberty safeguards in place.

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Patients received a comprehensive assessment of their mental capacity on admission. We saw evidence this was reviewed during MDT meetings.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Managers completed Mental Capacity Act audits every 3 months. The most recent audit, completed in June 2023, achieved 100% compliance.

Is the service caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity and understood the individual needs of patients. However, staff did not always support patients to understand and manage their care, treatment or condition. Staff did not communicate consistently with the patients which caused them to be distressed.

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

Inadequate

We spoke with 7 patients during our inspection. Most patients we spoke with said staff were respectful and responsive when caring for patients. Most patients said staff treated them well and behaved kindly. However, 2 patients we spoke with said they had complained to staff about noise levels on the ward, but no response or improvement came from this. One patient said the noise from music on another ward hindered his recovery.

Staff directed patients to other services and supported them to access those services if they needed help. One patient had been supported to attend the dentist on one day of our inspection.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff were aware of the provider's whistleblowing procedures.

Staff understood and respected the individual needs of each patient. During a handover meeting, we observed staff sharing examples of effective methods to provide good care to individual patients while managing their risks.

Staff followed policy to keep patient information confidential. Patient information was stored securely within the nursing office. Carers we spoke with said staff did not share information about their family member's care if they had not consented to this.

However, staff did not always support patients to understand and manage their own care treatment or condition. Some patients we spoke with said staff had not explained their treatment, medication, or any possible side effects to them. Four patients said they did not receive one-to-one time with their named nurse. This was not in line with NICE guidance which states patients should be offered daily one-to-one sessions with a healthcare professional familiar to them. The NHS liaison nurse said they had raised this as a concern with ward staff. Managers had raised the matter with staff, but improvements were still required.

Some patients did not feel staff were always visible on the ward. Two patients and 2 staff members we spoke with said staff often stood behind the nursing office glass rather than on the ward. One patient said this felt like, "them and us."

Some patients and staff felt miscommunication had negative impacts on care. For example, one patient showed us conflicting information displayed on the ward about where patients could use e-cigarettes. The community meeting minutes also contained conflicting information. Two members of staff we spoke with said miscommunication had caused issues on the ward, and improved communication would result in better care for patients. During our inspection we observed staff tell patients the garden they used for smoking was temporarily closed due to a damaged door. However, another staff member let some other patients into the garden to smoke. When another patient was told they could not go into the garden this caused them to become distressed and shout at a staff member.

Involvement in care

Staff actively sought patients' feedback on the quality of care provided. They ensured that patients had easy access to independent advocates. However, staff did not always involve patients in care planning.

Involvement of patients

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

Staff could access interpreters and translators where necessary to ensure patients understood their care and treatment. However, the service did not have access to information leaflets in languages other than English.

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

Inadequate

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. The ward held optional weekly community meetings. In one meeting, patients raised concerns about having to obtain tea, coffee and milk from the ward's reception rather than the kitchenette. During our inspection we found these items had been replaced for patients to access any time from the ward's kitchenette.

Other ways for patients to provide feedback had recently improved. All patients were able to complete a discharge questionnaire. A new initiative had started where the results of these questionnaires were collated, and an action plan created. Patients were invited to a presentation of these results where they were provided lunch and the opportunity to raise additional actions. Managers planned to do this every 3 months for patients on Byron ward. One example of a change made as a result of patient feedback was giving patients the opportunity to meet with the hospital's chef after they said the food could be improved. During our inspection, patients told us they liked the food.

Staff made sure patients could access advocacy services. The advocate was available to meet with in person or speak with via phone or email.

However, staff did not always involve patients or give them access to their care planning and risk assessments. Four patients we spoke with said they did not feel involved in their care and/or had no knowledge of their care plan. Three of the care plans we reviewed did not include patient views. We saw no evidence that patients received copies of their care plans. One member of staff we spoke with confirmed there was no process to provide patients with their care plan.

Involvement of families and carers

Staff involved families and carers appropriately. Managers recognised improvements were needed to enable carers to provide feedback.

We spoke with 5 carers. One of these carer's relatives had recently been discharged from Byron Ward. In general, carers spoke positively about the staff on Byron Ward. Carers used words such as patient, kind and helpful to describe staff.

Staff supported, informed and involved families or carers. Care records showed families were involved if the patient gave consent.

Managers recognised improvements were needed to involve carers more and enable them to give feedback on the service. They said carers meetings had stopped due to Covid and staff changes. Three carers we spoke with said they were not able to give feedback on the service or would not know how to. Leaders planned to restart the carers forum and had set up a dedicated carers email inbox. An in-person carers meeting was planned for August 2023.

Some carers we spoke with said staff did not give them information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

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

Inadequate

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. However, improvements were needed so management had oversight of delayed discharges.

Bed management

During our inspection, the ward's bed occupancy fluctuated between 80% and 95%. Managers had recently rejected some referrals because the referred individuals' acuity was too high for the ward.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The service worked closely with commissioning trust staff regarding admissions to the service. Due to these block bookings from relatively local trusts, the service had low out-of-area placements at the time of our inspection.

Managers and staff worked to make sure they did not discharge patients before they were ready. For example, one patient's discharge was delayed because they had accommodation issues in the community. When patients went on leave there was always a bed available when they returned.

Staff did not move or discharge patients at night or very early in the morning. All discharges were planned in advance in partnership with trust staff.

The psychiatric intensive care unit (PICU) always had a bed available if a patient needed more intensive care. One staff member we spoke with said it was easier to find a PICU bed for male patients than it had been when there were females on the ward.

Discharge and transfers of care

Staff said discharge plans commenced as soon as a patient was admitted, and most records we reviewed supported this.

Staff usually carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff met weekly with staff from the 2 commissioning trusts to discuss each patient and any issues. The ward held weekly MDT meetings which were also used to plan patient discharges. Staff we spoke with said some considerations prior to discharge included referrals to community mental health teams and to ensure patients had a place to live.

Patients did not have to stay in hospital when they were well enough to leave. Due to clinical reasons, one patient had been on the ward for about 5 months (153 days) which was significantly longer than the other patients. However, due to a recent improvement in their presentation staff had arranged a discharge discussion for later that day. The average length of stay of all other patients on the ward at the time of inspection was 29 days.

Staff supported patients when they were referred or transferred between services. This included patients who needed to attend the local hospital for physical health concerns.

However, we did not see evidence that managers monitored the number of patients whose discharge was delayed. None of the meeting minutes we reviewed or attended, for example, the daily situation report, clinical governance or head of department meetings, contained agenda items regarding delayed discharges. This meant hospital managers did not routinely discuss or have oversight of delayed discharges and possible solutions.

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. Patients could make hot drinks and snacks at any time. However, the ward did not have a dining room and most patients ate meals in their bedrooms.

Each patient had their own bedroom and had a secure place to store personal possessions. There was also a safe in the nursing office.

The service had quiet areas and a room where patients could meet with visitors in private. Visits took place off the ward. Two patients we spoke with said noise from other wards had caused them distress. They informed staff but the situation had not improved. During our inspection, we heard loud music coming from another ward.

Patients had access to their personal mobile phones in accordance with their risk assessments. The ward also had a phone available for patients to use.

The service had an outside space that patients could access easily when supervised by staff. At the time of our inspection, 1 of the 2 outdoor areas was closed to patients due to a broken fence. Staff said this had been reported and was due to be fixed.

Patients could make their own hot drinks and snacks and were not dependent on staff. The service offered a variety of good quality food.

Staff used a full range of rooms and equipment to support treatment and care. For example, clinic rooms, treatment rooms, a multifaith room, gym facilities, and outdoor areas.

However, the ward did not have a dining room. During our inspection we observed 2 lunch time shifts. Meals were delivered pre-plated and handed to patients from the nursing office. We found that most patients ate alone in their bedrooms. Over 50% of patients on the ward had been granted escorted or unescorted leave from the ward. Most patients we spoke with felt fine about eating in their bedrooms. One patient said it was "less than desirable" and led to social isolation. Three patients said the food was sometimes cold and there was no way to reheat it. Senior managers told us they encouraged patients to eat in the dining room and internet café based off the ward.

