Forest Hospital

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

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 Forest Hospital as requires improvement because:

- Governance systems were not in place to ensure managers were assured about all aspects of the care and treatment of patients. There was no system to monitor individual patient's activities and leave. Staff and carers said activity was low and not focused on maintaining independence and we observed low levels of activity on Maltby ward. Staff did not always complete effective audits and care records were not always complete and accurate records. Observation practices were not always safe; on occasion domestic staff, without suitable training completed them. When staff completed observations, they did not record the observation at the actual time it occurred.
- Staff did not complete detailed discharge plans and these were not present for all patients. Support plans were not strength based and staff did not always make sure they wrote support plans in the patient's voice, describing their preferences. Staff could not describe the rehabilitation model for the hospital and had not completed training in rehabilitation.
- Staff did not consistently complete records to demonstrate they had checked or cleaned equipment. Staff had not regularly checked resuscitation equipment, including a defibrillator to check it was safe to use. There were no records to evidence cleaning of portable physical health equipment, the hoist and clinic room.
- Staff did not always ensure records were complete and detailed. Staff did not always keep detailed handover records and care records did not always contain all relevant information for patient care.
- Staff told us morale was low, they worried about staff turnover and found the change in managers destabilising. Staff did not think all managers were visible and did not feel well supported or encouraged. There was no local staff survey for staff to feedback to managers.
- Risk was not always well managed. Four of eight risk assessments did not provide a full description of the risk identified. Two staff did not know where ligature risks were on the ward and a nurse did not know where to locate ligature cutters. Staff did not consistently complete all the physical health observations and record risks using the National Early Warning Scores.
- Staff could not describe the model that the service used. Psychological interventions for patients were limited; there were no psychological interventions for patients on Maltby ward.
- Staff did not ensure that patient community meetings took place regularly. Staff did not know who provided advocacy in the community and details of local advocacy services were not available on Horsfall ward.

However:

- Staff completed mandatory training for their roles and compliance with training was high. Staff received supervision and appraisals from their managers and engaged in team meetings.
- Staff demonstrated that they knew how to protect patients and had completed safeguarding children and adults training. Staff knew how to raise a safeguarding concern and identify abuse. Staff ensured they only used restraint as a last resort and levels of restraint were low. There was evidence staff only used restraint if de-escalation had not worked and that staff successfully de-escalated without using restraint most of the time.
- Staff were kind and responsive towards patients, they supported patients appropriately and demonstrated they knew patients well, they understood patients' likes and dislikes and cultural and religious needs. Staff communicated with patients in a way that suited them.
- The recently appointed interim hospital director and divisional director understood the hospital and challenges that the hospital faced and ensured all staff were familiar with the vision and values of the

wider organisation. Managers ensured nurses could complete leadership training, new staff had enrolled on this. There was a care practitioner leadership course available for recovery assistants.

- Staff ensured patients had access to physical health care and worked with external professionals including a local GP to ensure this was accessible to patients. Staff followed good practice in medicines management. Medicines were well organised, recorded effectively and stored safely.
- Staff supported patients to make contact with their family and carers including home visits. The hospital offered flexible visiting times for families and friends. Staff responded to complaints effectively and in line with policy. Staff made appropriate changes following complaints.
- The service held multidisciplinary ward round meetings. Discussions at ward round involved the patient and were thorough and staff recorded these.

Summary of findings

Contents

Requires improvement

Forest Hospital

Services we looked at

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

Summary of this inspection

Background to Forest Hospital

Forest Hospital, owned by Barchester Healthcare, is a 30-bed mental health independent hospital designed to provide accommodation, rehabilitation, personalised care and support for men and women over the age of 18. Patients required a complex model of care. The majority of patients could not carry activities of daily living without support. The hospital director described this as longer-term care for patients with a progressive brain disorder. However, there were two people at the hospital who did not have progressive brain disorders who required the care and rehabilitation provided by a high dependency unit.

There are two single sex wards called Horsfall (female) and Maltby (male). At the time of inspection, there were eight patients on Maltby ward and eight patients on Horsfall ward. The hospital opened in 2013. The hospital is set in large grounds with gardens, in a residential area and is served by a local bus service.

Forest Hospital is registered with the CQC to provide the following regulated activities:

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

Patients cared for at Forest Hospital:

- May be detained under the Mental Health Act (1983) sections 2,3,37 and 41 or informal.
- May be detained under Deprivation of Liberty Safeguards, which is part of the Mental Capacity Act
- (2005).
- Have a primary diagnosis of mental illness with complex needs.
- Typical diagnoses include dementia, Parkinson's, Huntington's Disease, Korsakoff's and Depression.
- May have a history of substance, drug and alcohol misuse.
- May have a history of sexual abuse or domestic violence.
- May be treatment resistant.

At the time of our inspection there was no registered manager. The hospital director had resigned from the post the month before our inspection. There was an interim hospital director who worked as a senior hospital director at another Barchester hospital; Billingham Grange. The interim hospital director was supported by other staff from Billingham Grange in their temporary roles at Forest hospital. After our inspection the interim hospital director became the registered manager and the hospital appointed a new hospital director who plans to start work in the new year of 2019. There had been three hospital directors in the last two years.

There have been seven inspections at Forest Hospital since registration with CQC; the last comprehensive inspection took place in March 2017. We rated the hospital as requires improvement over all; rated safe as good, effective as requires improvement, caring as good, responsive as good and well-led as requires improvement.

A follow up inspection took place in November 2017. At this inspection we considered the two key questions. Are services effective and are services well led? The rating for well led improved to Good whilst effective remained at Requires Improvement. However, overall the rating became Good. At this most recent inspection we issued a requirement notice in relation to Regulation 11 (need for consent). Staff had made changes and this was no longer an issue.

The most recent Mental Health Act review visit took place in July 2018; however, we did not complete this as no patients were detained under the Mental Health Act.

Our inspection team

Team leader: Liz Millet

The team that inspected the service included three CQC inspectors and a specialist advisor who was nurse with specialist knowledge in long stay rehabilitation.

Summary of this inspection

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. We also spoke to commissioners and other stakeholders.

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients; including carrying out a short observational framework for inspection to check on how staff were caring for patients
- carried out an unannounced visit to the ward at night and spoke to night staff
- spoke with a patient who was using the service. Not all patients were able to or wished to speak with us at the time of our inspection
- spoke with the divisional director, interim hospital director, deputy manager and a team leader
- spoke with 14 other staff members; including doctors, nurses, occupational therapist, clinical psychologist, domestic staff and recovery assistants
- received feedback about the service from care co-ordinators or commissioners
- spoke with an independent advocate
- spoke to the local GP who worked with the service
- attended and observed a ward round
- spoke to seven carers and family members
- looked at eight care and treatment records of patients
- carried out a specific check of the medication management on two wards; and
- 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 to seven carers; five carers were happy with care that their family member received. Six carers found recovery assistants were caring, approachable and polite. They felt involved with decision making and were happy with how staff communicated with them.

Four of the five carers told us there was not enough activity and this was not always individualised. Two carers said they would like to see their family members going out into the community more.

Two carers told us they received insufficient communication from the hospital and one carer expressed concern about the turnover of staff.

Overall carers were happy with the environment on the wards and felt they were spacious, clean and tidy. They were satisfied their family member's physical health was appropriately cared for. However, carers said staff had not given them information about the hospital when their family member was admitted. Three carers said that they did not know how to make a complaint. Not all carers felt well supported by the hospital.

The patient we spoke to was happy with their care and the care environment and said staff treated them well. However, they did not think there was enough activity available. The patient was not aware of their support plan or rehabilitation goals.

