

Victoria Gardens







Quality Report

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

Ratings

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

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 Victoria Gardens, a long-stay rehabilitation service, as good because:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including hand-washing
- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The service had enough nursing and support staff to keep patients safe and meet their needs. Levels of sickness were low
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice, following an established recovery model. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation
- Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health
- Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff had completed and kept up-to-date with their mandatory training

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them
- Staff followed policy to keep patient information confidential. The design, layout, and furnishings of the ward/service supported patients' treatment. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

However:

- Closed circuit television cameras were positioned outside some patient bedrooms and assisted bathrooms and could view into these if doors were left open. This could compromise patient privacy.
- Staff did not always record that patients had been involved in their care.
- A patient under the age of 18 was not receiving ongoing support at Victoria Gardens from a child and adolescent mental health service psychiatrist as recommended by the Mental Health Act Code of Practice.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working-age adults	Good 	Please see the summaries detailed below.

Summary of findings

Contents

Summary of this inspection

	Page
Background to Victoria Gardens	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
What people who use the service say	7
The five questions we ask about services and what we found	8

Detailed findings from this inspection

Mental Health Act responsibilities	11
Mental Capacity Act and Deprivation of Liberty Safeguards	11
Overview of ratings	11
Outstanding practice	23
Areas for improvement	23

Good



Victoria Gardens

Services we looked at

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

Summary of this inspection

Background to Victoria Gardens

Victoria Gardens is a purpose-built independent hospital provided by Elysium Healthcare Limited. The service provides a community-based rehabilitation hospital for male and female patients with complex mental health needs aged 18 and over. Patients with ongoing complex needs are rarely discharged directly from high dependency rehabilitation units to supported accommodation.

Victoria Gardens has been registered with the Care Quality Commission (CQC) since 15 February 2019 and has not been inspected before.

The service is registered to provide the following regulated services;

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

There are four self-contained apartments and four wards at the service;

- Bluebell ward, a nine-bedded unit for females aged over 60 years.
- Roby ward, a nine-bedded unit for male patients.
- Sefton ward, an eight-bedded unit but it was not in use at the time of inspection and
- Dovecot ward, a seven-bedded unit for male patients.
- Patients were allocated an apartment on consideration of needs and readiness for relocation into the community.

All patients were detained under the Mental Health Act at the time of the inspection but could have their section rescinded as they progressed through the service.

The service has a registered manager, and a controlled drugs officer.

Our inspection team

The team that inspected the service comprised three CQC inspectors and two specialist advisors - one nurse specialist advisor and one social worker specialist advisor. [Start here...](#)

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 the location and sought feedback from patients, families and carers by placing comment cards at the service two weeks prior to inspection.

During the inspection visit, the inspection team:

- visited all four wards and looked at the quality of the ward environment. We observed how staff were caring for patients

Summary of this inspection

- viewed all four flats
- spoke with four patients who were using the service
- spoke with the registered and ward manager
- visited the occupational therapy area that included a computer room, kitchen and art room
- visited the service kitchen
- spoke with four patients
- spoke with 12 staff members; including a consultant, nurses, occupational therapist, psychologist, assistant psychologist, health care workers and domestic staff
- collected feedback from seven patients using comment cards
- looked at nine care and treatment records of patients
- carried out a specific check of the medication management and clinic rooms on the three wards that were open
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with four patients and received seven comment cards from patients.

Patients told us they felt safe, supported and that staff are friendly and approachable. Staff respected patient views and treated everyone the same.

Patients had found the psychological intervention sessions enjoyable and helpful. They found that the sessions helped them with their emotions and social skills in the community.

Patients told us they had regular meetings with their care coordinator, they felt involved in their care planning, they had discussed treatment options, their rights had been explained and they had access to advocacy.

Patients felt welcome and the environment was safe and clean.

A couple of patients made negative comments about the service, including; a patient told us they did not like being 'patted down' on their return from leave but understood that it was service procedure and one patient we spoke to told us the food was not varied enough.