Patients' engagement with the wider community

Improvements around visits to patients was required as there was a lack of clarity about the arrangements. However, staff supported patients with activities outside the service, such as leisure activities and family relationships.

Improvements around visitor information was required to help patients to stay in contact with families and carers. Staff did not always adhere to the provider's visitor protocol which stated that, although visits off the ward were preferable,

visits onto the ward are possible with the approval of the MDT. The ward's blanket rules audits from December 2022 and June 2023 both contained staff or patient views (not specified on audit) that stated, "visitors are not allowed in the ward" and that visits took place in designated rooms outside the ward. One carer we spoke with said they were not allowed onto the ward for visits. The most recent audit stated visits should be supervised if patients are high risk to themselves, others, or absconding risks. During our inspection we heard a staff member tell a carer over the phone they could not visit their relative on the ward because they were at risk of absconding from the ward. We did not see any evidence they tried to facilitate this visit by using staff to supervise.

Staff did not seem clear on rules around visits onto the ward and told us different things. For example, a senior leader said visits onto the ward could be facilitated if required and risk assessed. The ward manager said if patients did not have leave from the ward it was harder to facilitate visits. A clinical team leader said visitors had not been allowed on the ward since the COVID-19 pandemic and the ward had not returned to pre-COVID-19 visiting arrangements. This confusion among staff could result in other patients at risk of absconding or without leave from the ward being prevented from having visits from people important to them.

Furthermore, carers were not always informed about visiting rules. For example, 2 carers we spoke with said they had not been told about visiting times. One carer said they attended the hospital 4 times and only saw their relative once. Another carer said they waited outside the hospital for up to 20 minutes every day for 2 weeks due to a lack of staff on the main reception desk. This reduced the length of time they could spend with their relative.

However, staff encouraged some patients to develop and maintain relationships both in the service and the wider community. Patients with leave from the ward had been on group trips in the community. For example, during weekdays the activity coordinator arranged sessions at the local swimming pool and recreation ground. Some patients had been on a trip to the cinema. We did not see any evidence of staff making sure patients had access to opportunities for education and work.

Patients had access to the ward phone if required. Some staff, carers and patients reported very poor mobile phone signal on the ward.

Meeting the needs of all people who use the service

The service met the needs of most patients – including those with a protected characteristic. Staff helped patients with advocacy and cultural and spiritual support. However, information leaflets were only available in the English language and some patients did not have access to toiletries.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Some patients' care records detailed equality and diversity needs discussed by the multidisciplinary team and on admission to the service.

Staff made sure patients could access information on treatment, local service, and their rights. Information displayed on walls around the ward included mutual expectations, the activities timetable, contact details for solicitors and the advocate, and information on Dialectical Behaviour Therapy (DBT). There was no information about how patients could make a complaint. Community meeting minutes from 10 May 2023 stated that 'service users can request the ward reception for information on the process'.

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. For example, kitchen staff adjusted catering for patients observing Ramadan.

Patients had access to spiritual, religious and cultural support. The room previously used as a female patient lounge was being turned into a multi-faith room following feedback from the patients. At the time of our inspection the room was bare. Staff told us a range of religious literature and prayer mats had been purchased and would be in the room the following week. Religious leaders in the community visit at patients' requests.

However, the service did not have access to information leaflets available in languages other than English. This could prevent patients who may not speak fluent English from fully understanding their treatment and the support available to them.

Patients did not always have access to personal hygiene products. For example, one patient told us they had no access to toothpaste or shower gel for 4 days. Another patient said they borrowed deodorant and toiletries from others. One carer we spoke with said they sent their family member parcels which contained toiletries. Managers told us staff had pre-paid bank cards provided by the hospital to make purchases for the ward.

Listening to and learning from concerns and complaints

The service did not treat all concerns and complaints seriously. When complaints were investigated, lessons were not always shared with the team.

Most patients, relatives and carers we spoke with did not know how to complain or raise concerns. The service did not clearly display information about how to raise a concern in patient areas. The provider's website detailed this information, but our evidence suggested patients and carers were not aware of this. This was not in line with the provider's complaints policy which stated all patients, and those acting on a patient's behalf, should understand their rights regarding complaints.

Over a 12-month period, Byron ward received 7 formal complaints from patients and carers. One was withdrawn, 2 were partially upheld, and 4 were not upheld. These were all categorised as being complaints about therapeutic interventions or communication/information.

Two patients we spoke with said they had complained to staff about noise levels on the ward, but said no response or improvements came from this. One of these patients said the noise from music on another ward hindered his recovery. Where a patient had complained, we saw they did not always receive written responses or resolutions to their concerns. We saw 6 emails from this patient to hospital managers over a 1-month period complaining about noise from another ward. Aside from one offer to change the patient's bedroom over a month after their first email, we did not see evidence to suggest the issue was addressed in a different way or responded to in writing. This was not in line with the provider's policy which stated the service must pursue all complaints or expressions of dissatisfaction with lessons learnt, changes made, and an apology given if necessary. The same patient raised the loud music and lack of improvements during their MDT meetings, but the there was no evidence an action plan was made about how staff planned to improve this. This indicated some staff did not understand the policy on complaints and did now know how to handle them. Furthermore, it did not suggest staff always protected patients who raised concerns or complaints from discrimination or harassment.

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

Inadequate

Managers shared feedback from complaints with staff, however not all staff received this information. For example, during a team meeting attended by 12 staff following a handover, the manager informed staff that 2 complaints had been received regarding confidentiality of information. However, these meeting minutes were not added to the shared drive. This meant most staff were not informed which could prevent wider learning to improve the service.

However, the hospital had a formal complaints log which suggested some staff knew how to acknowledge complaints, and that some patients received feedback from managers after the investigation into their complaint. For example, 3 of the formal complaints were from patients and final feedback letters were sent. However, as mentioned above, complaints were not always acknowledged.

Managers investigated complaints and identified themes. For example, staff reviewed feedback from discharge surveys and found some patients raised concerns about staff communication. In response, managers planned to arrange training for staff on how to interact with patients. Topics to be covered included active and reflective listening skills.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were included within group supervision and as a standard agenda item at the clinical governance meetings.

Is the service well-led?

Inadequate

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed but were not always visible in the service and approachable for patients and staff.

Managers and senior leaders were experienced at working for the provider.

All staff we spoke with said the ward manager was approachable, kind and supportive. Care records showed the ward manager had attended some patient's MDT meetings. Most staff appreciated the manager's weekly email update, but most staff said they wanted team meetings too. The ward manager's office was based off the ward and some staff said they were not always visible on the ward. Similarly, some staff we spoke with felt supported by senior leaders but said they did not visit the ward often. Medical staff felt supported by the medical director. One patient we spoke with said there was no oversight from senior managers and did not know who the ward manager was. Another patient said senior leaders and the ward manager needed to improve their visibility.

Leaders encouraged staff to develop professionally.

Vision and strategy

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

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

Inadequate

Staff we spoke with were familiar with the provider's values of care, respect, empower, trust and integrity. We saw these were incorporated into appraisals, individual supervision records, and policies. One member of staff we spoke with said values were also discussed during meetings. Most staff we spoke with felt proud to work on the ward.

Overall, we observed staff acting in a manner towards patients akin to these values. However, improvements were needed to empower patients to eat together in the hospital dining room, and to ensure all patients were allowed visitors where risk allowed.

Culture

Staff felt respected, supported and valued. They said the provider offered opportunities for development and career progression. They could raise any concerns without fear.

Staff we spoke with were generally positive about their roles, the morale, and the support they received.

Some staff gave examples of how the provider supported their professional development. Two members of staff in management roles told us they started in nurse and HCSW roles. The provider had recently created senior HCSW roles across all wards to retain staff and aid development.

Staff felt comfortable approaching managers to report any concerns and we saw evidence managers acted on these. For example, during a team meeting staff raised concerns about the lack of consistency and structure with the shadowing element of the induction process. This was escalated by managers, and, at the time of our inspection, the HR team had started to create a new standardised approach for all wards.

The provider had introduced ways to boost morale such as providing free staff lunches, staff awards, and additional annual leave. The hospital also provided an employee assistance programme for staff and their family members to obtain free support including bereavement, counselling or legal advice. The ward manager recognised staff achievements in their weekly update email.

