Cambian Churchill Hospital

Quality Report

Cambian Churchill Hospital
22 Barkham Terrace
80 Lambeth Road

Tel: 020 8694 2111
Website: www.cambiangroup.com

Date of inspection visit: 3-5 November 2015
Date of publication: 06/06/2016

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?	Requires improvement
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

Letter from the Chief Inspector of Hospitals

Start here.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

We rated cambian Churchill Hospital as **good** because:

- Staff treated patients with dignity and respect.
- A wide range of facilities and activities were available for patients to support their rehabilitation.
- Staff supported patients to devise their own activities and scheduled regular time for these activities to take place. This empowered patients to be involved in the planning of their recovery. Activities had a strong rehabilitation focus including staff supporting patients to apply for paid therapeutic employment in the hospital.
- The service supported patients to raise ideas and concerns directly with senior hospital managers via a monthly patients' forum. This took place before the hospital's clinical governance meeting allowing issues to be put immediately to managers.
- The service was very responsive to patients' complaints, acting promptly whenever they were raised and taking appropriate steps where necessary. Staff ensured that they met with patients to discuss their complaints and the outcome of any investigation
- The hospital was well-led with systems and procedures in place to ensure that staff were well managed. Staff morale was improving as a result of good leadership from senior hospital managers.
- The service worked well with external agencies including a local GP practice to ensure effective monitoring of patients' physical health.
- The service was very supportive of independent advocacy ensuring that patients could always raise issues concerning their care and treatment.

However:

- The provider had not taken appropriate steps to address the risks to patient safety it had identified on the wards where the layout did not give staff direct lines of sight.
- There were not always sufficient numbers of staff on the wards to keep patients safe at all times.
- The provider had not taken all appropriate steps to ensure that important lessons from serious incidents were fully incorporated into practice.
- The hospital's safeguarding procedures did not ensure that all safeguarding concerns were dealt with promptly. When managers responsible for dealing with safeguarding matters were absent there was a delay in responding to concerns creating a risk to patient safety.
- The records of incidents of when staff had restrained patients or administered rapid tranquilization were sometimes missing important details. This meant it was not always possible to know whether staff had acted safely and according to procedures.
- The provider had given information to informal patients about their legal rights that was inaccurate.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Good 	Start here...

Summary of findings

Contents

Good

Cambian Churchill Hospital

Services we looked at

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

Summary of this inspection

Background to Cambian Churchill Hospital

Cambian Churchill Hospital is an independent hospital with a focus on rehabilitation for up to 57 men with mental health needs who may have other conditions and complex needs. The hospital has four wards called Juniper, Mulberry, Maple and Elm.

Juniper ward has 17 beds and provides an admissions, assessment, diagnostic and treatment service for patients who are unwell. Its focus is on management, motivation, medical review and managing challenging behaviour. Mulberry and Maple ward both have 18 beds. Their focus is on therapeutic care, relapse prevention and increased independent living. Elm ward has four beds. Its focus is patient engagement in the community and self-medication.

The hospital provides services for people with mental health needs and dual diagnosis which includes learning disabilities and problems with substance misuse.

The hospital undertakes the following activities that are regulated by the Care Quality Commission: assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury. A Registered Manager is in place at the service.

We inspected the service four times between November 2011 and August 2014. At the time of the last inspection the hospital was meeting the essential standards that inspectors assessed.

Our inspection team

The team that inspected Cambian Churchill included an inspection manager, two inspectors, two nurses, a pharmacist and an expert by experience, who has experience using services. The lead inspector was Simon Pook.

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 all the information that we held about the location.

During the inspection visit, the inspection team:

- visited all four wards at the Cambian Churchill Hospital and looked at the whether the wards were safe for patients and whether the facilities were appropriate. We also observed how staff cared for patients
- spoke with 15 patients
- spoke with the senior nurses who managed the wards

Summary of this inspection

- spoke with 24 other members of staff including doctors, nurses, senior support workers, support workers, occupational therapists, psychiatrists, psychologists, healthcare support workers and kitchen staff.
- interviewed an independent mental health advocate who visited the wards to support patients to raise issues concerning their care and treatment
- interviewed the hospital director and the heads of care responsible for this service
- attended and observed one handover meeting, and one multidisciplinary team meeting
- looked at 25 care and treatment records of patients
- carried out specific checks to see if staff were managing medicines correctly
- looked at a range of policies, procedures and other documents related to the running of the service

What people who use the service say

Overall, patients said that staff treated them with respect and were caring. Some said that staff supported them, and their families and carers, to be involved in their care and treatment. Patients described the activities and facilities as good. Many said that the food was varied and of good quality. Most patients spoke positively about the complaints process saying that staff gave them support to use this. When things went wrong staff explained why.

However, some patients commented that staff did not spend enough time with them. Some patients also said that the presence of illicit drugs on the wards was a problem. This was despite the fact that staff were aware of the problem and regularly conducting searches in order to reduce the presence of such drugs.

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:

- All the wards had ligature risks. Although the purpose of the unit was rehabilitation and a majority of the patients were increasingly recovering and preparing for discharge a significant number of patients were still unwell and were spread across the wards of the hospital. Therefore it was necessary for staff to properly assess and reduce identified ligature risks that existed to ensure that patients were safe. While staff had taken some steps on the wards to mitigate the ligature risks which existed, the provider had not identified what specific work was required and did not have a schedule of works in place.
- The layout of Juniper, Mulberry and Maple wards, meant that there were not clear lines of sight for staff to see patients. Staff had not sufficiently mitigated these risks as there were no mirrors in place to allow them to see into those areas that were not in direct sight.
- At times there were insufficient numbers of staff on the wards to keep patients safe. Although the hospital always maintained minimum staffing levels there were times when these levels were insufficient, particularly when staff had to undertake one to one observations of patients.
- There was sometimes undue delay in reporting safeguarding concerns. This occurred when staff responsible for managing concerns were absent and response to them only took place when they returned. This created a significant risk of harm to patients.
- Recording of incidents where staff restrained patients and used rapid tranquilization was insufficient. Records of restraint did not always show the manner of restraint, the individuals involved, the time period of the restraint and that the patient was reviewed by a doctor after the incident.
- Two serious incidents had occurred over 18 months involving deaths of patients. Following investigations into their causes, which identified issues relating to staff ability to undertake observations and monitor physical health, the senior management had taken steps to ensure necessary improvements. However, further work was necessary to ensure that learning from these lessons was incorporated into practice.

Summary of this inspection

- Staff on all wards did not keep all cleaning records up to date to ensure that they were able to maintain a clean and safe environment for patients.
- Following safeguarding incidents staff did not always update patients' notes with details of the incident and appropriately amend any risk assessments and care plans.
- Staff gave informal patients information concerning their right to leave the hospital which was not correct. We raised this with the senior management, who undertook to change it immediately.

