The Limes

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

We rated The Limes as REQUIRES IMPROVEMENT because:

- Staff were not up to date with mandatory training and managers did not have clear oversight of this.
- We found several omissions in the cleaning and temperature of the clinic room and equipment and staff did not accurately adhere to national guidance for medicines management.
- Patient care and treatment files were disorganised and contained several assessments and care plans that were out of date. Care plans and mental capacity assessments varied in quality and detail.
- The hospital did not provide clinical and managerial supervision to staff as often as outlined in the provider's supervision policy and this impacted on the hospital's recording and auditing of supervision.
- Staff did not complete patient observations in line with the provider's policy guidance.
- The hospital did not effectively use nationally recognised tools to monitor patients' physical wellbeing.
- The hospital did not consistently use audits effectively to identify and learn from mistakes and make changes to processes.
- Some patients and their relatives/carers told us staff did not always engage with patients when completing their observations.
- There was no designated space for patients to meet with visitors.
- Staff were not aware of the provider's vision and values.
- Staff did not consistently review and record emergency equipment, in line with their policy.
- Staff did not consistently record they had reviewed patient's daily risk assessments, as outlined in their local procedures.

However:

- The hospital was well staffed and rarely used agency staff to cover short falls.
- We observed positive and friendly interactions between staff and patients.
- Staff provided a comprehensive programme of individual therapeutic activities to help patients achieve their recovery goals.
- The multidisciplinary team completed a robust assessment and regular review of risk for each patient and developed individualised plans to manage these.
- Staff worked hard to reduce restrictive practices wherever possible to support patients' rehabilitation.
- The hospital welcomed patients of different cultures, languages, religions, sexualities and staff had embedded equality and diversity into the everyday running of the hospital.
- Staff were well supported by the hospital manager and staff told us they had been supported by the provider during the transfer process.

Summary of findings

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The Limes

Services we looked at

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

Summary of this inspection

Background to The Limes

The Limes is a longer term high dependency rehabilitation mental health hospital in Langwith, Nottinghamshire. The hospital is run by the independent provider, Elysium Healthcare Limited, and provides care for up to 18 male patients aged 18 years and over. Patients have severe and enduring mental health presentations, including complex needs such as substance misuse. Patients may be detained for treatment under the Mental Health Act (MHA) 1983 and have histories involving the criminal justice system.

The Limes Hospital has a registered manager and provides the following regulated activities:

- treatment of disease, disorder or injury
- assessment or medical treatment, for persons detained under the Mental Health Act (1983).

The Limes Hospital registered with the CQC on 17 January 2010 under the provider Cambian Healthcare. The CQC carried out six inspections under this registration. The service registered under Elysium Healthcare in May 2018.

The most recent comprehensive inspection was on 20 April 2016. The Limes was rated as 'Good' in all domains except 'Effective', in which it was rated as 'Requires Improvement'.

A follow up inspection took place on 22 November 2016 to assess whether the service had made the improvements outlined in the requirement notice. During this most recent inspection, we found that the provider had addressed the issue that resulted in us rating the service as requires improvement for the effective domain in April 2016, by updating its Mental Health Act policies to reflect the revised Mental Health Act Code of Practice.

Our inspection team

The team that inspected the service comprised two CQC inspectors and one specialist advisor with a background in mental health nursing.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about this service as part of our ongoing engagement with the provider, asked a range of other organisations for information about this service and conducted telephone interviews with two carers/relatives of patients using the service.

During the inspection visit, the inspection team:

• Visited the hospital site and looked at the quality of the ward environment

Summary of this inspection

- Observed how staff cared for patients
- Spoke with six patients who were using the service
- Spoke with the manager of the hospital
- Spoke with the clinical director of the hospital
- Spoke with thirteen other staff members including the doctor, nurses, healthcare support workers, the psychologist, the assistant psychologist, the occupational therapist, a therapy coordinator, the independent advocate, and the external pharmacist
- Observed a multidisciplinary team meeting
- Observed a staff handover
- Observed the patients' morning meeting
- Reviewed cleaning records
- Looked at five care records of patients in detail and two other care records for specific documentation
- Carried out a specific check of the medication management on the ward and looked at five treatment cards
- Looked at a range of policies, procedures and other documents relating to the running of the service.

At the time of our inspection, 15 patients were receiving care and treatment at The Limes hospital. Thirteen patients were detained under the Mental Health Act and two patients were subject to Deprivation of Liberty Safeguards. One patient was on home leave.

What people who use the service say

Overall, patients were positive about their experiences and happy with the care they received. Patients told us the environment was always clean and the food was of good quality. All patients we spoke with felt safe on the ward. Patients felt engaged in their care plans and told us their physical healthcare was well looked after.

Patients were complimentary about the staff who supported them and told us they were kind and engaging. However, three patients told us staff did not engage with them during meal times and instead sat at separate tables.

We received mixed feedback from carers and relatives we spoke with about the attitude of staff towards patients and their relatives. One relative told us staff were caring towards patients and another relative told us the attitude of staff was not always positive.

Patients told us there was a good range of activities available to them, including community and hospital-based activities. One patient felt these activities were not always suited to their needs. Carers and relatives we spoke with told us they thought the activities programme needed reviewing and was not always suited to the patient group.

Patients said staff supported them to maintain contact with their relatives through home visits or by supporting their relatives to visit them in hospital. However, the carers/relatives we spoke with told us visits to the hospital could be an issue due to the lack of a visitor's room.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Staff had not followed the actions outlined in the environmental and ligature risk assessment to keep patients safe from hurting themselves.
- Staff did not maintain accurate records of their checks of emergency equipment or cleaning records in the clinic room. We found several omissions in the recording of fridge and room temperatures in the clinic room. Staff did not label sharps bins correctly.
- Not all staff had received or were up to date with the provider's mandatory training and there was a lack of management oversight of this issue.
- Staff did not consistently record they had reviewed patient's risk assessments daily.
- Staff did not complete observations at irregular intervals, as per the provider's observation and engagement policy. The service made immediate changes to this process following our inspection.
- Patient files, including medication files and treatment cards, contained several out of date care plans, assessments and other documentation relating to their care and treatment. This made it difficult for staff to easily access the most up to date records when reviewing information.
- The hospital did not adhere to good practice regarding their recording of medicines management. We found inaccuracies, missing signatures and contradictory information in the patient medication files we reviewed. There was one administration omission and two missing second signatures during August 2018 in the controlled drugs book.
- Staff did not adhere to the provider's policy around reporting of incidents.

However:

- All communal areas and patient bedrooms at the hospital were clean and well maintained.
- The hospital was well staffed and had low vacancies, sickness and agency usage.

Summary of this inspection

- Staff used a recognised tool to assess and regularly review patients' risk at multidisciplinary team meetings. Where appropriate, staff completed risk assessments to support the development of care plans around specific risk issues, including falls and tissue viability input.
- Staff used the least restrictive approach in managing patients' risk and we did not see any evidence of blanket restrictions being used.
- The hospital had not had any serious incidents in the 12 months prior to inspection.
- The hospital made changes as a direct result of the findings from feedback and investigation of incidents across the provider.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care records we reviewed varied in quality and were difficult to navigate due to them containing old care plans and assessments. For example, staff did not regularly review and record all patient's mental and physical health assessments within their care files and the resulting care plans lacked detail in some cases. Care plans were written in language used by staff, rather than by patients, and not all of the care plans we reviewed had been signed by the patient as evidence of their involvement.
- The hospital had introduced a physical health screening tool, National Early Warning Scores (NEWS) to support staff to monitor patients' physical health. However, this had been introduced without any training or guidance on how to use the tool effectively. We found this had been used incorrectly and gave inaccurate assurance about patients' physical wellbeing.
- The hospital did not always use audits effectively to identify where actions were required and what lessons were to be learned from these audits.
- Staff did not have access to specialist training around rehabilitation and recovery.
- The hospital did not provide staff with clinical and managerial supervision as often as outlined in the provider's supervision policy and this impacted on the hospital's recording and auditing of supervision.
- Staff handovers did not always cover and record the essential basic information about each patient and this was not routinely shared with multidisciplinary staff prior to them leading one to one sessions with patients.