Governance

Our inspection findings above demonstrate that while the hospital had governance systems and processes in place, these did not always operate effectively. We identified that areas of practice were not being closely assessed and monitored which affected the quality of care delivered.

Whilst systems were in place for staff to report incidents, we found that several incidents had not been reported in practice. When incidents were reported, managers were sometimes delayed with reviewing them. This meant that the hospital management team could not monitor the incidents to ensure appropriate action was always taken and to ensure patients always received safe care and treatment. It also meant it impacted on the ability to quickly share learning and identify where improvements to the service were required. The systems had not identified that the monitoring of patients after they had received rapid tranquilisation had potentially not taken place. Governance arrangements had not ensured that all previous breaches from our 2018 inspection had been improved upon. For example, we found that some equipment was still not appropriately checked and verified as safe to use on patients. The provider had introduced new systems to monitor supervision, but we found the quality of group supervision and overall supervision compliance rates still needed to improve. At the time of our inspection not all staff were able to attend team meetings, and processes to share meeting minutes with staff unable to attend these meetings were not robust. Learning from audits were not always being followed through to ensure that improvements were made. Hospital managers told

us they encouraged patients to eat off the ward, but we found that patients eating meals within their bedrooms was a daily occurrence. Managers did not have assurances food served to patients was at the correct temperatures and did not ensure staff followed policy on this. A number of other issues identified highlighted in the inspection of the ward highlighted the lack of robust governance.

Management of risk, issues and performance

Despite managers attending meetings to discuss risk and the ward having access to a risk register, leaders did not always manage risk, issues or performance well.

We identified a number of issues with risk management during our inspection which are referenced within this report. For example, poor risk management around ensuring patient safety following rapid tranquilisation, failing to ensure all instances of restraint were reported or contained sufficient details if they were reported, and failing to ensure all medical and emergency equipment was checked as per the manufacturer's guidance to ensure they were safe to use.

The ward had recently added the risks associated with patients going AWOL over the perimeter fence and this had been addressed. It was noted that very limited use was made of the risk register.

Information management

Staff collected and analysed data about performance, although data was not always reliable.

The service used systems to collect data from teams and had created roles, such as a training coordinator, to help oversee different areas of performance data.

Leaders met regularly to discuss data. For example, during clinical governance meetings they reviewed data including the number and type of incidents, instances of rapid tranquilisation and restraints, medicines management and supervision. However, as outlined above, not all incidents were appropriately recorded and leaders said the supervision system was ineffective, which meant senior leaders could not be assured all data was reliable.

Staff made notifications to external bodies as needed. The service submitted statutory notifications to CQC when required.

Engagement

Managers actively engaged 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.

The ward had become more integrated with local health and social care systems through its relationships with the two NHS trusts who block booked their beds. This meant ward staff were involved in weekly bed management meetings, could share information with greater ease, and worked closely to plan timely discharges. One of the trusts had a liaison nurse based on Byron Ward 2 days a week. They attended ward rounds, reviewed patient care records, and completed audits.

Learning, continuous improvement and innovation

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

Inadequate

At the time of the inspection no research or quality improvement programmes were taking place on Byron ward. The most recent quality improvement programme was conducted by the therapy services manager in 2022. This was about meaningful activity for patients on the ward, which included a wide range of activities including daily living skills, activities on and off the ward, clinical sessions, and physical healthcare. They found a higher rate of attendance to activities on the ward where patients had been involved in choosing the activities. However, despite these findings and informing staff the most useful element to improve engagement had been the daily planning meetings (discussions of activities for the day and feedback on past activities), these did not appear to be happening at the time of our inspection. We reviewed an activity timetable in the ward's activity folder and there was no evidence planning meetings had continued. As outlined in sections above, records did not reflect if regular activities happened, and some patients told us they felt bored on the ward.

The hospital director advised that Byron ward was in the early stages of re-introducing Safewards, having previously piloted the initiative. The aim of Safewards is to reduce the chances of conflict between staff and patients that lead to restrictive interventions on inpatient wards.

Inadequate

Wards for people with learning disabilities or autism

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

Is the service safe?

Inadequate

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

Safe and clean care environments

The ward where people were receiving care and treatment was not clean and poorly maintained. The fire alarm was ringing frequently in error which meant that people would be distressed by the noise and potentially not follow evacuation procedures.

Safety of the ward layout

Springs Centre is a locked ward located on the first floor of the hospital. People were cared for in a ward where staff had completed risk assessments of the environment and removed or reduced any identified risks. We reviewed the environmental risk assessments for the ward which included an assessment for blind spots and ligature points. Most environmental risks were managed by the use of convex mirrors, closed circuit television (CCTV) and regular eyesight observations.

Whilst the hospital ensured they carried out routine fire checks and fire drills, people and staff experienced frequent false alarms which had led to some people becoming accustomed to the alarm and not evacuating when required. During our inspection, we observed the fire alarm go off twice in one day. We identified on Springs Centre that two people refused to evacuate the building. One patient told us that they refused to leave the building because they had become frustrated with the frequency of alarms. The hospital manager told us that the fire alarm sometimes went off because of the steam from a shower. The fire alarm issue had been reported to the hospital maintenance team. The frequency of false alarms increased the risk of people not responding and evacuating the building in the event of a real fire.

People had easy access to nurse call systems and staff had easy access to alarms. A call bell was available in each bedroom and in various places across the ward. All staff were given personal alarms to wear in the event they needed to raise the alarm. Each ward alarm system was linked together, and an alert was sent to all wards when an alarm had been raised.

Maintenance, cleanliness and infection control

Inadequate

Wards for people with learning disabilities or autism

Springs Centre was not upholding basic infection control principles. Generally, the ward was not clean and well maintained. The environment of the ward was visibly dirty, and the décor was tired. We identified paint peeling off of the walls and overflowing rubbish bins. Although the hospital cleaners attended the ward twice weekly, the general cleanliness of the ward was poor. People were encouraged to clean their own bedrooms on the weekend.

Clinic room and equipment

At our previous inspection in 2018, we told the provider that they must ensure that equipment used to monitor patients' physical health is calibrated and maintained in line with the manufacturer's guidance. During our recent inspection in May and June 2023 we found that this had improved, and the ward was compliant. The ward had a fully equipped clinic room, which was clean, well-organised and with handwashing facilities. Physical health equipment was always checked, calibrated and recorded.

Seclusion

The seclusion room was located on Springs Unit. People who were secluded were able to communicate with staff. Staff were based in the de-escalation room which was adjoined to the seclusion room. Staff communicated with the person in seclusion via an intercom.

Safe staffing

Whilst there were enough staff working on the ward there was a high use of agency staff on Springs Centre although many of them knew the service. There was sufficient medical cover. Compliance with mandatory training had improved.

Nursing staff

Ward leaders used a staffing matrix that was designed to increase and decrease the numbers of staff in order to meet the needs of people using the service. In addition to the core nursing team, additional agency and bank staff were deployed to support the team in carrying out eyesight observations and facilitate external community outings and appointments. People who were able to leave the ward told us that they regularly went out and engaged in community activities.

During our inspection, we reviewed a sample of rotas for the ward between December 2022 and May 2023 which showed that familiar agency and bank staff regularly worked at the service to cover shifts that were not fulfilled. On average between December 2022 and May 2023 Springs Unit had deployed 45% of agency staff to available shifts. The high use of non-permanent staff was because of staff vacancies and the level of acuity of the ward. At the time of our inspection, there were 6 people needing 1:1 observation. During the day shift the ward had deployed 2 permanent nurses and 1 bank nurse, 6 permanent healthcare support workers (HCSWs) and 5 agency HCSWs. The use of bank staff was significantly lower. The ward manager was actively recruiting permanent staff into vacant posts. The provider aimed to reduce the usage of agency and bank staff. This was a key risk on the hospitals risk register.

The ward had implemented a therapeutic engagement and support observation plan which was also known as a 'grab sheet'. The document provided important information such as a person's likes and dislikes, their level of eyesight observation and their key risks. New, agency or temporary members of staff were required to read the grab sheets and familiarise themselves with the information.