However:

- Staff ensured that the clinic rooms on the ward were fully equipped and well maintained.
- Staff completed patients' risk assessments promptly upon admission and ensured that they updated them where appropriate.
- Staff kept all ward areas clean and tidy and adhered to infection control principles.
- A recruitment drive was in progress with management seeking to over-recruit by two staff members to ensure that the wards were adequately staffed at all times.

Are services effective?

Good

We rated effective as **good** because:

- Overall, staff were skilled, experienced and appropriately qualified to carry out their roles effectively and in line with best practice.
- Staff delivered a wide range of therapeutic activities that were focused on the rehabilitation and supporting patients to return to an active life in the community. This included supporting patients to apply for paid therapeutic work in the hospital.
- Staff planned and delivered patients' care and treatment in line with current evidence-based guidance, standards, best practice and legislation.
- Staff made sure that detained patients' rights were properly protected and that their actions complied with the Mental Health Act Code of Practice.
- Staff regularly reviewed clinical audits to ensure that they responded to issues identified in the audits.
- Staff worked collaboratively to provide effective care and treatment. Team working was clearly evident with different professionals providing advice and guidance to colleagues in order to ensure best practice.

Summary of this inspection

- The hospital fully supported the independent advocacy service to assist patients to raise issues concerning their care and treatment.

However:

- In the care plans of six patients staff had not fully set out how their care of the patient was to intended to support the patients' rehabilitation and discharge.
- Some staff supervision records were identical copies of each other and were therefore not individual and personalised records of support and guidance.
- Managers were not aware of the training that their staff team had undertaken so they could not be assured that staff were effectively deployed, according to their skills, throughout the hospital.

Are services caring?

Good

We rated caring as **good** because:

- Staff generally treated patients with dignity and respect. Patients mostly felt supported and cared for.
- Staff encouraged patients to be involved in their care, treatment and rehabilitation by asking for and responding to their views. Most patients felt listened to and involved in the planning of their care.
- Patients were able to put their ideas and concerns directly to the senior management of the hospital via a monthly patients' forum which met before the clinical governance meeting.
- Staff gave full support to the independent advocacy service to ensure that it could help give a voice to patients at every opportunity.

However:

- We observed some interactions between staff and patients that were short in duration and task-focused, rather than demonstrating an attempt to engage in a caring way to support patient recovery.

Are services responsive?

Good

We rated responsive as **good** because:

- Staff informed patients how to make a complaint and they supported patients during the process.
- Staff responded to complaints promptly and effectively, listening to the concerns of patients and taking appropriate steps where investigations identified this was necessary.

Summary of this inspection

- A wide range of facilities and activities were available for patients that promoted well being and recovery.
- Staff encouraged patients to plan their own activities in order to support their recovery.
- The service met the needs of patients by providing appropriate information on services and patient rights

Are services well-led?

Good

We rated well-led as **good** because:

- The leadership of the service understood the issues and priorities faced by the service and were in the process oftaking important steps to improve the quality of the service. This included putting in place a new system of ward management and implementing mandatory supervision on key areas of staff learning. Staffing levels were also to be increased on one ward from the beginning of 2016 to address shortages.
- Senior staff members demonstrated a clear commitment to improving services and working practices across the service.
- The leadership had identified the importance of maintaining and improving staff morale and had taken significant steps to address this. Many staff had positive views about the improved working conditions at the hospital.

However:

- Some staff felt that hospital senior management did not always respond to their concerns in a prompt and appropriate manner.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings to help determine an overall judgement about the Provider.

- Staff received mandatory training in the MHA and all staff had completed this at the time of our visit.
- Staff had properly completed records relating to whether patients had consented to treatment or not and these were kept with patients' notes.
- As required by the Act and Codes of Practice staff had informed patients of their rights, both on admission and subsequently. Staff recorded this information in detail in the patients' notes.
- In accordance with their legal right patients had access to an Independent Mental Health Advoacte (IMHA) on the wards.
- Hospital staff were very supportive of the independent advocacy service, making patient referrals to the service and ensuring that advocates could support patients at every opportunity.
- Information about patients' rights was freely available

However,

- Staff gave informal patients, (patients not detained in hospital under the MHA,) information concerning their legal rights that was inaccurate. This information was in the form of a notice. Staff put this notice on the walls of the wards as well as on informal patients' bedroom walls. It stated that informal patients' right to leave the ward depended upon the consent of staff. This was incorrect because hospital staff cannot detain patients without lawful authority. Such information needed to state that informal patients have the right to leave the hospital at any time and that if staff were concerned about a patient's health and wished to prevent this then they had to assess the patient for possible detention using the powers of the Mental Health Act.
- Blanket restrictions existed on the wards in relation to patient access to kitchens. All kitchens were locked and were only accessible with the consent of staff. Under the Code of Practice such restrictions must be proportionate and justified by an identified risk. There was no evidence, however, of a risk that staff had identified which justified such a blanket restriction.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was mandatory for nurses, doctors and HCAs and 100% of the relevant staff had completed this training. However, despite having received training, most staff had difficulty demonstrating an understanding of the key principles of the Act.

Staff had made no recent applications for Deprivations of Liberty Safeguards.

Overview of ratings

Our ratings for this location are:

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

Detailed findings from this inspection

Notes

Long stay/rehabilitation mental health wards for working age adults

Good

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

Summary of findings

Start here

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

Requires improvement

Safe and clean environment

- Three of the four wards, Juniper, Mulberry and Maple had the same layout. They were designed in such a way as to allow clear lines of sight from the nursing office along a main corridor which formed the centre of the ward. Patients' rooms as well as other rooms and facilities were accessed from the main corridor. However, the entrance to some bedrooms was recessed and they were not directly visible from parts of the corridor. Also at the end of each corridor was a small area that was not in a direct line of sight because the layout of the corridors was not straight. Although staff had placed CCTV cameras along each of the long corridors staff did not regularly monitor the screens. No mirrors had been placed along the corridors to allow observation of areas that were not in direct line of sight. When we pointed this out to staff they agreed that the installation of mirrors could help mitigate the risks posed by the ward layout.
- All the wards had ligature risks. These were identified on the environmental audit for the whole hospital and last updated in August 2015. The audit identified a number of risks in all patients' bedrooms and en-suite bathrooms. For example, the use of standard shower controls and standard taps. Clearly the focus of the hospital was patient rehabilitation and a majority of the patients were clearly moving towards complete recovery

and discharge. In such an environment there was a policy of positive risk taking in order to encourage patient rehabilitation. However, the presence of ligatures still presented a significant risk to patient safety. This was because the hospital admitted unwell patients in order to support their rehabilitation and such patients were spread across the wards. In the presence of such ligature risks the provider had put local controls in place to mitigate them. However, the provider had not identified that works were required to replace them, and no dates were in place for these works to start or be carried out. This meant that the provider was not taking all necessary steps to address the existence of ligature risks.

