St. Matthews Limited

Broomhill

Inspection report

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

Ratings

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

Summary of findings

Overall summary

The Chief Inspector of Hospitals is placing St Mathews Broomhill Hospital into special measures. Services placed in special measures will be inspected again within six months. If sufficient improvements have not been made such that there remains a rating of inadequate overall or for any key question or core service, we will act in line with our enforcement procedures to begin the process of preventing the operator from operating the service. This will lead to cancelling their registration or varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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

- The provider had not ensured they had effective governance structures and processes to provide oversight and assurance of all aspects of service delivery to be able to identify and improve practice in a timely manner and sustain that improvement. Examples included patients' identifiable information was not always kept securely. There was no effective monitoring to ensure patients received debriefs after incidents of violence or aggression from other patients. Such incidents were not recorded in a timely manner to allow for effective monitoring. There was little oversight to ensure that all patients received a comprehensive assessment and treatment plan in a timely manner, managers had not realised that some care planning information was cut and pasted between records, leading to recording errors. Managers were not monitoring the quality of the food served on the wards. Managers were not effectively monitoring the mandatory training compliance for all staff. A lack of governance oversight regarding mandatory training and sustainable action plans had been cited in previous inspection reports and enforcement action we had taken. This related to all wards in the hospital wide issue.
- The provider did not provide an environment which was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff could not observe patients in all parts of the hospital and there were reports of staff sleeping while on observation duties. We saw multiple blind spots throughout the wards in the long stay rehabilitation, which were not mitigated by mirrors or individual risk assessments. Numerous ligature points were identified on the ligature risk assessment, however the mitigation identified did not address the identified risk. This was reported on in previous inspection reports.
- Staff failed to ensure that all corridors were kept clear of hazards to enable safe exit from ward areas in the case of emergency and that patients had access to call alarms.
- The provider had failed to address maintenance issues and repairs in a timely way, leaving areas of risk for some patients. Staff had not ensured that all necessary repair works to improve the quality of the environment were completed within reasonable timescales and that high-risk requests were resolved on the same day. Not all ward areas were clean, and some wards had ripped, dirty, or broken furniture and fittings.
- Staff had not fully risk assessed all patient activities on the ward including potential risks relating to other patients. We saw electrical equipment placed on the floor in patient areas and staff had not fully risk assessed this issue. We found plastic bags in a drawer on one ward.
- Staff were not adhering to the hospital's policy and procedure when bed rails were used.

Summary of findings

- The service did not work to a recognised model of mental health rehabilitation, to meet patients' needs. Staff were not routinely offering patients regular access to activities that promoted rehabilitation such as employment and education opportunities. This had been cited in previous inspection reports.
- Staff did not always adhere to the hospital's infection prevention and control policy. Examples include food hygiene and storage of food. Lack of cleaning in areas where patients ate their food. Bedrooms that had not been cleaned before admission. Staff who were not bare below the elbows and wearing jewellery. Staff did not ensure that the traps used to manage the current mouse infestation on Manor ward were not placed in patient areas.
- Staff had not always followed best practice after administration of rapid tranquillisation regarding the monitoring and recording of physical observations. This had been cited in previous reports.
- Staff did not always ensure that patient medication was prescribed within British National Formulary limits and where this was needed, they were not recording a clear rationale for doing so and there was no evidence that second opinion was always sought. Staff had not ensured that all patients could give consent to treatment by medication.
- Staff had not always followed National Institute for Health and Care Excellence guidelines when undertaking enhanced patient observations. This was an area of concern in February and September 2020. Staff had not always used the correct techniques when restraining patients. Staff did not always have access to de-escalation facilities.
- Staff had not always routinely checked cleaned or calibrated medical equipment. Staff had not regularly checked the emergency grab bags and defibrillators, and emergency equipment was accessible in a timely manner.
- Staff had not always ensured that patients were protected from harm and safeguarded. Incidents included patient on patient assaults, sexual vulnerability and staff not managing known allergies. Managers had not managed the numbers of assaults and altercations between patients. Patients told us they did not always feel safe on the wards or received debriefs from staff following any incidents. Adequate safeguarding of patients was an area of concern in February 2021.
- Staff did not always treat patients with compassion and kindness, dignity, and respect. Staff did not always respect their privacy and dignity and did not always understand the individual needs of patients. We heard of several occasions when staff had been speaking to one another in front of the patients, in a language other than English. Staff did always knock on bedroom doors before entering. Staff who had made hurtful, racist, and derogatory remarks to patients. Dignity and respect issues been cited in previous inspection reports and enforcement activity.
- There were limited rooms for use as quiet areas on some wards. Wards had limited space for patients to meet visitors in private.
- Staff had not always made sure that patients were fully involved in the development and ongoing monitoring of their care plans, some patients told us they did not have copies of their care plans and there was no evidence in the care plan records that copies were routinely given to patients.

However:

- The ward teams included or had access to, the full range of specialists needed to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team. This was an improvement on previous inspection findings.
- Staff had developed care plans informed by a comprehensive assessment. This was an improvement on previous inspection findings.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Inadequate 	Our rating of this service went down. We rated it as inadequate because: • The ward environments were not safe. The provider had not identified appropriate mitigation for identified ligature risks. Staff had identified the potential ligature anchor points in the service; however, the identified mitigation did not adequately mitigate the risks identified to keep patients safe. Staff could not fully observe patients in all areas of the wards due to blind spots. Patients did not have access to a de-escalation room. • Wards were not clean or well maintained. We found ripped, dirty, and damaged furniture and fittings. • Staff had blocked the ward corridor on Manor ward with chairs, which would prevent the safe exit from the ward in the case of an emergency. • Staff had not checked and cleaned medical equipment regularly or ensured that clean stickers were in place. There was no evidence that medical equipment had been calibrated regularly. Regular checks of access to emergency grab bags and defibrillators had not taken place. • A patient had seen a mouse in his room on Manor ward. This had not been safely managed as we saw mouse traps on the ward. • Staff had not always undertaken non-contact observations post rapid tranquillisation, when patients refused to have their physical health observations undertaken. • Staff were not fully adhering to the hospital's infection prevention and control policy. Some staff were not bare below the elbows, and we saw that some staff were wearing earrings, watches, and other jewellery. • Staff had not conducted risk assessments in line with the hospital's policy and procedure for the use of bed rails. • We saw two incidents where staff had not restrained patients in line with hospital's policy. • The provider had not ensured that the hospital's policy on patient observations reflected the

Summary of findings

National Institute for Health and Care Excellence guidelines. We found that staff had not safely stored food and drink on the ward. Food items had been left out of the fridge and there were undated items which had been transferred into plastic containers.

- Staff had not ensured that electrical items (including toaster and kettle) were placed in a safe place on Manor ward or that any associated patient risks had been fully assessed.
- Not all patient medicines had been included within the patient's consent to treatment form. Some patient medications had not been prescribed within BNF limits.
- The provider did not have fully effective governance structures and processes in place to provide oversight and assurance of all aspects of service delivery, to be able to identify and improve practice in a timely manner and sustain that improvement.
- Staff had not supported all patients (where appropriate) in finding opportunities for education and employment.
- Staff had not fully met all mandatory training requirements.
- Staff had not maintained the safety of all patients, ensuring that patient safety risks (including allergies and sexual vulnerability) were safely managed. Staff had stored plastic bags in a drawer in the patient's dining room on Althorp ward, however staff removed these at the request of the inspector.
- Staff had not always treated patients with compassion and kindness or respected their privacy and dignity. They had not actively involved all patients and families and carers in care decisions.
- Not all patients had not been fully involved in the development and ongoing monitoring and given a copy of their care plan.
- The service did not work to a recognised model of mental health rehabilitation.

However

- Staff knew how and where to access ligature cutters.
- Most patients told us they would tell staff if they had any concerns.

Summary of findings

- Staff were aware of their individual responsibility in identifying any individual safeguarding concerns and reporting these promptly.
- The provider used a recognised risk assessment and risk management tool.
- The ward teams included or had access to the full range of specialists needed to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision, and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. The provider had effective processes for the management and recording of Mental Health Act paperwork.
- There was good access to the garden areas and fresh air.
- Staff followed good practice with respect to safeguarding.
- Staff engaged in some clinical audit activities to evaluate the quality of care they provided.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare.

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

Inadequate

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

- The ward environments were not safe. The provider had not identified appropriate mitigation for identified ligature risks. Staff could not always observe patients in all areas of the wards due to blind spots. The provider had not ensured that the hospital's policy on patient observations reflected the National Institute for Health and Care Excellence guidelines.
- We saw two incidents where staff had not restrained patients in line with hospital's policy. Patients did not have access to a de-escalation room.
- We found that staff had not maintained the safety of all patients, ensuring that patient safety risks (including allergies and sexual vulnerability) were safely managed. Staff had stored plastic bags in the drawer on Althorp ward.

Summary of findings

- Wards were not clean or well maintained. We found dirty and damaged furniture and fittings.
- taff had not checked and cleaned medical equipment regularly or ensured that clean stickers were in place. There was no evidence that medical equipment had been calibrated regularly. Regular checks of access to emergency grab bags and defibrillators had not taken place.
- Staff had not conducted risk assessments in line with the hospital's policy and procedure for the use of bed rails had not been fully adhered to.
- Staff had not always undertaken non-contact observations post rapid tranquillisation, when patients refused to have their physical health observations undertaken.
- Staff were not always adhering to the hospital's infection prevention and control policy. Some staff were not bare below the elbows, and we observed that some staff were wearing earrings, watches, and other jewellery. We found that staff had not safely stored food and drink on the ward. Food items had been left out of the fridge and there were undated items which had been transferred into plastic containers.
- Not all patient medicines had been included within the patient's consent to treatment form. Some patient medicines had not been prescribed within BNF limits.
- The provider did not have fully effective governance structures and processes to provide oversight and assurance of all aspects of service delivery, to be able to identify and improve practice in a timely manner and sustain that improvement.
- Staff had not fully met all mandatory training requirements.
- The service did not work to a recognised model of mental health rehabilitation. Staff had not supported all patients (where appropriate) in finding opportunities for education and employment.
- The provider had not ensured that all patient activities on the ward had been fully risk assessed including potential risks relating to other patients.
- Staff had not always treated patients with compassion and kindness or respected their privacy and dignity. They had not actively involved patients

Summary of findings

and families and carers in care decisions. Patients had not been fully involved in the development and ongoing monitoring and given a copy of their care plan.

However

- Staff knew how and where to access ligature cutters.
- Most patients told us they would tell staff if they had any concerns.
- Staff were aware of their individual responsibility in identifying any individual safeguarding concerns and reporting these promptly.
- The provider used a recognised risk assessment and risk management tool.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. The provider had effective processes for the management and recording of Mental Health Act paperwork.
- There was good access to the garden areas and fresh air.

Summary of findings

Contents

Summary of this inspection

Background to Broomhill

Broomhill provides care, treatment, and support to individuals with mental health concerns. Broomhill is part of the St. Matthews Limited, which consists of 5 care homes and 3 hospital locations in Northampton and Coventry.

Broomhill provides 99 beds across 2 core services and seven wards:

Acute wards for adults of working age and psychiatric intensive care units, consist of one ward.

- Holdenby ward – Acute admission ward - 14 beds for male patients.

Two acute wards were opened in 2020 as part of the provider's action plan to address the breaches we found at an inspection of the long stay mental health rehabilitation service earlier in 2020. However, at the time of this inspection only one acute ward remained open.

Long stay or rehabilitation mental health wards for working age adults consists of 6 wards.

- Althorp ward – High dependency unit - 14 beds for female patients.
- Cottesbrooke ward – Highly specialist high dependency rehab unit - 14 beds for female patients
- Kelmarsh ward – Longer term high dependency rehab unit - 14 beds for male patients.
- Lamport ward – Highly specialist high dependency rehab unit - 14 beds for male patients
- Spencer ward – Longer term high dependency rehab unit - 14 beds for male patients.
- Manor ward – Longer term high dependency rehab unit - 15 beds for male patients.

At this inspection we visited the 1 acute ward and 5 of the 6 rehabilitation wards. We did not visit Lamport ward. This unannounced, comprehensive inspection took place over 4 days in July 2023. The inspection was in response to previous action plans and ongoing concerns received via whistleblowing and other enquiries. The main concerns related to the quality of care and treatment and safeguarding concerns. In addition, the provider had requested a re-inspection, as the service had not been reinspected since February 2020.

The last inspection of Broomhill long stay or rehabilitation service was in January 2023. The inspection was an unannounced, comprehensive inspection of the rehabilitation service only, and looked at 3 key questions: safe, caring, and well-led. The inspection took place following concerns about an increase in the number of notifications between July and August 2022 and the findings of a Mental Health Act review visit in October 2022. The overall rating for the rehabilitation part of the service following the inspection was requires improvement, with safe, caring, and well-led key questions all rated as requires improvement. We found breaches of regulations 9 and 12 and issued requirement notices.