Inadequate

Wards for people with learning disabilities or autism

Whilst ward leaders made sure bank and agency staff had an induction before starting their shift, the staff induction checklist record did not include a prompt to ensure the staff member was shown the ward ligature points and how they were managed. Without a clear prompt on the induction checklist increased the risk of staff missing the opportunity to show a new member of staff the environmental risks and management plan in place.

The hospital had low turnover rates of nurses, but high rates of healthcare support worker turnover rates (HCSW). For example, over a period of 12-months the nurse turnover rate was 3.1%, whereas HCSW turnover was 24.7%.

Levels of sickness were low. The average sickness rate for the 12 months prior to our inspection for was 4.8%.

Medical staff

The service had enough daytime and night-time medical cover. The ward employed a consultant psychiatrist and a speciality doctor that was available during core work hours Monday to Friday. At the time of our inspection, the speciality doctor from Springs Centre was also providing support to another ward as the specialist doctor was on leave. Staff had access to the hospital medical cover out of hours.

Mandatory training

Staff had completed and kept up to date with their mandatory training. At our previous inspection in 2018, we told the provider that they must ensure that all staff are up to date with mandatory training. During this inspection, we identified that this had improved, and the average compliance rate was 93%.

Assessing and managing risk to patients and staff

The ward did not keep blanket restrictions under regular review, which meant that restrictions might remain in place for longer than needed. Records were not always in place to confirm that people had received the necessary monitoring after they had received rapid tranquilisation. People's records were not always well organised, and staff struggled to find essential information.

Management of peoples risk

When people were admitted to the ward, staff ensured they completed a risk assessment and reviewed it regularly including after an incident. Most people on the ward had been in hospital for long periods of time, therefore people's individual risks were known to ward the nursing staff and wider multi-disciplinary team (MDT). During our inspection we reviewed 4 records in total. Of the 4 reviewed, we specifically inspected 2 of the records to assess people's individual risk assessments. We found that both people had been risk assessed and there was a clear record in place that was up to date. The MDT reviewed every person's risk at the ward round meetings that took place every 2 weeks.

Staff knew about any risks to each person and prevented or reduced risks. The ward held a folder that included a summary document of each individual person on the ward. These were called therapeutic engagement and supportive observation plan also known as 'grab sheets'. The grab sheets were used to support all staff to briefly review a person and be aware of their presentation, risks and individual needs.

Staff shared key information to keep people safe when handing over their care to others. We reviewed a sample of nursing handovers from January 2023 and found that they covered key areas such as individual risks of people on the ward, mental health and physical health needs, section 17 leave status (permission to leave the hospital) and communication.

Use of restrictive interventions

Each person's care and support plan included ways to avoid or minimise the need for restricting their freedom. The responsible clinician reviewed individual restrictions placed on people at the regular ward round meetings. The doctors reviewed a person's rights to leave the hospital using Section 17 leave of the MHA and took into consideration their presenting risks. We found that most people regularly attended their ward rounds in person and were involved in treatment discussions.

Following our previous inspection in 2018, we told the provider that they must ensure that inappropriate blanket restrictions were not in place on ward. During our recent inspection in May and June 2023, we found that although blanket restrictions such as locking of communal toilets were not in place, we identified that ward leaders did not routinely review all blanket restrictions in order to reduce them or ensure they were the least restrictive.

However, we identified that ward leaders did not routinely review blanket restrictions in order to reduce them or ensure they were the least restrictive. We found that people on the ward did not have access to tea, coffee and sugar. The service took the decision to remove access to these items for all people so that they could mitigate the risks that they posed to a small number of people. People were required to ask staff for access to the kitchen to make a hot drink. We also found on Springs Centre that the ward kitchen was permanently locked. Staff told us that this was because food had gone missing earlier in 2023 and people on the ward had agreed for the kitchen to be locked. However, one person told us that food going missing was no longer an issue on and they did not understand why the kitchen remained locked. Following the inspection, we requested the provider to send us evidence that demonstrated blanket restrictions were routinely reviewed. The provider told us that the hospital did not formally monitor and review blanket restrictions in between the 6-monthly blanket restriction audit. However, going forward restrictions would be monitored at the monthly clinical governance meeting. The lack of system in place to ensure that blanket restrictions were closely monitored increased the risk of people living in an overly restricted environment which was not proportionate to the level of risk.

The hospital did not have the facilities to support long-term segregation.

Staff made attempts to avoid using restraint by using verbal de-escalation techniques and restrained people only when these failed and when necessary to keep the person or others safe. During the inspection of Springs Centre, we observed on 2 separate occasions staff verbally deescalating a person and were able to calm them.

Staff reviewed restraint and used the examples as learning. The hospital had a dedicated Prevention and Management of Violence & Aggression (PMVA) trainer and health and safety manager who were responsible to review incidents of restraint and support staff to learn lessons and improve. We identified one incident where staff had not used the correct PMVA technique to move a person between two wards. We reviewed the hospitals closed circuit television (CCTV) recording and whilst we did not identify staff being abusive towards the person, staff had not used the correct PMVA techniques to move the person from the ward to the seclusion room which was across the hospital. Following this incident, all staff from the ward had been booked onto a refresher course with the hospital's PMVA trainer across 2 days in June 2023. The hospitals training records showed that 98% of staff were trained in the use of restrictive interventions, the training was certified as complying with the Restraint Reduction Network (RRN) Training standards. The provider showed us the training certificate in place that confirmed the training was approved by the RRN.

The ward had implemented emergency simulations to ensure staff understood how to respond in a variety of emergency situations. Springs Centre had a rolling monthly programme that covered a different subject such as sepsis, anaphylaxis and choking. In May 2023, staff on the ward simulated an emergency response to a person having a heart attack. The outcome report demonstrated that overall staff had responded well with a few minor improvements to make.

Staff did not ensure that people on the ward received the appropriate physical health checks following rapid tranquilisation (RT). During our inspection, we identified 1 incident of rapid tranquilisation without records in place to confirm any post physical health monitoring. This was not in accordance with NICE guidance and the provider's own 'rapid tranquilisation procedure'. The lack of physical health monitoring post RT increased the risk of a person developing adverse side effects and not being appropriately treated. This put people at risk of avoidable harm.

Safeguarding

Staff understood how to protect people from abuse. Staff we spoke with knew how to recognise adults 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. Staff kept up to date with their intermediate e-learning safeguarding training and at the time of our inspection the completion rate was 89%. However, the compliance rate for the virtual classroom safeguarding training session was 55.6%.

Staff received group safeguarding supervision every six months. The provider's safeguarding lead told us that they facilitated sessions throughout the year to provide staff with an opportunity to learn about staff responsibility, how to report a safeguarding alert and reminding staff about the policies and procedures they can access to support them in their decision making. The provider's safeguarding policy provided a clear flowchart in how staff can report a safeguarding and highlights the importance of not finishing a shift without reporting their concerns.

Staff access to essential information

The electronic and paper-based recording systems used on the ward was disorganised. The service did not have an electronic system or paper-based system in place that enabled staff to access person's care and treatment record without delay. During the inspection, we observed that staff on Springs Centre were unable to find a person's next of kin's property address. Staff needed to contact the next of kin to report a concern. We observed staff to be anxious that they were unable to find the address in the person's care records. This led to staff having to directly contact the next of kin by telephone to ask them for their address. The way in which the care records were stored increased the risk of staff not being able to access important information when required.

Medicines management

Medicines were managed well.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. During our inspection we reviewed 5 medicine charts and found that medicines were prescribed appropriately and were not being used to control people's behaviour. High dose anti-psychotics were monitored by the medical staff and the external ward pharmacist. When required (PRN) medicines were prescribed on medicine charts for the management of agitation, insomnia and pain. We found that these medicines were administered appropriately and not overused.

Inadequate

Wards for people with learning disabilities or autism

People received support from staff to make their own decisions about medicines wherever possible. We saw that nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them.

People could take their medicines in private when appropriate and safe. The ward had access to an examination room off the ward that included an examination couch.

Staff made sure people received information about medicines in a way they could understand. We observed nursing staff introducing themselves to people before offering them medicines, they explained what they were giving, and observed the person to take them.