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?

We rated safe as good because:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including hand-washing.
 - Staff had easy access to alarms and patients had easy access to nurse call systems.
 - The service had enough nursing and support staff to keep patients safe.
 - The service had enough staff on each shift to carry out any physical interventions safely, keep patients safe and meet their needs
 - Staff had completed mandatory health and safety awareness training
 - Staff identified and responded to changing risks to, or posed by, patients.
 - Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed, and when necessary to keep the patient or others safe.
- However,
- The provider should ensure that the young person admitted to the service received input from a specialist child and adolescent mental health service psychiatrist whilst on the ward, as recommended by the Mental Health Act code of practice.

Good



Are services effective?

We rated effective as good because:

- Care plans reflected the assessed needs, were holistic and recovery-oriented.
- All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards.

Good



Summary of this inspection

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.

However;

- Staff did not always record that patients had been involved in their care.

Are services caring?

We rated caring as good because:

- Patients said staff treated them well and behaved kindly.
- Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.
- Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.
- Staff followed the providers policy to ensure it kept patient information confidential.
- Staff informed and involved families and carers appropriately.

Good



Are services responsive?

We rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.
- When patients went on leave there was always a bed available when they returned.
- The design, layout, and furnishings of the ward/service supported patients' treatment
- The food was generally of a good quality.
- The service could support and make reasonable adjustments for disabled people and those with communication needs or other specific needs.

However

- Closed circuit television cameras were positioned outside some patient bedrooms and assisted bathrooms and could view into these if doors were left open. This could compromise patient privacy.

Good



Are services well-led?

We rated well-led as good because:

Good



Summary of this inspection

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Leaders ensured there were structures, processes and systems of accountability for the performance of the service.
- Leaders had the skills, knowledge and experience to perform their roles.
- The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services.

Detailed findings from this inspection

Mental Health Act responsibilities

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.

Mental Capacity Act and Deprivation of Liberty Safeguards

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Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Good 

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

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

Good 

Safe and clean environment

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including hand-washing.

The service had only been open a short while and all furniture, fixtures and fittings were new, and the service was freshly painted throughout. Furniture in use was appropriate for the service, and due to the service being relatively new was in very good condition.

We saw recorded evidence that the service was regularly and consistently cleaned. During the inspection, staff were noted to be using sinks and soap/gel dispensers to maintain cleanliness and follow infection control protocols.

There were four wards at the location, and four independent apartments. Two wards had nine patients, one ward had eight patients and the fourth ward had four patients. All four of the wards were locked and could only be accessed by staff using an electronic fob. A report commissioned by the Care Quality commission in 2018 found that 63% of long stay rehabilitation wards had locked characteristics, including access control by staff. All patients at the location were detained under the Mental Health Act. There was a notice informing informal (non-detained) patients that they could exit the service at

any time. All patients had access to a communal courtyard when they wished. At the time of the inspection, all four independent flats were not occupied, but were clean and ready for use. The flats were located on the third floor and were accessible either through the main reception area or the accessible entrance at the side of the building, which had a lift or stairs access to the third floor.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The service had a thorough ligature audit and managed risks with patients well. A ligature point is anything which could be used to support strangulation or hanging. Staff were able to show us where the ligature cutters were stored and storage of them was secure but accessible for staff. Bluebell and Roby wards were assessed as having limited ligature risks, but these were managed appropriately, with all patients individually risk assessed for access to areas with ligature risks, and these were mitigated by increased observations for patients deemed at risk of ligature use. Care plans were developed as required. Full ligature risk audits were carried out monthly by the health and safety officer, with the audit tool sent to each ward manager for updating with regard to possible patient risk. Legionella checks were being carried out weekly. Water temperature checks were recorded, and the service had an up to date fire risk assessment.