The last inspection of Broomhill acute service was in October 2021. At that time this core service was rated RI overall with safe, caring and well led all rated RI. Effective and responsive were not and have not been rated.

The last comprehensive inspection of Broomhill took place in February 2020. At that time the provider did not have an acute core service. CQC rated the provider inadequate overall and placed the service in special measures. Between February 2020 and January 2023, we conducted three further inspections at Broomhill. These took place in July 2020, September 2020, and February 2021. Further to each inspection, a number of breaches of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014 were identified.

Summary of this inspection

In response to these breaches Care Quality Commission issued a Notice of Proposal (13 August 2021), followed by a Notice of Decision (30 July 2021), to vary a condition of the provider's registration (to remove the location). The provider submitted an appeal against the proposal. In the interim, a stay of proceedings was requested and approved until Friday 19 November 2021 to allow for a further inspection to be undertaken. The purpose of the 'stay of proceedings' was to enable the CQC to conduct a further inspection of Broomhill and determine if any of the breaches of regulation have now been addressed. As a result of this inspection, the appeal was upheld and enforcement action against the provider ceased.

Broomhill has a history of failing to respond adequately to serious concerns raised by the Care Quality Commission. While the provider does submit action plans to address the findings of each of our inspections these actions are often not sustained or embedded by the provider in practice. However, following our inspection in July 2023 the provider has implemented a range of further changes, which cannot be recorded within this inspection report.

What people who use the service say

While the rating from the most recent patient satisfaction survey undertaken by the provider for Broomhill, in July 2023 was positive. At this inspection we found peoples responses appeared to contradict this outcome.

During this inspection we spoke with 45 patients across both the acute and rehabilitation wards, and formally interviewed 24 patients.

Out of 24 patients we interviewed, and who told us if they were happy or not with their care and treatment, 16 patients (67%), told us that they were not happy. Of these 16 patients, 13 patients told us that they felt unsafe on the wards. One patient said that only having 1 ward round a month was not enough and ward rounds were rushed. Another patient told us that "the day is just full of people going to smoke outside. All day long - every half hour. If I am playing a game with staff, someone will interrupt asking for a smoke break and the staff will have to go, and I will have to put the games away." Two other patients raised concerns about the food and 1 patient stated that "there was very limited occupational therapy resource, and limited opportunities to take positive steps forward in my mental health."

Six patients raised concerns regarding their length of stay in the hospital. Comments from patients included "I'm stuck"," I've been here too long"," I have no discharge plans in place"," I want to leave and move into a flat" and" I am not moving on."

Three patients also shared several positive comments about staff stating, "staff are amazing and friendly," "good staff and good service," "very good staff and service overall "thank you for keeping me safe." Positive comments were also shared about patient's rooms, which were described by one patient as "very big and the fact you have en-suite is great."

We also spoke with 8 carers. Four out of 8 carers (50%) were mostly happy with the care and treatment provided. However, 3 carers expressed concerns regarding care and treatment. One carer told us that there were issues with communication, they said promises were made by staff which had not been delivered. One carer told us that their relatives need in relation to their diagnosis of autism were not being met. Another carer was concerned that their relatives' diabetes was not being monitored properly.

How we carried out this inspection

This was an unannounced comprehensive inspection.

Summary of this inspection

To fully understand the experience of people who use services, we asked the following five questions:

• 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.

During the inspection visit, the inspection team:

- visited six wards at the hospital, reviewed the quality of the ward environments and saw how staff were caring for patients.
- spoke with 6 patients who were using the service.
- spoke with 8 family members and carers.
- spoke with the registered manager, and deputy managers for each of the wards.
- spoke with 32 other staff members: including nurses, healthcare assistants, senior healthcare assistants, occupational therapist, occupational therapy assistant, psychology assistant and pharmacist.
- attended and saw a safety huddle and 'flash' meetings.
- reviewed 35 care and treatment records of patients.
- carried out a specific check of the clinics and medication management on six wards.
- reviewed a range of policies, procedures and other documents relating to the running of the service.
- reviewed incidents, patient observation records, risk register and governance files including meeting minutes.

The inspection team consisted of 1 CQC Deputy Director of Operations, 5 CQC Inspectors, 2 Specialist Advisors and 2 Experts by Experience.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

- The provider must ensure a recognised rehabilitation model of care is embedded within the rehabilitation wards to meet patient's needs. The provider must ensure patients have regular access to activities that promote rehabilitation such as employment and education opportunities. (Regulation 9)
- The provider must ensure that all patients are fully involved in the development and ongoing monitoring of their care plans, patients must be given a copy of their care plan and that this is evidenced within the patient's clinical records. (Regulation 9)

Summary of this inspection

- The provider must ensure that staff do not copy and paste from one patient's record into another. (Regulation 9)
- The provider must ensure that staff treat patients with kindness, privacy, dignity, respect, compassion, and support at all times. (Regulation 10) This was an area of concern in 2021.
- The provider must ensure that there is access to visiting facilities for patients and their careers, including a family visiting room. (Regulation 10)
- The provider must ensure that staff do not talk in languages other than English in front of patients unless it is the patient's native language (Regulation 10). This was an area of concern in July and September 2020.
- The provider must ensure that clear mitigation is in place for all identified ligatures, and that appropriate actions are taken to address blind spots on the wards. (Regulation 12). This was an area of concern in February 2020.
- The provider must ensure that staff follow National Institute for Health and Care Excellence guidelines when undertaking enhanced patient observations. (Regulation 12). This was an area of concern in February and September 2020.
- The provider must ensure that the correct techniques are used when restraining patients. The provider must aim to reduce the number of restraints. (Regulation 12).
- The provider must support staff to provide an environment where staff can de-escalate patients in a way that supports the patient's privacy and dignity. (Regulation 9)
- The provider must ensure the oversight of rapid tranquillisation administration and monitoring. The provider must ensure a competent professional maintains oversight of rapid tranquillisation administration and monitoring. That non-contact observations are undertaken post rapid tranquillisation, when patients refused to have their physical health observations undertaken. (Regulation 12).
- The provider must ensure that staff adhere to the hospital's infection prevention and control policy. The provider must ensure acceptable food hygiene and storage procedures are in place across the hospital, and that the current problems with mice infestation are safely managed and any traps are not placed in patient areas. (Regulation 12).
- The provider must ensure that clinical equipment is checked and cleaned regularly and that clean stickers are in place. (Regulation 12) This was an area of concern in July 2020.
- The provider must ensure that staff adhere to the hospital's policy and procedure when bed rails are used. That all electrical equipment is placed in safe areas on the ward and that patient risks are fully assessed. (Regulation 12).
- The provider must ensure that all patient medication is prescribed within British National Formulary limits unless there is a clear rationale for doing so and a second opinion in place. The provider must ensure that all patient medication is covered in the patient's consent to treatment form. (Regulation 12).
- The provider must ensure that all medical equipment is calibrated as per manufacturers guidance. The provider must ensure that staff regularly check the emergency grab bags and defibrillators, and emergency equipment is accessible in a timely manner (Regulation 12).
- The provider must ensure that staff meet all aspects of the available mandatory training requirements. (Regulation 12). This was an area of concern in February 2020.
- The provider must ensure that patients are properly always safeguarded. That patients feel safe on the ward and are protected from harm, this includes patient on patient assaults, sexual vulnerability and any known allergies are managed. The provider must ensure that they monitor the numbers of assaults and altercations between patients. (Regulation 13). This was an area of concern in February 2021.
- The provider must ensure that all ward areas are fully clean and that any ripped, dirty, or broken furniture and fittings are discarded. (Regulation 15).
- The provider must ensure that all corridors are kept clear to enable safe exit from the ward in the case of an emergency. (Regulation 15).
- The provider must ensure that it has effective governance structures and processes to provide oversight and assurance of all aspects of service delivery, to be able to identify and improve practice in a timely manner and sustain that improvement. (Regulation 17). This was an area of concern in September 2020 and February 2021.
- The provider must ensure the confidentiality of all patient's identifiable information. (Regulation 17).

Summary of this inspection

- The provider must ensure that de-briefs following incidents of violence and aggression are undertaken and recorded in a timely way. (Regulation 17)
- The provider must ensure that all patients receive a comprehensive assessment and treatment plan in a timely manner. (Regulation 17)
- The provider must ensure that food is of a good quality. (Regulation 17)

Action the service SHOULD take to improve:

- The provider should ensure that all patients receive an annual health check.
- The provider should ensure that patients have access to a dentist.
- The provider should ensure that patients have access to regular ward-based, community-bases and individualised therapeutic activities, including weekends and evenings. Activities should include to access to advice on healthy living and access to gym equipment.
- The provider should ensure that clinical records can be accessed by patient's name and not by ward, so that previous ward details are immediately evident.
- The provider should ensure that staff use the Mental Capacity Act section of the electronic health records, to ensure that key information is readily accessible.
- The provider should t ensure that any patient activities on the ward are fully risk assessed including potential risks relating to other patients.
- The provider should ensure that there are no plastic bags allowed on the ward

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

Is the service safe?

Inadequate

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

Safe and clean care environments

Not all wards were safe, clean well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

Although staff had completed and updated ligature risk assessments of all ward areas, managers had not taken steps to remove or reduce all the risks they had identified. However, staff knew how and where to access ligature cutters.

There were potential ligature anchor points on the wards. Whilst most staff knew about any potential ligature anchor points the identified mitigation had not adequately reduced or removed the risks identified to keep patients safe. We reviewed the environmental ligature risk assessments for each of the 5 rehabilitation wards inspected. We found that staff had completed ligature risk assessments of all ward areas, which had been reviewed in January 2023. However, managers had not removed or reduced the identified ligature risks. Some of the identified ligatures had been rated as green. This was an incorrect rating, as a green risk rating indicated that the risk was adequately mitigated. The identified mitigation for these risks was 'closed circuit television' (CCTV), which is not an alternative to staff presence. CCTV monitors were based in the nursing office, where staff were not dedicated to observing. Staff must be present and directly monitor patients in high-risk areas. CCTV can only be used to augment, but never replace, monitoring. Mitigation for the risks identified would require additional staff observations both via mental health and zonal observations. These were not identified as mitigation.

Staff could not see patients in all parts of the wards. We identified blind spots on each of the wards inspected. Whilst the provider had installed mirrors, these had not always reduced or fully addressed the blind spots.

The wards complied with guidance and there was no mixed sex accommodation. All wards were single sex.

Although staff had easy access to alarms and walkie talkies, we observed that messages were not always clearly heard. This resulted in delays in messages being received.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Maintenance, cleanliness, and infection control

Not all ward areas were clean, well maintained, well-furnished or fit for purpose. This included furniture and carpets which required replacement. We found several concerns on Manor ward including damaged walls, ripped chairs, problems with mice, we saw a mouse trap in a patient's bedroom, exposed wiring in the ceiling and windows which needed repair. As of June 2023, staff had raised 80 maintenance requests in the hospital, of which 59 had been completed and 21 were overdue.

Managers conducted 'ward walkarounds', looking at the environment in the nurses' station, ward communal areas, clinics, and patient bedrooms. However, managers had not documented these. Managers informed us those concerns regarding the fencing had been escalated and the issue was under review. On Kelmarsh ward we saw exposed wiring in the ceiling.

On Althorp ward a patient user had bed rails in place. The provider's policy and procedure on the use of bed rails, states that bed rails can only be used after a full risk assessment has been undertaken that includes the benefits and risks of use. Staff had not conducted a bed rail risk assessment to ensure that the potential risks associated with the use of the bed rails had been assessed. However, the provider has told us following our inspection, that "the assessment for bed rails was put in place on the day of the inspection." In addition, monthly maintenance checks had not been undertaken in line with the provider's policy. We also noted that staff had difficult opening and closing the bedrails. Staff had not completed a patient care plan to cover the use of bedrails.

Not all areas of the hospital were clean. Although staff had maintained cleaning records, which were up to date, and the provider shared copies of the cleaning schedules for July 2023, which evidenced that basic cleaning of areas had taken place. We saw several concerns regarding cleanliness, including dirty carpets on Manor ward, and reports of faecal matter on the chairs on Manor ward. We visited one patient bedroom on Spencer ward, where a patient had set a small fire the previous day. We found there was an offensive odour in the room and the room had not yet been cleaned. On Manor ward a patient had seen a mouse in his room and staff had placed a mouse trap on the floor.

Staff had not always followed the provider's infection control policy. Not all staff we saw were bare below the elbows, and some staff were wearing earrings, watches, and other jewellery. The dining room on Manor ward had not been adequately cleaned after lunch. There were stains left on the tables, this could pose an infection risk. Effective cleaning removes bacteria on equipment and surfaces, which helps to stop harmful bacteria and viruses from spreading onto food. A carer we spoke with told us that their relative's bedroom had not been cleaned by staff prior to his admission, and he had "ended up cleaning his own room."