Staff followed national practice to check that people had the correct medicines. Medical staff followed national guidance to ensure patients were prescribed correct medicines. We found that medicines were prescribed appropriately meeting the Mental Health Act requirements. An external pharmacist visited the ward once a week to screen prescriptions and advise medical staff when doses needed to be revised.

Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines. Staff reviewed the side effects of each person' medication on their physical health at weekly ward rounds. We reviewed two separate records for people who were prescribed anti-psychotics. We found that in one person's record they were prescribed an antipsychotic called Lithium. Staff regularly carried out appropriate side effect monitoring and regular blood testing. However, for the second person who was prescribed Clozapine, staff used two different side effect monitoring tools and the recording of side effect monitoring was not consistent. Following the inspection, the provider told us that they had recognised that this was an issue and would improve the recording of side effect monitoring.

Track record on safety

The service did not always manage incidents affecting people's safety well. Staff had not recognised that an incident of rapid tranquilisation (RT) required a formal incident report on the electronic incident reporting system. Debriefs were not recorded consistently after incidents so it was not possible to know if this had taken place to an appropriate standard. Staff had not recorded an incident of restraint in a caring way.

Ward leaders did not always ensure that they consistently recorded post incident debriefs. Whilst staff we spoke with told us that a verbal debrief took place with both the person and staff involved, we did not find consistent evidence of this. During our inspection, we reviewed a sample of 4 incidents. Of the 4 reviewed, we specifically checked 3 of the incidents to assess whether the provider had recorded that a debrief had taken place. We found that a debrief for 2 out of 3 incidents had not been recorded. The lack of recording meant that leaders could not be assured that staff and people involved were reflecting on incidents and learning from them. There was also no formal record for staff to refer back to at a later date.

We also identified that staff had failed to formally report an incident of rapid tranquilisation (RT). During our inspection we identified that a person in May 2023 had been a medication under RT and staff had not ensured they had reported on the electronic incident reporting system. Without consistent and accurate incident reporting, hospitals managers are unable to review and thoroughly investigate incidents to make sure that sufficient action is taken to prevent further occurrences and to make improvements as a result.

Inadequate

Wards for people with learning disabilities or autism

In one other incident we reviewed, the tone of the incident record was not appropriate and did not come across as caring. For example, staff had recorded that the emergency response team 'grabbed hold' of the person they were restraining.

Is the service effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

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

Staff completed a comprehensive assessment of each person's physical and mental health either on admission and at routine intervals thereafter. During the inspection, we reviewed 4 records in total. Of the 4 reviewed, we specifically reviewed 2 to check people's admission paperwork. We found that both people had received an initial assessment on admission and their mental health and physical health needs were reviewed at the fortnightly ward rounds. All disciplines were required to have input into each person's ward round. They recorded their feedback onto a centralised record that could be reviewed by the person and consultant psychiatrist.

We reviewed 4 care records and found that most people had care plans in place to support their needs and identified risks such as self-harm, physical health, and mental health.

Therapy staff ensured people had up-to-date care and support assessments, including psychological, functional, communication, preferences and skills. People had a variety of care plans in place that had been created by the speech and language therapy (SALT) team, the occupational therapy (OT) team and psychology team. During our inspection, we randomly sampled 2 therapy treatment records. Both records showed that people had individual communication passports that were used to support them to share important information about themselves in an accessible way.

The psychology team worked with people to develop positive behavioural support plans (PBS). A PBS plan is a person-centred framework for providing long-term support to people with a learning disability and/or autism, including those with mental health conditions, who have, or may be at risk of developing behaviours that challenge. During our inspection, we specifically checked 2 out of 4 records to assess whether each person had a PBS plan in place. We found that in all records reviewed a PBS plan was available and they were clear, accessible and of good quality. We identified in one record that the psychology team were working with a person from Springs Centre to create emotion picture cards.

Best practice in treatment and care

Staff did not consistently provide a range of care and treatment for autistic people based on national guidance and best practice. Whilst therapeutic activities were well structured during the week this was not the case at the weekend which was not autism focused or in line with NICE guidance. People received physical health

checks such as dental and optical care. Despite our findings, some carers said their relative's health had declined in hospital and they had gained weight. Staff used recognised rating scales to assess and record severity and outcomes. Whilst the provider carried out audits, these were not always completed to an appropriate standard.

The provider had guidelines in place to support people to live healthier lives and take an active role in maintaining their own physical health. During our inspection, we specifically checked 2 out of 4 records to assess whether each person was regularly receiving physical health monitoring. In both care records reviewed, we found that staff ensured that all people received the right physical health checks. For example, one person's record showed that they had diabetes and staff worked with them to attend routine appointments such as eye screening tests. Despite our inspection findings, carers had mixed views about the quality of care given to people's individual physical health needs. For example, 3 out of 4 carers we spoke with raised concerns about their relative's weight gain whilst in hospital.

The psychology team had recently implemented ways for new staff to be able to improve their understanding and communication with people on the ward. Despite people having individual positive behavioural support plans in place these were sometimes lengthy and did not always enable a new member of staff to understand people's needs quickly. As a result of this, the psychology team created therapeutic engagement support plans also known as grab sheets. The grab sheets provided staff with an overview of people's key risks and needs.

Staff supported people with their dietary needs and promoted healthy eating. Occupational therapy staff cooked meals in the kitchen as part of their care plan and led a healthy eating group once a week to provide education. During our inspection, we reviewed a good quality healthy eating care plan for a person with diabetes. The plan included a goal to manage the person's weight and how this goal would be achieved such as the person limiting the number of chocolate and sugar drinks they purchase. Some people and staff told us that the meal portions were small in size, and this meant that people snacked more often.

People were supported and encouraged to plan their days during the week. Each person had a personalised timetable that included activities from Monday to Friday.

However, at the weekends people's activity significantly reduced. People's individual timetables stated that the activities on the weekends were nurse led. We identified that on some weekends staff took groups of people on outings, however, when these trips did not take place individual care records showed that activities were limited. During our inspection, we carried out an out of hours visit and visited Springs Centre. We spoke with 3 people, and they all told us that the weekends were very different to the weekdays as there were limited activities. The people found the weekends boring and wanted more things to do. One person told us that due to boredom people's behaviours sometimes escalated. The lack of nurse led activities meant that people who were unable to leave the ward did not have any meaningful activities to do or clear structure to their day which was not autism focused and not in accordance with NICE guidance.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Occupational therapists measured outcomes for patients using the model of human occupation (MOHO). However, there was a plan to implement a new model of care called The Vona du Toit Model of Creative Ability. The ward used The Global Assessment Progress (GAP) scoring to measure outcomes. This included looking at an assessment of progress for each person. The GAP data was monitored by the senior leaders and discussed clinical governance meetings. Leaders had recognised that there had been an issue with how staff were recording whether people had been offered and received a meaningful activity. Additional staff training had been provided to improve this.

Inadequate

Wards for people with learning disabilities or autism

Whilst ward staff and hospital leaders took part in clinical audits, some audits were not carried out often enough and they did not always generate improvements. For example, the provider carried out a blanket restriction audit every 6 months and in between this time ward leaders did not monitor the use of blanket restrictions on the ward. Following our inspection, senior leaders told us that this audit would be reviewed at the monthly governance meetings going forward.

Skilled staff to deliver care

Nursing and support worker staff members did not receive adequate training on how to support autistic people. Staff access to regular supervision had improved since the most recent inspection.

Autistic people were not supported by staff who had the right skills and training to ensure they were understood, and their individual needs were met. The hospital offered all staff including bank and agency staff, a basic level of training called autism awareness training and for permanent staff they also received positive behaviour support training. However, staff did not receive specialist training in communication. For example, staff were not trained in picture-based communication tools such as Talking Mats and therefore were unable to support people who used this way of communication or preferred it.

Following our most recent inspection in 2018 we told the provider that they must ensure staff receive regular supervision. At the time of our inspection May and June 2023, we found that this had improved. Clinical staff received supervision every 30 days. At the time of our inspection, the supervision and appraisal rate was 93%. Medical staff and other members of the multi-disciplinary team carried out their yearly appraisal with a supervisor from their discipline. One doctor we spoke with told us that they had weekly supervision with the hospital's medical director. The head of psychology was also planning to reintroduce staff reflective practice meetings to provide staff with an opportunity to reflect and discuss their experiences.