Staff had easy access to alarms and patients had easy access to nurse call systems. On arrival at the location, the inspection team were given individual personal alarms the same as staff members. Nurse call alarms were in all of the patient bedrooms and each en-suite bathroom, as well as in assisted bathrooms. It was noted that all staff viewed

Long stay or rehabilitation mental health wards for working age adults

Good 

during the inspection had visible alarms present. Closed-circuit television cameras were installed in the communal areas and to some areas close to patient bedrooms and assisted bathrooms. Signage had been displayed notifying visitors that closed-circuit television was in operation in the communal areas. However, it was noted that one camera was directly opposite a bedroom door, and it was possible that the camera could monitor within a bedroom if the door was open: this had been pointed out to staff on a previous visit, but there had been nothing done to change the situation at the time of the inspection.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. There were clinic rooms on each of the wards. All the clinic rooms were spacious, well equipped, clean and tidy. All equipment was marked with dates for calibration and checking. Records held in clinic rooms showed regular monitoring of drugs and equipment. Emergency bags were located within nursing stations and were noted to be up to date and checked regularly. There was documentary evidence of cleaning within the clinic rooms.

Safe staffing

The service had enough nursing and support staff to keep patients safe. Levels of sickness were low. Gaps in staffing were made up by the service's own bank staff or regular agency staff. During inspection, all staff knew the patients and had received basic training to keep patients safe from avoidable harm. One of the wards had not yet opened. The service had ongoing recruitment for 13 staff posts, in order to ensure that suitable staffing numbers were available when the service had maximum admissions. The service was avoiding such discrepancy by ensuring that admissions to the service did not overload staffing.

The service used a safe staffing tool to ensure safe staffing levels on all wards. A resource administrator was employed full time to make sure staffing levels remained at the correct levels. Resource meetings were held twice per week with the resource administrator, nursing staff and managers to discuss staffing requirements and put advance plans in place to ensure safe staffing levels and skill mix. At the time of the inspection, there were 34 substantive staff, with two leaving in the previous 12 months, with a turnover rate of less than one percent, and a sickness rate of less than two percent.

The service had a bank staff system, using staff that were familiar with the service, systems, procedures and the patients, on a regular basis. Between May 2019 and June 2019, 24 shifts were covered by bank staff on Bluebell ward and 25 covered by bank staff on Roby ward.

Agency staff were used as a last resort and the service would aim to use agency staff that were familiar with the service, specifically requesting certain agency staff when required. Information received from the service showed that there had been low use of agency staff. Between May 2019 and June 2019, three agency staff had been recruited to cover shifts on Bluebell ward and three on Roby ward. Information for the other two wards was not available. Managers told us that all agency staff received an induction on to the wards that was completed with the nursing staff.

The ward manager could adjust staffing levels according to the needs of the patients. We saw evidence of this on the wards.

Patients had regular one to one sessions with their named nurse, this was recorded in care notes. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. We were told leave could be rescheduled to later that day, but not cancelled.

Bank staff received the same mandatory training as regular staff, including therapeutic management of violence and aggression, this complied with the provider's operational policy dated April 2019.

The service had enough staff on each shift to carry out any physical interventions safely should they need to. The service had a monthly on call rota and we saw that staff rotas had been prepared up to 6 weeks in advance.

Staff had completed and kept up-to-date with their mandatory training. Mandatory training was provided for all staff using an online learning system which also alerted staff via email when their training needs to be updated. Bank staff were contacted by the resource team to inform them of training available.

The service provided 20 mandatory training courses. All were above the service target of 85% except for immediate life support training which was just below target at 83% (five out of six staff had completed the training) and Prevent training, which had a compliance rate of 79% (22 out of 28 staff had completed the training). Managers

Long stay or rehabilitation mental health wards for working age adults

Good 

monitored mandatory training and alerted staff when they needed to update their training. The service had an action plan in place to monitor and consider actions should mandatory training levels fall below the target threshold.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed.

The service used a short-term assessment of risk tool, to help manage and mitigate risks. We reviewed nine risk assessments, all were holistic and comprehensive, with evidence of updating occurring after an incident.