Summary of this inspection

- Not all staff were trained in the Mental Health Act or Mental Capacity Act and Deprivation of Liberty Safeguards.
- Mental capacity assessments varied in their quality of recording evidence of discussion with the patient and the arrangement of best interest's meetings. This had not been identified in the audits to review this information.

However:

- Staff provided a range of treatment and care for patients based on national guidance and best practice. The hospital had a full multidisciplinary team who met regularly to support patient care and treatment and staff used a range of personalised, assessments, therapeutic activities and interventions to help patients achieve their recovery goals. Staff had developed holistic, detailed care plans for patients at the hospital.
- Patients had good access to physical healthcare and specialist input when required.
- Staff were well supported by the Mental Health administrator to work within the remits of mental health law.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs. Patients told us they felt safe on the ward.
- Staff were aware of the needs of the patients at the hospital, including their rehabilitation and recovery goals, and personal, cultural and social needs.
- Patients told us they were involved in their care plans and staff regularly involved patients in meetings to review these plans. Staff supported patients to understand their care plans and be involved in decisions about their care.
- Staff gave patients and their carers/relatives the opportunity to feedback about their care.
- The hospital held weekly community meetings for patients to share their feedback and keep up to date and involved with proposed changes to activity timetables for the upcoming week.
- The hospital ensured patients had access to independent advocacy services during set times each week and between these times when requested.

However:

Summary of this inspection

- Some patients told us staff did not engage with them during meal times and sat separately to patients when eating in the dining room. Carers/relatives we spoke with also reported concerns about the level of engagement staff had with patients.
- Three out of the six patients we spoke with reported there were not enough staff and that this impacted on their activities.
- Staff did not support patients to sign their care plan as evidence of their involvement in the development and review process.
- Patients and relatives raised concerns about access to rooms for family visits at the hospital.

Are services responsive?

Good

We rated responsive as good because:

- The hospital's facilities promoted recovery and supported care and treatment.
- There were no delayed discharges from the hospital and staff planned for patients' discharge in a person-centred way to make sure patients moved on to the most suitable placement.
- There was a structured programme of individual and group therapeutic activities, educational and vocational opportunities for patients both within the hospital and in the community.
- Equality and diversity was well embedded as part of the culture of the hospital.

The hospital welcomed patients of different cultures, languages, religions and sexual orientation.

- Patients and staff reported the food was of good quality and alternative options were always available.
- The hospital facilities were suitable for patients requiring disabled access and staff completed comprehensive specialist assessments to develop care plans to support people with a physical disability.

However:

- The hospital did not have a designated room for patients to meet with visitors, including advocacy.
- Staff told us only having one meeting room and sharing a nursing office with reception staff created a problem when arranging staff meetings and therapeutic sessions with patients.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

Summary of this inspection

- The local management of the hospital did not have clear oversight of the service's key performance indicators, including training. This was due to the change in systems and processes inherited during the change in provider.
- The hospital did not have effective procedures in place to make sure staff were suitably trained and there was no local oversight of this.
- Staff were not aware of the provider's vision and values or how this impacted on the hospital.
- The service did not always use audits to effectively monitor and review their performance and it was not always possible to see whether staff had learned lessons from themes identified in audits.
- The hospital's risk register did not reflect the difficulties and risks associated with the changes in systems and processes for record keeping and sharing of information. This had been raised several times by staff prior to our inspection in governance and team meetings.
- Staff compromised the confidentiality of patient information during ward round and multidisciplinary team meetings. Staff projected patient identifiable information on the screen in a room that could be viewed from the garden that was accessed regularly by patients.

However:

- Staff told us the local management were visible in the service and approachable for patients and staff.
- Staff felt proud and positive to work for the service and told us they had been well supported by local management during the change in provider.
- The provider had visited the service and had begun to engage with staff, patients and carers about its values and hopes for the hospital's development.
- The staff team was cohesive and worked collaboratively to best meet the needs of patients.
- We saw examples of innovative practice taking place within the hospital in the form of bespoke risk assessments for individual activities.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Fifty-eight percent of staff had completed mandatory training in the Mental Health Act. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and the Code of Practice. Staff knew who the Mental Health Act administrator was and reported they were accessible and helpful when staff had queries about the Mental Health Act.
- The provider had relevant policies and procedures that reflected the most recent guidance.
- We found no capacity to consent to treatment forms within the same file on two occasions. This was immediately addressed by staff and the out of date form was removed.
- Patients who were detained under the Mental Health Act and informal patients had easy access to information about independent mental health advocacy. An independent mental health advocate visited the service twice a week to support patients on a one to one basis. The advocate attended ward rounds when requested and maintained contact with patients' relatives where appropriate.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.
- Staff ensured that patients could take Section 17 leave (permission for patients to leave hospital) when this has been granted. Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. All records had detailed Section 17 leave forms for both planned and emergency leave that were signed by the patient and where appropriate by relatives (where the patient consented). Staff liaised with the Ministry of Justice when required to discuss Section 17 leave for patients who were subject to Ministry of Justice restrictions and recorded this appropriately.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Fifty-eight percent of staff had received training in the Mental Capacity Act. Staff we spoke with had a good understanding of the Mental Capacity Act, including the five statutory principles.
- The hospital made two Deprivation of Liberty Safeguards applications in the period June 2017 to May 2018 to protect people without capacity to make decisions about their own care.
- The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it.
- Staff knew where to get advice from within the organisation regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.
- Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it. We saw examples of this support in patient care records and staff we spoke with gave us examples of having done this in relation to patient finances and physical healthcare.
- We looked at capacity assessments for six patients regarding a range of decisions, from capacity to consent to medication to capacity to make decisions about finances. Four of the six assessments we looked at did not contain all the detail outlined in the requirements of an effective Mental Capacity Assessment, including evidence of discussion with the patient and a best interest's meeting. The Act places a duty on the decision-maker to consult others who are close to a patient who lacks capacity, where practical and appropriate, on decisions affecting the patient and what might be in their best interests.

Detailed findings from this inspection

- Several members of the team were involved in the assessment of patients' capacity. They did this on a decision-specific basis regarding significant decisions.
- Staff made Deprivation of Liberty Safeguards applications when required and monitored the progress of applications to supervisory bodies.
- The Mental Health Act administrator monitored adherence to the Mental Capacity Act in relation to capacity to consent to treatment through regular audits. We saw these audits were effective in ensuring actions were taken where required. However, these audits did not identify the issues we noted in the capacity assessments.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

Safety of the ward layout

- Staff completed monthly risk assessments of the general ward environment and specific ligature risk assessments every six months. Ligature points are fixtures to which people intent on self-harm might tie something to strangle them self. However, during our inspection we noted that the disabled toilet located on the ground floor of the building was open, contrary to the environmental ligature risk assessment. This was a risk to patient safety because it contained assistance bars and pull cords that patients could use to hurt themselves. We raised this concern during our inspection and staff addressed this immediately by locking the door and placing a sign on the door to state the door must remain locked when not in use. Since the inspection, we have gained reassurance about the ongoing management of this issue. The hospital manager informed us the patient requiring use of the disabled toilet informs staff when he wishes to use the toilet and this is opened and locked again after use. This issue has also been added to the staff observation sheet so staff check the toilet is locked every fifteen minutes. This change in observation process has been added to the ligature risk assessment.
- The hospital had one entrance at the front of the building. To enter the building, patients, staff and visitors passed through a secure airlock consisting of two separate doors. Visitors and staff were asked to sign in and show identification at this point to reception staff. This meant the hospital was secure from unwanted visitors.
- The service was spread across two floors with patient bedrooms located on both floors. This meant that the layout of the hospital did not allow staff to observe all parts of the ward. However, to keep patients safe, staff positioned themselves in communal areas of the ward, including the garden. The hospital also had therapy staff based upstairs and other staff in upstairs areas whilst completing observations. Staff used clinical risk assessment to determine the need for one-to-one observations of patients when a patient was at higher risk. Closed-circuit television cameras allowed staff to maintain a view of the garden and outside the building from the nursing office. This was used to investigate incidents. There were three staircases within the building. Two of the staircases, located at each end of the unit, were accessible to staff only and the middle staircase was monitored by staff to ensure patient safety.
- The hospital was a single-gender hospital for male patients. This complied with national guidance about, and expectations governing the provision of single sex accommodation.
- All patients had their own bedroom and ensuite bathroom. There were two additional communal patient bathrooms on the unit, one on each of the two floors, as well as staff toilet.
- There was no seclusion facility at the hospital.
- Staff had easy access to alarms and patients had easy access to a nurse call system within their bedrooms and in communal areas of the ward. Staff ensured all visitors

were given an alarm when entering the unit and were instructed on how and when to use it. We saw these alarm systems were tested regularly by maintenance staff.