At the time of our inspection, the food hygiene rating for the hospital kitchen was 5 (highest rating: hygiene standards are very good). However, we observed several concerns relating to food storage, cleanliness, and patient cooking on the wards. We found that butter on all wards had been left out of the fridge and stored in cupboards. This included unopened butter. Staff had left fruit juices out of the fridge when opened. We found a bottle of prune juice that had gone fizzy after being left in a warm place too long. We saw a staff member taking a patient's meal through the building to another room where the patient was to eat, the food had not been covered. This could pose an infection prevention and control risk. Covering food protects it from harmful bacteria and other harmful substances.

Clinic rooms were not fully equipped, however staff informed us that equipment was available in separate room used by the General Practitioner (GP). This room was on the second floor in the main building and was easily accessible. Medical equipment had not been checked or cleaned, and emergency equipment had not always been checked weekly as required. There were no records of when staff had cleaned medical equipment, and there were no 'clean' stickers in place. This could pose an infection prevention and control risk. We were not provided with evidence that clinical

equipment had been calibrated including blood monitoring (BM) machine, oximeter, sphygmomanometer and weighing scales on Holdenby, Althorp, Spencer, Kelmarsh, and Manor wards except for BM machine on Manor which had been calibrated recently. The purpose of calibrating medical equipment is to ensure that any discrepancies in measurements are identified and fixed. The risk of not calibrating medical equipment is that the accuracy of medical devices is important, as inaccurate results can seriously affect the diagnostic procedure and potentially endanger a patient's life.

Staff had not always undertaken weekly checks of the emergency equipment. The purpose of weekly checks of emergency equipment is to ensure that the emergency bag is fully equipped. We found that the nasopharyngeal airway, O2 mask, and Intravenous (IV) cannulation kit, were missing from emergency bags on Manor and Cottesbrooke wards. Weekly reviews would have ensured that staff would have identified these missing items and replaced them. The risk of not having a fully equipped emergency bag is that essential equipment may not be available in the case of an emergency which could adversely affect the ability of staff to safely response to the patients and potentially endanger a patient's life.

Staff had not always ensured that clinical equipment was in date. On Kelmarsh ward, we found expired clinical equipment. This included out of date saline, oxygen masks, blood monitoring tests, and different sets of needles which had expired in February, November, and May 2023.

On Althorp ward we found that the emergency bag had not been checked weekly. There were 4 gaps in the room temperatures chart (April x1, May x1 and June 2023 x 2) and 3 gaps in fridge temperature recordings (April x1 and June 2023 x2). Sharps had been discarded in yellow bin which had no lid. The yellow bin had a notice on the front, which clearly stated – no sharps. The suction machine had not been cleaned and was dirty.

On Cottesbrooke ward, the suction machine was not usable. On the 25 September 2022, staff had identified that there was no suction catheter in place. This was not reported to the deputy manager until 25 July 2023, who arranged for a replacement. This piece of equipment eventually arrived and is now in situ. This meant that in the case of an emergency, ward staff did not have immediate access to a suction machine for 10 months. We were told in the case of an emergency; staff would have had to access a suction machine from another ward. However, there was no evidence that the provider had carried out scenario testing of the suitability of these arrangements. Suction machines are an essential part of the ward's emergency equipment to prevent hypoxia associated with obstructions and difficulties breathing. We also found that there was missing equipment from the emergency bag (missing nasopharyngeal airway, oxygen mask and intravenous cannulation kit), and there were no cleaning records available.

Safe staffing

The service had enough nursing and medical staff; however, they relied on a high number of agency staff. The service did not have a formal establishment rate instead they based staffing figures on patient's complexity and needs.

Nursing staff

The service had enough nursing and support staff with the use of agency staffing, to keep patients safe. Staff told us that staffing had improved and there were enough staff on the wards.

Although the service had high vacancy rates these were reducing. As of June 2023, the vacancy rate for the hospital was 22%. The provider had appointed 8.60 whole time equivalent (WTE) Senior Healthcare Support Workers. The highest number of vacancies was for registered nurses (35.70 WTE), followed by health care support workers (15.40 WTE).

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Between April and June 2023 there had been 42 new starters of which 30 were healthcare support workers, 2.5 registered nurses and 1 occupational therapist.

The service did not have low rates of bank and agency nurses. In June 2023, the percentage agency staff usage was 53%. The provider was actively trying to recruit and had plans in place for a recruitment day for qualified nurses on 18 July 2023.

The service used a high rate of bank and agency support workers. As of June 2023, the total agency staff usage of block booked support workers was 32%. However, this had reduced from March 2023, when the total agency usage of support workers was 46%. The number of ad hoc agency support workers was 9%, a reduction from 10% in March 2023.

Whenever possible, managers used and requested bank and agency staff familiar with the service. The provider shared figures on agency usage, which showed that most agency staff were block booked for consistency.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff followed the provider's local induction process for agency and temporary staff.

The service had reducing turnover rates. In 2022, there had been 55 staff leavers. The provider reported that as of July 2023, the turnover rate was 9.5%. This is an improvement from 2021 when the turnover was 50%.

Managers supported staff who needed time off for ill health. However, staff told us that they did not receive sick pay. This had resulted in staff attending work when they did not feel well enough to do so.

Levels of sickness were low and reducing. The provider reported a sickness rate April to June 2023 of 5.6%, which mirrors the national average sickness rate.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The provider was working to a set staff to patient ratio. This was one staff member to two patients.

Managers could adjust staffing levels according to the needs of the patients. Managers told us that they could request additional staff when needed. However, patients told us that due to lack of staffing they had not had regular one-to-one sessions with their named nurse. Sixteen patients across the hospital told us that they had not had the opportunity to discuss their views on care and 25 patients told us that they did not have a care plan.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The provider reported that there had been no incidents of cancelled leave. Staffing figures were always at safer staffing levels. Ward staff completed a weekly trip planner which was provided to reception to plan driver schedules and journeys. Where last minute trips such as urgent appointments, had been requested, staff had facilitated these where possible, prioritising any medical appointments and booking extra staff if required.

The service had enough staff on each shift to carry out any physical interventions safely. In the 6-month period January to June 2023, across the hospital there had been 103 episodes of physical interventions. The highest number (33) of physical interventions across the hospital occurred in May 2023, and the lowest numbers were in February and March 2023 (11).

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff shared key information to keep patients safe when handing over their care to others. We attended two daily 'flash' meetings which was attended by managers and or a senior nurse from each ward. The meeting was chaired by the registered manager and was structured and informative.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Although all managers had access to monthly training figures, and managers told us they monitored mandatory training and alerted staff when they needed to update their training. We found there were some significant shortfalls in compliance with all mandatory training courses.

While the hospital's overall mandatory training rate as of June 2023 was 86%, the following courses fell significantly short of the provider target of 90%. These courses included: Safeguarding training - level 4 (the provider considered this to be their gold standard for those staff handling safeguarding concerns) was 25%, level 3 safeguarding (that most staff were expected to complete) was 68% and level 2 (the level that all non-clinical staff were expected to have achieved) was 80%. Immediate life support was 71%, NEWS 2 (event) 49%, Prevention and Management of Violence and Aggression (PMVA) refresher 59%, and Rapid tranquillisation was 6%.

Assessing and managing risk to patients and staff

Staff had not always assessed and managed risks to patients and themselves well.

Assessment of patient risk

While staff completed risk assessments for each patient on admission, using a recognised tool, staff had not always identified and responded to changes in risks to, or posed by patients. Staff had not ensured that environmental risk was reflected in all individual risk plans. Staff did not always know about risks to each patient and therefore we were not assured that staff always acted to prevent or reduce risks.

We viewed 9 risk assessments and risk management plans. We saw that patient's risk assessments had been fully completed and regularly updated, however risk management plans had not always been updated after incidents. However, staff had not ensured that environmental risks had been identified within the risk assessment documentation of patients who had a history of self-harm. We found that patient's risk assessments did not include reference to ligature risks, however, did refer to self-harm where this had been identified as a specific risk.

Management of patient risk

Staff did not always know about risks to each patient and therefore we were not assured that staff always acted to prevent or reduce risks. One patient who had numerous allergies told us that they had been having allergic reactions on the ward. As a result, they had to use their EpiPen on several occasions. The patient told us that when they became unwell, they had been made to feel a nuisance. Our review of incidents between 1 April and 19 July 2023 showed that this patient had experienced 6 incidents of an allergic reaction. One of these incidents resulted in the patient being

transferred to the local Accident and Emergency Department. There is no evidence that staff had actively reviewed the patient's allergies in relation to substances used on the ward or within the patient's diet. However, we were informed that medics were of the view that the patient needed to have his EpiPen in his possession. This view was not shared by some of the nursing staff who were able to administer the medication.

We spoke with and reviewed the records of a patient who was considered to be sexually vulnerable. During our review of this patient's records, we found 5 sexual safety incidents which had involved co-patients. Despite the identified risks, incidents continued to take place. Staff had raised a safeguarding alert and further to the most recent risk incident a plan was put on place for the patient not to be in the garden with the patient with a particular peer. Staff had not adhered to this plan. Staff and both patients told us that the two patients were allowed out into the ward garden on the evening of the 20 July 2023. As a result, the vulnerable patient was exposed to verbal abuse and felt very unsafe.

We were told by patients about several concerns relating to the conduct of staff. This included 3 patient reports that staff had been sleeping on the ward and watching television all night. However, staff told us that these concerns had not been escalated to management. The provider had taken appropriate actions following incidents they had been made aware of.

Staff had not always identified and responded to changes in risks to, or posed by, patients. Thirteen patients told us that they felt unsafe on the wards (Kelmarsh, Manor, Holdenby and Althorp). Between 1 April and 19 July 2023, there had been 84 incidents of verbal and physical aggression between patients. One patient told us that they "had been punched several times, with very little if anything done about it" adding "it's not safe here." Another patient told us that they felt "scared, unsafe and feel nervous." In the 6-month period January to June 2023, there had been 65 episodes of patient to staff altercations. The number of staff to patient incidents were reported to the board within the key performance reports, however, the number of patient-to-patient incidents were not reported.

Staff were not always conducting patient observations in line with safe practice. The provider's policy outlined two levels of constant observations: "Level 3: Within Eyesight Engagement and Observation" and "Level 4: Within arm's length Engagement and Observation." We observed staff on one to one (within eyesight and arm's length), and two to one observation, to be conducting patient observations through a closed door, which had no vision panel. We escalated our concern that both two to one and one to one observation was being conducted through a closed door to staff on 19 July 2023; however, this practice was still taking place on 20 July 2023. This was brought to the attention of the senior nurse on duty and Registered Manager.

We reviewed 10 observation records. None of these contained a record of the patient's mood or behaviour. The records were location based as they only identified the patient's whereabouts. The provider's 'Safe and Supportive Observations Policy and Procedure' stated that: ''the supportive observation of Service Users must be seen as a skilled and valued duty involving the assessment of the Service User's functioning and an opportunity for the development of rapport and therapeutic relationship." Documentation of the patient's mood and behaviour would enable staff to obtain an ongoing picture of the patient's mental state. It would enable staff to make informed decisions of when to increase levels of patient observations in response to risk and decrease patient observation level in response to an improvement in the patient's mental state.

We had concerns regarding environmental risks that staff and managers had not mitigated. This included the placement of 4 pieces of electrical equipment on Manor ward which posed environmental risks. A kettle on a table in the day room with stretched flex, an air frier and toaster in the dining room, with unsecured flexes on the floor.

The ward's microwave was in the nursing office. We saw a patient sat in the ward office whilst the food was cooking. Staff were talking on the telephone and confidential patient information was clearly visible on the office wall. We also found two large chairs were blocking the corridor on Manor ward. This posed a risk to the potential evacuation in the case of a fire. We informed the manager about this on the first day of our inspection. However, when we checked again on the second day of our inspection, the chairs had not been removed. We saw one patient cooking chicken in a ward dining room on a double hotplate. The patient was using a sharp knife and cooking oil, whilst another patient was in the vicinity. While staff had conducted a risk assessment of the activity this had not included risk from the environment to be used or other patients in the vicinity. We also found plastic bags and aprons on the kitchen door in Althorp ward's dining room, which staff removed on the day of inspection, at the request of the inspector.

Staff could not see patients in all areas of the wards and managers had not identified procedures to minimise risks where they could not easily observe patients. We found a number of blind spots on each of the 5 wards visited. Staff could not observe all areas of the ward. Mirrors were in situ, however, these did not mitigate the risks, as the mirrors did not enable staff to see around the areas where there were blind spots.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff conducted pat down searches of patients, where and when a risk had been identified.