- Three of the four wards, Juniper, Mulberry and Maple had a fully equipped clinic room. Elm ward had no clinic room because its purpose was the most advanced stage rehabilitation ward where patients stayed prior to discharge. In the event that Elm patients required clinic room facilities staff took them to one of the other wards. In the three clinic rooms all emergency equipment was in place and records showed that staff checked the equipment every week to ensure it was working properly. All emergency drugs were in date. Staff regularly checked and recorded the temperatures of fridges, which were within the required range. Staff kept ligature cutters in the nursing offices so that all staff had access to them.
- The hospital had no seclusion facilities. In circumstances where patients were particularly unwell staff put patients under increased levels of observation and where appropriate transferred them to an intensive care ward at a different hospital.
- All areas on all wards, including communal areas, clinic and examination rooms were generally clean and tidy and reasonably well maintained with good furnishings.
- Staff adhered to infection control principles. Handwashing facilities for staff were available throughout all wards.
- Staff kept cleaning schedules mostly up to date. However, although Juniper ward was visibly clean the cleaning schedule was not up to date in respect of the cleaning that the schedule listed as the responsibility of nurses. These responsibilities included the cleaning of fridges, sinks and the removal of clinical waste. The failure to keep proper cleaning records created a risk to patients because such records are an important way for staff to check that the ward environment was regularly cleaned and safe.
- Staff regularly undertook environmental risk assessments. These identified risks such as bathroom taps in the and staff then linked these to individual patient risk assessments to ensure that unwell patients at risk did not have access to those bathrooms with ligature risks.
- All staff had access to personal alarms on the wards.

Safe staffing

- The staffing establishment over the four wards of the hospital was 24 qualified nurses (including senior nurses) and 45 healthcare assistants (HCAs), including senior HCAs. The hospital had developed a senior HCA position to strengthen the management of staff on the wards and to provide a development opportunity for staff.
- There were four vacancies for nurses and eight for HCAs. The hospital was recruiting for all these posts. The hospital was also planning to provide extra staff cover by over-recruiting two nurses. It intended to do this so that it did not have to employ bank or agency staff to cover staff shortages.
- The hospital employed bank staff, largely from its own pool of staff. This pool consisted of some permanent staff doing overtime as well as some specifically recruited bank staff. The hospital used its own pool of bank staff in order to provide patients with consistency of care.
- The use of agency staff was very low and where possible the hospital employed regular agency staff on fixed term contracts, again to help ensure continuity of care.
- The provider did not supply any information regarding levels of staff sickness and turnover at the hospital.
- Ward management duties were undertaken by senior nurses. The senior nurses said that they could request additional staff when they needed them. For example, this could happen when extra staff were required to carry out one to one observations.
- There was a qualified nurse on Juniper, Mulberry and Maple wards at all times. This was not the case on Elm ward as this ward was intended only to support informal patients who were self-medicating.

Long stay/rehabilitation mental health wards for working age adults

Good

- The provider employed two different levels of staffing on the wards, according to what resources were available. The provider named the first as a 'safe staffing' level. This constituted a basic staffing requirement below which numbers could not fall. The provider always met the safe staffing level for every shift on each ward. It did not use a recognised tool to calculate these 'safe' levels. The provider employed a staffing level when more staff were available called an 'optimum staffing' level. These were staffing levels the provider aimed to achieve on a daily basis. It did not use a recognised tool to calculate this level of staffing. The provider monitored both these levels on a daily basis during the morning multidisciplinary team meeting, as well at the weekly senior nurses meeting, which was also attended by a bank staff co-coordinator to ensure that all shifts were covered.
- Managers ensured that the 'safe staffing' levels on all wards were always met. On Juniper, Maple and Mulberry wards this provided for one qualified nurse and two HCAs day and night and one HCA on Elm ward day and night. At the time of inspection, optimum staffing levels on Juniper ward were two qualified nurses and five HCAs during the day and one qualified nurse and three HCAs at night. For Mulberry ward this level was two qualified nurses and four HCAs during the day and one qualified nurse and three HCAs at night. Maple ward's optimum level was two qualified nurses and three HCAs during the day and one qualified nurse and two HCAs at night. On Elm ward the level was one qualified nurse and HCA during the day and two HCAs at night. Many staff said that staffing levels had recently improved. Many also said improved pay and conditions had helped with staff retention and recruitment. However, several members of staff also expressed concerns about the safer staffing level being insufficient and that this negatively affected patients and staff. Two senior members of staff observed that overall there were too few staff in the hospital. The minutes of staff meetings for the past six months also repeatedly detailed staff concerns regarding staff shortages. Many staff members said that the frequent need for staff to undertake one to one observations of patients caused staff shortages. One senior member of staff said that observations were challenging because the first staff member required for this task had to come from the existing staffing level. Therefore if staff were already busy with other jobs, such as supervising activities, then finding staff for one to one observation could put a ward under strain. Further evidence supported these concerns. Records showed that following an incident in May 2015 a staff investigation identified that staffing levels were an issue. There were only three staff on the ward during the incident and one of them was undertaking one to one observations. In addition the provider had investigated the causes of two serious untoward incidents (SUIs) in the past 18 months. These investigations had concluded that staff shortages were a factor in staff not properly conducting observations of patients.
- Staff and patients described the effects of staff shortages on patients and staff. Four members of staff said that insufficient staffing meant that patients could not always have 1:1 time with their named nurse. Three members of staff said that patients were sometimes unable to participate in activities taking place in the community because there was not enough staff to escort them outside the hospital. Three patients and one senior staff member said that staff often cancelled or postponed leave because there were too few staff to escort patients. Other staff observed that the cancellation of leave because of staff shortage was sometimes the cause of incidents on the ward. This was because such cancellations could be frustrating for patients. A senior member of staff commented that because staff were having to undertake more one to one observations this was affecting the standard of care that staff could deliver. A member of staff on Juniper ward also expressed concern that insufficient staffing levels affected the care staff were able to give to patients. Two occupational therapists (OTs) said that all OTs were sometimes over-stretched because of lack of staff and that OTs' caseloads could sometimes be too large to properly carry out their duties.
- A senior staff member said that problems were caused by the admission of unwell patients onto Mulberry and Maple wards. This process had started a few months ago and was contrary to the aims of the hospital's care pathway. This was because the provider had designed the pathway so that more unwell patients were first admitted to Juniper ward. Once their condition had improved they would then step down to Mulberry and Maple wards as these wards had an even greater focus on patient rehabilitation. The senior staff member said that such admissions onto Mulberry and Maple wards

put pressure on staff on those wards. This was because staff were often required to undertake one to one observations of newly-admitted patients who were unwell. This meant that there were fewer staff to undertake other duties on those wards. The senior staff member said this had happened twice recently on Mulberry ward.