Maintenance, cleanliness and infection control

- All communal ward areas were clean, had good furnishings and were well-maintained. Cleaning records demonstrated that staff regularly and thoroughly cleaned patients' bedrooms and communal ward areas.
- Staff adhered to infection control principles, including handwashing. In the therapy kitchen, there was an information board to support patients and staff to wash their hands properly, and show which chopping boards should be used when handling different foods. Staff told us that a patients' understanding of infection prevention control formed part of the risk assessment process for a patient to access cooking activities in the therapy kitchen.
- We reviewed the maintenance folder. Staff made appropriate environmental and equipment safety checks on a regular basis. We saw evidence that damaged equipment was repaired quickly.

Clinic room and equipment

- The daily clinic cleaning records did not document cleaning of any portable health check equipment, such as weighing scales and blood monitoring machines. There were nine omissions in the daily clinic cleaning records between 6 June 2018 and 11 September 2018.
- The clinic room was too small to accommodate an examination couch. Staff asked patients to lie down in their bedrooms if a physical examination required this.
- We noted eight omissions in the recording of maximum and minimum fridge temperatures between 1 June 2018 and 31 August 2018. On two occasions during July 2018, the fridge temperature had been reset after reaching 12 degrees as per policy. Nursing staff had alerted all staff about the high temperature via email and had requested a re-order of the medication. However, staff did not report this as an incident and we were unable to locate recording of the disposal of a medicine that needed to be stored within this temperature. We noted nine omissions in the recording of room temperatures during the month of June. The quality and effectiveness of medicines can be affected by changes in storage temperatures.
- Staff used sharps bins to dispose of sharps. However, the bins were not labelled correctly with the date of opening or location, in line with clinical best practice. This could make it difficult for the identification and tracking of safe use and storage of items that pose a clinical risk.
- We reviewed the emergency bag which contained all the necessary equipment, which was in-date. However, records showed three omissions in the daily checks of the defibrillator between 24 June 2018 and 11 September 2018. Staff stored emergency medicines and ligature cutters in the nursing office for easy access for all staff. All staff we spoke with knew where the ligature cutters were stored.

Safe staffing

Nursing staff

- The hospital had seven whole-time equivalent (WTE) qualified nurses and 33 other multidisciplinary staff members at the time of our inspection. There were no nursing vacancies.
- The hospital had a two-shift system. To care for 15 patients, there were two qualified nurses and four healthcare workers on day shifts, and one qualified nurse and three healthcare workers on night shifts. This meant that a qualified nurse was always present on the ward.
- Staff told us and we saw there were enough staff to deliver the care and support that patients needed. We reviewed the rotas between 10 September and October 2018 and saw that the hospital was staffed in line with the required numbers and where cover was needed this was clearly identified.
- The manager could adjust staffing figures according to both the number of patients receiving care within the service and the clinical needs of the patients daily. In addition to nursing staff, the manager supported patient care and treatment four and a half days per week. The manager and members of the senior multidisciplinary team were never included in nursing staffing numbers.
- From 1 April 2018 to 30 June 2018, 115 shifts were covered by bank staff to cover sickness, absence or vacancies. Two shifts were covered by agency staff. When agency and bank staff were used, they received an induction and were familiar with the ward. No shifts were left unfilled during this period.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- From 1 March 2018 to 31 August 2018, the average staff sickness rate was 2.7% and the staff turnover rate was 7.5%. The staff sickness rate had reduced since our last inspection (previously 4.7%) and the staff turnover rate had increased (previously 4%).
- Staffing levels allowed patients to have regular one-to-one time with their named nurse.
- Escorted leave for patients was rarely cancelled due to staffing shortages. However, staff told us and we saw that occasionally due to unforeseen circumstances, leave was cancelled when several patients required transport to hospital appointments at the same time. In this instance, public transport was used where possible.
- There were enough staff to carry out physical interventions safely, including observations and restraint when required. Staff had been trained to carry out these interventions. The hospital was in the process of moving from Management of Actual or Potential Aggression (MAPA) training to management of violence and aggression (MVA) training. All but one staff had been trained in MVA.

Medical staff

- A consultant psychiatrist worked three days per week and was available by telephone every day. On the other days, a regional on-call consultant provided out of hours cover to a number of locations including the Limes. This meant they were able to access the hospital quickly during an emergency.

Mandatory training

- Not all staff had received or were up to date with the provider's mandatory training. Prior to the change in provider in May 2018, the hospital's average mandatory training compliance between December 2017 and March 2018 was 97.9%. However, at the time of our inspection, 21% of staff were compliant with the provider's mandatory training courses. The hospital stated they were in the process of arranging in house refresher training sessions. Seventy one percent of staff had completed first aid training. This had become mandatory since the hospital changed providers in May 2018. Staff told us classroom sessions were being arranged and an in-house tutor role was under development.

Assessing and managing risk to patients and staff

- We reviewed the care and treatment records for five patients at the hospital. Staff completed a detailed risk assessment of every patient on admission and updated this regularly, including after an incident. The multidisciplinary team reviewed patients' risk assessments as part of each patient's ward round review meeting and more frequently if required. Staff also completed red amber green (RAG) rated daily risk assessments to allow staff to quickly review a patient's current level of risk and how best to support each patient. However, we found 45 omissions across four patients' records in the daily risk assessments completed by nursing staff. We noted that all staff we spoke with had a good understanding of the patients in their care and their current level of risk and therefore this appeared to be a recording issue, rather than staff being unaware of the patients' needs.
- Staff used the short-term assessment of risk and treatability (START) to assess and review patient risk. This is a recognised tool to evaluate the risks for each patient. Staff identified each patient's risk in relation to violence, suicide, self-harm, neglect, unauthorised absence, substance misuse and victimisation.
- Staff completed risk assessments of patients' mental and physical health prior to patients using Section 17 leave.

Management of patient risk

- Staff completed risk assessments to support the development of care plans around specific risk issues, including falls and tissue viability input. These assessments were detailed and supported the patient in their rehabilitation through clear management interventions.
- Staff identified and responded to changing risks to, or posed by, patients. For example, we observed a detailed discussion around a patient's suitability for unescorted leave. This involved a multidisciplinary review of the patient's current mental and physical wellbeing and their current risks. Staff then discussed the outcome with the patient.
- All patients had a key fob to access their bedroom. Patients were risk assessed for their access to certain high-risk items, including personal care sharps. If a patient did not have access to these items in their

bedrooms, staff stored them securely in an area behind a locked door that only staff had access to. Patients also stored their own food in a separate store, which was kept locked, in the therapy kitchen.