Use of restrictive interventions

Levels of restrictive interventions were low. However, we saw that the ward doors to the garden on one ward (Althorp ward) were locked. Staff told us that patients could not access the garden without asking staff.

Staff took part in the provider's restrictive interventions reduction programme, which met best practice standards. The provider was working in collaboration with the East Midland Collaborative group and were currently working on reducing restrictive interventions. However, staff had not always followed the provider's policy when using restraint. We reviewed 19 patient records which showed there had been no debrief for 4 patients who had been restrained by staff.

We watched 5 incidents on the CCTV recording. Two incidents showed evidence of patients not being restrained appropriately. During one of these restraints, 2 staff members were seen to escort 1 patient to another area of the ward, using incorrect holds. During a second incident of restraint, staff had carried a patient (via arms and legs), into the corridor and into the lift exposing the patient's underwear. The patient was placed in their bedroom by staff. The patient was seen to come out of their room to get a bag from staff and go back into their bedroom, shutting the door. The patient was not being observed and there were no staff in the vicinity of the patient's bedroom. The patient was then seen to come out of their bedroom and was restrained again back to their bedroom. Despite the large number of staff involved across these incidents, none of them had been reported as inappropriate restraint and no staff had raised concerns about the practices.

On Manor ward, we found a record of 1 inappropriate restraint which took place in June 2023. The patient had been calm when staff had administered medicines. One patient had been given rapid tranquillisation on in June 2023 as part of their treatment plan. However, there was no evidence that staff had undertaken a debrief with the patient, or that the doctor had been notified. The patient had been calm when staff had administered the medication.

On Cottesbrooke ward, 8 staff members had been involved in a restraint of 1 patient. The provider's policy stated that: "the numbers of staff involved should be the minimum necessary to restrain the user, while minimizing injury to all parties." When there is more than a minimum of staff in attendance, the patient can become intimidated and feel threatened.

Staff had not always tried to reduce the numbers of restraint by correct use of de-escalation techniques. However, staff did not have access to a de-escalation room, therefore had to de-escalate patients on the ward. Between 1 May and end of July 2023 there had been 22 episodes of restraint in the hospital (acute and rehabilitation wards). CCTV footage showed staff had not always followed the provider's policy when using restraint.

Staff understood the Mental Capacity Act definition of restraint. Staff had completed a capacity assessment when required, however the outcome of these assessments were not entered onto the Mental Capacity section of the electronic health records.

Staff did not consistently follow NICE guidance when using rapid tranquilisation. The provider had introduced a non-contact ABCDE physical health assessment tool. The tool was to be used when patients refused to have their physical health observations undertaken. The tool looked at the patients Airway, Breathing, Circulation, Disability and Exposure. However, we found 16 incidents across the service, where the patient's respirations had not been recorded after being administered intramuscular (IM) Lorazepam.

Safeguarding

Not all staff understood how to protect patients from abuse. Compliance with safeguarding training was low, and we had some safeguarding concerns.

Some staff had not received training on how to recognise and report abuse, appropriate for their role. The number of staff across the hospital who had undertaken safeguarding level 3 training was 68%, and the number who had undertaken the safeguarding and protection of vulnerable adults training was 81%.

Staff had not always protected patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Between January 2023 to June 2023 across the hospital, patients had reported 43 incidents of patient-to-patient assaults, racism, and sexually inappropriate behaviours or assaults.

Staff had not always recognised adults at risk of or suffering harm and worked with other agencies to protect them. During our conversations with patients, several expressed safeguarding concerns. Five patients told us that they had been assaulted by co-patients. One patient told us that they had been subjected to a sexual assault by a co-patient. This had taken place in front of staff member. Consequently, the patient was moved wards. The Registered Manager confirmed that each of these incidents had been recorded. However, staff had not taken appropriate steps to ensure that the patients were safeguarded from abuse.

Review of the safeguarding referral data for Broomhill showed that between January 2023 to June 2023, showed that there had been 83 referrals for the rehabilitation wards made to safeguarding. Across the hospital there had been 38 episodes of patient-to-patient aggression, 1 incident of verbal aggression, 4 episodes of sexually inappropriate behaviour or assaults, 2 incidents of sexually inappropriate relationships between patients and two episodes of abuse referred to the Local Authority.

Staff told us that children would not be allowed to visit on the wards. There was no family room. Staff told us that any visits by children would need to be pre-planned. However, it was not clear where these would take place due to the lack of facilities available.

Most staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had raised 47 safeguarding incidents between the beginning of April and end of June 2023. Staff had followed up 100% of safeguarding concerns with a debrief.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers took part in serious case reviews and made changes based on the outcomes when applicable. However, between the beginning of April and end of June 2023 there had been no serious incidents.

Staff had access to essential information.

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

Patient notes could be accessed by staff easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

When patients transferred to a new ward, there were potentials for delays in staff accessing their records. We found when searching for patient records that these were accessible by ward. Patient records from stays on other wards in the hospital were archived. Whilst these records were easily accessible, staff would need details of previous ward stays to access all relevant records.

Records were generally stored securely. The provider mainly used electronic care records. Staff kept paper copies of some records which were safely stored in the ward office. However, on Lamport ward we noted that patient identifiable information could be viewed through the ward office window.

Medicines management

The service had not always used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff had not always followed systems and processes to prescribe and administer medicines safely. We found several concerns regarding medicine management. We found that staff had not always recorded patient's respiration after being given intramuscular (IM) Lorazepam. We found 7 incidences where the patient's respirations had not been recorded after IM Lorazepam had been administered. In these instances, patients had refused to have their blood pressure (BP) and other vital signs recorded. In these situations, staff should observe the patient's respiration rate, as Lorazepam can lower respiration rate. The provider had a process in place for these circumstances and had advised staff to record visual checks. However, staff were not always adhering to the process. Systems in place to audit compliance had highlighted that the correct process had not always been followed. However there had been a delay in response from the manager to ensure that staff were complying with this requirement.

On Kelmarsh ward we found that 2 patients were being given medicines which had not been included on their Certificate of Consent to Treatment (T2) forms. In the case of one patient, the T2 consent to treatment form, indicated the patient was to be prescribed one hypnotic namely Zuclopenthixol. However, the patient had also been prescribed and administered Zolpidem. Inspectors informed staff of this error. In the second case, the patient's depot medicine was not covered on the Section 62 (second opinion). This was raised by inspectors on 22 July 2023 and the provider agreed to request a second opinion. We also found that staff had not recorded observations for three patients on high dose anti-psychotic medicines (HDAT).

On Manor ward we found 1 patient had been prescribed 1 to4mg Lorazepam PRN (pro re nata – as required), which was above the British National Formulary (BNF) limit. The British National Formulary (BNF) is a medical and pharmaceutical publication that contains information and advice on prescribing and pharmacology, along with specific facts and details about all medicines available on the NHS). The British National Formulary (BNF) limit for Lorazepam is a maximum of 4 mg daily. Fortunately, the medicine had not administered. Staff were not aware until advised by our inspector, however contacted the prescriber immediately after this was raised. A review of the incident form indicated that the patient did

not require rapid tranquillisation. The records showed that the nurse had taken the patient off the ward for a cigarette. The patient (who had been agitated) had become calm, however, the nurse still persuaded them take medicine IM (intramuscularly). A second patient had been administered rapid tranquillisation on 27 June 2023. There was no evidence that the ward doctor had been notified.

We found 2 concerns on Manor ward regarding patient's prescriptions. The Section 62 for one patient covered two antipsychotics within BNF limit. However, the psychotic medications prescribed (Clozapine and Amisulpride) were 170% which is above the BNF limit as indicated on the T3. A T3 is the form which is completed by a second opinion appointed doctor. The Section 62 for another patient was unclear. The Section 62 indicated 1 benzodiazepine regular and PRN. However, the patient had been prescribed 2 benzodiazepines.

On Spencer ward we found 1 concern regarding certificate of second opinion by second opinion doctor (SOAD) and T3. The patient had been prescribed Lorazepam PRN. This was not covered by the T3, Inspectors informed staff of this omission. A second patient had been given rapid tranquillisation on 29 August 2022; however, the patient had refused to have physical health observations recorded. Staff had recorded 'declined' on the rapid tranquillisation chart but failed to enter the patient's respirations and level of alertness.

On Cottesbrooke ward we found that 1 patient was on high dose anti-psychotic medicines, however staff had not recorded the patient's respirations and level of alertness, when the patient declined to have physical health observations recorded.

Although staff reviewed each patient's medicines regularly, they had not always provided advice to patients and carers about their medicines. Staff reviewed patient medications at the muti-disciplinary meetings and when required in the interim. Of the 27 patients on the rehabilitation wards who spoke to us about their medicines, 19 told us that they understood their medicines. Three patients told us that they did not understand their medicines and 5 patients were not sure.

The provider used an electronic medicine prescribing and administration system. Staff had not always administered medications correctly. Staff had administered some medications outside those identified with the patient's consent to treatment forms.

Staff stored and managed all medicines and prescribing documents safely. We found that all medicines had been stored in line with best guidance.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The provider had a contract with a local GP, who reviewed medication reconciliation upon admission.

The provider produced a monthly safety and incident alerts to improve practice. However, we noted that not all the identified learning had been embedded in practice. For example, the learning alert from March 2023 stated that 'planned reviews were taking place across all services, to ensure grab bags and emergency equipment are accessible and contain all required equipment'.

Staff reviewed the effects of most patient's medicines on their physical health according to NICE guidance. However, staff had not always conducted physical checks post rapid tranquillisation as required. Staff generally reviewed patient's medicines in the multi-disciplinary meetings.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Track record on safety

The service did not have a good track record on safety. Neither had the service always managed patient safety incidents well.

Most staff knew what incidents to report and how to report them. At the time of our inspection the provider was reviewing three serious incidents. However, in the three-month period April to June 2023 the number of reported incidents was high. Staff had reported 621 incidents. These included 69 incidents of physical interventions, 47 safeguarding incidents, 38 patients to staff incidents, 24 patients to patient altercations, 34 referrals to the police, 32 transfers to accident and emergency and 14 incidents of patients going absent without leave (AWOL). The total number of patients going absent without leave (AWOL) in the 6-month period January to June 2023 was 27.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff had not raised any duty of candours between March to May 2023, as there had been no notifiable safety incidents during that period.

Managers debriefed and supported staff after any serious incident. The provider had a system and process in place which included support from managers and psychology where required.

Managers investigated incidents. However, patients and their families had not always been involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. We observed posters on the wards, which outlined learning from incidents which had taken place. The provider produced a monthly leaning alert which provided details where incidents had increased, stayed the same and had been reduced. The learning alerts also summarised recent learning from inspections and internal reviews.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, in April 2023, the provider implemented a daily count process for stock medicines, following an increase in errors which had been related to discrepancies to stock medicine counting.

Is the service effective?

Inadequate

Our rating of effective stayed the same. We rated it as inadequate.

This key question was last rated in May 2020

Assessment of needs and planning of care

Patients had not been involved in the development of their care plans. Neither did we see evidence of staff using a recognised rehabilitation model of care or rehabilitation care planning. Although staff had completed mental health assessment of each patient either on admission or soon after.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

At the time of our inspection, most patients appeared settled on the ward. However, in June 2023 only 56% of patients had a MOHOST (model of human occupation screening tool) assessment and only 50% of appropriate patients across all wards, had an occupational therapy treatment plan in place by week 4 of their admission.

Most patients had their physical health assessed at admission and some patients had not had their physical health reviewed during their time on the ward. As of June 2023, the number of patients across the hospital who had received the following physical health checks were as follows; long term review (96%), new patient assessment (90%), ECG (95%), bloods (100%), and malnutrition score (MUST 91%). However, as of June 2023, only 58% of patients had received an annual physical health check, however staff had undertaken assessments of cardiac and metabolic health for 84% of patients. We saw evidence that staff were undertaking records of patient's vital signs using the National Early Warning System (NEWS).

Care plans were not always personalised and holistic. While patient records contained care plan headings. Such as, Covid 19, discharge, legal status, observation, mental health, protection and management of violence and aggression, physical health and risk and observation. Staff had not completed specific rehabilitation care plans, and staff were not working to a recognised rehabilitation model. Managers told us that plans were in place to introduce a rehabilitation assessment, however, to date only the ward deputy managers had received training for this.

Best practice in treatment and care

Staff had not always provided a range of treatment and care for patients based on national guidance and best practice. The provider did not have a clearly defined rehabilitation model in place, therefore support for patients in relation to self-care and the development of everyday living skills and meaningful occupation was limited. Staff offered some activities including board games, gardening, animal therapy and craft. Staff supported patients with aspects of their physical health and encouraged them to live healthier lives. Staff used some recognised rating scales to assess and record severity and outcomes. They participated in several clinical audit, benchmarking, and quality improvement initiatives; however, the recommendations had not always been embedded in practice.