All permanent and bank staff had received therapeutic management of violence and aggression training and the service had policies in place for the involvement of police and managing aggression. Staff could observe patients in all areas.

The service had a patient under the age of 18 (17 years of age) with complex care needs. The patient was cared for at Victoria Gardens due to the lack of an available, appropriate inpatient bed within child and adolescent mental health services nationally. Staff were working with NHS England and other providers to ensure the patient's needs were assessed. Staff had made adaptations to ensure the patient's health and education needs were met whilst maintaining a safe and age-appropriate environment. The service had completed a specialist risk assessment with the patient and the patient was receiving input from specialist services. Staff were awaiting the outcome of a recent, one-off assessment from specialist child and adolescent mental health services. However, there was no input from a specialist psychiatrist, as recommended by the Mental Health Act Code of Practice. We discussed this with the registered manager who accepted the need to ensure the staff and patient received input from a clinician from child and adolescent mental health services.

Staff used de-escalation techniques to assist patients in managing aggression. There were areas at the service where patients could be taken from possible incidents that might cause anxiety, to assist in de-escalation, low stimulus

environments. The service followed the management of violence and aggression policy to ensure safe handling of such situations. As the service was rehabilitation in nature, the admission criteria also considered risk before a patient was admitted to the service.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. We saw evidence of search records in patient notes, along with a rationale for the search. The service used a randomiser button in reception, each patient on return from leave would push the button, if it alarmed then a search of bags would be done, if not there would be no search, unless the staff had reason to believe that the patient might be taking prohibited items into the service. This followed the provider search policy.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only as a last resort and when necessary to keep the patient or others safe. Staff followed national institute for health and care excellence guidance when using rapid tranquilisation. Each patient had a positive behaviour support plan. There had been 38 incidents of restraint in the six-months prior to the inspection, involving a limited number of patients, with use of rapid tranquilisation on five occasions. There was one report of prone restraint for a short period to administer medication. Staff followed the provider's rapid tranquilisation policy.

The service completed a thorough pre-admission assessment report with all patients. Crisis plans were completed prior to admission, during admission and reviewed at multi-disciplinary meetings.

Mental health risk assessments were reviewed during weekly ward rounds for new admissions and monthly as a minimum for longer term patients or as and when required. There were no blanket restrictions in place.

Safeguarding

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

Long stay or rehabilitation mental health wards for working age adults

Good 

The service had a safeguarding lead and they had safeguarding adults and safeguarding children and child protection policies in place. Adult and child safeguarding training was included in mandatory training and was up to date for the service.

There had not been any safeguarding concerns raised by the service at the time of inspection.

Staff access to essential information

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

Management told us there had initially been some issues with online access for some staff when the service first opened and that some notes had to be written up and then placed on the electronic record by other staff or at a later time. Management assured us that this had been rectified. On inspection there were no problems accessing records, and they were securely stored.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. The service had a monthly audit completed by the pharmacy that supplied medication and completed a clinical audit within each clinic room of the service. The use of rapid tranquilisation was monitored during a weekly meeting held each Friday by the senior management team.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed 10 patient's medicine administration records and spoke with nursing staff. All medicine cards were detailed and thorough.

Information relating to patient consent to treatment was evident and nursing staff understood their responsibilities for the safe administration of medication and including physical health checks of patients.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patient care records indicated clear discussion regarding medication during multi-disciplinary team meetings, including patient participation.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. This included the use of a positive cardiometabolic health resource tool as part of an intervention framework for adults with psychosis and taking antipsychotic medication.

Staff followed current national practice to check patients had the correct medicines.

Two of the mandatory courses that the service provided for nursing staff were 'safe administration of medication' level one and two.

A pharmacist attended monthly to complete audits of all medication charts, Mental Health Act T3 and T2 audit and a clinic audit. Nursing staff completed a medication audit weekly.

Audits for 'prescribing observatory for Mental Health' and 'stopping over medication of people' were to be completed annually but this had not happened yet due to the service being open less than a year.

The service has had one minor medication error in the six months prior to inspection.