Summary of this inspection

We spoke to two of the four commissioners who funded patients at Forest hospital. One commissioner told us they were satisfied with the standard of care and said the hospital was successful in moving patients on appropriately. However, they expressed concerned about the instability of managers at the hospital; they thought care standards had deteriorated after the last hospital director had left their post. They did not think support planning was robust.

The other commissioner was positive about the hands on care the patients received but was concerned about staff turnover and did not always think communication with staff was effective.

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:

- We spoke to two members of staff who could not identify where ligature anchor points were on the ward. One nurse did not know where the ligature cutters were.
- Four of eight patient risk assessments we looked at lacked detail and did not always contain a full description of the risk identified. We found that three care records did not include up to date, relevant information about patient risk. The missing information included an initial mental health assessment and two missing support plans, one for choking risk and the other for risk of allergic reaction.
- Staff did not complete records to demonstrate they had cleaned the portable physical health equipment, the hoist and clinic room.
- Staff did not check emergency resuscitation equipment, including a defibrillator regularly to ensure it was safe to use. Staff should have checked this weekly but in the last three months prior to our inspection staff had omitted to do this on four occasions on Horsfall ward and six occasions on Maltby ward.
- Staff did not consistently complete all the physical health observations for the National Early Warning Scores Tool. This meant they did not record patient's physical health risks and may not have taken suitable actions if required.
- The hospital had experienced a high turnover of staff, 26 staff had left in the year prior to our inspection.
- Staff felt under pressure and told us that they could not always manage the personal care needs of patients due to staff numbers on the ward. Some staff told us that this sometimes meant that staff had to postpone or cancel patients' leave and activities.
- Staff occasionally called upon domestic staff to carry out observations if staff were busy on the ward. Domestic staff did not complete training in how to carry out observations or the full Managing Actual and Potential Aggression training. This was not in line with the organisational observation policy.
- When staff recorded patient observations they did not record the actual time that they saw the patient. This meant that patient records were not an accurate record of when staff had last seen the patient.

However:

Summary of this inspection

- Staff completed mandatory training and training compliance was at 91%. There were no training courses where compliance was lower than 84%.
- Staff used restraint as a last resort. There had been 21 occasions of restraint in the five months prior to our inspection. Staff only used restraint when they had attempted to de-escalate. In the five months prior to our inspection staff successfully de-escalated 56 incidents.
- Staff completed training in safeguarding children and adults and 90% of staff were up to date with this. Staff knew how to raise a safeguarding alert and gave a good account of how to identify abuse and when they needed to report it.
- Staff demonstrated good practice in medicines management. Medicines were well organised and stored safely. Staff effectively monitored temperatures of the refrigerator and the clinic room. Staff completed medicine cards correctly and in full, including recording patients' allergy status.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff completed a range of support plans, but they did not demonstrate that they focused on patient's strengths. Of the eight care records reviewed, none fully demonstrated they were focused on patient's strengths and in two this was completely absent.
- Staff did not always complete detailed handover records. Handover records did not include all necessary information. For example, we saw records that were missing the dates, observation levels, risks and legal status. There were at least five occasions of missing handover notes for specific patients.
- The clinical psychologist provided limited interventions. We reviewed care records for all 16 patients and saw that the clinical psychologist was carrying out psychological work with two patients on Horsfall ward and had completed one formulation for another patient. No patients on Maltby ward were working with the clinical psychologist or had a psychological formulation.
- We observed that during our inspection, activities that staff planned did not always take place and there was a low level of activity on Maltby ward. Six members of staff told us activities did not take place regularly and when they did were not always individualised. Four of seven carers we spoke with expressed concerns about the level of activities that took place. At the time of our inspection there was an occupational therapist available for only one day each week.

Summary of this inspection

- Clinical audits did not always take place. For example; monthly medication card and clinic room audits had not taken place regularly. Staff audited care records but did not always identify where omissions occurred.

However:

- Patients had access to physical health care and worked with a wide range of professionals external to the service. The ward worked closely with the local GP, who ensured that patients accessed annual physical health screening and relevant physical health checks.
- Staff received supervision and appraisals, 85% of staff had received regular clinical and management supervision and 95% of staff had completed an appraisal. There were regular team meetings and staff attended these.
- The service held multidisciplinary ward round meetings. These were attended by the consultant psychiatrist, staff, the patient and family, if they could attend. We observed that ward round discussion was thorough and involved the patient. Staff recorded discussions at ward round.

Are services caring?

Good

We rated caring as good because:

- We observed staff behaving in a kind and responsive way towards patients. Staff were responsive to patients' needs and gave them support and advice. Staff were genuinely warm towards patients.
- Staff knew patients well, they understood patients' likes and dislikes and cultural and religious needs.
- Staff communicated with patients in a way that suited them. Staff made referrals to speech and language therapists. Staff demonstrated and understanding of the individual communication needs of their patients.
- Staff protected the confidentiality of patients and ensured when they shared information this was in line with the patient's wishes.
- Staff provided information for patients when they were admitted to the ward. This information included patient rights and how to make a complaint and was available in easy read format.

However:

- Staff did not ensure that patient community meetings took place regularly. These should have taken place every two weeks but this did not happen. Patients who were able to did not have the opportunity to attend regular meetings.

Summary of this inspection

- Staff did not make the patient's voice clear in support plans. Although patients signed their support plans, and there was evidence that they were involved in the process, the patients' preferences were not clear.
- Staff, apart from two managers did not know who provided advocacy and details of local advocates were not displayed for patients to see on Horsfall ward.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- We did not see examples of patients accessing community activities. This made it difficult for patients to engage in relationships in the community away from the hospital.
- The stated purpose of the service was to move patients on to a less restrictive environment, typically this was a care home setting. We did not see discharge plans in all care records. These were present in five of eight care records, but these were not detailed.
- The picture boards displayed around the hospital, were not up to date. The picture boards had photographs of all the staff who worked at the hospital and identified who they were.

However:

- Patients had their own spacious bedrooms and ensuite bathroom. Patients had personalised their rooms with photos and possessions and had somewhere to store their valuables.
- Patients had a choice of food to meet their dietary needs and preference. Staff facilitated special diets for patients and the chef ensured they provided patients with a balanced choice of meals.
- Staff supported patients to contact their family and carers. Where possible patients went home to see family. The hospital offered flexible visiting for families and friends.
- Staff responded to complaints effectively. We saw that staff had made changes in response to complaints. Staff knew how to handle complaints in line with policy.

Are services well-led?

Inadequate

We rated well led as inadequate because:

- Governance systems were not in place to ensure the safety of patients when staff carried out observations. Staff occasionally asked domestic staff to observe patients. Domestic staff did not complete training in carrying out observations and had not

Summary of this inspection

completed a full Managing Actual and Potential aggression course. In addition, staff used prepopulated forms to record observations and did not record the actual time they had completed them.

- Staff could not clearly describe what the model of care was for the hospital and had not completed training in rehabilitation. Staff told us the changes of hospital directors had impacted on a clear model, as each director had a different vision.
- Staff did not think that all managers were visible or accessible and that they did not feel well supported or encouraged. Staff worried about turnover of staff and said morale was low. More staff planned to leave the hospital and they told us the change of managers had been destabilising.
- Managers did not have a system to monitor activities and leave for individual patients. Managers were unable to effectively evidence that patients took part in activity to aid their recovery.
- Barchester staff completed a staff survey but this was for the whole organisation. Mangers did not have access to specific staff feedback for the hospital.
- Staff did not always complete audits and audits were not always effective. Therefore, managers did not have assurance about all aspects of the quality of the service.