Multi-disciplinary and interagency team work

People had access to a range of specialists although the psychology team were only recently appointed and were just starting to carry out their role. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

People had access to speech and language therapy, occupational therapy and some psychological support. The psychology team were a new team and had been in place since March 2023. At the time of our inspection, the head of psychology told us that the team were aware that people on the ward had been unhappy with the lack of psychology input over the past few months and that they were looking to improve this soon. The team currently offered weekly drop-in sessions for people to attend and were mainly carrying out basic assessments of people to understand their motivation and individual needs. The team recognised that it was difficult to motivate people to engage in therapy.

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had consistent care. People were discussed at ward round meetings on a fortnightly basis and people were invited to attend. Records of MDT discussions were recorded within the persons individual care record.

The ward teams worked effectively with other agencies that provided aftercare following people's discharge and engaged with them early on in people's admission to plan discharge. During our inspection, we observed additional staff on Springs Centre that had visited from a person's discharge placement. Their role was to work with the person to understand their needs. The MDT also worked with community professionals such as GPs, community mental health teams and clinical commissioning groups.

Inadequate

Wards for people with learning disabilities or autism

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 usually discharged these well. Managers made sure that staff could explain peoples' rights to them. However, where shortfalls were identified during audits, actions to address issues were not always carried out.

Staff received and kept up to date with training on the MHA and the Mental Health Act Code of Practice. The completion rate for staff for Mental Health Act awareness training was 100%. Staff had access to the provider's MHA administration team for support and advice when required.

Staff mostly ensured that they explained to each person their rights under the Mental Health Act in a way that they could understand, repeated it as necessary and recorded it clearly in the people's notes each time. During our inspection, we 4 records in total. Of the 4 reviewed we specifically checked 2 of them to assess whether staff routinely read people their rights. We found that in both records, staff had read people their rights.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or the Ministry of Justice or both. People's individual care records showed that for people who were permitted to leave the ward they were supported to do so. The daily planning meetings were an opportunity for people to plan their days and for people to inform staff that they would like to take their leave. The ward had allocated staff to accompany people during their leave.

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

Staff had ensured that the appropriate MHA consent paperwork was in place for the prescribing of medicines. We reviewed 15 medicine charts and found that medicines were prescribed appropriately meeting the MHA. We reviewed 7 medicine charts and found most T2's and T3's was correctly in place. We identified that one person's T3 did not include their mental health medication that was prescribed to be taken as and when required. During the inspection we escalated this to the registered manager. The provider later informed us that this had been addressed and that records showed that the person had not been administered the medication since transferring to the service 2 months ago.

Staff stored copies of people's detention papers and associated records correctly, and staff could access them when needed. The hospital's MHA administration team held detention paper records and could be accessed when required.

Whilst the managers and staff carried out frequent audits to ensure they applied the Mental Health Act correctly; improvements were not always made as a result. During our inspection, we reviewed the December 2022 MHA audit for Springs Centre. We found there were a small number of gaps in how often staff were reading people's rights to them. Springs Centre had put an appropriate plan in place to address the shortfalls. The ward had a tracker system in place that highlighted when people required their rights to be read.

Good practice in applying the Mental Capacity Act

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

Inadequate

Wards for people with learning disabilities or autism

Staff supported people to make decisions on their care for themselves. They assessed and recorded capacity to consent for people who might lack the mental capacity to make certain decisions for themselves. We found that clinicians recorded people's capacity appropriately when they needed to make an important decision such as a medication change.

The provider had a policy on Mental Capacity Act and advance decisions or statements. Staff were able to access the policy electronically.

The provider monitored how well it adhered to the Mental Capacity Act and acted when they needed to make changes to improve. Managers completed Mental Capacity Act audits every 3 months. The most recent audit, completed in June 2023, achieved 100% compliance.

Is the service caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff who lacked autism specific training did not know how to interact appropriately with the people they were supporting. This meant that while people felt safe, they did not feel treated with compassion and kindness. Some people said they did not have a positive rapport with the staff. The approach of the nursing and care staff was at times custodial and threatening rather than supportive.

The lack of specialist training to support autistic people impacted on how the nursing staff interacted with people on the ward. Staff lacked the awareness and understanding of how their behaviours could be perceived by an autistic person. During our inspection we observed staff standing for long periods observing people but not interacting with them. During our on-site inspection we spoke with 7 people and 4 of those people raised their concerns about how staff treated them. Three out of the 4 people told us that they felt that staff mimicked them and laughed at them. One person told us that they wanted staff to give them more privacy and knock on their bedroom door before entering.

People did not always feel that staff took the time to understand and develop a rapport with them. In February's clinical governance meeting minutes 2023, people from Springs Centre had fed back to senior leaders that they wanted more time to get to know staff. People suggested for staff to play football or board games with them.

People on the ward were regularly asked to share their experiences. People were able to provide feedback about their experience during the weekly community meetings and via the hospital survey twice per year. People were also invited to attend the clinical governance meetings to provide direct feedback. During our inspection, we reviewed the survey results for Springs Centre between January and March 2023. The results showed that generally people felt safe and that they received care and treatment that helped them to progress. A lower number of people (66%) reported that the food was of good quality. The feedback from the survey generally matched what people had told the inspection team during the on-site inspection.

Inadequate

Wards for people with learning disabilities or autism

Staff ensured that people's information was kept confidential. Information about people was stored securely on an electronic system or in folders in the nursing office. The ward also had information about people kept on a whiteboard in the nursing office. The whiteboards could be covered over to ensure the information remained private.

Involvement in care

Staff actively sought patients' feedback on the quality of care provided and involved them in the planning of care. They ensured that patients had easy access to independent advocates. The hospital recognised that it did not sufficiently communicate with and involve carers.

Care and treatment records created by the nursing and therapies teams showed that people were involved in the planning of their care. We reviewed 4 individual care plans and found that the people had been involved and had received a copy of their care plan.

Staff respected people's choices and wherever possible, accommodated their wishes, including those relevant to protected characteristics – for example, due to cultural or religious preferences. People from Springs Centre fedback that they wanted more care to be taken to ensure religious leaders could attend the ward. The ward manager told us that as a result of the feedback people are now routinely supported to attend their preferred place to pray. One person requested to attend a mosque. The hospital advocate had been involved in planning the visit with the person.

Generally, people were supported to access independent, good quality advocacy. An independent mental health advocacy (IMHA) service visited the ward on a twice weekly basis to speak with people. The hospital advocate told us that they attended weekly ward rounds.

People were involved and supported to make decisions about the service when appropriate and felt confident to feed back on their care and support. People from Springs Centre had fedback that the weekends were boring as they did not have many activities planned. As a result of the feedback, the ward OT had begun facilitating a planning meeting on a Thursday to ensure people planned their weekends activities in advance.

Three out of 4 carers we spoke with told us that they felt that staff communicated with them. One carer told us that communication from ward staff could be improved. One other carer told us that they felt that there was an unreasonable limitation on their visits to the ward and they were unable to visit as often as they would like.

Hospital leaders recognised that ways for carers to feedback about the service needed to improve. There were plans to restart carer forums in August 2023 and surveys as well as offering carers a dedicated carers email address. The lack of family involvement meant that individual people could not receive support from people they know, and carers were unable to advocate for the person and share their views.

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Inadequate

Wards for people with learning disabilities or autism

Staff managed beds well and worked with external stakeholders to facilitate discharge arrangements. Most people only stayed in the hospital for as long as needed although there were a few delayed discharges.

Staff planned and managed discharge well. During our inspection, Springs Centre was 83% full. The ward accepted people who lived outside of London. Discharge plans were discussed and recorded during ward round meetings.

Staff regularly reviewed people's length of stay to ensure they did not stay longer than needed. This was dependent on the availability of appropriate discharge placements and people being ready to move on. The ward liaised with services that would provide aftercare and escalated issues with people's discharges or transfers of care to community professionals and clinical commissioning groups. Breakdown in discharge placements meant that at times people stayed in hospital longer than needed. People on Springs Centre fed back that they wanted more information about their estimated discharge dates. As a result of this, the MDT had plans in place to provide every person with an estimated discharge date.