- In recognition of some of these problems the hospital management said that they had added an extra HCA in the budget for 2016 for Maple ward. This would increase the optimal levels at night to 1 qualified nurse and 3 Support HCAs to reflect the same level as the other wards. The hospital was also in the process of reviewing its care pathway to consider whether its current admission and step down model was most appropriate to meet the needs of patients.
- Overall, insufficient staff numbers meant that staff could not always properly support patients. This was because patients could be denied leave, access to activities or may not receive the level of nursing observation required. Also staff could sometimes become overworked and be less effective in their roles.
- Staff said that there were sufficient numbers of staff to safely carry out physical interventions involving the restraint of patients. When staff required assistance from colleagues on other wards to undertake a restraint they used rapid response bleep system to summon help quickly.
- There were enough doctors day and night to attend to the needs of patients.
- Staff received mandatory training and the average completion rate for it was over 90%. There were no mandatory courses where completion was less than 85%. However, senior management had identified that the mandatory training monitoring tool was not providing sufficient detail. For example, it did not identify which staff had completed the recently introduced face to face life support training. A member of staff was due to develop a database to provide complete training information. However, this was not yet available at the time of our inspection.

Assessing and managing risk to patients and staff

- There were no incidents of seclusion in the hospital during the six month period between March and August 2015.
- During the same period there were 32 incidents of restraint across all four wards
- The provider had a restraint policy and procedure in place. Records showed that there were 32 incidents of restraint in the hospital between March and August 2015. Staff restrained patients in the prone position infrequently. Between May 2015 and August 2015 there were three incidents where prone restraint had been used. One patient had been restrained in the prone position on two occasions. Records showed that staff only restrained patients after they had attempted to make the situation safe by using de-escalation techniques.
- Records of restraint made by staff following incidents were mostly complete. However, in one record it was not clear what restraint hold staff had used on the patient. Also, two other records did not show the length of time staff had held the patients in the prone position. In another record staff had not recorded which members of staff were involved or who was responsible for monitoring the patient's breathing. The restraint of patients must always be done in a safe way according to strict training procedures. A part of those procedures is for staff to keep a detailed record of the restraint. Where records of restraint are incomplete it is not possible to verify whether the restraint was safe or not.
- Records showed that staff used rapid tranquilization infrequently. Rapid tranquilization is where staff give medicines to a patient who is highly agitated in order to quickly calm them. Between May and August 2015 there had been five occasions where patients had received rapid tranquilization. On two of the five occasions patients had been reviewed by a consultant psychiatrist following the administration of this medicine, on the other three occasions there was no record to show that the patient had been reviewed by a consultant psychiatrist. On four of the five occasions where rapid tranquilization had been administered the patient had been asked to comply with physical health monitoring afterwards but had declined. On one occasion the patient had consented and physical health monitoring after the administration of rapid tranquilsation had taken place.

Long stay/rehabilitation mental health wards for working age adults

Good

- Staff undertook risk assessments for each patient on admission. Ward staff also undertook daily risk assessments as well as updating the risk of any patient where they had been involved in an incident.
- Staff used a recognised risk assessment tool to assess risk upon admission. This was called START, meaning the Short Term Assessment of Risk and Treatability. In addition staff completed daily risk assessments for each patient using a traffic light system. Green indicated no current concern, amber where staff were able to manage concerns about a patient's risk and red for where staff needed to immediately address risks.
- Generally staff only used blanket restrictions when they determined it was justified. Staff employed a policy of 'positive risk assessment'. An example of this approach was staff did not automatically deny leave to patients who tested positive for drugs. Instead staff assessed each patient individually and granted leave where it was appropriate to support a patient's rehabilitation and safe for the individual. For example, one patient who tested positive was still allowed leave to take up a placement for work. Records showed that other patients could have their leave suspended or withdrawn after discussion with the multi-disciplinary team if deemed appropriate.
- However, blanket restrictions did exist in respect of the kitchens on Juniper, Mulberry and Maple wards. On these wards the staff locked the kitchens. Patients were only able to have access to food and make drinks with staff permission. This was not appropriate or justified in a hospital whose principal objective was rehabilitation. When this was pointed out to staff on Maple ward the kitchen was unlocked.
- Staff said that informal patients were free to leave the hospital at any time. Notices explaining their rights were given to informal patients and displayed in their rooms as well as on the wards. However, these notices were not appropriate as they said that staff could reject an informal patient's request to leave, which was incorrect. Hospital staff cannot deny this right and may only detain a patient with lawful authority under the Mental Health Act.
- Policies and procedures were in place for the use of observation. Staff also followed policies and procedures in respect of searching patients, their property and rooms to reduce the risk of patients bringing drugs onto the wards. Staff demonstrated that they knew how to report safeguarding concerns appropriately on the wards. However, there were some shortfalls in how the hospital kept safeguarding records and in its reporting processes. We examined three safeguarding logs and the related patient notes. In respect of one safeguarding record there was a brief note of the incident in the log, but no corresponding note of the incident in the patient's treatment notes. It was also not clear that the incident had fed into the person's care plan or risk assessment. In addition, although staff had recorded each incident separately, queries to the safeguarding lead were merged in a single communication. This meant that it was not always easy to follow individual safeguarding concerns from the start to their conclusion.
- Staff indicated that they knew how to raise safeguarding concerns. However, there was evidence that there could be some delay in reporting safeguarding matters within the hospital and to the local authority. Just before our inspection a patient reported that two staff members had assaulted him during a restraint. In the absence of the senior manager responsible for safeguarding matters the hospital only raised a safeguarding alert with the local authority four days later. Moreover, a meeting to discuss the incident occurred six days after the inicident. As a result of this meeting two staff members were suspended pending an investigation. The delay in responding to safeguarding allegations could put patient safety at risk.
- The hospital had a contractual arrangement with an external pharmacy to provide medicines for all patients. There were additional arrangements for staff to obtain medicines in an emergency. A pharmacist did not work onsite. However, the hospital identified this as a shortfall and had changed its contract with the external pharmacy from January 2016. Under this new arrangement a pharmacist would visit every week to supervise medicines management.
- Staff securely stored medicines throughout the hospital. Controlled drugs were stored and recorded appropriately. The hospital ran its own clozapine clinic and staff were appropriately trained to do this. Nurses checked the stocks of all medicines every day. All the prescriptions and medication administration records that we examined were clear and had been completed correctly. Codes were used to show when staff had not

given medicines for any reason. Forms indicating whether patients had consented to medication forms were kept with the prescriptions to allow for appropriate reference.