- We reviewed the observation records between the 9 and 10 September 2018. For patients who were subject to half hourly observations, we saw staff had signed the observation record and included a comment about the patient's wellbeing/whereabouts, for example, "breathing noted". For patients who were subject to high level intermittent observations (to be observed at least every 15 minutes), we saw that staff had signed the observation record and included a comment about the patient's wellbeing/whereabouts.
- On all observation records reviewed, we did not see any evidence of staff observing patients at irregular intervals, as outlined in the provider policy. This meant that patients may predict when the staff were due to conduct their observations, leaving them vulnerable to engaging in risk-related or self-injurious behaviour. Additionally, it suggests that all patients were seen across the hospital at the same time. As this is unlikely, this indicates that patient observations were not being recorded in real time. Staff who were observing patients on a one-to-one basis recorded the patient's activity and wellbeing hourly. Since our inspection, we have seen examples of observation records where staff have recorded patient observations in real time, as per the policy. The service made immediate changes to this process following our inspection.
- Staff had conducted risk assessments with patients to determine their level of observation requirement during the night. Some patients had been assessed as not needing to be disturbed during the night and this was care planned.
- Hospital staff randomly searched patients on return from unescorted community leave based on their individual risk.
- Staff risk assessed patients individually for access to high risk items. Staff followed the authorisation and control of high risk items policy by being as least restrictive as possible in their decision making about what items patients could have. For example, we saw some patients had access to shaving razors and keys to the therapy kitchen as their risk assessment deemed them to be at low risk.
- Staff applied blanket restrictions on patients' freedom only when justified. Blanket restrictions are the restriction on the freedoms of patients receiving mental healthcare that apply to everyone rather than being based on individual risk assessments. We did not see any blanket restrictions during our inspection. Patients had free access to the garden area, free use of their own telephones and the hospital's phone. Patients were asked not to have e-cigarette chargers in their bedrooms as this posed a serious fire risk. Staff charged patients' e-cigarettes in the nursing office where they could be monitored.
- The provider had not yet instructed the hospital to implement a smoke-free environment. However, staff offered smoking cessation and this was encouraged in patient ward rounds. Nicotine patches were offered to patients where appropriate to support patients to reduce their smoking.
- Informal patients could leave at will and a sign was displayed on the front door to support informal patients to do so.

Use of restrictive interventions

- The hospital reported no incidents of long-term segregation or rapid tranquilisation in the period 1 January 2018 to 1 June 2018.
- During the period 1 January 2018 to 30 June 2018, there were 14 incidents of restraint on five different patients. There is no data on number of restraints in the previous inspection report to make a comparison on this. There were no incidents of face-down restraint in this time. Face-down restraint - or prone restraint, is when someone is pinned on a surface and is physically prevented from moving out of this position. There are concerns that face down, or prone, restraint can result in dangerous compression of the chest and airways and put the person being restrained at risk.
- The hospital included reducing restrictive practice as an agenda item for community and staff meetings. This ensured staff met to review practices regularly. Staff we spoke with had a good understanding of the benefits of reducing restrictive practice and an awareness of how to individually assess patients and their needs to achieve this.
- Staff used restraint only after de-escalation had failed and used correct techniques. Staff were trained in de-escalation techniques as part of their restraint training. Staff we spoke with had a good understanding of each patient's triggers and communication

preferences when they became agitated. This awareness supported staff to de-escalate situations and reduce the likelihood of a patient requiring further intervention, such as restraint.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- The provider had a rapid tranquilisation policy and procedure available to guide staff. The policy referenced guidance on practice from the National Institute for Health and Care Excellence. Between 1 January 2018 and 1 June 2018, there had been no incidents of rapid tranquilisation.

Safeguarding

- The hospital provided data around their safeguarding training figures prior to the change in provider. This indicated that 46% of staff had completed safeguarding training. This training had not been updated by the new provider. The plan from November 2018 was for an in-house trainer to deliver adult and child safeguarding training to the staff team at the hospital. However, staff knew how to make a safeguarding alert, and did that when appropriate.
- We reviewed the hospital's internal safeguarding log and saw that referrals were made appropriately. However, in three out of seven internal referrals, no initial action was recorded. This meant we were unable to determine what actions had been taken in response to the safeguarding concern. We raised this with the staff who agreed this required improvement.
- The service had not made any external safeguarding referrals in the 12 months prior to our inspection. The hospital manager reported good working links with the local authority safeguarding team and an ability to seek advice when required.
- Staff knew the signs and symptoms of the different types of abuse. They knew how to act to promote patient safety in line with the provider's adult safeguarding procedures and were confident in raising a safeguarding alert or concern when required.
- Children under 18 years of age were not allowed to visit the ward. The hospital had no visiting room separate to the ward which meant that all visitors had to walk through the main ward to access any of the rooms. Patients were encouraged to maintain contact with child visitors by spending time with them in the community.

Staff access to essential information

- Staff typed up patient care plans and printed these and stored them as paper care records. Staff kept these records in a locked cupboard in a room that only staff had access to.

Medicines management

- Staff did not follow best practice in the management of medicines. We noted several practices contrary to the provider's safe storage, control and administration of medicines policy.
- We reviewed five prescription charts. All five charts had care plans to guide staff when and how to use as required medication. However, all of these care plans had been added in January 2018. We saw no evidence that staff had reviewed or updated these plans since this date. We raised this with the provider during our inspection and showed us there were more up to date care plans in patients' main care and treatment records, but these had not been added to prescription charts.
- In one of the medication files we reviewed, we found a note on the front of the file stating that the file contained the patient's plan for medication as required, but we saw no reference to this or any interventions recorded. In one patient's file, we noted that a medicine had been recorded as appropriate for use, but elsewhere in the file we noted this medicine was recorded as an allergy.
- Across the files we reviewed, we noted old patient photograph consent forms, suggesting the decision to include these patient photographs had not been revisited.
- Records did not demonstrate evidence of two members of staff having signed the controlled drugs register on two occasions during the month of August 2018. These omissions had been highlighted in the external pharmacy audit.
- Two of the files we reviewed were unclear about the guidelines for a patient to self-medicate. Staff had not detailed any record of a stage one review or any evidence that the patient was no longer self-medicating. The paperwork was confusing and contradictory because it indicated that a patient remained on a T3 (no capacity to consent to treatment) whilst being on a self-medication care plan. One file also contained an out of date risk assessment. Another file did not contain

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

any evidence of weekly reviews between 21 May 2018 and 18 June 2018 and the forms had not been signed, as required in line with national guidance, by the responsible clinician and the patient's named nurse.

- Staff regularly reviewed the effects of medication on patients' physical health. patients attended a monthly well-man's clinic at the hospital where staff recorded patients' physical observations. This included reviewing blood test results, electrocardiograms and monitoring of patients prescribed lithium. All of these activities contributed to staff's monitoring and review of patients who were prescribed high-dose anti-psychotic medication.
- An external pharmacist visited the hospital weekly to complete medication audits and review the medication stock. We found an administration omission in one of the medication files we reviewed.

Track record on safety

- During the period June 2017 to May 2018, the hospital had not had any serious incidents.
- The staff described serious events that were recorded and reviewed as an incident and demonstrated clear learning from these incidents. We saw evidence of multidisciplinary discussion around learning from incidents.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and when they should report them. The provider had processes to ensure serious incidents were shared with statutory bodies. However, staff did not follow the provider's policy around reporting incidents. Correct procedure around reporting incidents was for whoever was involved in the incident to report the incident on an electronic incident reporting form. Staff we spoke with told us only qualified nurses or members of the multidisciplinary team could report incidents. Healthcare support workers were instructed to report any incidents directly to the nurse, but not to complete the incident report form. This was contrary to the provider's policy which did not specify only qualified staff could report incidents.
- Staff reviewed and discussed incident reporting forms at morning meeting. The clinical director and senior leadership team could view these incidents electronically and maintained oversight to feed up to the Board.
- Staff understood the Duty of Candour. They were open and transparent, and gave patients and their relatives a full explanation if and when things went wrong.
- Staff received feedback from investigations of incidents, both internal and external to the service through lessons learned flyers from the provider and team meetings. Staff met to discuss lessons learnt from incidents within monthly reflective practice sessions. The psychology team held monthly reflective practice sessions for staff. Reflective practice is the ability to reflect on one's actions so as to engage in a process of continuous learning.
- Learning from incidents was embedded in the culture of the hospital. For example, in response to an increase in interpersonal difficulties between patients. Staff had planned an anti-bullying day for October 2018 and the psychology team were setting up an interpersonal skills group. A staff member informed us of changes to the window locks as a result of a patient safety incident. This was implemented across the hospital.
- Following an incident, all staff and patients involved were offered a debrief as soon as practically possible.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked five sets of patient care records. Staff had completed a comprehensive mental health assessment of the patient in a timely manner in all the records we looked at. However, we noted that in three of the five patient records staff had not updated some of the patient's documentation for several years. This documentation included interest checklists, occupational therapy community skills assessments,

night observation engagement agreements and communication agreements. One patient's file contained assessments that recorded a patient's name as their previous name and this had not been updated.