However:

- The interim hospital director and divisional director understood the hospital. The interim hospital director and divisional director understood the challenges the hospital faced and where improvements were needed.
- There were leadership development opportunities available to staff. Barchester had a leadership course. All nurses and leaders completed this and new staff had enrolled on this course. There was care practitioner training for recovery assistants to develop leadership skills and a member of staff was completing this.
- Staff said they would raise concerns without fear of retribution. Staff knew how to whistle blow and there was accessible information for staff about how to do this.

Detailed findings from this inspection

Mental Health Act responsibilities

- Staff understood the Mental Health Act and had completed training in the Act; staff training compliance was 85%.
- The Mental Health Act administrator was accessible for staff and suitably qualified to support them. Staff had access to up to date policy concerning the Mental Health Act.
- There was no information about local Mental Health Act advocacy services displayed on the ward and staff were not familiar with who provided this. However, patients had advocates.
- Staff explained patient's rights to them at admission and regularly afterwards and recorded when this had happened. The Mental Health Act administrator audited this.
- Mental Health Act paperwork was organised well and stored correctly. Staff attached consent to treatment forms to patients' medicine cards.
- The Mental Health Act administrator completed regular audits to ensure that staff applied the Mental Health Act correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had completed training in the Mental Capacity Act and compliance was at 85%.
- Staff demonstrated they understood of the Mental Capacity Act and the five statutory principles. Staff talked about how they applied this in their daily work.
- Staff had access to up to date policies and support in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards from the hospital director and multidisciplinary team.
- Staff ensured that where a patient lacked specific decisions were made by the multidisciplinary team and in patient's best interests.
- Staff assessed patients' capacity for individual, significant decisions and staff recorded this correctly.
- Nurses from another Barchester service regularly reviewed capacity assessments to ensure they were completed and recorded properly.

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	Requires improvement	Inadequate	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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 regular risk assessments of the ward environments. They completed a health and safety assessment and a ligature risk assessment annually. These were in date and staff had assessed risk thoroughly.
- The ward design allowed staff to observe all areas of the ward, there were convex mirrors on the ceiling on both wards to aid observation. The nurses station was positioned in the centre of the ward and this aided observation.
- There were ligature anchor points on both Horsfall and Maltby wards. There were reduced ligature fittings in patient bedrooms but there were still ligature risks in patient bathrooms, for example; taps. Staff assessed individual patient's risk to reduce risk. Both wards had a bedroom where there was a viewing panel on the bedroom door for patients who required a higher level of observation. We spoke to two members of staff who were unaware of where ligature anchor points were on the ward and one nurse did not know where the ligature cutters were located. The hospital did not normally admit patients with a ligature risk.
- Wards complied with guidance on mixed sex accommodation. Maltby ward was a male only ward and Horsfall ward was female only ward.
- Staff wore personal alarms. However, when we inspected we saw two staff who were not wearing alarms. Patients had access to nurse call alarms in their bedrooms. We saw staff responding promptly to nurse call alarms.

Maintenance, cleanliness and infection control

- Both wards were clean and furnishings were in good condition. The service employed maintenance staff who ensured wards were well maintained. We observed on Maltby ward there was a strong smell of urine. We spoke to staff about this and they cleaned the ward. Staff told us the smell was due to patients having urine infections. Due to the smell of urine on Maltby ward, the provider had recently removed the carpet from the corridor area and replaced it with hard flooring.
- We reviewed cleaning records; domestic completed these consistently. Records demonstrated staff cleaned ward environments regularly.
- Staff adhered to infection control principles, including handwashing. There was accessible antibacterial hand gel throughout the hospital and infection control posters on display.

Clinic room and equipment

- Clinic rooms were fully equipped. Clinic rooms were clean and tidy. Portable physical health equipment including blood pressure monitors and thermometers were checked to see they worked properly. However,

staff did not complete records to demonstrate cleaning of the clinic room or portable physical health equipment. There was no examination couch, so doctors used patient's bedrooms if required.

- When we inspected, the service had one hoist that was shared between both wards. We saw no records to demonstrate that staff cleaned the hoist regularly, or when staff moved it between wards. However, patients did have their own slings. There had been a request for a new hoist made in May 2018. The interim hospital director told us that this had been delayed due to an incorrect order. A new hoist was in place the week after our inspection.
- There was accessible emergency resuscitation equipment, including a defibrillator on both wards. Staff stored this in the ward office and it was accessible to all. The emergency resuscitation equipment on Maltby ward contained a patient's anaphylaxis pen, but there was no anaphylaxis pen available for use if other patients required one. There was however an anaphylaxis pen available on Horsfall ward. Staff could reach this quickly as there was a short staircase connecting the wards. Staff did not check the emergency equipment to make sure it worked effectively. Staff should have checked equipment and recorded this once a week. On Horsfall ward this had been omitted six times and on Maltby ward four times in the three months prior to our inspection.

Safe staffing

Nursing staff

- Nursing establishment levels were seven whole time equivalent nurses. This included the deputy hospital manager, who was a nurse and had the role of team leader on Maltby ward. These seven nurses had different roles. There were two team leaders, two senior nurses and three staff nurses. There were three whole time equivalent nurse vacancies at the time of our inspection for two staff nurses and one senior nurse. There was an ongoing recruitment programme for these posts. In addition, a senior nurse was at pre-employment stage and was due to start work in the following month.
- Unqualified staff establishment levels were 29 whole time equivalent recovery assistants. There were no vacancies for support staff and the hospital had over recruited to one extra post.
- Between 1 April 2018 and 1 July 2018 there had been 97 shifts filled by bank or agency staff to cover sickness, absence or vacancies. This accounted for 9% of total shifts.
- The staff sickness rate was low at 3%. The organisational average was 2%.
- The service had a high turnover of staff, with 26 staff leavers in the 12 months prior to our inspection. Since the beginning of 2018 seven nurses, nine recovery assistants and the hospital director had left the organisation. We reviewed staff exit interview information between April and September 2018. We saw that out of 20 leavers three had completed exit interviews; of these two recorded there was little chance of advancement in their career and one had an overall negative view of the hospital.
- The hospital manager told us they had calculated the number and grade of nurses and recovery assistants recommended using the Accreditation for Inpatient Mental Health Rehabilitation guidance. There was a minimum staffing ratio of one nurse on day shift on each ward and a ratio of one recovery assistant for every three patients. At night this was reduced to one nurse between the two wards and a ratio of one recovery assistant for every five patients. At weekends there were two nurses on both day and night shifts. These levels of staff had been assessed as safe and there had been no increase in incidents as a result of staff numbers. There was an additional support worker in place across the hospital to ensure patient safety.
- Recovery assistants reported that their staff numbers had been reduced since the previous hospital director had left, and it was sometimes difficult to manage the needs of all patients and particularly those with high personal care needs. Staff told us some personal care required three members of staff. Staff moved between wards to support care giving when required, but staff reported this was not always possible if both wards were busy.
- We asked the interim hospital director whether the Accreditation for Inpatient Mental Health Rehabilitation guidance was suitable for patients with a high level of personal care needs. They told us that the service had previously been over staffed with recovery assistants and they were satisfied with current staffing numbers.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- On the day of our inspection the number of staff was at the minimum staffing level on Maltby ward. On Horsfall ward staffing was above minimum levels; there were two extra recovery workers to facilitate enhanced observations to ensure patient safety.
- The hospital director and nurses could adjust staffing levels and were supported by the organisation to do this. Managers increased staffing when there was an increased level of patient need.
- The service used bank and agency staff when required.
- Temporary staff received an induction and they were familiar with the ward before they commenced their duties. Most agency staff worked regularly on the ward and knew the patients well.
- There was one qualified nurse available on each ward in the day time but the hospital director had made the decision to have one nurse covering both wards at night. This was because there were a low number of patients on each ward. There was one nurse who worked at night. Another nurse from the day shift supported the night nurse at the beginning of their shift with the ward handover meeting and administered medicines to patients. After this there was one nurse throughout the night. Nurses were satisfied that this was a safe arrangement but only if a second nurse continued to be in place to support the beginning of the shift.
- Patients had 1:1 time with their named nurse and this happened at least once a week.
- Some staff told us that ward activities and patient's leave from the ward did not always take place. Staff sometimes postponed activities and leave. These staff said that this was due to there not being enough staff to facilitate them and staff had to prioritise looking after patient's personal care needs.
- There were enough staff to carry out restraint. All staff completed Management of Actual or Potential Aggression training and most staff were up to date with this. Staff who required refresher training or were new employees were clear that they could not be involved in restraint. At the time of our inspection there were nine staff who required training renewal and seven of these had training booked for the following week. The hospital director was assured there were sufficient staff on each shift who were up to date with this training to carry out restraints when required.
- Staff told us that occasionally ward staff called on domestic staff to carry out observations, when they were busy carrying out personal care. Domestic staff were not trained in how to carry out observations. They did not receive full Managing Actual and Potential Aggression training but breakaway techniques only. This practice was not in line with the organisational observation policy.