Track record on safety

The wards had a good track record on safety. The service managed patient safety incidents well.

The service had reported one incident at the time of inspection. On review of the information provided by the service, procedure and protocols had been followed in line with the service policy.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

There had been one serious incident since the service opened, this had been reported to CQC and the incident had been thoroughly investigated by senior managers at the service.

Staff knew what incidents to report and how to report them. The service used an online portal to record incidents which could be linked to individual patient clinical notes.

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

Long stay or rehabilitation mental health wards for working age adults

Good 

received feedback from investigation of incidents, both internal and external to the service. Incidents were reviewed by the senior clinician, managers and the services health and safety lead. Any incidents that were identified as serious were reported to the relevant commissioner and CQC.

Managers told us that learning from incidents would be discussed during supervision and at ward meetings. Staff told us they were confident that sharing of information regarding incidents was relevant and taking place.

Duty of Candour

All healthcare services have a legal duty to inform and apologise to patients when things go wrong with their care or treatment that could cause harm or distress. The service had a policy in place that had regard to duty of candour. All staff were expected to adhere to the policy.

Duty of candour training and information was included in staff induction to the service. The service was aiming to provide staff with annual updates.

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

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were holistic and recovery-oriented. All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

We reviewed nine patient care and treatment records. All records were detailed and up to date. They were holistic, person-centred and included comprehensive assessments of risks and evidenced that full physical health examinations had been carried out. However, care plans did not indicate they had been prepared with direct input from patients or including their needs and wishes. All

patients were given a full physical health check within 24 hours of admission, dependent on their mental state. These full physical health checks continued to be completed, at least, every six months. Care plans were individualised, from a physical healthcare perspective, to ensure that those with physical ailments were seen more frequently by the visiting practice nurse. This was audited via the service electronic dashboard on the ward to board report which was reviewed in hospital governance on a monthly basis.

Information and discussions about treatment options were seen to have taken place with patients.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to had good access to physical healthcare and supported patients to live healthier lives.

Best practice guidance from the National Institute for health and Care Excellence, as well as other national programmes, were introduced to the service via the regional and head office clinical governance groups for the provider, and application and monitoring of adherence was completed via clinical audit.

The service had an internal referral system to efficiently refer patients to a range of services in the community, including the GP, dietician, chiropodist, dentist, opticians and practice nurse. The service linked in with the GP on the quality outcome framework.

There was a psychology lead and two psychology assistants. The service was supporting the two staff members to take part in a psychology graduate programme alongside their substantive role, working one day a week with the lead psychologist.

The service had a variety of psychological interventions and group activities available for patients. The occupational therapist followed a comprehensive process that included meeting the patient within 48 hours of admission, completing an assessment within seven days with the patient, working collaboratively with the patient to develop a therapeutic programme, complete an

Long stay or rehabilitation mental health wards for working age adults

Good 

occupation screening tool within 12 weeks and review goals, presented outcome and treatment plan at multi-disciplinary meetings and made referrals to specialist services including speech and language therapy if required.

Some of the group and activity sessions, run by the occupational therapist, included healthy lifestyles, budgeting, internet safety, baking group, horticulture group, arts and crafts, sport sessions and community walking group. The occupational therapist and lead psychologist worked together to deliver stress management and relaxation group and mental health awareness groups sessions.

Patients were offered a variety of psychological therapies in line with National Institute for Health and Care Excellence guidance. These included cognitive behavioural therapy, dialectal behaviour therapy, eye movement desensitization and reprocessing mindfulness, stress management, art therapy, substance awareness and mental health awareness.

The psychology lead and assistants were working with the occupational therapist to look at training other staff in cognitive behavioural therapy.