- We saw evidence that staff assessed patients' physical health needs in a timely manner after admission. Staff used the admission assessments and ongoing knowledge of patients to develop care plans that met the needs identified during the assessment. For example, staff developed specific falls care plans for a patient who had been assessed as being at risk of falls. However, we noted that some of these care plans lacked detail. For example, we reviewed one patient's care plan that did not indicate the frequency of physical health appointments required.
- Staff developed care plans that were personalised to each patient and that covered a wide range of needs. For example, care plans included rehabilitation, religious needs, mental health needs, discharge plans and physical health needs. Care plans were written in the first person to indicate the patients' involvement in the care plan. However, staff used language that did not reflect the patient's voice. For example, "I will comply with…", and "I will report to…". We also reviewed one care plan that indicated the patient did not have capacity to care for themselves, but staff had written the care plan in the first person. Two out of the five care plans we looked at had been signed by the patient. This suggests staff did not always make it clear whether a patient had been involved in the development of the care plan.
- Staff updated care plans at least every 16 weeks and reviewed them each month as part of the multidisciplinary team meeting. However, patient care files contained several care plans and assessments that were out of date and this made it difficult to easily locate the most up to date paperwork to support the patient's care and treatment.
- All patient care files contained information, including assessments, that were out of date. In some cases, where assessments had been updated, this was recorded onto the original assessment. This made it difficult for the occupational therapy team to record and follow up patient outcomes.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions that were suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. This included medication and psychological therapies and, activities, training and work opportunities intended to help patients acquire living skills. The therapy co-ordinators monitored how many hours of therapeutic activity per week each patient engaged in, with a target of at least 25 hours per week. Between 1 June 2018 and 31 August 2018, on average, 87% of patients engaged in 25 hours of activity per week.
- The occupational therapist and therapy co-ordinators developed a master therapy programme and reviewed it every three months to encourage patients to engage. Following a period of assessment, patients had individual therapy timetables that were tailored to their preferences and rehabilitation goals. The occupational therapy team used recognised models of assessment and treatment, including the model of human occupation screening tool (MoHOST).
- The hospital had input from a psychological therapist three days per week and a full time assistant psychologist to provide individual sessions to patients. The psychology team was new in post and planned to develop positive behaviour support plans for all patients. The team used therapeutic interventions recommended by the national institute for health care and excellence in their work with patients, including cognitive behavioural therapy. They kept a detailed record of their one-to-one sessions with patients in a private electronic folder and wrote a summary of each session in each patient's clinical notes for nursing staff.
- Staff ensured patients had good access to physical healthcare, including access to specialists when needed. All patients were registered with the local GP. Staff offered a monthly well-man's clinic that encouraged patients to review their physical health needs. Some patients refused to engage with this aspect of care and thereby put their health at risk. In these cases, staff had completed capacity assessments regarding physical health monitoring refusal recorded the patient's views accurately.
- The provider had introduced the national early warning score (NEWS) charts to support staff to monitor patients' physical health. This is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients. However, staff had not received training in how to use it

and were not using it correctly. This made its use ineffective and presented a risk to patient harm through inaccurate assurance. This could also mean that staff were delaying the escalation of a patient's deterioration, presenting a risk to patients.

- The service had recently introduced individual health and well-being books for patients. This included a monthly record of their physical observations, the patient's opinions about their physical health and wellbeing, and ways to improve their physical health.
- Staff completed nutritional risk assessments and monitored patients' nutritional needs where patients were identified as being at risk.
- Staff supported patient to live healthier lives through access to the gym, outdoor activities, providing healthy eating advice, and by offering smoking cessation support.
- Staff used recognised rating scales to assess and record severity and outcomes, including Health of the Nation Outcome Scales and mental state examinations. Staff also used more specific risk assessments for individual patients to monitor their progress, such as the Historical Clinical Risk Management-20, Version 3. We saw and psychology staff told us there were improvements to be made around outcome measures for psychological therapy to improve staff's ability to monitor progress in patient's mental wellbeing.
- Staff participated in clinical audit and could identify learning from these audits. The hospital participated in the provider's clinical group audit monthly. An external pharmacist completed a weekly audit of the clinic room and medication charts. However, the audit did not always record actions taken or learning for staff. We could identify that actions had been taken but this was not always recorded by staff and learning was not clearly identified. The provider reported in their pre-inspection information pack that national early warning score (NEWS) audits of assurance were completed. However, we found several issues with the national early warning score charts and no evidence of learning from these errors.
- As the service had recently changed provider, they had not yet begun participating in any specific quality improvement initiatives. However, staff we spoke with were aware of some of the planned changes to the service to improve the experience for patients and staff alike. For example, there were plans in place to move from paper to electronic care records.

Skilled staff to deliver care

- The staff team included the full range of appropriate disciplines. There was a registered manager, a psychological therapist, an assistant psychologist, an occupational therapist, three therapy coordinators, a psychiatrist, hospital administrators, a receptionist, a Mental Health Act administrator, a visiting pharmacist, an external independent mental health advocate, maintenance, kitchen and housekeeping staff, and nursing staff. The service was supported by a regional clinical director and operations director. The team also accessed support from external agencies including the local authority safeguarding team and the local GP.
- Staff had the relevant qualifications and experience to complete their roles. For example, the hospital supported healthcare support workers to undertake the Care Certificate qualification. We observed that staff had good knowledge of the patients in their care and their individual needs.
- The provider had an onsite induction package before beginning work at the hospital. This included a tour of the hospital with the maintenance staff to understand the alarm system. During a staff member's first week, they were on the rota as supernumery to other staff to allow them to shadow more experienced staff. We also reviewed the provider's corporate induction pack which contained information about the client group and managing risks.
- Supervision is a meeting between staff to discuss case management, to reflect on and learn from practice, and for personal support and professional development. The hospital did not provide clinical and managerial supervision every four to six weeks in line with the provider's supervision policy. The hospital provided supervision every 12 weeks and reported their supervision figures based on this 12-week timeframe, which was in line with the previous provider's policy. Between 1 May 2018 and 12 September 2018, average supervision compliance was 90%. This was above the provider's clinical supervision target of 85%. However, as noted, supervision compliance was not accurately recorded in line with the provider's policy on how frequent supervision should be carried out. The ward administrator audited compliance with supervision weekly (at the 12 week frequency) and supported staff by reminding them when their supervision was due.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Staff also had a supervision passport to record their clinical and managerial supervision. Multidisciplinary staff received separate professional supervision in line with their clinical registration.

- When we inspected, 90% of staff had received an annual appraisal and the medical staff working at the hospital had completed medical revalidation where required.
- The provider had a training coordinator that supported the hospital. Multidisciplinary staff reported good access to specialist training to support the needs of the patients and staff development. Nursing staff told us they did not have access to specialist training around rehabilitation and recovery or other topics specific to the patient population. However, the hospital manager told us there were provider-led training opportunities, for example around how to take bloods.
- The provider had procedures and policies in place to manage poor performance of staff. At the time of inspection, there were no current staff performance issues.

Multi-disciplinary and inter-agency team work

- The hospital held weekly multidisciplinary team meetings. The team reviewed each patient's care and treatment in detail every four weeks. Patients could request more frequent reviews where required and did not have to wait for their allocated week to make requests of the team. We observed a multidisciplinary meeting and saw the staff team held robust discussion about patient well-being, risk, care plans and a personalised discussion with individual patients.
- The multidisciplinary team met every four weeks to conduct a detailed review and analysis of incidents during that month using the data shared at clinical governance meetings. Staff also used this meeting for continuous professional development, including discussion around clinical fayres that different disciplines could attend.
- The service held quarterly staff meetings. These were planned to encourage staff attendance across shift patterns. We reviewed the minutes of the last staff meeting that was held in July 2018 and saw that 11 out of 40 staff attended.
- Staff held a clinical nursing handover between shifts and an additional multidisciplinary team handover each morning. However, staff did not routinely record the number of patients on the ward, how many patients were on leave, patients' current risk level or patients' observation level in the handover book.
- Staff across the hospital did not always receive an up to date and detailed handover of patients' mental state and current risk. Multidisciplinary team staff aimed to have a handover with nursing staff before and after individual therapeutic sessions with patients. However, multidisciplinary team staff reported this did not always happen and recognised this presented a risk to staff and patient safety if a patient's risk had changes without multidisciplinary staff being aware.
- The hospital team had effective working relationships with other relevant teams involved in patients' care, such as care co-ordinators and commissioners. Staff told us the participation of patients' local community teams varied, but they were always invited to attend review meetings of the patient's care and treatment. Prior to our inspection, we spoke with one care-coordinator who reported a positive working relationship with the hospital.