Medical Staff

- One consultant psychiatrist worked at the service one day a week on a Thursday. The consultant did not live locally but was on call 24 hours a day, seven days a week. During annual leave there was another consultant psychiatrist who provided cover, they could travel to the service within two hours if there was an emergency. Staff told us the consultant psychiatrist responded to any calls promptly and staff had never needed to request that a doctor attend the service urgently. For physical health concerns and emergencies, staff contacted the GP or 999.

Mandatory training

- The provider made mandatory training available to all staff. Mandatory training compliance was 91%. Training included safeguarding, infection control, food safety, manual handling, equality and diversity and basic life support.
- There were no areas where staff compliance with mandatory training was lower than 84%.

Assessing and managing risk to patients and staff

- We reviewed eight care records in detail.
- Staff completed a risk assessment of every patient when staff admitted patients to the ward and these were updated regularly. Seven of the eight risk assessments were up to date and updated after incidents. However, four of the risk assessments from Maltby ward lacked detail and sometimes there had been a risk identified but without a description.
- The ward used a recognised risk assessment tool called the Sainsburys clinical risk assessment tool.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Management of patient risk

- Staff referred patients to community tissue viability nurses, physiotherapy and speech and language therapists. There was evidence that staff assessed specific issues such as falls, pressure sores and choking risks.
- Staff met daily and discussed patient risk during two daily handovers and the morning ten at ten meeting. Staff discussed incidents, complaints, patients and risk issues and fed back relevant information to staff on the ward. We also observed staff reviewing each patient's risk individually during the multidisciplinary ward round.
- Staff did not systematically complete all physical observations using National Early Warning Scores. This meant staff did not record a patient's risk properly and may not have taken relevant actions if the score was of concern. On Matlby ward we did not see any scoring and not all observations were completed in all cases. Although this was better on Horsfall ward there were omissions.
- Staff used observation to maintain patient's safety. Observation records were pre-printed. Staff did not record the actual time the observation took place. This meant observation records were not an accurate record of when staff had last seen a patient.
- Staff only used blanket restrictions when justified. The door was locked on Maltby ward and this was because of one patient's risk. However, another patient liked to go out and sweep up and staff were alert to the signs that the patient wanted to go outside and opened the door for them. Four of the seven patients on the ward did not have sufficient mobility to go out into the garden unaided.
- Patients could smoke in the garden. Smoking cessation was available to patients.
- There were no informal patients at the time of our inspection. The service displayed information explaining that informal patients could leave wards and how to do so.

Use of restrictive Interventions

- The service did not use long-term segregation.
- There had been 21 occasions of restraint used in the five months prior to our inspection. Of these; 19 were standing holds and two were seated holds. Staff had carried out these restraints on five patients.
- Staff had not used prone restraint in the last twelve months.
- There were low levels of rapid tranquillisation. Staff had not used rapid tranquillisation in the year before our inspection. There was an up to date policy to guide staff which was in line with National Institute of Health and Care Excellence guidance.
- Staff worked to reduce restrictive practice. Staff were aware of restrictive practices and how these could affect patients. We saw evidence of staff managing as required medication in the least restrictive way. In June 2018 a manager identified that patients on Maltby ward did not have free access to snacks and that this was restrictive practice. We observed this had changed and patients now had free access to snacks.
- Staff only used restraint with patients after they had attempted to de-escalate. In the five months prior to our inspection staff successfully de-escalated 56 incidents. We saw staff had developed positive behaviour support plans for some patients, these were not present in all cases but these had only been recently introduced. The service planned for these to be in place for all patients who required them. Staff only used restraint as a last resort.
- Staff demonstrated they understood the Mental Capacity Act definition of restraint.

Safeguarding

- Staff completed trained in safeguarding children and adults and 90% of staff were up to date with safeguarding training. The hospital director was the safeguarding lead. Staff knew how to raise a safeguarding alert and did so when required. Staff gave a good account of how to identify abuse and when they needed to report this.
- Staff gave examples of how they had protected patients from abuse and harassment. Staff ensured that they updated all relevant professionals when there were concerns to ensure communication was shared effectively.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff could identify adults at risk of abuse and worked with external partners to ensure their safety. Staff gave examples of how this had taken place in practice. However, in the last year there had been three occasions where professionals external to the service and other stakeholders had raised concerns about the care of patients at the hospital. The local authority had investigated these, there had been no safeguarding issues identified and the cases had been closed.
- Children could visit patients if risk had been assessed first. There was a suitable room for patients to meet with children.

Staff access to essential information

- Information about patient care was accessible to all staff. Staff kept paper care records in locked cabinets in the nursing station.
- In our review of care records, we did not find it easy to find information as the records were large and contained a lot of historical information. A commissioner told us it was not always easy to find information about patients when they looked in files. A recent quality visit had identified that there were care records that required archiving.
- We identified that the hospital had admitted a patient five weeks ago and their mental health assessment present in their care records. When we requested this the consultant psychiatrist sent this to the interim hospital director so it could be stored properly.

Medicines management

- Staff demonstrated good practice in medicines management. Medicines were well organised and stored safely. However, we did find one patient's anaphylaxis pen stored in the emergency bag. Staff effectively monitored temperatures of the refrigerator and the clinic room and these were within a safe range. Staff stored medicines safely and checked that medicines were in date. Staff stored controlled drugs securely, maintained a complete record of administration, and made regular stock balance checks. We looked at eleven patients' medicine cards, staff had completed medicine cards correctly and in full, including recording patients' allergy status.
- Staff reviewed the effects of medication on patients' physical health and followed relevant National Institute of Health and Care Excellence guidelines. Staff worked with the local GP to ensure that patients prescribed anti-psychotics were monitored appropriately with regular blood tests and referred patients for electrocardiograms to monitor cardiac health where clinically required. Where patients were prescribed lithium staff ensured they saw the GP for three monthly blood tests. All nurses had completed a medication competency assessment. Staff used a side effects scale/ checklist for antipsychotic medication (SESCAM) to review side effects.