When people went on leave there was always a bed available when they returned. When a person's risk increased and the service was unable to support the person, they would refer the person to an appropriate setting.

People were moved between wards during their stay only when there were clear clinical reasons, or it was in their best interests.

Staff did not move or discharge people at night or very early in the morning. People's discharges or transfers of care were planned in advance jointly with community professionals such as care coordinators and care managers.

Staff supported patients when they were referred or transferred between services. This included patients who needed to attend the local hospital for physical health concerns or external appointments.

Facilities that promote comfort, dignity and privacy

The ward environment did not meet the sensory needs of autistic people. There were some improvement plans in place. Several people said the food needed to improve and it was poor quality and small portion sizes. People were observed eating their meals in their bedroom rather than using the dining area.

The ward environment of Springs Centre was not autism friendly, did not meet people's sensory needs and did not follow the principles of CQC's right support, right care, right culture guidance. The ward environment was impersonal and unwelcoming. The ward OT had formally assessed the environment and had put some plans in place to improve it. For example, there was a plan to improve the lighting in bedrooms and to make them dimmable. The ward was also planning to install ventilation that removes offensive smells by the end of July 2023. Not all actions identified on the action plan had clear timescales in place.

People's access to easy read information was limited. On Springs Centre the keys to the lockable notice boards had been lost, therefore staff were unable to update the boards. The environmental audit highlighted that pictures on the walls were taking up the space that could accommodate more easy read information. There was a plan to address this.

During our inspection in 2018, we recommended to the provider that they should improve the ward environment including a sensory room. During our recent inspection in May and June 2023 we found that Springs Centre had installed a sensory room, the sensory room was small and basic. The ward manager told us that plans for a new sensory room were being developed.

Inadequate

Wards for people with learning disabilities or autism

Whilst the ward regularly employed a large nursing team to support the needs of people, this impacted on the ward environment being overcrowded. During our inspection we observed the ward to deploy a high number of additional staff. For example, on the day of our inspection there were 14 members of staff plus the 14 people. Due to the ward corridors being narrow and small in size, staff were unable to spread out. We observed that the high numbers of staff on the ward at times created an atmosphere that did not support a person with sensory differences. This increased the risk of people feeling overwhelmed and causing an escalation in their behaviour.

People had access to full range of rooms and equipment to support treatment and care. For example, clinic rooms, a multifaith room, a quiet room, gym facilities and outdoor areas.

Despite the ward having a dining room, there was a culture of people eating in their bedrooms. During our inspection, we identified that there was a culture of people eating in their bedrooms and not in the dining areas. For example, we observed 10 people on the ward to eat their lunch in their bedrooms and 3 people ate in the communal areas. Senior managers told us they encouraged patients to eat in the dining room and internet café based off the ward.

The layout of the ward supported people's privacy and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. People on the ward were also able to store their personal belongings in the nurse's office. The ward had a quiet room for privacy. People were able to meet visitors in a private room on the ward or in a room located within the hospital.

The portion sizes of meals were not always enough, and people were not freely able to access tea, coffee and sugar to make a hot drink. During our inspection, 3 people told us that the food was not of good quality and the portion sizes were too small. People were dependent on staff to make hot drinks. The service made the decision to remove access to tea, coffee and sugar for all people across the ward so that they could mitigate the risks that they posed to a small number of people. Leaders of the service acknowledged that these restrictions were not routinely reviewed, and this would be improved going forward. The service recognised that the food offered to people on the ward needed to improve to ensure it met their dietary requirements and preferences. As a result of the latest survey results, 'meet the chef' meetings had been initiated which provided people with an opportunity to meet the catering team and provide feedback. Hospital leaders recognised that there were still some improvements to be made to ensure staff supported people to choose food that met their needs.

People could make phone calls in private. People had access to the ward cordless phone. The hospital had experienced issues with the internet and some people had reported that they were unable to use the computer as a result. During our inspection, the registered manager told us that this had been reviewed by the IT team. The IT team had plans to speak with people who were unhappy with their access to the internet and assess whether it could be fixed.

At the time of our out of hours inspection in June 2023, we found that the temperature of the ward was unbearably hot. The ward manager told us that people had access to fans as a measure to cool them down. However, at the time of inspection we did not see this in practice.

Patients' engagement with the wider community

The service supported people during the week to access a range of activities supporting their rehabilitation and, in some cases, accessing opportunities in the community.

Inadequate

Wards for people with learning disabilities or autism

Activity and therapy staff supported people to take part in their chosen social and leisure activities on a regular basis. Most people were able to access different opportunities to try new experiences, develop new skills and gain independence. The therapies team ensured that people had a personalised timetable of activities Monday to Friday. People had access to a range of activities that would support them in their recovery and to live independently such as cooking, shopping to the local town centre and voluntary work.

People were supported by staff to try new things and to develop their skills as part of the occupational therapy programme. The hospital had set up a car wash so that people who were able to leave the hospital could earn their own money. The hospital had also set up a regular tuck shop that was led by the people from the ward and was a way to earn money and develop their social skills.

Staff enabled flexibility and helped people to have freedom of choice and control over what they did. The hospital had employed drivers who were able to transport people to their desired destination. This was a way of encouraging people to go out into the community.

Meeting the needs of all people who use the service

The service met the needs of most people – including those with a protected characteristic. Staff helped people with advocacy and cultural and spiritual support.

The service was working to improve the support for people with their sexual, religious, ethnic, gender identity without feeling discriminated against. People were supported to learn about religions and attend their preferred place to pray. The hospital social worker was supporting a person to learn more about Islam.

The therapy teams ensured people had individual communication plans that detailed effective and preferred methods of communication. People had pictured based timetables that provided a schedule of activities that met their needs. Pictured based information about what each person could expect from their experience was visible on the walls around the ward.

Staff made sure people could access information on treatment, local services, their rights and how to complain. Leaflets were not available on the ward, but staff told us that people could access the leaflets that were stored in the nursing office. Complaints information posters were visible around the ward.

People had some access to spiritual, religious and cultural support but people fedback that the offer could be improved. Survey results from people on the ward showed that they wanted more care for everyone's religious beliefs such as visits from religious leaders and speakers. As a result of the feedback, the ward social worker was working to ensure that this was facilitated for people.

Listening to and learning from concerns and complaints

People and those important to them could raise concerns and complaints easily, and staff supported them to do so.

2 out of 4 carers we spoke with understood how to raise concerns and felt comfortable to do so. Two carers told us that they were not aware of the complaint's procedure.

Inadequate

Wards for people with learning disabilities or autism

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them. Over a 12-month period, 3 separate complaints had been received. Out of the 3 received, 2 complaints were from family members or carers. The complaints related to therapeutic interventions and communication issues.

Staff knew how to acknowledge complaints, and people received feedback from managers after the investigation into their complaint. During the inspection, we randomly reviewed 1 complaint that had been received in the past 12 months. We found that the provider's complaints response timescales had been adhered to and acknowledgement letters had been sent on the same day as the complaint had been received. The provider had appropriately investigated each concern and had provided an outcome letter to the person within the timescale of 20 working days.

The service clearly displayed information about how to raise a concern in areas used by people. Information about how to complain was visible on the walls around the ward.

Managers shared feedback from complaints with staff, and learning was used to improve the service. Lessons learnt were a standard agenda item during team meetings. Team meetings provided an opportunity to discuss lessons identified following complaint investigations and improve practice. Hospital leaders discussed complaints during clinical governance meetings.

Is the service well-led?

Inadequate

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

Leadership

Whilst the hospital leadership team at the hospital showed a commitment to deliver good quality care, they did not ensure that the service was not meeting the needs of autistic people, that staff were not adequately trained leading to a variable quality of interactions with people using the service.

Whilst the ward leader worked hard to manage the running of the ward, there were aspects of people's care that required improvement. Staff were not adequately trained to be able to care and support an autistic person. Some people on the ward told us that staff laughed and mimicked them. At the weekends activities significantly reduced leading to people becoming bored. We identified blanket restrictions in place that were not being closely monitored to ensure they were the least restrictive measure.