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

- Fifty-eight percent of staff had completed mandatory training in the Mental Health Act. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and the Code of Practice. Staff knew who the Mental Health Act administrator was and reported they were accessible and helpful when staff had queries about the Mental Health Act.
- The provider had relevant policies and procedures that reflected the most recent guidance.
- Patients who were detained under the Mental Health Act and informal patients had easy access to information about independent mental health advocacy. An independent mental health advocate visited the service twice a week to support patients on a one to one basis. The advocate attended ward rounds when requested and maintained contact with patients' relatives where appropriate.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- We found no capacity to consent to treatment forms within the same file on two occasions. This was immediately addressed by staff and the out of date form was removed.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.
- Staff ensured that patients could take Section 17 leave (permission for patients to leave hospital) when this has been granted. Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. All records had detailed Section 17 leave forms for both planned and emergency leave that were signed by the patient and where appropriate by relatives (where the patient consented). Staff liaised with the Ministry of Justice when required to discuss Section 17 leave for patients who were subject to Ministry of Justice restrictions and recorded this appropriately.

Good practice in applying the Mental Capacity Act

- Fifty-eight percent of staff had received training in the Mental Capacity Act. Staff we spoke with had a good understanding of the Mental Capacity Act, including the five statutory principles.
- The hospital made two Deprivation of Liberty Safeguards applications in the period June 2017 to May 2018 to protect people without capacity to make decisions about their own care.
- The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it.
- Staff knew where to get advice from within the organisation regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.
- Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it. We saw examples of this support in patient care records and staff we spoke with gave us examples of having done this in relation to patient finances and physical healthcare.
- We looked at capacity assessments for six patients regarding a range of decisions, from capacity to consent to medication to capacity to make decisions about finances. Four of the six assessments we looked at did not contain all the detail outlined in the requirements of an effective Mental Capacity Assessment, including evidence of discussion with the patient and a best interest's meeting. The Act places a duty on the decision-maker to consult others who are close to a patient who lacks capacity, where practical and appropriate, on decisions affecting the patient and what might be in their best interests.
- Several members of the team were involved in the assessment of patients' capacity. They did this on a decision-specific basis regarding significant decisions.
- Staff made Deprivation of Liberty Safeguards applications when required and monitored the progress of applications to supervisory bodies.
- The Mental Health Act administrator monitored adherence to the Mental Capacity Act in relation to capacity to consent to treatment through regular audits. We saw these audits were effective in ensuring actions were taken where required. However, these audits did not identify the issues we noted in the capacity assessments.

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

Good

Kindness, privacy, dignity, respect, compassion and support

- During the inspection, we observed positive and warm interactions between staff and patients. We saw staff always knocked on patients' bedroom doors before entering and were discrete when carrying out of observations.
- Patients told us staff were kind and treated them well. However, during a group discussion with three patients, patients told us that staff did not engage with them during meal times and reported that staff sat separately from patients when eating in the dining room. Patients told us they had raised this in community meeting. We reviewed the minutes of two community meetings from May and June 2018 and did not see this issue recorded. Both of the carers we spoke with also raised concerns about the level of engagement staff have with patients, reporting that staff were watching patients rather than interacting with them.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Patients reported staff were responsive to their needs and supported them to access other services when they needed it. For example, all patients we spoke with reported good access to physical health care, both within and outside of the hospital. However, three of the patients we spoke with told us there were not enough staff and that this impacted on the activities they were able to engage in.
- All patients we spoke with told us they felt safe on the ward and that incidents of verbal or physical aggression were rare.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Staff begun understanding patients' preferences from the day of their admission through likes and dislikes forms, formal assessments and informal conversations with the patients.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.
- Staff maintained the confidentiality of information about patients. For example, notes were kept in a locked cupboard in the meeting room, which was also kept locked. However, we observed that during multidisciplinary team meetings, patient sensitive information was projected onto a screen which was visible from the garden. During the meeting we noted that patients were in the garden area and the blinds to the room were not closed. This meant that patients in the garden would have been able to see confidential information about other patients through the windows. Since the inspection, the provider reported the hospital intends to utilise privacy screening on these windows. In the meantime, the curtains will be drawn on clinical review days.

Involvement in care

- Upon admission to the hospital, staff provided patients with a welcome booklet and gave them a tour of the ward. Some patients had been able to visit the hospital before their arrival, depending on the flexibility of their previous placement. We saw there was lots of information available on display boards to inform patients of who the staff team were, what activities were available and upcoming events at the hospital.
- All the patients we spoke with told us staff supported them to be involved in their care. Staff made patients aware of their care plans and we saw patients were regularly included in meetings to review these plans and update risk assessments. However, two out of the five care plans we reviewed had not been signed by the patients to say they had seen them/been involved in their development. One patient told us he felt that staff impose some therapeutic activities on him that are not suitable for his needs.
- Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. We saw evidence of this in staff interactions with patients and during the multidisciplinary team meeting. Staff explained clearly and sensitively to patients any proposals around changes to their treatment and sought their views effectively.
- Staff held weekly community meetings with patients. These meetings were well-attended by patients and staff. Meetings included the opportunity to raise concerns, or update staff and other patients on upcoming events. Staff displayed the minutes of the most recent community meeting on a board in the communal area. This allowed patients who may have missed the meeting to see what was discussed, or remind those who attended.
- Staff enabled patients to give feedback on the service they received through informal discussions with staff, community meetings, multidisciplinary ward round meetings and the patient survey. The patient survey results reflected a positive patient view of the hospital. Staff developed an action plan in response the 2018 patient survey, which was displayed in the communal area of the ward. We saw that all actions had been followed up by the responsible individual. Staff and patients had created a 'journey tree' which was on display and encouraged patients to share their thoughts and feelings about their time at the hospital.
- When appropriate, staff supported patients to make advance decisions or statements (to refuse treatment, sometimes called a living will).
- Staff ensured that patients could access advocacy. Several patients within the hospital had regular meetings with the independent mental health advocate, who supported patients on a one-to-one basis and in review meetings, where requested. Outside of the times the advocate was on site, patients could contact the advocate directly or through staff.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Involvement of families and carers

- We spoke with two family members of patients currently receiving care and treatment at the hospital. Both relatives told us they were always invited to meetings about their relative's care and were involved in decision making around this. However, one relative told us it could take up to three months to receive the minutes following a meeting about their relative's care and treatment.
- One of the relatives told us visiting hours were limited, particularly at times when the hospital was busy and both relatives told us access to a visiting room could be problematic. We raised these concerns with the hospital manager who assured us visiting hours were flexible up until 8:00pm and acknowledged the lack of a designated area is an ongoing concern.
- Staff informed and involved patients' relatives and carers appropriately and provided them with support when needed. For example, one relative of a patient at the hospital told us how staff supported them to attend review meetings by providing transport. This made them feel welcome and valued.
- Staff enabled relatives and carers to give feedback on the service they received through surveys. However, the 2018 carer's survey did not gain any responses.
- Relatives of patients we spoke with knew how to raise concerns about the care and treatment of their relatives. One relative told us their concern had not been responded to appropriately and had escalated this through the complaints procedure. We saw the provider had investigated this complaint.

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

Good

Access and discharge

Bed management

- Average bed occupancy between February 2018 and June 2018 was 92%. As part of the provider's specialist services division, the hospital admitted patients from outside of the local 'catchment area' so did not measure out of area placements.
- There was always a bed available when patients returned from leave. Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. When patients were moved or discharged, staff ensured this happened at an appropriate time of day.