Track record on safety

- There had been no serious incidents that had taken place in the year prior to our inspection.

Reporting incidents and learning from when things go wrong

- Staff knew what kind of incidents to report and how to report them. The hospital used a paper system to report incidents.
- We reviewed incident data. Staff reported incidents including trips and slips, minor injuries, falls, patient on patient aggression, patient on staff aggression and choking.
- Staff completed training in duty of candour and staff talked about being honest and open with families. There had been no serious incidents where staff had needed to speak to family. However, there was sufficient evidence of staff openly communicating with families and other stakeholders regarding safeguarding or other issues to evidence the hospital acting in an open and transparent way.
- Staff received feedback from the investigation of incidents both from within the service and from other locations in the wider organisation.
- Staff met to discuss feedback from incidents at monthly team meetings.
- There was evidence that changes had been made as a result of feedback. For example, all staff had completed skin integrity training following an incident of a patient with a pressure sore.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff received debriefs after incidents, staff recorded debriefs on incident forms so that managers knew they had taken place and we saw examples of this. Staff debriefed patients after incidents.

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

- Our inspection team reviewed eight care records in detail. Staff completed a comprehensive assessment as part of the admission process.
- Staff did not assess patients' physical health at admission. The hospital relied on a local GP to support them with this. The GP told us that they normally completed physical health examinations, and blood tests within a week of admission. However, staff completed a comprehensive assessment form before admission and this contained an assessment of physical health. Patients were referred to the service by other hospitals, so they were admitted with a thorough physical health risk assessment.
- Staff completed a wide range of support plans. However, support plans did not focus on strengths. In six care plans we did not see strength based support planning and in two support plans it was entirely absent.
- Staff updated support plans monthly, we saw that staff had signed to review them but staff did not always record changes made and therefore they did not always demonstrate patient's progress. However, support plans were reviewed in ward round and were changed if required.

Best treatment in treatment and care

- The service had care and treatment options for patients that were in line with National Institute of Health and Care Excellence guidance and quality standards in relation to physical health. For example, patients with schizophrenia had specific physical health assessments.
- We did not see best practice in psychological interventions. Staff told us that the clinical psychologist was in the process of working on a formulation for each of the patients in the hospital but we only saw one of these in place. There was some evidence of the clinical psychologist carrying out psychological work with two patients on Horsfall ward, but there was no psychological work with patients on Maltby ward.
- The occupational therapist assessed patients and designed support plans for patient's specific needs in relation to activity, physical and mental health. The hospital had just recruited an occupational therapy assistant who was due to start work the week after our inspection, there was a plan for this member of staff to focus on patient activity.
- There was an absence of activities and therapies that supported patients to maintain skills they would require to maximise their independence such as budgeting, shopping and cooking.
- We saw staff displayed activity timetables on the wards. On Maltby ward staff used sensory stimulation apparatus with patients. We observed that patients on Maltby ward were inactive and they were often sleeping or positioned in front of the television. On Horsfall ward we saw activities took place; tea and cakes and colouring in. We also observed two patients went out for lunch in the community. Six members of staff told us that activities did not always take place regularly. Staff said they did not always think that activities were individualised and staff said there was a lack of diversity in activities. Managers told us that staff did not always record activities effectively. Four of the seven carers we spoke to did not think there was enough activity for patients and did not always think it was individualised.
- Patients had access to physical health care. The ward worked closely with the local GP, who ensured that patients accessed annual health screening and facilitated blood tests and electrocardiograms. We saw copies of electrocardiograms in patient's files but these were not dated. We saw evidence patients saw specialists, including diabetes care, tissue viability nurses and physiotherapists.
- Staff used the Malnutrition and Universal Screening Tool and monitored patients' hydration levels. There were specific support plans relating to patients' nutrition and

hydration. Some patients needed pureed diets and this was documented in support plans. One patient was at risk due to too high levels of fluid intake, staff managed this in a sensitive way.

- The hospital was responsive to the dietary needs of patients and ensured patients had healthy choices in their meals and snacks. There was available exercise equipment and information about healthy eating.
- We saw limited evidence that staff used outcome scales with patients. We saw in two care records that the occupational therapist told had used the Model of Occupational Screening Tool and the Pool Activity Level. Staff also used a ward round document to assess progress.
- There was a schedule of clinical audits but these did not always take place. For example; monthly medication card and clinic room audits. Staff audited care records but did not always identify where omissions occurred.
- Staff were not involved in bench marking.

Skilled staff to deliver care

- The service had staff from different disciplines including a consultant psychiatrist who worked one day a week, an occupational therapist who worked one day a week and a clinical psychologist who worked one and a half days a week. Their input was limited however due to the hours they were contracted to work. There were plans to increase the psychologist's and occupational therapist's working hours and input into the service if there was an increased number of patients.
- The service had mental health nurses and the hospital had recently recruited a registered general nurse who had been appointed as team leader. The hospital planned to recruit two senior nurses to ensure the nursing staff had a good range of experience and skills.
- New staff received an induction, there were two specific induction pathways for nurses and recovery assistants. The induction programme was supported with a comprehensive record of training and activity which was signed off by mentors supporting new staff. This included mandatory training and Managing Actual and Potential Aggression training. All new recovery assistants completed the Care Certificate. All new staff completed mandatory training and had to evidence that they were competent in specific areas including moving and handling.
- Staff received supervision; 85% of staff had received regular clinical and management supervision. This took place every two months. The clinical psychologist and occupational therapist received supervision from outside the hospital. The service held regular team meetings. We reviewed meeting minutes, they had structured agendas and meetings were well attended.
- Staff completed an appraisal and 95% of staff were up to date with this.
- Staff completed a range of training for their role including positive behaviour support, falls, dysphasia and skin integrity. Over 90% of staff had completed these training courses. However, staff had not completed training in rehabilitation or recovery.
- Managers dealt with poor staff performance and absence effectively. Manager and staff gave examples of this having taken place. We saw managers had managed staff capability issues effectively.

Multi-disciplinary and inter-agency team work

- The service held multidisciplinary ward round meetings. The consultant psychiatrist, nursing staff, clinical psychologist, patients, and their family, attended these. The occupational therapist did not attend but did contribute written feedback about patient's progress. We observed one ward round meeting and saw patients were engaged in discussion about their treatment and care. The ward round meeting was thorough and staff recorded discussions.
- Ward staff held handovers at the change of shifts. We reviewed hand over records on both wards and observed that staff did not always completed detailed records. For example, we saw records that were missing the dates, observation levels, risks and legal status. There were at least five occasions of missing handover notes for specific patients.
- In addition to ward handovers, nurses and managers attended a daily morning meeting called the 'ten at ten' meeting.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The hospital had effective relationships with external professionals including commissioners and care coordinators. The team worked closely with a local GP who reported positive working relationships with hospital staff.

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

- Staff completed training in the Mental Health Act, and training compliance was 85%. Staff had a good understanding of the Mental Health Act and the Code of Practice.
- Staff had easy access to a Mental Health Act administrator. The Mental Health Act administrator had completed a Mental Health Act Law and Practice certificate and was suitably qualified.
- Policies and procedures concerning the Mental Health Act were up to date and relevant. Staff could access these easily on the intranet.
- Patients had access to easy read information about mental health advocacy, and worked with advocates. However, the information displayed on Horsfall ward did not provide details or a contact number for the local advocacy service.
- Staff explained patient's rights to them; they did this at admission and there were easy read if a patient did not have capacity to understand their detention then the hospital contacted the nearest relative with this. The Mental Health Act administrator audited whether staff had discussed patient's right with them monthly.
- Staff ensured that patients could take section 17 leave. The Mental Health Act administrator stored and monitored documentation. Staff offered patients and nearest relatives a copy of leave forms.
- Staff requested second opinion doctors for patients who were not able to or had not consented to treatment.
- Staff kept copies of patients' detention papers in a specific file with their care records. Records were well organised and stored correctly. Staff attached patients' consent to treatment forms to medicine cards.
- There were no patients with section 117 aftercare in place at the time of our inspection. Patients that this was relevant for were not yet ready for discharge.
- The Mental Health Act administrator completed audits regularly to ensure staff applied the Mental Health Act correctly.