Staff had not always provided a range of care and treatment suitable for the patients in the service. We visited 5 rehabilitation wards. The provider did not have a clearly defined rehabilitation model in place. Mental health rehabilitation services provide specialist assessment, treatment, and support to stabilise the person's symptoms and help them gain/regain the skills and confidence to live successfully in the community. Rehabilitation services that adopt a recovery orientation are more likely to achieve successful community discharge, including individualised, collaborative care planning to help individuals develop self-management skills, positive risk taking and therapeutic optimism. Six patients told us that they felt stuck on the wards. Comments from patients included "I'm stuck"," I've been here too long"," I have no discharge plans in place"," I want to leave and move into a flat" and" I am not moving on."

During inspection we were not assured that the 5 wards inspected had patient care plans in place, which were recovery oriented. Staff had access to two occupational therapy kitchens. However, we were told that the kitchens were not fit for purpose. service did not have an identified activities room.

While staff delivered some care in line with best practice and national guidance, they were not always conducting patient observations in line with safe practice.

Staff identified most patient's physical health needs and recorded them in their care plans. Staff had not completed physical health care plans for all patients.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff made sure patients had access to physical health care, including specialists as required. As of June 2023, 70% of patients had an oral health assessment in place, 76% of patients had seen a podiatrist and 90% of patients had seen an optician. However only 4% of patients had seen a dentist.

Staff had not always met patient's dietary needs or assessed those needing specialist care for nutrition and hydration. We spoke to one patient who advised that the diet provided contained food they were allergic to. The patient told us that as a result they had to use their EpiPen (medicine to counteract an allergic reaction). A review of patient incidents confirmed that this patient had suffered several allergic reactions on the ward.

While staff helped some patients live healthier lives by giving advice on wellbeing and healthy eating, however 3 patients complained that they had become unfit and had put on weight since admission to hospital. Patients also expressed concern that the gym equipment in the hospital was not accessible as it had been packed away.

Staff used recognised rating scales to assess and record the severity of patient's conditions and care and treatment outcomes. Examples included MOHOST (model of human occupation screening tool), and the health of the nation outcome scores (HoNOS).

Staff used technology to support patients. We observed staff to be using handheld devices so that observations could be recorded in real time.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives; however, these had not always ensured high standards of care were sustained. Audits across the hospital included care records, incidents, and complaints. As of July 2023, the compliance rate for the care records was 96%, incidents 98%, and complaints (100%). However, during inspection we found that clinical audits and monitoring were not always effective as demonstrated by missing emergency equipment and identified gaps in the requirements for emergency equipment (one of which had not been actioned for 10 months). A lack of clinic and clinical equipment cleaning records, patient medications prescribed not indication on T3 in line with Section 62 (Second Opinion and a patient having been 1-4mg Lorazepam prn (above BNF limit).

Skilled staff to deliver care.

While the ward teams included or had access to the full range of specialists required to meet the needs of patients, not all staff had trained in a specific rehabilitation model of care. While managers provided an induction programme for new staff, and supported staff with appraisals, and supervision, they had not provided opportunities to update and further develop their skills in mental health rehabilitation.

The service had access to a full range of specialists to meet the needs of the patients on the ward. The multidisciplinary team was comprised of nurses, healthcare support workers, occupational therapists, occupational therapy instructors, psychologists, psychology assistants, consultant psychiatrists, and doctors. The patient also had access to a local GP and physical healthcare team.

Managers had not ensured staff had all the right mandatory skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. At the time of our inspection, the overall mandatory training rate was 86%. However, the compliance rate for all the mandatory training courses were not over 75%.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers gave each new member of staff a full induction to the service before they started work. Managers followed the provider's policy which outlines that local induction will normally take place in the first 6 weeks of employment. The general (corporate) induction will take place in the first 3 months of employment. Managers provide agency and temporary workers with a local induction in line with the provider's agency staff policy and procedure.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. At the time of inspection across the hospital, the appraisal rate was 97%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. The provider held monthly team meetings on all wards. Managers had a set agenda for staff meetings on Manor, Spencer, Cottesbrooke and Kelmarsh wards.

Managers had not made sure staff received specialist training required for their role. Staff had access to a range of additional training courses including catheter care, dignity and respect, freedom to speak up, ligature prevention and awareness and self-harm awareness. However, staff had not received training in staff had not received training in the individual recovery outcomes counter (IROC).

Managers recognised poor performance, could identify the reasons, and dealt with these. Managers had informed us of an incident which had resulted in managers acting in line with the provider's disciplinary policy.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended two safety meetings and a 'flash' meeting. These meetings were attended by the deputy manager or nurse in charge for each of the wards. The meetings were chaired by the Registered Manager and had a structured agenda. The meetings were an opportunity for each ward to shared key clinical information, priorities, and concerns. Staff attended the 'flash' huddle meetings both in the morning and afternoon.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff handovers took place between nursing staff at shift change. In addition, the registered manager chaired daily flash meetings where a brief handover from all wards was provided.

Ward teams had effective working relationships with other teams in the organisation and teams external to the organisation.

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

Staff mostly understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. However, managers had not made sure that staff had fully explained patient's rights to them or that treatment was in line with the patient's consent to treatment.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The training figures for Mental Health Act training at the time of inspection was 96%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff had access to Mental Health Act advisors within the hospital.

Staff knew who their Mental Health Act administrators were and when to ask them for support. All staff we spoke with knew how to obtain support in relation to the Mental Health Act.

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The provider had a Mental Health Act policy in place which was in date and not due for review until September 2024.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The provider had displayed posters on the Independent Mental Health Advocacy service (IMHA) in all patient areas.

While staff told us they explained to each patient their rights under the Mental Health Act, and the figure for patients receiving their rights in June 2023 was 98%, seven patients across the hospital told us they were not fully aware of their rights.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. The provider had a robust procedure in place for the approval and monitoring of section 17 leave.

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

Staff stored copies of patient's detention papers and associated records correctly and staff could access them when needed. During inspection we observed that MHA documentation was available within the patient's records.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of our inspection, the training figures for Mental Capacity Act and Deprivation of Liberty standards (across all hospital wards), was 90%.

There were no Deprivation of Liberty Safeguards applications made across any of the wards in the hospital in the previous 6 months.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. However, these assessments were documented in the patient's daily notes. The Mental Capacity section of the patient's record was not being used routinely by staff.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service had not monitored how well it followed the Mental Capacity Act. At the time of our inspection, the provider told us that a Mental Capacity audit had not been carried out as a routine audit. However, the Mental Health Act office was in the process of compiling an audit to be completed monthly per ward/unit.

Is the service caring?

Inadequate

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

Kindness, privacy, dignity, respect, compassion, and support

Staff had not always treated patients with compassion and kindness. They had not always respected patient's privacy and dignity. They did not always understand the individual needs of patients and supported patients to understand and manage their care, treatment, or condition.

Staff were not always discreet, respectful, and responsive when caring for patients. During inspection we observed a few positive interactions between staff and patients. However, of the 32 patients we spoke with across the hospital, 9 patients (28%) told us that staff had not respected their rights and wishes. Five patients told us that staff do not always knock when entering their bedroom, and two patients stated that staff entered their room when the patient was in a state of undress.

Thirteen out of the 35 patients we spoke with (37%) across the hospital, told us that they had to wait to have their needs met. One patient told us they had been ridiculed by staff over their chosen gender. Another patient told us staff were "rude, hateful, racist and do not take me out due to my size", adding that "staff make fun of me."

Although staff had supported some patients to understand and manage their own care treatment or condition, and directed some patients to other services if they needed help. The number of patients accessing external agencies such as education, employment and for support and treatment was limited. Staff were not actively engaging patients in engagement with further education or employment. Patients could access the town centre, however due to the location of the hospital, this was mainly via hospital transport.

Two patients reported that staff had been speaking in a foreign language when in their presence and had been on their phones.

Staff did not fully understand and respect the individual needs of each patient. Eleven out of 32 patients who spoke to us about their care planning process, told us that staff had not given them the opportunity to give their views about their care and treatment.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients. Staff were aware of who to go to raise concerns and were aware of the freedom to speak up guardian. During the six-month period January to June 2023, across the hospital the provider had received 5 concerns via the freedom to speak up guardian. The highest number of concerns received were raised in January 2023 (3 concerns). No concerns were raised via the freedom to speak up guardian in June 2023.

Most staff followed policy to keep patient information confidential. However patient information in the ward office could be viewed by patients, through the ward office window.

Involvement in care

Staff had not always involved patients in care planning and risk assessment or actively sought their feedback on the quality of care provided. However, staff did ensure that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. The provider had produced a handbook which was shared with patients on admission. The handbook contained information about the multi-disciplinary team, meal and medicine times, facilities, how to be involved, the values of St. Matthews Healthcare, information and contact details regarding advocacy, and details of how to raise a complaint.

Staff had not involved all patients in their care and given them access to their care planning and risk assessments. Of the 15 patients who spoke about their care plans, 10 (75%) stated that they had not been involved in their care planning process and did not have a copy of their care plans.

Although staff tried to ensure that patients understood their care and treatment and found ways to communicate this information with patients who had communication difficulties. Three patients interviewed did not understand the purpose of their medicines and a further 5 patients were not sure about the purpose of their medicines.

Staff had involved patients in some decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could provide feedback and be involved via the weekday planning meetings, quarterly service user and family support forum, monthly community meetings and ad hoc co-design groups. Patients could also provide feedback within the hospital via compliments and complaints and online via 'I want great care'. An example of which was the development of patient surveys. The provider target for patient's surveys was 35%. The figure for June 2023 was 59%.

Staff had not supported most of the patients we spoke to, to make decisions on their care. Ten out of 15 patients who spoke about involvement in care planning and decisions about care told us that they had not been involved.

Staff made sure patients could access advocacy services. We observed contact details for advocacy displayed on each of the ward notice boards. Staff also provided information via the patient's handbook.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Involvement of families and carers

Staff had not always informed and involved families and carers appropriately.

Where patients had given consent to share information, staff invited families or carers to care programme approach meetings and multi-disciplinary review meetings.

However, staff had not always helped families to give feedback on the service. Two carers told us they were unhappy with the care and treatment and raised issues regarding communication. Staff had not given all carers information on how to find the carer's assessment.

Is the service responsive?

Inadequate

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

This key question was last rated in May 2020.

Access and discharge

Staff had not always planned and managed patient discharge well, as the provider had delayed discharges. However, they worked well with services providing aftercare and managed patient's move out of hospital.

Managers regularly reviewed length of stay for patients. As of June 2023, the average length of stay for patients across the rehabilitation wards was 249 days.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. We found that patient transfers between wards were mostly planned, and any unplanned moves were undertaken in relation to clinical needs.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and knew which wards had the most delays; however, staff had not always taken action to reduce them. As of June 2023, there were 5 delayed discharges in the hospital. The highest number of delayed discharges since January 2023 was 11, in March 2023.

We found that the length of stay for patients was not actively addressed via a robust rehabilitation model of care. Some patients viewed the hospital as their home, as there was a limited discharge ethos. Delivery of a rehabilitation and recovery model could improve patient outcomes and reduce patient's length of stay.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff planned patient's discharge and worked with care managers and coordinators to make sure this went well. During inspection we found effective working relationships were in place to support patient's discharge.

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of the ward supported patient's treatment, privacy, and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. However, there was not enough or adequate quiet areas on the wards for privacy or rooms for patient cooking and activities. The food was of variable quality, though patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. Patient bedrooms were of a good size and had ensuites.

Patients had a secure place to store personal possessions.

Staff did not have access to a full range of rooms and equipment to support treatment and care. We found that space on the wards was limited. Wards did not have a quiet room for patients who may not want to sit in the television room, and there were no interview rooms on the ward for staff to meet with patients.

The service did not have enough quiet areas and a room where patients could meet with visitors in private. Staff and 19 patients told us that visits usually took place in the grounds, weather permitting.

Patients could make phone calls in private. Most patients had access to mobile phones. In addition, patients could make a private call using a ward phone.

The service had an outside space that patients could access easily. The hospital is situated in the countryside and has access to extensive grounds. However, the hospital is a distance away from main facilities. Staff and patients could access local facilities via 1 of the 4 vehicles provided by the hospital.

Patients could make their own hot drinks and snacks and were not dependent on staff for this. We found that patients had access to hot and cold drinks and snacks on each of the wards.

Patients told us the service did not offer a variety of good quality food. Of the 17 patients across the hospital who spoke to us about the quality of the food, 14 (82%) told us that the food was not good. Two patients told us that the food was bland, two patients told us that the food was boring, and one patient told us that there were limited options for vegetarian meals.