The ward manager was visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. Staff we spoke with felt supported to be able to carry out their roles. During our inspection, we observed the ward manager to have a good rapport with people on the ward. We observed them to be directly involved in coordinating people's care. Although the ward manager regularly spent time on the ward, their office was not located on the ward itself. This meant there was an increased risk of the manager missing key opportunities to observe the growing culture of people routinely eating in their bedrooms, staff interactions with people and the general quality of care being provided.

Vision and strategy

Inadequate

Wards for people with learning disabilities or autism

Whilst staff knew and understood the provider's vision and values, some staff did not always act in line with them.

During our inspection, people told us that staff did not always show compassion and respect when interacting with people. Out of the 7 people we spoke with 4 people raised concerns about how staff treated them. The behaviours displayed by some members of staff meant that the general culture of the ward was at risk of decline.

Culture

Staff felt respected, supported and valued.

During our inspection we spoke with 6 clinical members of staff who spoke positively about their place of work and their roles. Staff told us that the provider offered them opportunities for development and career progression, and they received regular supervision. We saw some evidence of the service promoting equality and diversity. For example, employing staff from diverse backgrounds and staff feeling listened to and included.

Staff felt able to speak up and raise any concerns without fear. During our inspection, we reviewed a sample of team meeting minutes. We found that generally team meetings were well attended, and staff routinely discussed important matters with their peers.

The provider had implemented new ways of retaining and rewarding staff. Staff were entitled to receive support with costs for their health check-ups such as eye tests, an employee assistance programme for staff and their family members that included counselling and advice, free staff lunches and on-site parking.

Governance

Whilst governance systems and processes were in place, they did not enable the provider to identify, understand, monitor and address current risks relating to the quality and safety of care delivered to autistic people.

During the inspection, we identified the following concerns, which had not been identified by the service. The governance systems were not tailored to assess and identify the individual needs of autistic people. The processes in place had not identified that the quality-of-care people received was being impacted by the lack of specialist training provided to the nursing staff. We found several examples of staff behaving in a way that was not effective and lacked compassion.

Several incidents had not been reported in practice. For example, an incident of rapid tranquilisation had not been reported on the electronic incident reporting system. This meant that the hospital management team could not review the incident and take appropriate action to ensure the patients received safe care and treatment. It also meant impacted on the ability to learn and make improvements to the service. Learning from audits were not being followed through to ensure that improvements were made such as people not being read their MHA rights on a regular basis.

Management of risk, issues and performance

Inadequate

Wards for people with learning disabilities or autism

Whilst senior leaders used a risk register to track and monitor risks related to the running of the hospital and individual ward, they were not sighted on some of the quality of care issues that we had identified during our inspection.

Information management

Staff collected and analysed data about outcomes and performance although some aspects of the data could not be relied upon.

Leaders recognised that the quality of data was not always accurate because staff were not routinely reporting incidents via the electronic reporting system.

The ward manager had access to information to support them to do their role effectively. This included having access to management systems that provided information about people's care, staff training compliance and supervision completion rates.

All services registered with the Care Quality Commission (CQC) are required to notify the Commission of certain incidents, without delay. The service notified the Care Quality Commission of notifiable incidents.

Engagement

Managers engaged and participated in meetings with local health and social care systems.

Staff, people and carers had access to up-to-date information about the work of the provider. The provider had a comprehensive website available to keep the public informed of the work they were undertaking to support people, their families and carers. At the time of our inspection, the service was not providing carers with an opportunity to meet face to face with leaders to share their feedback.

Learning, continuous improvement and innovation

At the time of our inspection, Springs Centre was not participating in any research or improvement projects. Springs Centre was not accredited by the National Autistic Society. For a provider to be accredited demonstrates that they are able to meet a strict criterion and provide evidence that they were meeting the National Autistic Society standards.

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 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that staff working on Springs Unit, Springs Centre and Springs Wing were adequately trained and skilled to make sure that they can meet the care and treatment needs of autistic people. This must be in line with good practice and support the staff to communicate effectively with people using the service. The provider had not ensured all staff had access to regular good quality supervision. Improvements to supervision was required at the last comprehensive inspection of the hospital.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider had not ensured that all patients and carers on Byron Ward were provided with information about how to make a complaint, and that staff respond to complaints in line with the provider's policy.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that patients' physical health on Springs Unit, Springs Centre and Byron Ward was

This section is primarily information for the provider

Requirement notices

checked appropriately and recorded consistently after they had received medicines via rapid tranquilisation, in line with national good practice guidelines and the provider's own policy.

The provider had not ensured that equipment on Byron Ward, Springs Unit and Springs Wing used to monitor patients' physical health was properly maintained and calibrated. This was required at the previous inspection.

The provider had not ensured staff on Byron Ward and Springs Unit completed weekly checks of resuscitation equipment in line with national good practice guidelines.

The provider had not ensured on Byron Ward that staff understood how they will manage blind spots on the ward and maintain oversight of the patients across the whole environment in order to keep them safe.

The provider had not ensured that all incidents were recorded and that these were reviewed and where needed measures taken to address patient safety.

The provider had not ensured that people on Springs Unit and Springs Wing had access to regular physical health checks including dental and chiropody.

The provider had not ensured that the fire alarms on Springs Unit, Springs Centre and Springs Wing did not go off unnecessarily to avoid distress for the patients and to also prevent people from becoming accustomed to alarms sounding and therefore not responding in the event of a real fire.

The provider had not ensured that the ward environment of Springs Unit and Springs Centre including the seclusion room was clean to ensure infection control principles are maintained.

The provider had not ensured that the number of paper and electronic record systems used on Springs Unit, Springs Centre and Springs Wing were organised and easily accessible so staff can find essential information.

The provider had not ensured that staff on Springs Unit correctly signed and witnessed the administration of controlled drugs (CDs).

This section is primarily information for the provider

Requirement notices

	The provider had not ensured that people's treatment records on Springs Unit and Springs Centre were completed accurately so that they can be checked to ensure people are receiving safe treatment in line with best practice.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured governance processes operated effectively across the hospital and that local procedures and policies were met. This included having the processes in place to monitor whether patients are having their physical health monitored following rapid tranquilisation; whether staff are routinely reading patients their section 132 rights; whether equipment is being regularly checked and calibrated; whether staff are receiving regular good quality supervision and whether restrictions are recognised and regularly reviewed. It also includes ensuring managers have access to accurate data about incidents and other operational matters to enable them to have effective oversight of the hospital.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that people on Springs Unit and Springs Centre had access to healthy food of a high quality and sufficient quantity.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983	The provider had not ensured that the restrictive practices on Springs Unit such as the use of handcuffs were appropriately recognised, reported, and reviewed to ensure they are only used if absolutely needed. The provider had not ensured that restrictive practices taking place on Springs Unit, Springs Wing and Springs Centre were appropriately recognised, reported, and reviewed to ensure they were only used if absolutely needed.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured ensure that patients on Byron Ward had regular one-to-one sessions with their named nurse to ensure they can develop therapeutic relationships and express any individual needs they may have. The provider had not ensured that patients on Byron Ward were provided with information about their medicines and possible side effects. Staff had not ensured that patients on Byron Ward and Springs Wing were involved with their care plans and provided with copies of these if requested. The provider had not ensured that people on Springs Unit and Springs Centre had access throughout the week including the weekend to therapeutic activities which provide structure and meet their individual needs. The provider had not ensured that people on Springs Unit and Springs Centre were supported by staff in an appropriate and supportive manner, treat them with kindness and understand their individual needs. The provider had not ensured that Springs Unit and Springs Centre provided an environment that met their sensory needs.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

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

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

The provider had not ensured that all patients on Byron Ward that were risk assessed as safe to have visitors were allowed visits from families, friends and/or carers, whether on or off the ward. Not all staff were clear on the provider's protocol on visits.

The provider had not ensured that it supported patients on Byron Ward to eat meals off the ward where risk allowed. Furthermore, staff did not follow the provider's policy to ensure all meals delivered from the kitchen to the ward were at the correct temperature.

The provider had not ensured that all patients were given access to personal hygiene products.