- Medication audits were done monthly on all wards. Where audits identified concerns staff took action to address them. Learning from medication incidents was shared at clinical governance meetings.
- The staff supported many patients, where appropriate, to manage their own medicines to enable them to live more independently. By the time patients were discharged from the hospital they were able to look after their own medicines successfully. Patients on leave were given medicines for that period of time. In this situation either the pharmacy supplied patients with their medicines or nurses sometimes dispensed them. However, records were not kept when nurses did this. This absence of recording created a potential risk for patients because nurses were not able to provide evidence that they had given patients the correct medication when giving it for patients on leave. We raised this immediately with staff, who said that they would now record this process appropriately.
- Procedures were in place for patients to safely meet child visitors. Such visits took place in a family room on the ground floor of the hospital.

Track record on safety

- The staff appropriately reported all cases of serious untoward incidents (SUIs). All SUIs were also robustly investigated using root cause analysis methods.
- We examined two SUI reports. The first incident had been the subject of an inquest in August 2015 following the death of a patient in the hospital in 2014. The second SUI concerned the death of an elderly patient in September 2015. The root cause analysis conducted by the hospital in respect of both incidents identified several issues that the hospital needed to address. These included improving staff training and competence around conducting observations, providing basic life support and caring for patients with complex health conditions. Senior staff confirmed that this was an area that they understood needed to improve.
- Senior managers had taken steps to address the issues identified in the root cause analysis. These steps included disciplinary measures against the staff involved, team discussions of the observations policy and training sessions and mandatory supervision sessions around engagement and observations. Nevertheless, the fact that these very serious incidents had common causes was evidence that changes as a result of learning from incidents had not been embedded and was not robustly monitored. In addition there was evidence that patients had absconded, some whilst being nursed on two to one observations. This further highlighted that management had not taken all appropriate steps to ensure that staff learned lessons from serious incidents relating to observations.
- Staff had taken steps to improve safety on the wards, especially in respect of drug misuse. This was because patients sometimes brought drugs into the hospital and staff acknowledged that this had been a problem. Steps taken included random drugs tests for targeted patients at risk, room searches, both random and regular, use of a sniffer dog and ongoing police liaison. The hospital had also developed links with local drugs services and psychology services within the hospital could provide individual and group work therapy programmes addressing drug misuse.

Reporting incidents and learning from when things go wrong

- We examined nine investigation reports of incidents that had taken place since the beginning of 2015. The staff understood what incidents should be reported and how this should be done. There were effective procedures in place to investigate incidents, report findings and share them with staff.
- Staff said that they were open with patients when things went wrong and explained to patients when such things happened. Most patients said that staff explained to them why something had gone wrong. For example, when leave or activities had to be cancelled or postponed.
- Most staff said that they received feedback following incidents. This happened during daily handover meetings as well as at staff meetings. These were held approximately every six weeks where incidents were discussed and feedback given to staff. In addition full multidisciplinary team meetings were held every week for all staff to discuss learning from incidents.

Long stay/rehabilitation mental health wards for working age adults

Good

- Some records showed that action was taken as a result of an incident. For example, several patient records showed that where staff found drugs on their person their rooms were then searched. Following another incident where staff observed a patient's relative passing drugs to them staff responded by ensuring that visits from that relative were always supervised.
- Staff said that they were offered a debrief and support after a serious incident. One staff member described how, following an incident of sexually inappropriate behaviour by a patient, how their manager had supported them. This included help to report the matter to police, as well as arranging a meeting with a psychologist to discuss the experience.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We looked at 25 care records. All the records showed that comprehensive assessments had taken place and care plans addressed the patients' assessed needs. Staff had completed timely assessments of patients on admission and care plans addressed how staff would manage identified risks. Care records contained risk assessments, physical health assessments, detailed care plans, Mental Health Act paperwork and ward round notes with action plans.
- Staff completed separate and individualised physical health care plans for each patient. We looked at 15 physical health care plans. All records showed that staff undertook physical examinations of patients and monitored their physical health problems including conditions such as diabetes. Specialised staff were also available to support patients with their physical health needs, including a diabetes nurse and a smoking cessation nurse. In addition a local GP visited the hospital every week to hold surgeries and provide healthcare and treatment where it was required.
- All care records were up to date. Every statement in all the care plans and physical health plans were written as if spoken by the patient. Although some statements clearly represented the spoken wishes of patients it was not clear that this was always the case. For example, seven physical healthcare records of Juniper patients were all written as if recording their actual words, but none of them were signed by the patient concerned. On Maple ward a patient told us that staff asked him to sign his care plan without discussing it with him first.
- We looked at patient care plans at across all four wards. In most of them staff had detailed how they would support patients' care. However, in six records there was no information as to how staff planned to support patient rehabilitation. The principal objective of the hospital was to promote patient rehabilitation and recovery but these key aims were not always reflected in patient care plans.
- Information to deliver patient care was securely stored and accessible for all staff.

Best practice in treatment and care

- Medicines were prescribed in accordance with national guidelines.
- Patients had access to psychology services in the hospital and staff made referrals to hospital psychologists for individual therapy.
- The service delivered a wide range of therapeutic activities to help promote the recovery of patients. These took place at weekends as well as during the day. The occupational therapists we spoke to said that the senior management of the hospital supported innovation in devising new rehabilitative activities for patients. An example of this was therapeutic paid work in the hospital that patients could apply to do. This work included cleaning, car washing, and newspaper delivery. Its purpose was to prepare patients for returning to the community to work, promoting time management, self-discipline and self-confidence. Staff supported patients to apply for this work, including help with completing application forms and preparing for interview. Following a request from the patients' forum the hospital also gave patients the opportunity to devise and propose their own rehabilitative activities. One example of this was that staff agreed to a suggestion from patients that a regular slot each week in the activities schedule should be set aside for activities suggested by patients. A recent activity suggested by patients that had taken place was go-karting. Most

patients said that that they enjoyed the variety of activities available. Other activities undertaken by patients included walking, swimming, a gardening project and gym sessions. Activities were taking place at the time of inspection and were well-attended. However, sometimes patients were not able to participate in activity because there were not enough staff to supervise their involvement. Staff on Mulberry ward said that they hoped the recruitment of an additional HCA on the ward would help reduce this from happening.

- There was a service level agreement with a local GP practice where all of the patients were registered. Under this agreement a GP from that practice visited the hospital each week to meet with patients who had concerns about their physical health. A member of staff accompanied patients when meeting the GP to provide support and information. Staff also referred patients to see the GP where appropriate. In addition to these surgeries the GP was also involved in best interest decisions. These are specific decisions made by legally authorised person in the best interests of someone who lacks the capacity to make it for themselves.
- Patients' nutrition and hydration needs were assessed and monitored. Kitchen staff regularly liaised with nursing staff regarding patients' dietary requirements to ensure that food was appropriate for their physical health needs. For example, nursing staff informed kitchen staff where patients were diabetic to ensure that food type and portion sizes were appropriate. A nutritionist also reviewed the patients' menu every month.
- Staff regularly reviewed clinical audits in a variety of meetings to ensure that they responded to issues identified in the audits. A wide range of staff were able to attend these meetings in order to provide input.