Patient's engagement with the wider community

Staff did not consistently support patients with activities outside the service, such as work, education, and family relationships.

Staff had not always ensured that all patients had access to opportunities for education and work, and supported patient's rehabilitation.

However, staff helped patients to stay in contact with families and carers and encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service.

The service met the needs of most patients – including those with a protected characteristic.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospital had clinical areas on the ground floor and patients could access one of two lifts to access the upper two floors.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. We observed a range of notices on patient notice boards. Notices included how to complain, information on advocacy, treatment, and activities.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff also told us that they were able to access interpreters or signers when required and that the hospital had a contract in place for this.

The service could access information leaflets available in languages spoken by the patients and local community. However, one patient who had dyslexia informed us they had requested information in an easy-to-read format but had not received one.

Patients had access to spiritual, religious, and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them, and shared these with the whole team and wider service. However, the service had not evidenced learning.

Patients, relatives, and carers knew how to complain or raise concerns. Of the 22 patients across the rehabilitation wards who spoke to us about complaints, 9 patients (40%) told us they had made a complaint, 4 (20%) patients told us they would know how to complain, and 9 (40%) patients told us they had not complained. One patient told us that they felt able to raise a concern, 1 patient was awaiting a response and 1 patient told us that 'nothing ever changes.

During the six-month period January to June 2023, the provider (across all 6 wards), had received 5 complaints. The highest number of complaints received per month was in March 2023 when 3 patient complaints were submitted. Two patient complaints related to peer conduct, one staff complaint related to replacement equipment for staff, one was a staff-to-staff complaints (which was reclassified) and one patient complaint related to staff talking in a language other than English.

The service clearly displayed information about how to raise a concern in patient areas. Patients were given a patient's handbook on admission. This contains information on how to complain, how to provide feedback via 'I want great care'. Staff had also displayed posters on how to complain or raise a concern on notice boards in patient areas.

Staff understood the policy on complaints and knew how to handle them. All staff we spoke with were aware of what actions were required and what to do if a patient complained.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. The provider shared lessons learned for each of the complaints, which were shared with staff through the provider's learning from incident reporting system, with any trends being reported to the executive team. However, learning from complaints had not always been embedded in practice. For example, the provider had identified learning further to a complaint (received April to June 2023), where it was reported that staff had been speaking in a language other than English in a communal area. This concern was reported during this inspection.

The service used compliments to learn, celebrate success and improve the quality of care. In the three-month period April to June 2023 the hospital (across all 6 wards) received 16 compliments. The highest number of compliments received was in June 2023 when 11 compliments had been received.

Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders did not all have the skills, knowledge, and experience to perform their roles. They did not have a good understanding of the services they managed; however, they were visible in the service and approachable for patients and staff.

Leaders had not always ensured that services were safe. There had been a high number of incidents, and during inspection 12 patients told us that they did not feel safe. Between 1 April and 17 July 2023 across the hospital, there had been 132 incidents of violence and aggression toward staff and 84 patients to patient.

While leaders were fully committed to the service and service improvement, they were not fully aware of all the aspects that needed improvement. At the time of inspection, leaders did not have a good understanding of the services they managed. They could not explain clearly how the teams were working to provide high quality care. However, managers did have immediate access to information relating to key information including staffing, patient observations, incidents, safeguarding referrals, and notifications to the Care Quality Commission.

Leadership development opportunities were not always available, including opportunities for staff below team manager level.

Vision and strategy

Staff were able to outline some of the provider's vision and values and how they applied to the work of their team. The provider has six core values in place. These were 'people first, passion for care, pursue diversity, progressive, partnership and positivity'.

While the provider's senior leadership team had communicated their vision and values to the frontline staff in this service; there was limited evidence that these values had been translated into practice.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The service did not have a clear model for rehabilitation and patients told us that they felt stuck, and they could not see themselves moving forward.

While the provider's senior leadership team had communicated their vision and values to the frontline staff in this service. Not all staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Our findings from other key questions in this report and a review of recent incidents, including whistleblowing reports, suggest that there were indications of a closed culture at the hospital. We found evidence of ongoing issues and lack of cohesive working between different ethnic groups at the hospital. The inspection team discussed this with the provider who immediately carried out a full review of the culture in the hospital and introduced various training and awareness sessions to address any cultural issues. We received assurance that where any issues had arisen senior managers had dealt with these in a timely manner.

The overall scoring for the staff survey within the previous 12 months (July 2023) was good.

While staff told us they felt respected, supported, and valued, and could see there had been an improvement in the culture of the hospital over the previous 6 to 12 months, they also identified areas that still required further improvement. Comments from staff included the need to employ more permanent staff, the need for improvements in relation to rehabilitation care planning that "promotes and encourages independence to assist in budgeting, healthier eating, laundry, tidying the bedroom with assistance, and cooking." Other comments focused on how agency staff were being treated by permanent staffing adding that "they don't treat agency staff like their colleagues."

Staff knew how to use the whistleblowing process and the role of the speak up guardian.

Managers had dealt with poor staff performance when needed. Teams worked well together and were there were difficulties managers dealt with them appropriately.

The provider recognised success within the service. Awards included caring excellence, clinical excellence, rising star and behind the scenes ward.

Governance

Our findings from the other key questions demonstrated that governance processes had not operated effectively at team level or that performance and risk were managed well.

The service was not adequately mitigating risk to patients and supporting a pathway to recovery. Our findings from the safe key question demonstrated that governance processes did not always operate effectively at ward level and that performance and risks were not always managed well. Although policies were in place at the service to ensure that visual observations were undertaken post rapid tranquillisation (when patients had refused to have their physical observations undertaken), observations had not always been recorded. Managers had not ensured effective compliance with this requirement.

Leaders had not ensured a safe environment for patients. Although staff had completed ligature risk assessments of all ward areas, managers had not taken steps to remove or reduce the identified ligature risks. Some of the identified ligatures had been rated as green, which indicated that the risk was adequately mitigated. This was not the case. The

identified mitigation for these risks was 'closed circuit television' (CCTV), which is not an alternative to staff presence. CCTV can only be used to augment, but never replace, monitoring. Mitigation for the risks identified would require additional staff observations both via mental health and zonal observations. These were not identified as mitigation. The fence surrounding the ward was too low and did not reduce the risks of patients absconding.

Leaders did not have sufficient oversight of infection, prevention, and control measures. We found that some staff were wearing jewellery, were not bare from the elbow and were wearing nail varnish. We found several concerns regarding the maintenance, cleanliness, calibration of medical equipment. Leaders had not ensured that there was adequate oversight in these areas to ensure that any concerns were highlighted and resolved at an early stage.

Concerns were raised regarding relating to the conduct of some staff members. This included 3 patients who individually reported that staff had been on the ward and watching television all night.

There was a lack of patient rehabilitation. Within the patient's handbook, the provider stated that they work closely with patients to develop their individualised recovery and rehabilitation programme, and that patients would be provided with 'group and individual sessions focused on rehabilitation and promoting your independence in the community.' We found that there was no clearly defined rehabilitation model in place. Six patients raised concerns regarding their length of stay in the hospital. Comments from patients included "I'm stuck"," I've been here too long," "I have no discharge plans in place"," I want to leave and move into a flat" and" I am not moving on." There were no specific rehabilitation care plans in place for patients and furthermore care plans were not recovery orientated.

Staff had copied patient entries from one patient record to another. There was no evidence that this practice had been identified as a concern during audits of clinical records.

Management of risk, issues, and performance

Teams had access to the information they needed to provide safe and effective care however had not always used that information to good effect.

Staff maintained and had access to a risk register for the organisation. Staff at ward level could escalate concerns to senior managers when required. Concerns raised by staff matched those on the risk register. At the time of our inspection, the provider had four areas of risk on the risk register. These included qualified nurse vacancies, concerns re potential access to reception, a lack of vision panels in bedroom doors and a high use of agency staffing. The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Information management

While staff collected and analysed data about outcomes and performance and engaged actively in local quality improvement activities, these findings were not used to ensure sustainable high standards of care.

While the service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. We found that clinical audits and monitoring were not always effective. This is demonstrated by missing emergency equipment, identified gaps in the requirements for emergency equipment, one of which had not been actioned for 10 months. The lack of clinic and clinical equipment cleaning records, which were not identified in audits. A patient's medicines prescribed outside T2 not identified and a patient's medicines prescribed which was not on the T3 in line with Section 62 (Second Opinion).

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patient's records were not easy to navigate, and we found information in various places of the records for different patients and wards. This meant that anyone working on the wards and who was not familiar with the patient recording systems might miss some essential information.

While the provider had closed circuit television (CCTV) in place in general ward areas. However, we did not see any evidence around the ward areas that patients had been informed that CCTV was in use. We did not see evidence of any appropriate signage placed around the ward areas to inform patients that they may be under surveillance. Making individuals aware that their information was being collected is critical because individuals have a right to make enquiries or submit a complaint if they feel their privacy has been breached.

However, staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well, and helped to improve the quality of care. Information governance systems included confidentiality of patient records. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Engagement

Managers engaged actively with other local and national health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the patients.

Learning, continuous improvement and innovation

Managers had produced learning alerts which they circulated to all staff, which highlighted learning. However, managers had not always used results from audits to make improvements.

The provider is currently working with the East Midland Collaborative group and are currently working on reducing restrictive interventions. To date the provider has introduced a change idea form for both patient and staff debrief. The aim is to review how the incident was dealt with, who was involved and the outcome they wish to achieve. However, this should have been standard practice.

Some staff were participating in research. Innovations had taken place in the service. Staff had access to hand devices to record patient information in real time. Staff did not participate in national audits relevant to the service.

The provider has created a safeguarding accreditation for services to work towards. The aware has been designed to reward the services for reaching compliance in safeguarding across 3 different levels: bronze, silver, and gold award. Broomhill is currently working towards Bronze across all seven wards.

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

Inadequate

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

Is the service safe?

Inadequate

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

This key question was last rated in October 2021

Safe and clean care environments

The ward was not safe, clean well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

While staff had completed and updated ligature risk assessments of all ward areas, the provider had not taken steps to remove or reduce all the risks they had identified. However, staff knew how and where to access the ligature cutters.

There were potential ligature anchor points on the ward. While staff knew about the potential ligature anchor points; the identified mitigation had not adequately reduced or removed the risks identified to keep patients safe. We reviewed the environmental ligature risk assessments for the ward. We found staff had completed ligature risk assessments of all ward areas. However, managers had not removed or reduced the identified ligature risks. Some of the identified ligatures had been rated as green. This was an incorrect rating, as a green risk rating indicates that the risk was adequately mitigated. The identified mitigation for these risks was 'closed circuit television' (CCTV), which is not an alternative to staff presence. CCTV monitors were based in the nursing office, where staff were not dedicated to observing. Staff must be present and directly monitor patients in high-risk areas. CCTV can only be used to augment, but never replace, monitoring. Mitigation for the risks identified would require additional staff observations both via mental health and zonal observations. These were not identified as mitigation. The fence surrounding the ward was too low and did not reduce the risks of patients absconding.

Managers conducted 'ward walkarounds', which examined the environment in the nurse's station, ward communal areas, clinic, and patient bedrooms. However, managers had not documented these.

Staff could not observe patients in all parts of the wards. We identified blind spots on the ward. Whilst the provider had installed mirrors, these had not always reduced or addressed the blind spots.

The wards complied with guidance and there was no mixed sex accommodation. All wards were single sex.

While staff had easy access to alarms and walkie talkies, we saw that messages were not always clearly heard, which resulted in delays in messages being received.

Maintenance, cleanliness, and infection control

Not all ward areas were clean, well maintained, well-furnished and fit for purpose. This included furniture and carpets which required replacement.

While staff had maintained cleaning records which were up to date, not all areas were clean. The provider shared copies of the cleaning schedules for July 2023, which evidenced that basic cleaning of areas had taken place. However, we saw several concerns regarding cleanliness. This included stained curtains on Holdenby ward and dust on the suction machine in the ward clinic.

Staff had not always followed the provider's infection control policy. We noted that not all staff were bare below the elbows, and we saw some staff were wearing earrings, watches, and other jewellery.

While the food hygiene rating for the hospital kitchen was 5 (highest rating; hygiene standards are very good). We saw several concerns relating to food storage, cleanliness, and a patient cooking on the wards. We found butter on the ward had been left out of the fridge and stored in cupboard. This included unopened butter. Staff had left fruit juices out of the fridge when opened.

The clinic room was not fully equipped, though staff informed us equipment was available in the room used by the General Practitioner (GP). We found this room was on the second floor in the main building. This room was easily accessible to authorised persons, to ensure that staff could access the emergency equipment and drugs in a timely manner. We did not see that staff had completed any scenario records for this purpose. Staff had not completed required weekly checks of the emergency equipment and drugs. There were two missing weekly checks for May 2023. The purpose of weekly checks of emergency equipment is to ensure the emergency bag was fully equipped. In addition, the checks for the emergency equipment held at reception, were missing for May and April 2023.