Good practice in applying the Mental Capacity Act

- Staff completed training in the Mental Capacity Act and compliance was 85%.
- Staff demonstrated they understood the Mental Capacity Act and the five statutory principles. Staff talked about how they applied this in their daily work.
- There had been four Deprivation of Liberty Safeguards applications in the last six months prior to our inspection. There were 13 patients who were subject to Deprivation of Liberty Safeguards in the hospital at the time of our inspection.
- There was a policy on the Mental Capacity Act and Deprivation of Liberty Safeguards, staff knew how to access this on the intranet.
- Staff accessed support about the Mental Capacity Act from the hospital director, multidisciplinary team members, and the Mental Health Act administrator.
- Staff could give examples of how they supported patients to make specific decisions and assumed patients' capacity.
- We saw staff assessed patients' capacity for specific, significant decisions where appropriate and staff recorded this in patients' care records.
- Staff ensured that where patients did not have capacity to make a specific decision they made decisions that were in patient's best interests. We saw evidence of best interest decision meetings in care records. These assessments demonstrated that patients, family and carers and the multi-disciplinary team were involved in supporting patients to make decisions. Staff used best interest assessors and Independent Mental Capacity Advocates where appropriate. Staff considered the patient's wishes, feelings and values, and involved family where possible.
- Staff made Deprivation of Liberty Safeguarding applications and followed these up. Staff monitored dates for renewals.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Nurses from another hospital audited mental capacity assessments to ensure staff at Forest Hospital complied with the Mental Capacity Act. The audits were correctly recorded and complete.

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

Good

Kindness, privacy, dignity, respect, compassion and support

- We carried out observations throughout our visit and a specific type of observation called a short observational framework for inspection. We observed staff were consistently kind, respectful and responsive when they interacted with patients. Staff gave emotional support, advice, and responded to patients' needs and requests. We saw staff respond promptly to call bells and displayed patience and genuine warmth towards patients.
- Staff supported patients to understand and manage their care, treatment and condition. At ward round we observed that staff communicated with the patients seen and talked about the care and treatment provided to them.
- Staff supported patients to access external health appointments in the community. Where patients were unable to attend appointments in the community, health professionals came to see them.
- We spoke with one patient during our inspection. The patient we spoke to was positive about their care, and told us they felt safe, staff were kind, respectful, and supportive.
- Staff demonstrated that they knew patients well and support plans covered a wide range of issues. Staff understood patients' personal likes and dislikes, such as musical tastes, cultural needs and religious needs.
- Staff could raise concerns about disrespectful attitudes of other staff towards patients. They felt confident to raise concerns without fear of consequences for doing so. All staff said they felt able to speak up.
- Staff gave us examples of how they had protected the confidentiality of patients. For example; when a patient had not wanted to share information with their family.

Involvement in care

Involvement of patients

- Staff made information available for patients when they were admitted to the ward, including information about their rights and how to make a complaint. This was available in an easy read format. Staff showed patients around the ward and we saw patients had their names and photos on their bedroom door to help them orientate to the ward environment.
- We saw evidence that staff involved patients in support planning. Staff offered patients' a copy of their support plan and signed to say they agreed with it if they could. However, staff did not clearly record the patients' preferences in support plans and support plans focused on what staff needed to do for patients. We observed that staff knew patients well but this was not always evident in care plans. However, staff involved patients in multidisciplinary team ward rounds where staff listened to opinions and feedback from patients.
- Staff communicated with patients in a way that the patient could understand that suited them. We saw evidence of this throughout the wards. Staff made referrals to speech and language therapists. We saw staff using gestures that patients personally understood. Staff showed an understanding of sounds that patients made when they were communicating with them.
- Staff consulted with patients at community meetings and patients could give feedback. However, these meetings did not take place every two weeks as planned. Patients who were able did not have an opportunity to attend regular community meetings to give feedback and consult with staff about the hospital and care provided. Staff had planned these to take place at the same time as the multidisciplinary ward round. Since May 2018 only three meetings had taken place on Horsfall ward and six meetings on Maltby. There should have been a community meeting on the morning of our inspection on Maltby ward, but this did not take place. Where meetings did take place, they were well attended and chaired by a member of staff.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

There was also evidence that some actions had taken place following these meetings. Patients could feedback to staff through their one to one appointments and meetings about their care.

- We saw no specific advance decisions in place for patients apart from those relating to managing incidents or decisions for do no attempt resuscitation.
- Patients were referred to advocacy. However, apart from the interim hospital director and deputy director staff we spoke to were not aware of who provided advocacy services. Information about local services was not displayed on Horsfall ward.

Involvement of Families and Carers

- Staff involved families and carers. Staff invited them to meetings including multidisciplinary ward round and care planning approach reviews. Some families lived a long way from the service. The service organised conference calls to allow these families to take part in meetings they could not attend. Five of the seven carers we spoke to felt included in patient care. Care records showed examples of family members being involved in patients care. The interim hospital director wanted to improve carer's attendance at meetings and had set up a system to inform carers about meetings several weeks in advance.
- The service did not run a carers' meeting. Staff said this was because many carers lived far away. However, staff encouraged carers to feedback with comments cards via a box in reception. There had been a recent carer's survey, but only one carer had given feedback. Staff were unable to locate this when we asked to see it. The hospital had organised a summer fair but only one carer had attended this.