Skilled staff to deliver care

- An appropriate mix of mental health disciplines were available to support patients. These included psychiatrists, clinical psychologists and occupational therapists, their assistants and therapy coordinators.
- Staff were experienced and qualified to undertake the duties required of them.
- Permanent staff were supervised every four to six weeks. The heads of care monitored this to make sure it was happening and to ensure that managers maintained standards of supervision. The hospital also kept an up to date monthly supervision matrix to record what supervision had taken place. Managers also attended continuing professional development (CPD) sessions to improve supervision skills. To help ensure that supervision addressed all relevant issues the hospital had issued directions to all supervisors on what supervision should cover. This included specific learning from incidents.
- We looked at six records of staff supervision notes. Three of these were detailed and discussed the objectives for each staff member with clear input from manager and worker. However, three records from Juniper ward contained minimal staff input and were completely generic. Two of these records were also identical in content, except that the names of the staff were changed. It is essential that all staff receive appropriate supervision in order to enable them to carry out their duties to effectively support and care for patients. Failure to effectively supervise staff could create a risk that they will not be able to perform their duties and that patient care will be less effective or unsafe.
- Staff attended weekly multidisciplinary meetings as well as monthly team meetings to discuss good working practice.
- Staff received the specialist training required to undertake their duties. This included training in first aid, immediate life support and the prevention and management of violence and aggression.
- Hospital and ward managers addressed poor staff performance initially through supervision and performance management. Where necessary staff were also disciplined and dismissed. This work was supported by a staff member working in a recently created human resources position.

Multi-disciplinary and inter-agency team work

- There were daily multidisciplinary meetings, attended by a representative from each discipline and each ward. This meeting had a set agenda and each department provided feedback for the minutes. One of the its purposes was to share and promote best practice. Staff spoke positively of the value of these meetings.

Long stay/rehabilitation mental health wards for working age adults

Good

- There were effective handovers between shifts. We observed one of these meetings on Mulberry ward. The focus was on discharge planning and the care plans and risk assessments were updated. Physical health was discussed as well as capacity and Mental Health Act status. Minutes of multidisciplinary meetings on other wards also showed a range of issues discussed. These included staffing, patient issues over last 24 hours, incidents, complaints and compliments.
- There were effective arrangements in place with external agencies to attend the hospital to support patients. These included local social services and an independent advocacy service. Outside organisations were also involved in providing activities for patients. For example, a drama therapist had come from Southwark Playhouse to provide acting workshops.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- MHA training was mandatory for nurses, doctors and HCAs and 100% of the relevant staff had completed this training. Staff were also receiving training in the new Codes of Practice in the Mental Health Act. This included training as part of refresher courses on the Mental Health and Mental Capacity Acts. All staff also received copies of the codes and staff could access information about them on the staff intranet.
- Staff mostly demonstrated that they had an appropriate knowledge of the MHA. However, there was some evidence that staff lacked knowledge of the Act and the MHA Codes of Practice. Firstly, information given to informal patients concerning their human rights was incorrect. Secondly, there was a blanket blanket restriction which operated on three of the wards. On Juniper, Maple and Mulberry wards the staff locked the kitchens at all times. The Codes of Practice state that blanket restrictions must be proportionate and in response to a risk that staff had identified. However, there was no evidence to show that the locking of all the kitchens was justified. When we pointed this out to staff during the inspection they immediately unlocked the kitchens.
- Staff informed patients of their rights under the Act, both on admission and throughout their stay at the hospital. Staff recorded in detail that they had explained to patients their legal rights.
- A MHA administrator worked in the hospital and provided staff with support and guidance regarding the Act.
- Staff had appropriately completed detention paperwork for patients.
- Patients had access to an independent advocacy service. Advocates from the service regularly visited all the wards in the hospital and provided patients with support to raise issues concerning their care and treatment. Staff were clear on the role of advocacy and were very supportive of the service. Staff supported advocacy by referring patients to the advocate and by providing advocates with information concerning the timing of meetings.

Good practice in applying the MCA

- Mental Capacity Act training was mandatory for nurses, doctors and HCAs and 100% of the relevant staff had completed this training. However, when asked most staff had difficulty in demonstrating an understanding of the key principles of the Act.
- Staff had not made any applications for Deprivation of Liberty Safeguards under the Mental Capacity Act in last six months.
- Where staff had undertaken capacity assessments to determine a patient's capacity to make specific decisions staff had done these assessments in a detailed and proper way.

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

Good

Kindness, dignity, respect and support

- We made observations on all the wards regarding how staff interacted with patients. On two of the wards, Maple and Elm we observed positive interactions between staff and patients. On these wards staff demonstrated a caring, respectful and supportive attitude to patients. However, on Juniper and Mulberry wards our observations were less positive. On both wards staff interaction with patients was minimal. On both wards we saw patients continually walking and

sitting alone on the wards while staff were elsewhere. The interactions we saw were mainly brief and task-focused. On Mulberry ward over a period of fifteen minutes we saw patients sitting together in the lounge watching television. On the other side of the lounge were three members of staff who interacted with each other but not with patients.

- We observed a ward round on Mulberry ward. Present at the ward round were the consultant, a psychologist, an OT, a nurse and a nursing student. We observed two patients being seen in the ward round which was conducted in a kind, considerate and courteous manner. Every effort was made to give the patient time, and the patient's views were taken seriously. Staff encouraged patients to participate in their care planning. We observed sensitive negotiations about leave with two patients, which left both feeling satisfied and listened to.
- We spoke with 15 patients across all wards about the care they received. Many said that the staff treated them with respect and were caring and polite. Several commented upon how staff always knocked before entering their room. However, some patients expressed concerns about their care. One patient on Juniper ward said the staff were aggressive to patients and shouted at them. Another Juniper patient commented that the staff were depressed all the time and did not conceal this when interacting with patients. A patient on Mulberry said that staff had to improve on how they interacted with patients and felt that they communicated too infrequently with him. One patient on Mulberry ward said that staff sometimes talked to each other in their own language, rather than English. The patient said that this was disrespectful to patients.
- Staff sometimes demonstrated an understanding of the individual needs of patients, during ward round meetings, interactions with patients and during interview. This understanding was especially true of senior nursing staff, psychologists and occupational therapists who showed care and compassion in their interaction with patients.