Staff used recognised rating scales to assess and record severity and outcomes. They included 'health of the nation outcome scales', the 'Liverpool University neuroleptic side effect rating scale' and 'malnutrition universal screening tool'.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the wards. Staff at the service comprised of medical, nursing, psychology, occupational therapy, domestic and hospitality disciplines.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. All service staff were subject to the same checks prior to starting employment at Victoria Gardens: Disclosure and Barring Service check, the Right to Work - one of the forms of ID collected for the

Disclosure and Barring Service check was also used as proof of right to work, and proof of a biometric residence permit was sought for staff who weren't born in the European Union. Other standards included fit and proper persons checks.

Managers gave each new member of staff a full induction to the service before they started work. Evidence of induction was seen during review of staff files. Managers supported staff through regular, constructive appraisals of their work. All staff received regular supervision ranging between every six to eight weeks. At the time of inspection, all staff, except one, had received regular supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We saw evidence that regular team meetings were taking place, including minutes from meetings and in discussion with staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Training for staff was clearly encouraged at the service, with staff taking part in different relevant courses. The Mental Health Act administrator was being funded to complete a relevant course at university.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The service had effective working relationships with other staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge. This was evident in the patient care and treatment records we looked at.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. This was evident in the care records reviewed during the inspection. There was clear evidence of care coordinators, social workers and independent mental health advocates in attendance.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We saw handover notes at the service that were concise, conveying relevant information to staff.

Long stay or rehabilitation mental health wards for working age adults

Good 

Managers told us the service had effective working relationships with community health services, social services and independent mental health advocates. Patient care records documented evidence of joint working with other disciplines in the community.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them and patients were provided with leaflets about their rights prior to admission.

Patient care plans confirmed that patients' rights had been discussed with them and all detention paperwork required was correct.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff were able to give details of the Mental Health Act administrator, and how to contact the administrator.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Patients we spoke to confirmed they had received information on their rights and had access to advocacy. Referrals were made to independent mental health advocacy as and when required. There was no formal contract in place for regular advocacy, however, the service predominantly utilised a service that could supply both mental health and capacity advocates.

Staff requested an opinion from a second opinion appointed doctor when they needed to. Staff told us there had been delays in the past for a second opinion appointed doctor, but delays were beyond their control. We saw that requests had been made by the service appropriately.

Patients' legal files had been audited to ensure that there are no issues with regards to the Mental Health Act. Section 132 rights were monitored via the services dashboards to ensure they had been read as and when required.

The Mental Health Act (Code of Practice) training was mandatory for all staff and all staff had received this. Informal patients would be informed that they could leave the ward freely and the service displayed posters to tell them this. The service had signs on doors reminding informal patients of their right to leave the service. The

service were made aware of the Code of Practice requirement to ensure access by a children and adolescent mental health psychiatrist for the young person who had been admitted to the service.

A Mental Health Act administrator was employed at the service and would link in with the regional Mental Health Act team. Staff could approach them for advice and support when needed. The service was supporting the Mental Health Act administrator to study Mental Health law and practice at university.

The pharmacist conducted T2 and T3 audits every three months as a minimum, depending on individual patients. The pharmacist for the company that supplied medication to the service also did monthly audits of medication records.

Good practice in applying the MCA

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

The Mental Capacity Act and Deprivation of Liberty Safeguards training was mandatory for all staff. At the time of inspection, All staff had completed the training. Staff were able to speak clearly about the five principles of the Mental Capacity Act.

Staff we spoke with told us that they had a good understanding of both Mental Capacity Act and Deprivation of Liberty Safeguards and knew where to get advice and support. Records showed that capacity was being considered and recorded appropriately. There was evidence of best interest consideration for patients who were deemed to have limited capacity.

At the time of the inspection there were no patients admitted to the service who were detained under Deprivation of Liberty Safeguards.

Long stay or rehabilitation mental health wards for working age adults

Good 

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

Good 

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. Staff respected patients' privacy and dignity and we saw positive interactions between staff and patients. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However, close circuit television cameras were placed to provide a view on ward general areas also pointed into some of the patient bedrooms and assisted bathrooms (if the door was open) on the wards. This had been raised prior to inspection (at the registration stage) and the registered manager had informed CQC that the cameras were going to be rectified either by hazing out certain parts of the camera sight or re-positioning of the cameras. At the time of inspection, no improvement works to rectify the issue had been completed, having a possible impact on patient privacy and dignity.