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

Requires improvement

Access and discharge

- Bed occupancy over the 12 months prior to our inspection was low at 65%. Local commissioners did not routinely refer into the service. The divisional director told us that local commissioners looked for other kinds of rehabilitation services. There were four commissioners who regularly referred to the service but these were from out of area.
- The average length of stay was 253 days for Horsfall ward and 593 for Maltby ward. On average across the hospital this as 423 days. Maltby ward admitted a cohort of patients with diagnoses of organic brain diseases including dementia and Huntington's. Patients on Horsfall ward had a mixture of diagnoses including functional mental illness. In the twelve months prior to our inspection there had been 10 referrals made to the hospital and in the period between July 2017 and July 2018 there had been seven successful discharges.
- Nearly all patients were from out of area. Staff discharged patients in almost all cases to live in the area they had come from and closer to their families.
- Beds were available for patients who lived locally but the service's current referrals were from a wide geographical area.
- The provider ensured there was always a bed available for patients when they returned from leave.
- When staff moved or discharged patients this happened between 9am and 5pm. There were no patients admitted unless the consultant psychiatrist was present to admit them. The consultant psychiatrist usually worked on a Thursday but was able to be flexible with this and could change the day they worked if requested.
- Staff worked with commissioners when planning for discharge, commissioners attended care programme approach meetings, ward round and discharge planning meetings to support successful discharge. However, we did not see discharge plans in all care records. These were present in five of eight care records, but were not detailed.
- There had been no recent cases of patients who had required a move to a local psychiatric intensive care unit.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Delayed discharges were rare. When there were delays, staff worked to manage these efficiently. When delays came about these were usually due to a lack of availability of community placements and staff described a recent example of this.
- Staff supported patients during transfer and discharge and worked with external partners to support patients in this process. Staff gave examples of when they had supported patients moved to acute care. They told us how they had communicated with external staff to ensure patient care and safety.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms; all bedrooms were spacious and had an ensuite bathroom.
- Patients could personalise their rooms with photos and possessions.
- Patients stored their possessions in their bedrooms. Most patients did not have keys for their room because they were considered to be at risk of losing their keys. However, staff could lock bedrooms if patients requested. Patients could lock their rooms from inside and staff were able to access the room from the outside if required. There was a safe to store valuables. Staff kept keys for this.
- Staff and patients had full access to a range of rooms to support treatment and care. This included a clinic room, lounge, dining room and a visitor's room.
- Staff told us that two patients were unable to go out into the community because they did not have the correct wheel chair adaptations. The interim hospital director explained there had been a delay in the patients' commissioners approving and funding these adaptations. We saw that applications had been made, and after our inspection the hospital director said the hospital would fund one adaptation themselves.
- There were areas on the ward where patients could be quiet if they did not want to go to their room including their bedrooms. The quiet lounge on Maltby was undergoing improvements so was not in use at the time of our inspection.
- Patients could make a phone call in private. There was a phone in the nursing office that staff moved around the ward for patients, some patients also had access to a mobile phone. There was internet access for all patients.
- Patients had access to well-maintained gardens and balcony.
- Food was of a good quality. Kitchen staffed cooked this on site. There was a choice of food available for patients.
- Some patients could make themselves drinks and snacks. For those patients who could not do this staff regularly offered drinks and a choice of snacks. Staff made drinks and snacks accessible to patients in communal areas.

Patients' engagement with the wider community

- Staff supported patients to have contact with their family and carers. Visiting hours were flexible. Some patients went home to see their family.
- Staff encouraged patients to develop relationships with other patients in the hospital. For example, staff and patients went out for lunch or to the park together.
- Patients did not regularly attend community groups or facilities where they could engage in relationships with others outside of the hospital.

Meeting the needs of all people who use the service

- The hospital was accessible to wheel chair users and there were ramps, a lift, and adapted bathrooms and toilets. Corridors were wide and there was clear signage and some adaptations for patients with dementia. For example, toilet seats were a different colour that the toilet and easy to see, there was a dementia friendly clock, and photos of patients on their bedroom doors to help them identify their room.
- There was information available for patients and some of this was in easy read. There was information about a range of subjects including patients' rights, making a complaint, activities and health. However, staff told us the staff picture boards displayed around the hospital, were not up to date. The picture boards should have had photographs of all the staff who worked at the hospital and identified who they were.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- At the time of our inspection, there were no patients that required leaflets in languages other than English. Staff knew where they could access these if the need arose.
- Staff organised a sign language interpreter for deaf patients. Signers attended to support one to ones and meetings.
- Patients had a choice of food to meet their dietary needs and individual likes and dislikes. There were examples of how staff had facilitated this including a gluten free and diabetic diet. The chef carefully considered how they could provide patients with a balanced diet and balanced health needs with patient choice.
- Staff ensured patients had access to spiritual support, where they wanted this. The religious leader who had supported the hospital had retired and the interim hospital director was due to meet with a local religious leader to discuss how they could support patients at the hospital.

Listening to and learning from concerns and complaints

- There had been three complaints and four compliments made in the 12 months prior to our inspection. Of the three complaints, one was upheld and the other two partially upheld. There had been an issue regarding a patient not being able to access a telephone in privacy and we saw evidence that staff had responded to this effectively.
- Staff gave patients information about how to raise a complaint or a concern when they admitted patients to the hospital. Staff gave this to patients in an accessible format.
- The service provided feedback to the person who complained. Staff feedback was in a way the person could understand.
- Staff protected patients who made a complaint from discrimination or harassment and ensured that patients' complaints were dealt with fairly and that patients were safe when patient on patient aggression occurred.
- Staff understood how to handle complaints and escalated these appropriately. They could describe how to make a complaint.
- We reviewed complaints and saw staff dealt with them in line with policy guidance. Staff discussed learning from complaints at team meetings and in supervision.

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

Inadequate

Leadership

- The interim hospital director and deputy were qualified nurses. They had the knowledge and experience to carry out their roles. Managers told us that there had been a lack of effective clinical leadership on the ward and that they hoped this would improve through the new staff they had recruited and their on-going plan for further recruitment.
- The newly appointed interim hospital director and divisional director could explain how the hospital was working to improve care. Both the interim hospital director and divisional director understood the service, where they needed to make improvements and the challenges that the hospital faced. The interim hospital director had supported the previous manager before they resigned and so understood the hospital well. They identified that clinical leadership had not always been effective and they hoped that newly recruited staff would improve this.
- Staff told us they did not think all managers were accessible. They did not feel well supported and encouraged by managers. They did not feel they received positive feedback when their work was good. However, they were happy with the support they received from staff from another Barchester hospital. Staff told us managers were not always visible. However, the divisional director was on site a minimum of once every two weeks and the interim hospital manager was on site for half of the week. Patients could speak directly to managers and we observed that managers knew and understood patient's needs.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The provider made leadership development opportunities available to staff. Barchester had a leadership course. We saw evidence of staff completing this, and new staff had enrolled. Barchester had developed a care practitioner role for recovery assistants and a member of staff at the hospital was completing this.

Vision and strategy

- All staff knew the vision and values of the wider organisation. The organisation had reviewed their values 12 months ago, all staff from Barchester services had designed their new simplified vision and values. These were: respect, integrity, passion and empowerment.
- The hospital director explained that the hospital was not a high dependency rehabilitation service. The intended patient group were patients with a progressive brain disorder. Two patients did not have progressive brain disorders and should have been cared for in a high dependency rehabilitation unit and required rehabilitation. All patients were working towards discharge to a less restrictive environment.
- Staff could not clearly describe what the model was for the hospital and had not completed training in rehabilitation. Staff told us the changes in hospital director had impacted on the model as each director had a different vision. Staff told us they worked with patients to reduce behaviour that challenged so they could support patients to rehabilitate discharge successfully from the hospital environment.
- Managers introduced the vision and values of the organisation at staff induction. We also saw how staff and managers discussed them at team meetings.
- Staff could discuss the service and changes with managers in supervision and at team meetings, we saw that this had taken place, However, the occupational therapist and clinical psychologist did not receive any supervision from the hospital.
- The divisional director and interim hospital director could explain how they were working to deliver care within budgets available. There were no negative impacts from budget and there were sufficient available funds. There were no cost improvement initiatives.

Culture

- Most staff we spoke with expressed concerns and talked about low morale. Staff, particularly recovery assistants, did not feel well supported. Staff worried about staff turnover and more staff said they planned to leave. Staff found the change in hospital directors destabilising.
- There was a strong feeling that staff worked well together as a team and that they were passionate about patient care. The staff survey carried out by Barchester was for the whole organisation and there was no specific data available for Forest Hospital. This meant staff who worked were not able to feedback to the hospital managers about their experiences at the hospital.
- Staff said they would raise concerns without fear of retribution. Some staff gave examples of how they had done this in the past.
- Staff knew how to access the whistle blowing policy. The service displayed a poster in reception with a phone number for whistle blowers.
- Managers dealt with poor performance and there was evidence that this had taken place. Records demonstrated that mangers came in to the hospital and carried out checks during weekends and night shifts to ensure teams were working well and fulfilling their responsibilities.
- Teams worked well together. Managers were aware of where there were difficulties and dealt with them. Staff reported good relationships between nurses and recovery assistants.
- Staff appraisals included conversations about how to support staff with their careers.
- Staff attended equality and diversity training as part of their mandatory training programme. Barchester published their gender pay gap report in 2017 and this demonstrated that they had a significantly smaller gap than the national average. Their average pay gap is 1.55% compared to a national average of 18.1%. Barchester did not have groups or forums for staff from minority groups.
- The service's sickness and absence level was one percent above the organisational average of 2% which was low. There had been two recent cases of long term sickness.