The involvement of people in the care they receive

- Patients generally said that they received a lot of helpful and supportive information upon their admission to the hospital
- Several patients said that they had copies of their care plans. Three patients said that they had also discussed with staff about what was to be in their plan. However, two patients said that they had not been involved in the planning of their care and another said they did not know what was happening in relation to a discharge plan for them.
- Ward rounds to discuss patients' care, treatment and rehabilitation took place every month. One patient said that this was not frequent enough and he would like to meet staff more often to discuss his situation. However, one of the independent advocates who visited the hospital said that whenever a patient requested to meet with one of the clinical team staff usually responded to this request immediately.
- Patients had access to an independent advocacy service and advocates regularly visited the wards to support patients to raise issues concerning their care and treatment. One of the advocates said that staff were very supportive of independent advocacy and referred patients directly to the service if they thought the patient might benefit from advocacy support. The advocate said that staff informed advocates of all patient meetings where advocacy could support patients. This included ward rounds, CPAs and meetings with patients to discuss their complaints.
- A monthly advocacy forum had also been established for patients to raise issues that the advocacy service could then feedback to senior management at a clinical governance meeting. The forum was scheduled directly before the governance meeting to allow patient issues to be immediately communicated. The managers of the hospital responded positively to some of the suggestions arising from the patients' forum. This included a request from patients to decide some of their own activities.
- Families and carers were able to play an active role in the patients' care and rehabilitation. For example, following concern expressed by the family of one patient regarding his care and treatment staff encouraged the family to attend the patient's meetings at the hospital and to contribute to those meetings. Two patients also said that their parents were actively involved in their care plans.

Long stay/rehabilitation mental health wards for working age adults

Good

- Daily planning meetings took place on each of the ward for the patients to raise issues with staff. Other opportunities for patients to do this were the advocacy forum, a monthly patient community meeting and ward rounds.
- The advocate said that the hospital was responsive to patients' ideas and views arising from the advocacy forum including a request from the patients that they could make suggestions for their own activities.

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

Good

Access and discharge

- Average bed occupancy in the last six months across all four wards was 97%
- Patients were referred to the hospital from a variety of agencies in the UK, including London and Devon. Before individuals were admitted clinical assessors from the hospital went to visit the referred patient and completed an assessment report within a week. The multidisciplinary team then made a decision about whether or not to admit the patient based on this report. The hospital only admitted someone if a bed was available.
- Beds were always available when patients returned from leave.
- Staff only moved patients between wards on admission if there were clinical reasons to support this.
- Staff always transferred or discharged patients at an appropriate time of day. The contractual agreement the hospital had with its commissioners stated that 28 days' notice had to be given before a patient was moved to or from the hospital. As a result staff could plan transfers and discharges in advance.
- Psychiatric intensive care unit (PICU) beds were not always immediately available in other hospitals when staff required them. In one such situation a patient on Juniper ward had to wait 10 days for a PICU bed to become available. In such situations staff used increased observation levels to safely care for the patient until a PICU bed became available.
- Discharge from the hospital was usually to a community based move on placement, rather than back to an NHS bed. Discharge was rarely delayed for other than clinical reasons. Occasionally delay was caused by the time required to find suitable accommodation for a patient. There were no delayed discharges at the time of our visit. The care pathway of the hospital was to plan for the discharge of each patient upon admission. This pathway meant that as patients' health improved they moved to wards where staff supported them to self-care and undertake activities in the community.

The facilities promote recovery, comfort, dignity and confidentiality

- A wide range of facilities were available for patients. This included a lounge, laundry, kitchen, meeting room and quiet room. In the basement there was a multi-faith room, a gym, a therapy room, music studio a shop and a kitchen.
- Quiet areas were available on the wards where patients could meet visitors.
- A private phone booth containing a pay phone was available on each ward for patient use. In addition a cordless phone was available to patients on request from staff, which patients could use throughout the ward. This enabled patients to make confidential calls from their rooms.
- Patients had access to a garden located in the hospital. Staff drew up a weekly timetable for scheduled garden visits for all patients.
- Many patients said that the food was of good quality and most were happy with variety of food provided by the hospital.
- Patients were able to make hot drinks and snacks where they were permitted access to the kitchens. However, patients only had free and continuous access to a kitchen on Elm ward. On the other wards the kitchens were locked and access was only available with staff permission.
- Patients were able to personalise their rooms.
- Staff gave each patient a key to lock their room so that they could safely store their belongings inside.

Long stay/rehabilitation mental health wards for working age adults

Good

- A wide range of activities were available for patients to participate in, including at weekends. These included activities devised by the staff as well as the patients themselves.

Meeting the needs of all people who use the service

- Access to the hospital, the different wards, therapy and activity areas was available to wheelchair users.
- A wide variety of information for patients was available on the wards. This included information on advocacy services, patients' legal rights, how to make complaints, activity groups and patient facilities in the hospital such as the gym. Information for patients was only in English. Staff said that this was because it was rare for patients not to speak English. Where a patient required information who did not speak English staff contacted local interpreting services. Staff also used these services if they needed to explain a patient's legal rights to a non-native speaker.
- There was a wide variety of food available for patients prepared by kitchen staff. This included food to meet the dietary requirements of religious and ethnic groups. For example, the kitchen staff only ordered halal meat. Kitchen staff regularly liaised with nursing staff regarding patients' dietary requirements to ensure that food was appropriate for their physical health needs. A nutritionist also reviewed the patients' menu every month. Patients generally commented positively on the food available, including the variety that was provided. Where appropriate staff allowed patients to use kitchen facilities to prepare their own meals.
- Patients had access to a multi-faith room in the basement of the hospital which contained resources to support a range of religious beliefs. Where patients required spiritual support they usually accessed this with appropriate staff help when on leave. Staff were also able to contact external services to access spiritual support if patients without leave needed it.

Listening to and learning from concerns and complaints

- Most patients said that they knew how to make a complaint. One of the independent advocates also said that staff supported patients throughout the complaints process. They did this by assisting patients to complete complaint forms and referring patients to the advocacy service. Staff also met with patients to discuss the outcome of investigations into complaints and the advocate was always notified of this meeting. Patients were informed of outcomes both verbally and in writing.
- Staff indicated that they understood the complaints process. An advocate said that complaints staff always handled complaints promptly and that all complaints were investigated.
- We looked at a random sample of seven complaints that patients had made over the past 12 months. In all cases staff investigated the complaint promptly and took clear and appropriate action to meet patients' concerns. Where necessary senior staff met to discuss the issues raised by a complaint and any required action. In every case there was clear evidence that staff fed back to the patient concerned the outcome of any investigation and any steps they were taking to meet the concerns of that patient.

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

Good

Vision and values

- Staff generally said that the principal objective of the staffing teams was the rehabilitation of patients. Staff said that they agreed with this objective and it helped lead to positive outcomes for patients.
- Staff said that they knew who the senior hospital managers were and that these managers regularly visited the wards.

Good governance

- Staff received mandatory training across a wide range of areas of practice and most staff were up to date with this training.
- All staff received regular supervision and appraisals. However, we found some evidence on Juniper ward that some supervision records were not completed correctly.
- Staff working on shifts were experienced and qualified. However, the numbers of staff employed on each shift were not always sufficient to meet patients needs. Although the provider always met their 'minimum

staffing levels' there were sometimes too few staff to always meet the needs of patients. This included where staff had to undertake one to one observations. The provider had taken some steps to address this problem. An additional HCA was due to be employed on Mulberry ward from the beginning of 2016.