Patients said staff treated them well and behaved kindly.

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

Staff followed policy to keep patient information confidential. Patient records were secure, and staff knew not to speak openly about patient information.

Involvement in care

Discussions between staff and patients had been documented in care plans, although not written in a way that indicated direct involvement. Patients had access to independent advocates when required. Patients we spoke to told us they had been involved in their care planning.

Staff informed and involved families and carers appropriately. Carers events were to be held on a regular basis to encourage working partnerships between families, patients and the service. Carers were invited to care

programme approach meetings and ward rounds at the patient's discretion. The service planned to have a carer's representative who would attend quarterly governance meetings.

For patients, ward-based community meetings were held on a weekly basis. Patient council meeting was held once a month and was chaired by the hospital director. A patient representative would be invited to attend part of the hospital governance meetings to discuss complaints and any issues they had and opportunities they would like to see for their peers, although at the time of the inspection there was no evidence that this was in place yet.

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

Good 

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.

The service had a discharge policy in place. A comprehensive assessment form was completed prior to admission with patients. There had only been one patient that had been discharged from the service since opening and the manager told us that the estimated length of stay was between six and 12 months. However, as the service was new and the patient base growing, it was difficult to give accurate data regarding length of stay and discharge. We saw that discharge plans were evident in patients care and treatment plans and that discussions had taken place with the patient, the patients care coordinator, clinical commissioning groups, community home team, advocacy and family about discharge. Discharge planning was evident from the pre-admission stage that included estimated discharge dates.

When patients went on leave there was always a bed available when they returned. At the time of the inspection, there had been no incidents where a patient did not have a bed to return to. There had been no readmissions to the service since it had opened.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer. There were protocols in place for the safe transfer of patients between service. At the time of the inspection, there had been no requirement to transfer a patient.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward/service supported patients' treatment.

Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

Each of the wards had a secure air lock system on entry. Access could only be gained by staff using an electronic fob. Patients did not have access to a fob. Each of the wards had well equipped clinic rooms, private room with a telephone, quite lounge, a communal lounge/dining area and each patient had their own bedrooms with en-suite facilities and lockable storage to keep belongings safe. There were rooms where visitors could be met and engaged.

Closed-circuit television cameras were able to view into some patient bedrooms and assisted bathrooms when doors were open, which could have an impact on patient's privacy and dignity, should they leave the doors open when using the rooms. The service had been informed that this required attention prior to inspection but no measures had taken place to rectify the issue.

Patients had access to their bedrooms during the day and patients were able to personalise their rooms.

All wards gave access to the communal courtyard. Patients were seen using the courtyard when they wanted to. A member of staff was always present when patients were in using the courtyard, especially if there were both men and women in the area.

Patients could go out into the community, if not detained under the Mental Health Act, or with sanctioned leave from the responsible clinician. One patient was volunteering in the local community.

Roby ward and Bluebell ward had a well-equipped sensory room for patients.

The service had a monthly newsletter that detailed current and upcoming events, top tips, positive quotes, recipes and patient achievements.

The food was of a good quality, according to most patients, and patients could access hot drinks and snacks at any time. Some patients could make their own drinks and snacks in accordance with individual care plans, each patient was individually risk assessed as to accessing kitchens. Meal times were protected, meaning visitors could not visit during meal times. However, one patient we spoke to said that the food was not varied. Patients could use their own mobile telephones if risk assessed, and there was Wifi available at the service.

Meeting the needs of all people who use the service

The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication and referrals to advocacy.

Patients had access to education and volunteering work. Referrals were made to specialist services when needed.

The service could support and make reasonable adjustments for disabled people and those with communication needs or other specific needs. All wards were accessible for people with reduced mobility. Wards on the first floor were accessible using the lift. Equipment in bathrooms allowed for consideration of people with reduced mobility.