Discharge and transfers of care

- During the period 1 June 2017 to 12 September 2018, the hospital reported eight patient discharges. The average length of stay calculated by these eight discharges was 87 weeks (approximately 20 months). Patients discharged from the hospital typically moved to step-down houses in the community or supported living environments.
- From June 2017 to May 2018, there were no delayed discharges from the hospital and discharge was never delayed other than for clinical reasons. Staff planned for patients' discharge, including good liaison with care managers/co-ordinators. We saw an example of person-centred care and discharge planning for one patient who required short periods of support within the hospital to stabilise their mental health before returning to the community.
- Staff supported patients during referrals and transfers between services. For example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital had a spacious communal lounge which had open access to the garden to the rear of the building. Patients had access to the garden where they could smoke at any point during the day or night. The staff encouraged patients to have a healthy sleep pattern, but did not refuse access to the garden at any time.
- Patients could access a separate dining room throughout the day and we saw patients were able to make their own hot drinks and snacks whenever they

wished. Staff individually risk assessed patients for access to the therapeutic kitchen. Patients who had access to the kitchen had a fob that enabled them to enter whenever they chose to. Staff supported patients who did not have access to this kitchen by giving them access to make hot drinks and snacks at any time. Patients used this kitchen when completing occupational therapy assessments and sessions.

- The hospital had quiet rooms and activity/educational and multi-faith rooms. The multi-faith room contained handbooks about a range of different religions, as well as religious scriptures for patients to read. However, there was no designated visitors room and visitors were required to come onto the main ward area to use one of the meeting or quiet rooms to meet with patients. Patients met with visitors in the meeting room or multi faith room. The hospital advised visitors to book in with the unit and if the meeting room was not available, the hospital made arrangements for either a staff member to escort a community visit or, where appropriate, unescorted leave was granted for the patient to meet their visitor in the community. The psychology and occupational therapy office were also used for visits during ward round days.
- There was one meeting room on the ground floor of the building. If this was in use, staff had to use the occupational therapy space to meet, which was not suitable for staff meetings. Staff raised this as an issue. The nursing office was shared with the hospital reception staff and staff told us they would benefit from having a larger space and a separate staff room. The independent advocate also told us that finding space to meet with a patient in the hospital could be an issue.
- All patients had their own bedrooms with ensuite. Fourteen bedrooms were on the first floor and four bedrooms on the ground floor. Patients could personalise their bedrooms. Additional communal bathroom and toilet facilities were located on both floors.
- The furniture throughout the hospital appeared comfortable, clean and was in good order. The service had recently received some new furniture and we saw comprehensive plans to modernise the furniture and update the décor within the service.
- Staff risk assessed patients individually for access to their mobile phone. Where no risk was present, patients had access to their mobile phones at all times. If patients did not have access to their own mobile phone, patients could make a phone call in private in the dining room telephone box.
- Patients and staff reported the food was of good quality. Kitchen staff displayed the menu in the dining area. The menu was rotated every four weeks and patients were able request alternative options if they did not like what was on the planned menu.

Patients' engagement with the wider community

- Staff ensured that patients had access to education and work opportunities. Staff displayed a noticeboard offering volunteering opportunities and encouraged patients to engage in these activities.
- Staff supported patients to maintain contact with their relatives and carers by supporting relatives with their transport where possible and facilitating visits both within and outside of the hospital.

Meeting the needs of all people who use the service

- The service made adjustments for patients with physical disabilities. The service had a slope at the front of the building to make it easier for wheelchair users to access the building. Staff ensured that patients requiring disabled access had a bedroom downstairs. The building had a lift to support patients to access both floors of the building. The occupational therapy and medical team conducted comprehensive assessments of patients with a physical disability to ensure staff met their needs appropriately, for example, falls assessments helped staff to know how to support a patient. Staff told us there were plans in place for one of the communal patient bathrooms to be made into a wet room.
- Staff ensured all rooms had written and pictorial signs on the doors to help patients who may be confused about their surroundings.
- The hospital had several, well-maintained notice boards that displayed a range of information to patients and staff. Each discipline of the multidisciplinary team had their own notice board, which displayed information about treatments and activities on offer. Staff displayed information about patients' rights, how to complain, how to contact a solicitor, the structured day, and how to access support from an independent mental health

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

advocate or independent mental capacity advocate. The hospital provided information in a form that was accessible to the patient group and showed an awareness of the accessible information standard.

- The service had embedded its equality and diversity policies well into the everyday running of the hospital. The hospital held awareness and respect days addressing a range of different topics. For example, we saw photographs displayed from a recent lesbian gay bisexual transgender queer (LGBTQ) respect day held at the hospital. Patients and staff had participated in decorating the ward to show their respect for this community. Equality and diversity was a standing agenda item on patient community meetings and we saw equality and diversity resource files for both staff and patients. There were respect posters on display around the hospital highlighting how the hospital welcomed everyone from all different walks of life and a list of protected characteristics. The hospital manager demonstrated a good understanding of transgender needs and explained how transgender patients would be cared for appropriately.
- At the time of inspection, all patients' first language was English. The hospital had access to information leaflets in languages spoken by patients and interpreters and/or signers as and when required.
- The kitchen staff were aware of the patients' preferences, cultural and religious needs, as well as any specific allergies and staff considered these in their menu planning. There was a range of meals available each day and patients could request alternatives if they did not want something from the menu.
- Staff ensured that patients had access to appropriate spiritual support. Staff displayed a multi-faith board in the communal area of the ward which had a range of information about different religions. The multi-faith room gave patients access to a range of religious scriptures as well as a private place to pray. Staff told us they had supported patients to access religious places of worship within the community.
- Staff reviewed the hospital activity and therapy programme on a quarterly basis to make sure it reflected the needs and goals of the patients currently within the hospital. The hospital offered patients access to maths and English courses, as well as volunteering opportunities, for example with the forestry commission.

Listening to and learning from concerns and complaints

- The hospital had received three informal complaints and two formal complaints between June 2017 and May 2018. No complaints were referred to the ombudsmen. We saw that where a complaint was upheld, staff added regular updates within the complaints file and held regular reviews with the complainant. When patients complained or raised concerns, they received feedback.
- Patients and carers knew how to complain or raise concerns. One patient told us they knew how to complain but they felt staff changed their words in the management of the complaint.
- Staff knew how to handle complaints appropriately. Staff responded to and acted upon complaints in a timely manner, including providing a written response to the complainant. Staff told us and we saw that most concerns were raised as informal complaints and a local resolution was put in place immediately to resolve the issue.
- Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff we spoke with gave us examples of how they had acted on complaints, primarily around reducing restrictive practice.

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

Requires improvement

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. The hospital manager had a good understanding of the service and could explain clearly how the teams were working to provide high quality care. We saw and staff told us the manager operated a supportive approach to patient care and staff leadership and had a good knowledge of the patients' needs. Regional, provider level support was under development at the time of our inspection.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff told us leaders were visible in the service and approachable for patients and staff. This included visits from the provider's chief executive, regional operations and clinical directors.
- Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

- The provider displayed its vision and values within the hospital. The provider's shared values were innovation, empowerment, collaboration, integrity and compassion. However, the staff we spoke with did not have an awareness or understanding of the vision or values of the provider.
- Staff were unaware of the provider's strategy for the service and were unaware of when changes were due to take place. For example, staff told us they were waiting for the implementation of an electronic care notes system but did not know when this would be.

Culture

- The service had not yet participated in the provider's staff survey.
- Staff reported there had been a dip in morale around the time of the change in provider. However, staff told us this had begun to improve and the management team had supported staff through this transitionary phase. The hospital manager held one to one meetings with staff to answer questions about the change in provider and a central human resources team held drop-in sessions to answer staff queries. There were no reported instances of bullying or harassment at the hospital at the time of inspection and managers encouraged staff to raise any concerns openly.
- Staff were positive and proud about working for the provider and their team. Staff reported supportive working relationships within the team and described the environment as friendly. Staff felt able to raise concerns without fear of retribution and had an awareness of the whistleblowing process. All staff told us their managers were responsive to their needs and they felt their managers trusted them.
- At the time of inspection, there were no staff on performance management. The hospital manager could explain clearly the process for managing staff performance and measures taken where concerns arose.
- We saw staff appraisals included conversations about career development and how it could be supported.
- The hospital's staff sickness and absence figures were low and managers could identify where these figures came from.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. The provider recognised staff success within the service through a range of incentives such as monthly draws in which staff had the opportunity to win a holiday.