- Staff generally maximised their time as much as possible in providing direct care and support to patients rather than on administrative tasks. However, when staff members were out on the ward we observed several examples of a lack of engagement between staff and patients. We observed interactions between staff and patients on Juniper and Mulberry wards that were short and task-focused and lacking in care.
- Staff regularly reviewed clinical audits in a variety of meetings to ensure that they responded to issues identified in the audits. A wide variety of staff were able to attend these meetings in order to provide input. These meetings included daily multidisciplinary team meetings and a monthly clinical governance meeting open to all members of the multidisciplinary team. Senior staff also discussed audits at the regional clinical governance board.
- Staff knew how to report incidents promptly and kept most incident records up to date. Staff effectively investigated incidents producing detailed analysis of the causes and understanding of the issues raised.
- When incidents occurred investigations were prompt and thorough with lessons to be learned identified. However, there was evidence that managers had not taken sufficient steps to ensure that changes in practice based on learning from incidents was embedded.
- Overall safeguarding procedures were followed and staff knew how to raise safeguarding alerts. However, there was evidence that staff did not always promptly respond to serious safeguarding allegations.
- Staff understood and followed procedures in respect of the Mental Health Act.
- Staff monitored the quality of the work undertaken at the hospital through the use of key performance indicators (KPIs). Weekly KPIs were available for senior staff to discuss at local MDT and senior leadership meetings. KPIs included information relating to the number of restraints, complaints, safeguarding, medication errors, serious incidents (SUI) and patients absent without leave (AWOL) over the four wards. All KPIs were within target ranges and being met.
- KPIs and issues discussed at senior leadership meetings fed into clinical governance meetings, both at the hospital and at a corporate level. The hospital manager informed the hospital board of all significant data and issues. Senior staff responsible for quality and risk attended corporate governance and board meetings. This information allowed the board to compare the overall performance of the hospital against others run by the same provider. This process also allowed for early warnings for potential concerns.
- Ward managers received appropriate administrative support. They also had sufficient authority to take the necessary steps on their wards to ensure effective management and support for patients.
- There were robust systems in place to for staff to record risks. Where staff had identified local issues they recorded them on a local register. Local risk register items for the hospital included medication errors, and learning from recent serious incidents. Where appropriate staff then fed these matters into a regional risk register and a corporate register. At the time of our inspection no locally identified risk register entries were significant enough to be included on the corporate register.

Leadership, morale and staff engagement

- Senior managers were in the process of making improvements to staff working practices and the overall management of the wards. These improvements included two new senior night nurse positions to undertake an onsite manager role for each night. They attended the weekly senior nurse meeting and undertook a shift together each month for peer support. Senior managers had also taken steps to address staff concerns relating to pay and conditions. Many staff reported that they were happy with the steps the senior managers had taken and that these had helped to improve the working environment.
- No data or other evidence was available concerning levels of staff sickness absence.
- Most staff said that they knew how to use the whistle-blowing process.

Long stay/rehabilitation mental health wards for working age adults

Good

- Most staff said that they felt confident in raising concerns with senior management. However, one staff member said that they only received support following an incident where they were assaulted after complaining to a manager that they had received no help. Also two staff members said that they were not confident raising concerns because senior management did not listen to staff problems.
- Morale was generally high. Many staff said that that staff teams were supportive and that conditions had improved for them following a recent pay rise. Several members of staff said that they enjoyed working in the hospital and that their main satisfaction was helping patients to recover. However, some staff were concerned that the turnover of staff was very high and that this caused instability for employees and patients alike.
- There were opportunities for staff development and several staff members identified this as a positive feature of the organisation.
- Staff were open and transparent in feeding back to patients when things went wrong. An example of this was that staff always met with patients to discuss the outcome of an investigation into a complaint and helped to ensure that an advocate was available to support this process.
- Staff generally felt that they had opportunities through staff meetings and supervision to give feedback on services and help with service development. However, some support workers felt that they were too busy to attend meetings and should have more opportunity to discuss observations with multidisciplinary teams and management.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that a plan of works, with completion dates, is developed to respond to identified ligature risks.The provider must also take steps to reasonably mitigate the risks caused by unclear lines of sight on the wards.
- The provider must ensure that sufficient staffing levels are maintained to keep patients safe at all times.
- The provider must ensure that there are appropriate procedures to manage all safeguarding matters without any undue delay.
- The provider must take appropriate steps to ensure that appropriate lessons are learned following incidents, that learning is incorporated into practice and those robust systems and procedures are in place to verify this learning. The provider must also ensure that all incidents of restraint are properly recorded.
- The provider must ensure that after a patient has been administered rapid tranquilization they are reviewed by a doctor and that this review is recorded.
- The provider must ensure that information given to informal patients complies with the Mental Health Act

Action the provider SHOULD take to improve

- The provider should ensure all cleaning records are kept up to date.
- The provider should ensure that patients' records, risk assessments and care plans are appropriately updated following a safeguarding incident.
- The provider should ensure that care plans which state the opinion of patients only do so where the words recored are an accurate representation of patients' views.
- The provider should ensure that all care plans demonstrate a clear focus on recovery.
- The provider should ensure that staff supervision records should accurately reflect the support given to a staff member and detail the issues discussed, rather than being generic.
- The provider should ensure that staff training records are up to date to make sure that all wards have sufficient numbers of adequately trained staff .
- The provider should ensure that staff interactions with patients are, wherever possible, communicative and demonstrably caring, not simply short in duration and task focused.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not always provide safe care and treatment for patients because they did not fully record the details of each patient restraint and rapid tranquilization. These incomplete records meant that the provider could not demonstrate that it was conducting restraint and rapid tranquilization safely and in accordance with its policies and procedures. The provider had not taken sufficient steps to ensure that it improved the safety of its services. It had not put in place robust systems and procedures to verify that learning from serious incidents was incorporated into staff practices. **This was a breach of regulation 12(1)** The provider had not mitigated risks created by unclear lines of sight on the wards to ensure a safe ward environment. The provider had not specified what work it would carry out to mitigate identified ligature point risks on the wards. **This was a breach of regulations 12(2)(b) and 12(2)(d)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have adequate systems and processes in place to ensure that staff responded to all serious safeguarding allegations without undue delay. **This was a breach of regulations 13(2) and 13(3)**

This section is primarily information for the provider

Requirement notices

The provider gave information to informal patients concerning their rights under the Mental Health Act which was not accurate. There was therefore a risk that staff could deprive informal patients of their liberty without lawful authority.

This was a breach of regulation 13(5)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not deployed sufficient numbers of staff on the wards to keep patients safe at all times. **This was a breach of regulation 18(1)**

This section is primarily information for the provider

Enforcement actions

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.