Information leaflets were available in different languages on request.

Catering staff told us they were able to provide foods to cater to different dietary needs and requirements when needed. We saw that the kitchens were clean and well equipped to cater for patient needs.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Long stay or rehabilitation mental health wards for working age adults

Good 

Information received from the service stated that three complaints had been received in the 12- months prior to inspection. None of the complaints were upheld and none were referred to the Ombudsman. Avenues for learning from complaints were in place at the service.

Staff and patients we spoke to knew how to complain and the service had a complaints policy in place. Signage on notice boards gave information on how to make complaints to the service staff.

Managers told us that complaints would first be dealt with at ward level with the ward manager and more serious complaints would be raised with the registered manager and with the aim to resolve within 72 hours. Staff received debriefs of any incidents, complaints or concerns at team meetings or through supervision. Managers told us personal meetings would be arranged if required.

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

Good 

Vision and strategy

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

The service was provided by Elysium Healthcare, and the provider vision and values for the service were incorporated into the daily delivery of care.

The core values were innovation, empowerment, collaboration compassion and integrity. We saw evidence of the values throughout the service, and during the inspection we saw staff acting in ways that embodied the values.

Leadership

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

Staff we spoke with knew who the most senior leaders were and that there was a good working relationship between senior multi-disciplinary team staff.

Staff told us they had the opportunity for leadership development, however, there was limited progression available for senior health care support workers.

Managers we spoke with had a good understanding of the service and were secure in their knowledge about staff and patients.

Culture

Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

All staff were required to complete mandatory equality and diversity training on an annual basis.

Staff told us they felt it was a very supportive and encouraging environment at the service and that staff are encouraged to develop their skills and abilities.

Staff told us they were happy to work at the service.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers used electronic dashboards to monitor training, staffing levels, care programme approach, security, risks, incidents, clinical notes, incidents, complaints, observations, legal data, leave and physical health checks in real time.

The services 'ward to board' dashboard was monitored and discussed weekly with senior managers and monthly at regional operational and clinical governance meetings. There was evidence of regular audits taking place, including section 132 Mental Health Act rights audit and ligature risk audit.

Long stay or rehabilitation mental health wards for working age adults

Good 

Handovers were held daily with all staff to discuss any concerns, risks, staffing, clinical decisions update, medication changes, safeguarding, physical health observations, legal updates, ward environment updates and operational plans.

Managers felt they had enough authority to carry out their roles.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

The service had a risk register that had strategic plans in place. The risk register had been revised in April 2019 and updated in August 2019. The risks entered on the system were monitored using a red, amber and green system, and the register showed that there were no risks perceived to be in the red (highest) section of risk.

Managers and leaders had access to information to support them in their roles. Managers used the electronic dashboards to monitor performance in real time.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients. The

service provided the names of the clinical commissioning groups associated with the service, we had no information from the groups suggesting any problems with the relationship with the service.

Staff did not engage in national quality improvement activities. We were told that the service would be more involved with national groups as it developed and grew.

Staff were kept up to date with activity relating to the service through team meetings, handovers and supervision. Staff told us that they felt they could put forward their suggestions and feelings about the service without fear of adverse reaction.

Information management

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

Staff had secure electronic access to patient's information, guidance, online support (policies and procedures), peer support and through supervision to enable them to carry out their roles sufficiently.

Learning, continuous improvement and innovation

The service had not participated in any research or benchmarking at the time of inspection.

However, we found that the service was committed to quality improvement and innovation by implementing the dashboards on the wards that enabled staff and managers to see information relating to patients and operational activity in real time and reduced the need for paper reports.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that the young person admitted to the service received input from a specialist child and adolescent mental health service psychiatrist whilst on the ward, as recommended by the Mental Health Act code of practice.
- The provider should ensure that care plans and risk assessments clearly indicate patient involvement in the preparation.
- The provider must ensure that closed-circuit television cameras do not affect patient privacy and dignity.