- Staff could access the organisation's telephone counselling support service. Staff had access to occupational therapy which the organisation contracted.
- The organisation celebrated staff success in the employee of the month programme and care award within the division and nationally. Staff at Forest had been nominated for the most recent national awards. In addition to these awards there were financial incentive schemes for staff.

Governance

- The provider had a framework of what staff discussed at ward, hospital and regional level meetings. Staff shared information and learnt from incidents and complaints. There was a cycle of governance meetings and managers shared information from these at team meetings. Similarly, managers shared information from team meetings at governance meetings.
- Governance systems were not in place to ensure the safety of patients when staff carried out observations. Occasionally ward staff asked domestic staff who had not completed training in carrying out observations to complete observations. In addition, clinical staff used pre-populated forms to record observations and did not record the actual time they had completed.
- Managers did not monitor individual patient activities or leave, this meant that they did not have assurance that sufficient levels of individualised activity took place on the ward. Managers were unable to effectively evidence patient activity.
- Staff were responsive to complaints and incidents and made changes. Staff had implemented changes in response to a recent safeguarding incident. We saw examples of how staff had made specific changes following a complaint.
- Staff did not always complete audits in line with the audit cycle and when staff completed them they were not always effective. Managers could not be assured about the quality of the service. For example, staff did not complete clinic room audits; staff did not regularly check emergency equipment, and there was no record of when staff cleaned the clinic room. Staff completed care record audits but did not identify omissions of information in support plans and physical health observations and scoring. However, the divisional director carried out quality visits once a month; these were assessments of the hospital environment and care provided.
- Staff understood how to work with other teams. Staff worked with external partners to ensure patients' physical health was cared for and patients were safe.

Management of risk, issues and performance

- The risk register was accessible to staff at ward level and located in nursing offices. Staff at ward level could escalate concerns in supervision, team meetings both formally or informally.
- The risk register contained concerns staff had expressed during a team meeting about Barchester going up for sale. It highlighted concerns about quality of support plans and demonstrated that there had been actions taken in respect of previous concerns.
- The service had a business continuity plan. This was up to date and outlined the service plans and clear instructions what actions to take in the event of an emergency.

Information management

- The provider had recently introduced a hospital dashboard this was accessible to the hospital director and the deputy director. The hospital dashboard monitored and generated information across the whole Barchester group. This information included information about clinical risk issues including; falls, choking incidents and medication errors. It also provided information about staffing, complaints, incidents and staff training compliance. The system identified concerns and compared data across services.
- Information governance systems ensured patient records were confidential.
- Ward staff and team leaders did not have access to the hospital dashboard, however managers discussed information about the service with nurses and expectations were set.
- The dash board contained up to date accessible information so that the hospital managers understood the performance of the service and where there were areas that required improvement.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Earlier this year the hospital had identified that they had not consistently informed the Care Quality Commission of when they had made a Deprivation of Liberty safeguarding application, however they rectified this immediately.

Engagement

- Staff received up to date information about the organisation and the service from their managers. The most senior managers in the organisation communicated with staff regularly by email and managers shared information with staff at team meetings. Barchester had developed a staff phone application called 'It's all about you'. This provided staff with up to date information about the organisation. There were two staff conferences each year that gave staff the opportunity to keep updated with information about the organisation. We saw evidence staff shared information about the service at patients' community meetings. Staff shared information with carers informally by telephone or face to face.
- Patients and carers could give feedback about the service and they could do this in a way that met their needs. Patients and carers could feedback directly to senior managers by email and through comments boxes. The divisional director carried out quality visits and listened to staff feedback during these.
- Managers and staff had access to feedback and there was evidence that staff had made changes in response to feedback.
- Staff considered patients and carers when they made changes to the service. Staff asked patients for their opinions about aspects of treatment and care and could give feedback at patient meetings when these took place.
- Patients could meet with the divisional director when they visited the hospital. Carers could contact senior managers when they had a concern and there was a specific example given of a carer who did this.
- The hospital communicated with commissioners regarding funded patients. Managers had recently met with local commissioners and invited them to visit the service.

Learning, continuous improvement and innovation

- The focus of the work of the hospital was on improving. Managers were clear that there were improvements that they and staff needed to make. The quality visits that the divisional director carried out were evidence of this.
- There were no innovations taking place in the service at the time of our inspection.
- The staff had recently amended the positive behaviour support care plans as a quality improvement initiative, this was to include an additional stage of working with the patient to help them feel calm after incidents.
- The service did not take part in national audits.
- The hospital was not involved in any accreditation schemes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that there are effective governance systems in place so that managers can monitor and be assured about all aspects of treatment and care including the following:

1. Safe observation practices are carried out by appropriately trained members of staff.
2. Audits are completed in line with the audit cycle and effectively identify any issues that may affect patient care and treatment.
3. All care records are up to date and complete with all relevant information required.
4. Individualised patient activity to support independence and patient leave takes place. This must be recorded and monitored.

- Support plans must include thorough discharge planning for all patients and focus on patients' strengths.
- The provider must ensure that the emergency resuscitation equipment and defibrillator is checked regularly to ensure it is safe to use.
- The provider must regularly monitor patients' physical health risks and respond to these risks.

Action the provider SHOULD take to improve

- The provider should ensure that patient community meetings take place as planned every two weeks.
- The provider should ensure that patient risk assessments are detailed and staff fully describe risks identified.
- The provider should ensure that they provide patients with sufficient opportunity for psychological input from the clinical psychologist
- The provider should ensure that staff can describe the rehabilitation model for the hospital and staff should be trained rehabilitation.
- The provider should ensure that all staff can identify ligature anchor points and that all staff know where to locate the ligature cutters.
- The provider should ensure that when staff complete handover records these are complete and detailed records.
- The provider should ensure that all managers are visible and accessible and that they provide a support and encouragement to staff.
- The provider should ensure staff can feedback through a local staff survey and managers can access feedback about from staff with a view to improving retention.
- The provider should ensure all staff know who provides advocacy to the hospital and details of the local advocacy service are displayed on the ward.
- The provider should ensure the clinic room and clinical equipment is cleaned and that staff record when this cleaning has taken place.
- The provider should review staffing, the needs of patients and how staff carry out their care activities so that they ensure that ward activities are not postponed or cancelled.
- The provider should ensure patients are given the opportunity to engage in community activities that support them to have contact with people outside the hospital.
- The provider should ensure that support plans should demonstrate the patient's voice, that is their likes, dislikes and preferences.
- The provider should consider reviewing whether the multidisciplinary team work sufficient contracted hours to offer patients a full programme of treatment.

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 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective governance systems in place so that managers could monitor and have assurance about all aspects of treatment and care. **17 2 (a, b, c, e)**

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 Staff did not check emergency resuscitation equipment and the defibrillator to ensure it was safe to use. Staff did not use National Early Warning Scores correctly to assess and monitor patients' physical health risks. **12 2 (e, f)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Support plans were not strength based Support plans did not include thorough discharge planning. **9 1 (a, b)**