Governance

- The hospital had effective procedures in place to ensure that wards were safe and clean, that there were enough staff, that patients were assessed and treated well and remained in hospital for the shortest time possible. We found performance to be of a high standard, including sufficient staffing figures, detailed care plans and risk assessments, low vacancy and sickness rates, and good compliance with supervision and appraisals. However, the provider did not have effective procedures in place to ensure that staff received mandatory and specialist training and managers did not have adequate oversight of this. This presented a risk to patient care and treatment, and demonstrated poor governance in this area. Since our inspection, we have received assurance that the hospital manager receives updates about the service's key performance indicators to enable oversight of staff training.
- Staff did not always follow policies and procedures effectively, for example, when conducting observations and reporting incidents. Some staff appeared confused about which provider policies they were supposed to follow and this resulted in staff not following the correct policy.
- Whilst staff took actions to report safeguarding concerns and act on the findings from audits, records did not always demonstrate a complete and accurate description of what actions staff had taken to keep patients safe.
- The hospital had a clear framework of what must be shared and discussed in team meetings. This included learning from incidents and complaints. Staff carried out detailed analyses of incidents effectively and used this information to regularly review patient risk.
- Staff undertook or participated in local clinical audits. Many of these audits were sufficient to provide

assurance and staff acted on the results when needed. However, the medicines audit did not demonstrate what actions had been taken, who had taken them, or how learning from the audit was identified and shared. Audits of physical healthcare records had failed to identify issues noted above with regards to the National Early Warning Score (NEWS) monitoring tool.

- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

- Staff maintained and had access to the risk register. Staff at ward level could escalate concerns when required. Generally, staff concerns matched those on the risk register. For example, we noted that the implementation of new policies and procedures was recorded as a current risk on the register. However, this did not reflect the difficulties and risks associated with the changes in systems and processes for record keeping. This demonstrated a lack of awareness of this risk and of plans to support staff during the transitionary phase of moving between systems.
- The service had plans for emergencies, for example, adverse weather or a flu outbreak.
- There were no current cost improvements taking place that would compromise patient care. The provider was in the process of reviewing the service and making plans to support the development of the hospital.

Information management

- Patient care files were disorganised and it was difficult to find the most up to date assessments and care plans. Staff used paper notes to record patient progress and created care plans on a word document that were printed and put into patient care files. Staff said they had difficulty navigating patient care files to find the most up to date information relevant to their sessions with patients. Members of the multidisciplinary team also raised concerns about different software preventing them from sharing information between colleagues using different computers. We saw this was discussed in the internal governance meeting in May 2018 and continued to remain a problem. Working with paper records also presented an issue in reporting from ward to board level. The manager and clinical director told us there were plans in place to address this and move the hospital back to electronic record keeping before the end of the year. The hospital manager did not have easy access to information about the running of the hospital to support them in their role. They did not have access to a dashboard containing all the key performance indicators, such as training compliance, for the hospital. This meant they were unable to identify areas of concern and relied on a central human resources system at provider level to report back on this. However, the hospital manager had good oversight of patient care within the hospital.
- Staff made notifications to external bodies as needed.

Engagement

- Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. For example, through the intranet, drop in sessions, and bulletins shared in team meetings and with relatives/carers. The clinical director had plans to deliver some 'introduction to the provider' consultation sessions to staff at the hospital.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients had the opportunity to attend the provider's service user conference and share their feedback. The service received a good response rate for the patient survey and had developed and shared an action plan to address any concerns raised by patients. However, we noted that the carer survey received no responses. Carers we spoke with had been able to give their feedback about the care and treatment of their relatives to the service either directly or in multidisciplinary review meetings.
- The senior leadership team shared plans for engaging with carers and relatives of patients receiving care and treatment at the hospital. This involved sending letters to all patients and their relatives/carers introducing the new team.
- The staff survey had not been completed at the time of our inspection. Managers told us staff shared their feedback regularly during team meetings and supervision sessions. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.
- Where possible, patients and carers were involved in decision-making about changes to the service. For example, patients were involved in decisions about the therapeutic activity timetable, décor of the service and of their individual bedrooms.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Members of the senior leadership team, including the chief executive, had visited the hospital to meet with patients and staff. This provided them with an opportunity to gain feedback from those using the service. Staff told us they requested some new furniture and this was immediately listened to and granted.
- Managers engaged with external stakeholders such as commissioners and local authority safeguarding teams, as and when appropriate.

Learning, continuous improvement and innovation

- At the time of inspection, the hospital was focused on adopting new policies and procedures under its new provider. As a result, staff were not heavily engaged in quality improvement initiatives. However, the clinical director told us there were plans to improve the way the hospital measured its clinical interventions by introducing some more robust evidence-based outcome measures.
- Staff members had the opportunity to participate in research.
- We saw examples of innovation taking place within the service. For example, the occupational therapist had designed an assessment to solve a common problem around regular measurement of patients' risk of participating in different activities. We saw this was brought to the multidisciplinary team meeting and new ideas were welcomed by the team.
- At the time of inspection, the hospital did not participate in any accreditation schemes.

Outstanding practice and areas for improvement

Outstanding practice

Staff and patients had embedded equality and diversity principles in the everyday culture of the hospital. We saw some innovative examples of events held at the hospital and displays to celebrate the diversity and demonstrate a respectful and welcoming attitude of all those at the hospital.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff complete observations at irregular intervals, in line with the provider's observation and engagement policy.
- The provider must ensure staff follow best practice in the safe storage, control and administration of medicines
- The provider must ensure staff are provided with regular supervision in line with their policy.
- The provider must ensure staff use nationally recognised tools to monitor deterioration in patients' physical health accurately.
- The provider must ensure patient care and treatment records are stored in an organised and accessible format to enable effective sharing between colleagues and these risks must be considered within the hospital risk register.
- The provider must ensure staff record actions taken following audits and other record keeping to make sure patients are kept safe.
- The provider must ensure the local management team have access to key performance indicators to maintain an oversight of the staff mandatory training.
- The provider must ensure staff complete mandatory training to safely complete their role.

Action the provider SHOULD take to improve

- The hospital should ensure staff review patient daily risk assessments at the frequency outlined in local procedures.
- The hospital should ensure the risks associated with the environment are adequately mitigated against, as outlined in their environmental and ligature risk assessment.
- The hospital should ensure staff complete and record mental capacity assessments in a thorough and robust way to capture the details of discussions held with patients.
- The hospital should ensure staff record what actions are taken to safeguard patients when safeguarding alerts or concerns are raised internally and externally.
- The provider should ensure staff consistently review and record emergency equipment, in line with their policy.
- The hospital should ensure all staff report incidents as per the provider's incident reporting policy.
- The hospital should ensure care plans are written in collaboration with patients and provide evidence of this.
- The hospital should ensure audits are used to identify concerns and learn lessons for future practice.
- The hospital should ensure patients' confidentiality is protected when reviewing confidential and personal information about patients during multidisciplinary team meetings.
- The hospital should ensure handovers are routinely completed with all members of the multidisciplinary team prior to therapeutic activities and that these are accurately recorded.
- The provider should ensure they share their visions and values with staff.
- The hospital should consider providing staff with training around supporting patients in rehabilitation and recovery.
- The provider should consider the need for additional meeting space for visitors and staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The hospital did not complete patient observations at irregular intervals in line with the provider's policy. **This was a breach of Regulation 12 (2) (a) (b)** Staff medicines management practices did not ensure that the storage and administration of medicines was safe. **This was a breach of Regulation 12 (2) (g)** The hospital did not use tools to monitor deterioration in patients' physical health accurately. **This was a breach of Regulation 12 (2) (a) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The hospital did not keep patient care and treatment records in an organised and accessible format for the sharing of information between colleagues. The hospital did not ensure records contained a complete and accurate record of actions taken by staff. **This was a breach of Regulation 17 (2) (c)** The hospital did not consider the risks associated with the transition between electronic and paper systems and this was not reflected on the hospital's risk register. **This was a breach of Regulation 17 (2) (b)** The hospital management did not have oversight of staff key performance indicators.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 17 (2) (c) (d)

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 did not ensure staff had completed mandatory training necessary to complete their role. The provider did not ensure staff were supervised at the required frequency outlined in their supervision policy. **This was a breach of Regulation 18 (2) (a)**