Staff had not always checked, maintained, and cleaned the clinic and clinical equipment. We found no evidence that the clinical equipment (including blood monitoring machine, oximeter, sphygmomanometer, thermometer and weighing scales) on the ward had been calibrated. We found 3 gaps in weekly audits of the blood glucose monitoring machine. This meant that staff could not be sure the recordings they were taking of people's physical health were accurate.

Staff could not locate records to show when they had cleaned medical equipment, and there were no 'clean' stickers in place, this could pose an infection prevention and control risk.

Clinic temperature charts showed that staff had not been checking the clinic temperatures regularly, this meant that if the clinic had become too hot then medicines stored in there could have lost their efficacy.

On Holdenby ward, we found the suction machine had not been cleaned and was dusty. This could pose an infection prevention and control risk. There were no records of the cleaning of equipment. There were gaps in the glucose machine audit. Regular audits of the glucose machine should be undertaken to ensure that when required, the glucose machine is fully functional and clean. The risks associated with staff not completing regular audits is the risk of inaccurate results and infections risks.

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

Inadequate

Safe staffing

The service had enough nursing and medical staff (with the support of agency staffing), who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service generally had enough nursing and support staff (with the support of agency staffing), to keep patients safe. Staff told us that staffing had improved and generally there were enough staff on the ward. However, patients told us staffing could be short weekends and at night.

The service had high vacancy rates; however, these were reducing. As of June 2023, the vacancy rate across all wards in the hospital was 22%. The provider had recently appointed 8.60 Senior Healthcare Support Workers. The highest number of vacancies was for registered nurses (35.70 whole time equivalents), followed by health care support workers (15.40 whole time equivalents).

Between April and June 2023 there had been 42 new starters across all wards in the hospital, of which 30 were healthcare support workers, 2.5 registered nurses and 1 Occupational Therapist.

The service did not have low rates of bank and agency nurses. Managers attempted to limit their use of bank and agency staff and requested staff familiar with the service. However, as of June 2023, the percentage agency staff usage was 53%. The provider was actively trying to recruit and had plans in place for a recruitment day for qualified nurse on 18 July 2023.

The service had high rates of bank and agency support workers. As of June 2023, the total agency staff usage of block booked support workers across all wards in the hospital was 32%. However, this had reduced from March 2023, when the total agency usage of support workers was 46%. The number of ad hoc agency support workers was 9%, a reduction from 10% in March 2023.

Whenever possible managers limited their use of bank and agency staff and requested staff familiar with the service. The provider shared figures on agency usage, which showed that most agency staff were block booked.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff followed the provider's local induction process for agency and temporary staff.

The service had reducing turnover rates. In 2022, across all wards in the hospital there had been 55 staff leavers. The provider reported that as of July 2023, the turnover rate was 9.5%. This is an improvement from 2021 when the turnover was 50%.

Managers supported staff who needed time off for ill health. However, staff told us that they did not receive sick pay. This had resulted in staff attending work when they did not feel well enough to do so.

Levels of sickness were reducing. The provider reported a sickness rate April to June of 5.6%, which mirrors the national average sickness rate.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The provider was working to a set staff to patient ratio. This was one staff member to two patients.

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

Inadequate

The ward manager could adjust staffing levels according to the needs of the patients. Managers told us that they could request additional staff when required.

Patients told us that they had not had regular one- to-one sessions with their named nurse. Sixteen patients across the hospital told us that they had not had the opportunity to discuss their views on care and 25 patients told us that they did not have a care plan.

Patients rarely had their escorted leave or activities cancelled. The provider reported that there had been no incidents of cancelled leave. Staffing figures were always at safer staffing levels. Ward staff completed a weekly trip planner which was provided to reception to plan driver schedules and journeys. Where last minute trips (appointments etc) had been requested, staff had facilitated these where possible, prioritising any medical appointments and booking extra staff if required.

The service had enough staff on each shift to carry out any physical interventions safely. However, in the 6-month period January to June 2023 across all wards in the hospital, there had been 103 episodes of physical interventions. The highest number (33) of physical interventions across all wards in the hospital occurred in May 2023, and the lowest numbers were in February and March 2023 (11)

Staff shared key information to keep patients safe when handing over their care to others. We attended two daily 'flash' meetings which was attended by managers and or a senior nurse from each ward. The meeting was chaired by the registered manager and was structured and informative.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had not completed and kept up to date with most of their mandatory training. The hospital's overall mandatory training rate as of June 2023 was 86%. However, the training rate across all wards in the hospital for safeguarding level 4 was 25%, safeguarding level 3 68% and safeguarding level 2 80% (against a provider target of 90%) we also found the training rate for immediate life support was 71%, NEWS 2 (event) 49%, Prevention and management of Violence and Aggression refresher 59%, Rapid tranquillisation 6%.

Managers monitored mandatory training. All managers had access to monthly training figures.

Assessing and managing risk to patients and staff

Staff had not always assessed and managed risks to patients and themselves well.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. We viewed 3 risk assessments and risk management plans. While patient risk assessments

had been completed and regularly updated, including after incidents, staff had not ensured that environmental risks had been identified within the risk assessment documentation of patients who had a history of self-harm. We found that patient's risk assessments did not include reference to ligature risks, though they did refer to self-harm where this had been identified as a specific risk.

Management of patient risk

Staff did not always know about risks to each patient and acted to prevent or reduce risks. Staff had not fully identified and responded to any changes in risks to, or posed by, patients. One patient told us that they felt unsafe on the ward.

Staff had not identified and responded to all changes in risks to, or posed by, patients. Between 1 April and 19 July 2023, there had been 84 incidents of verbal and physical aggression between patients across all wards in the hospital. In the 6-month period January to June 2023, there had been 65 episodes of patient to staff altercations. The number of staff to patient incidents were reported to the board within the key performance reports, however, the number of patient-to-patient incidents were not reported.

Staff did not always conduct patient observations in line with safe practice. The provider's policy outlines two levels of constant observations; Level 3: Within Eyesight Engagement and Observation and Level 4: Within arm's length Engagement and Observation.

We observed staff on one to one (within eyesight and arm's length), and two to one observation, to be conducting patient observations through a closed door, which had no vision panel. We escalated our concern that both two to one and one to one observation was being conducted through a closed door to staff on 19 July 2023; however, this practice was still taking place on 20 July 2023. This was brought to the attention of the senior nurse on duty and Registered Manager.

We observed 10 observation records. None of these contained a record of the patient's mood or behaviour. The records were location based as they only identified the patient's whereabouts. The provider's 'Safe and Supportive Observations Policy and Procedure' stated that: ''the supportive observation of Service Users must be seen as a skilled and valued duty involving the assessment of the Service User's functioning and an opportunity for the development of rapport and therapeutic relationship." Documentation of the patient's mood and behaviour will enable staff to obtain an ongoing picture of the patient's mental state. It will enable staff to make informed decisions of when to increase levels of patient observations in response to risk and decrease patient observation level in response to an improvement in the patient's mental state.

Staff could not observe patients in all areas of the wards and managers had not identified procedures to minimise risks where they could not easily observe patients. We found a number of blind spots on the ward. Staff could not observe all areas of the ward. Mirrors were in situ; however, these did not mitigate the risks, as the mirrors did not enable to see around the areas where there were blind spots.

However, staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff conducted pat down searches of patient, where and when a risk had been identified.

Use of restrictive interventions

Levels of restrictive interventions were low. However, two patients told us that they were not allowed to watch television after 10pm and they had to be in their bedroom by 11pm.

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

Inadequate

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The provider was working in collaboration with the East Midland Collaborative group and were currently working on reducing restrictive interventions. However, staff had not always followed the provider's policy when using restraint. We reviewed 6 patient records that showed there had been no debrief for 4 patients who had been restrained by staff.

Staff tried to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. However, staff did not have access to a de-escalation room, therefore had to de-escalate patients on the ward. Between 1 May and end of July 2023 there had been 22 episodes of restraint in the hospital (acute and rehabilitation wards).

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Not all staff followed NICE guidance when using rapid tranquilisation. The provider had introduced a non-contact ABCDE physical health assessment tool. The tool was to be used when patients refused to have their physical health observations undertaken. The tool looked at the patient's Airway, Breathing, Circulation, Disability and Exposure. However, we found an incident where the patient's respirations had not been recorded after being administered intramuscular (IM) Lorazepam.

Safeguarding

Not all staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Some staff had training on how to recognise and report abuse and they knew how to apply it.

All staff had not received training on how to recognise and report abuse, appropriate for their role. The number of staff across the hospital who had attended the safeguarding and protection of vulnerable adults training was 81%. The safeguarding audit compliance rate dated 7 July 2023 was 100%.

Not all staff had kept up to date with their safeguarding training. Across the hospital, the current training level for safeguarding level 3 across all hospital wards was 68% and safeguarding and protection of adults training was 81%.

Staff had not always protected patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Between January 2023 to June 2023 across the hospital, patients had reported 43 incidents of patient-to-patient assaults, racism, and sexually inappropriate behaviours or assaults.

Staff had not always recognised adults at risk of or suffering harm and worked with other agencies to protect them. Review of the safeguarding referral data for Broomhill between January 2023 to June 2023, showed there had been 4 safeguarding referrals made to the local authority including 2 referrals in both January and May 2023. There had been no safeguarding referrals made in February, March, April, June, and May 2023.

Staff told us that children would not be allowed to visit on the wards. There was no family room. Staff told us any visits by children would need to be pre-planned.

Managers took part in serious case reviews and made changes based on the outcomes when applicable. However, between the beginning of April and end of June 2023 there had been no serious incidents.

Staff had access to essential information.

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

Patient notes were comprehensive, and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. However, we found 2 incidents where a patient's daily summary and had been cut and pasted into another patient's notes.

When patients transferred to a new team, there was potential for delay in staff accessing their records. We found when searching for patient records that these were accessible by ward. Patient records from stays on other wards in the hospital were archived. Whilst these records were easily accessible, staff would need details of previous ward stays to access all relevant records.

Records were stored securely. The provider mainly used electronic care records. Staff maintained paper copies of some records which were safely stored in the ward office.

Medicines management

The service had not always used systems and processes to safely prescribe, administer, record and store medicines. However, staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff had not always followed systems and processes to prescribe and administer medicines safely. We found that staff had not always recorded patient's respiration after being given rapid tranquillisation. We found an incident where the patient's respirations had not been recorded after intramuscular (IM) Lorazepam had been administered. In these instances, patients had refused to have their blood pressure (BP) recorded. However, staff should observe the patient's respiration rate, as Lorazepam can lower respiration rate. The provider had a process in place for these circumstances and had advised staff to record visual checks. However there had been a delay in response from the manager to ensure that staff were complying with this requirement".

Staff had not always administered patient medications in line with their Certificate of Consent to Treatment (T2) form. We found that one patient had been administered Zuclopenthixol, however which was not on the patient's consent to treatment form. We also found that staff had not recorded observations for a patient on high dose anti-psychotic medications (HDAT).

Staff reviewed each patient's medicines regularly, however had not always provided advice to patients and carers about their medicines. Staff reviewed patient medicines at the muti-disciplinary meetings and when required in the interim.

Of the 6 patients on Holdenby who spoke to us about their medicines 1 patient told us that they understood their medicines. Three patients told us that they did not understand their medicines and 1 patient was not sure.

The provider used an electronic medicine prescribing and administration system. Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely. We found that all medicines had been stored in line with best guidance.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The provider had a contract with a local GP, who reviewed medication reconciliation upon admission.

Staff learned from safety alerts and incidents to improve practice. During inspection we noted that the provider produced a monthly learning alert for all staff.

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

Inadequate

Staff ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff generally reviewed patient's medicines in the multi-disciplinary meetings.

Track record on safety

The service did not have a good track record on safety.

The service did not have a good track record on safety. Neither had the service always managed patient safety incidents well.

Staff knew what incidents to report and how to report them. In the three-month period April to June 2023 staff had reported 621 incidents across all hospital wards. These included 69 incidents of physical interventions, 47 safeguarding incidents, 38 patients to staff incidents, 24 patients to patient altercations, 34 referrals to the police, 32 transfers to accident and emergency and 14 incidents of patients going absent without leave (AWOL).

Of these staff had recorded 84 incidents of verbal and physical aggression between patients, and 132 incidents of verbal and physical aggression toward staff.

Staff had reported serious incidents clearly and in line with the provider's policy. At the time of our inspection the provider was reviewing three serious incidents.

The service had no never events on the ward.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff had not raised any duty of candours between March to May 2023, as there had been no notifiable safety incidents during that period.

Managers debriefed and supported staff after any serious incident. The provider had a system and process in place which included support from managers and psychology where required.

Managers investigated incidents thoroughly. However, patients and their families had not always been involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. We observed posters on the ward, which outlined learning from incidents which had taken place. The provider produced a monthly leaning alert which provided details where incidents had increased, stayed the same and had been reduced. The learning alerts also summarised recent learning from inspections and internal reviews.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, in April 2023, the provider implemented a daily count process for stock medicines, following an increase in errors which had been related to discrepancies to stock medicine counting.

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

Inadequate

Is the service effective?

Requires Improvement

We rated effective as requires improvement.

While this key question had previously been inspected this was the first time this key question had been rated

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They had developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. However, care plans were not always personalised and holistic.

While staff completed a mental health assessment of each patient either on admission or soon after. In June 2023 only 56% of patients had a MOHOST (model of human occupation screening tool) assessment and only 50% of appropriate patients had a treatment plan in place by week 4 of their admission.

Most patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. In June 2023, the number of patients across the hospital who had received the following physical health checks were as follows; long term review (96%), new patient assessment (90%), ECG (95%), bloods (100%), and malnutrition score (MUST 91%). As of June 2023, only 58% of patients had received an annual physical health check, however staff had undertaken assessments of cardiac and metabolic health for 84% of patients. We saw evidence that staff were undertaking records of patient's vital signs using the National Early Warning System (NEWS).

Staff developed a care plan for each patient that met their mental and physical health needs. Care plans mostly reflected patient's assessed needs; however, these were generic and not tailored to the needs of the patient or written from the patient's perspective. Staff had not always developed care plans in line with from the National Institute for Health and Care Excellence (NICE). Of the 5 patients who spoke to us about care plans, all advised that they had not been involved in their care planning process. One patient told us that they did not have a care plan and another patient asked us what a care plan was and said, "I don't have a care plan do I?" We found care plans did not always include the patient's views. Patient records contained care plan headings. These were COVID-19, discharge, legal status, observation, mental health, protection and management of violence and aggression, physical health and risk and observation.

Best practice in treatment and care

Staff had not always provided a range of treatment and care for patients based on national guidance and best practice. The provider did not always provide support for patients in relation to self-care and the development of everyday living skills and meaningful occupation was limited. Staff offered some activities including board games, gardening, animal therapy and craft. Staff supported patients with aspects of their physical health and encouraged them to live healthier lives. Staff used some recognised rating scales to assess and record severity and outcomes. They participated in several clinical audit, benchmarking, and quality improvement initiatives; however, the recommendations had not always been embedded in practice.

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

Inadequate

Staff did not always deliver care that was in line with best practice and national guidance. Patients did not have access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm, in line with guidance from the National Institute for Health and Care Excellence (NICE). Staff did not have access to an identified activities room. Staff had access to two occupational therapy kitchens. However, we were told that the kitchens were not fit for purpose.

Staff were not always conducting patient observations in line with safe practice.

Staff identified most patient's physical health needs and recorded them in their care plans. However, staff had not completed physical health care plans for all patients. However, staff ensured that patients could access physical health care. In June 2023, across all hospital wards, 70% of patient had an oral health assessment in place, 76% of patients had seen a podiatrist and 90% of patients had seen an optician. However only 4% of patients had seen a dentist.

Staff met patient's dietary needs and assessed those needing specialist care for nutrition and hydration. While staff helped some patients live healthier lives by giving advice on wellbeing and healthy eating, 2 patients complained that they had become unfit and had put on weight since admission to hospital.

Staff used some recognised rating scales to assess and record the severity of patient's conditions and care and treatment outcomes. Examples included MOHOST (model of human occupation screening tool), and the health of the nation outcome scores (HoNOS).

Staff used technology to support patients. We saw staff to be using handheld devices so that observations could be recorded in real time.

While staff took part in clinical audits, benchmarking, and quality improvement initiatives, these had not always ensured high standards of care were sustained. Audits across the hospital included care records, incidents, and complaints. As of July 2023, the compliance rate for the care records was 96%, incidents 98%, and complaints 100%. However, during inspection we found that clinical audits and monitoring were not always effective as demonstrated by missing emergency equipment, a lack of clinic and clinical equipment cleaning records.

Skilled staff to deliver care.

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

The service had access to a full range of specialists to meet the needs of the patients on the ward. The multidisciplinary team comprised of nurses, healthcare support workers, occupational therapists, occupational therapy instructors, psychologists, psychology assistants, consultant psychiatrists, and doctors. The patient also had access to a local GP and physical healthcare team.

Managers had not ensured that staff had all the required mandatory skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. At the time of our inspection, the overall mandatory training rate was 86%. However, the compliance rate for all the mandatory training courses were not over 75%.

Managers gave each new member of staff a full induction to the service before they started work. Managers followed the provider's policy which outlines that local induction will normally take place in the first 6 weeks of employment. The general (corporate) induction took place in the first 3 months of employment. Managers provided agency and temporary workers with a local induction in line with the provider's agency staffing policy and procedure.

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

Inadequate

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. At the time of inspection across the hospital, the appraisal rate was 97%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. The provider held monthly team meetings on the ward.

Managers identified any training needs their staff had, however had not given all staff the time and opportunity to develop their skills and knowledge.

Managers provided staff with some specialist training required for their role. Staff had access to a range of additional training courses including catheter care, dignity, and respect (event), freedom to speak up, ligature prevention and awareness and self-harm awareness. However, staff had not received rehabilitation or recovery training.

Managers recognised poor performance, could identify the reasons, and dealt with these. Managers had informed us of an incident which had resulted in managers acting in line with the provider's disciplinary policy.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. However, they had not always worked effectively with each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended two 'flash' meetings. These meetings were attended by the deputy manager or nurse in charge for each of the wards. The meetings were chaired by the Registered Manager and had a structured agenda. The meetings were an opportunity for each ward to shared key clinical information, priorities, and concerns. Staff attended the flash huddle meetings both in the morning and afternoon.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff handovers took place between nursing staff at shift change. In addition, the Registered Manager chaired daily flash meetings where a brief handover from all wards was provided.

Ward teams had effective working relationships with other teams both in the organisation and external to the organisation.

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

Most staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. However, managers had not made sure that staff had fully explained patient's rights to them or that treatment was in line with the patient's consent to treatment.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The training figures for Mental Health Act training at the time of inspection was 96%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff had access to Mental Health Act advisors within the hospital.

Staff knew who their Mental Health Act administrators were and when to ask them for support. All staff we spoke with knew how to obtain support in relation to the Mental Health Act.

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The provider had a Mental Health Act policy in place which was in date and not due for review until September 2024.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The provider had displayed posters on the Independent Mental Health Advocacy service (IMHA) in all patient areas.

Staff told us they explained to each patient their rights under the Mental Health Act in a way they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. The figure for patients receiving their rights in June 2023 was 98%. However, 7 patients across the hospital told us that they were not fully aware of their rights.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. The provider had a robust procedure in place for the approval and monitoring of section 17 leave.

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

Staff stored copies of patient's detention papers and associated records correctly and staff could access them when needed. During inspection we observed that MHA documentation was available within the patient's records.

Informal patients knew that they could leave the ward freely, however the service had not displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

The service had not monitored how well it followed the Mental Capacity Act. The provider told us that a Mental Capacity audit had not been carried out as a routine audit. However, the Mental Health Act office was in the process of compiling an audit to be completed monthly per ward/unit.

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of our inspection, the training figures for Mental Capacity Act and Deprivation of Liberty standards (across all hospital wards), was 90%.

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

Inadequate

There were no Deprivation of Liberty Safeguards applications made across any of the wards in the hospital in the previous 6 months.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. However, these assessments were documented in the patient's daily notes. The Mental Capacity section of the patient's record was not being used routinely by staff.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

Is the service caring?

Requires Improvement

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

This key question was last rated in October 2021.

Kindness, privacy, dignity, respect, compassion, and support

Staff had not treated all patients with compassion and kindness. Three out of the 6 patients we spoke with told us that they had no concerns relating to staff. However, 2 patients told us they did not feel listened to be staff, and 1 patient told us they had raised concerns with staff.

Staff were not always discreet, respectful, and responsive when caring for patients. All 6 patients we spoke with told us that they had to wait to have their needs met. One patient told us things move slowly on the ward. Another patient told us they had to wait 5 weeks for a haircut.

Staff had not understood and respected the individual needs of each patient. Four out of 6 patients told us that staff had not given the opportunity to give their views about their care and treatment. The other 2 patients we spoke with told us they had been asked to give their views on the day of the inspection.

Staff did not fully understand and respect the individual needs of each patient. Eleven patients out of 32 patients who spoke to us about their care planning process, (34%) told us staff had not given them the opportunity to give their views about their care and treatment.

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

Inadequate

While staff supported some patients to understand and manage their own care treatment or condition, and directed and supported some patients to access other services. The number of patients accessing external agencies for support and treatment such as education, employment and for support and treatment was limited.

However, most patients said staff treated them well and with respect. Of the six patients we spoke with, 5 told us that staff had treated them with respect. However, staff had recorded in one patient's record that the patient's behaviours were "attention seeking." Review of the patient's history showed that the patient suffered from a neurological disorder.

Staff felt they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients. Staff were aware of who to go to raise concerns and were aware of the freedom to speak up guardian. During the six-month period January to June 2023, across the hospital the provider had received 5 concerns via the freedom to speak up guardian. The highest number of concerns received were raised in January 2023 (3 concerns). No concerns were raised via the freedom to speak up guardian in June 2023.

Staff followed policy to keep patient information confidential. However, we noticed that patient details could be seen through the window in the ward office.

Involvement in care

Staff had not always involved patients in care planning and risk assessment or actively sought their feedback on the quality of care provided. However, staff ensured that patients had easy access to independent advocates.

Involvement of patients

Staff had not involved all patients in their care and given them access to their care planning and risk assessments. All 6 patients we spoke with told us they had not been involved in their care planning process and did not have a copy of their care plans.

While staff tried to make sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Four out of the 6 patients we spoke with did not understand the purpose of their medicines and a further 1 patient was not sure about the purpose of their medicines.

Staff had not supported all patients to make decisions on their care. Four out of six patients told us they had not been involved in decisions about their care and 2 patients told us that they had been asked for their views on the day of inspection.

However, staff introduced patients to the ward and the services as part of their admission. The provider had produced a handbook which was shared with patients on admission. The handbook contained information about the multi-disciplinary team, meal and medicine times, facilities, how to be involved, the values of St. Matthews Healthcare, information and contact details regarding advocacy, and details of how to raise a complaint.

Staff had involved patients in some decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could provide feedback and be involved via the weekday planning meetings, quarterly service user and family support forum, monthly community meetings and ad hoc co-design groups. Patients could also provide feedback within the hospital via compliments and complaints and online via 'I want great care'. An example of which was the development of patient surveys. The provider target for patient's surveys was 35%. The figure for June 2023 was 53%.

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

Inadequate

Staff made sure patients could access advocacy services. During inspection we observed contact details for advocacy displayed on each of the ward notice board. Staff also provided information via the patient's handbook.

Involvement of families and carers

Staff had not informed and involved families and carers appropriately.

Interviews with carers indicated that staff had not always supported, informed, and involved families or carers. However, where patients had given consent to share information, staff invited families or carers to care programme approach meetings and multi-disciplinary review meetings.

Staff had not always helped families to give feedback on the service. One carer told us that they had not been given the opportunity to provide feedback on the patient's care and had not been involved in the patient's care planning.

Staff had not given all carers information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement

We rated it as requires improvement.

While this key question had previously been inspected this was the first time this key question had been rated

Access and discharge

Staff had not always planned and managed patient discharge well, as the provider had delayed discharges. However, they worked well with services providing aftercare and managed patient's move out of hospital.

While managers had not made sure bed occupancy did not go above 85%. In June 2023, the occupancy level across all wards in the hospital was 90%. Managers had regularly reviewed length of stay for patients. In June 2023, the average length of stay for acute was 50 days.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were only moved between wards during their stay when there were clear clinical reasons, or it was in the best interest of the patient. We found that patient transfers between wards were mostly planned, and any unplanned moves were undertaken in relation to clinical needs.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. In June 2023, there were 5 delayed discharges in the hospital. The highest number of delayed discharges since January 2023 was 11, in March 2023.

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

Inadequate

Patients did not have to stay in hospital when they were well enough to leave. However, 2 patients told us that they felt stuck on the ward.

Staff planned patient's discharge and worked with care managers and coordinators to make sure this went well. During inspection we found effective working relationships were in place to support patient's discharge.

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of the ward supported patient's treatment, privacy, and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were not adequate quiet areas for privacy or rooms for patient cooking and activities. The food was of variable quality, 3 out of 6 patients told us the food was good. One of the 3 patients who were not happy with the quality of the food told us that the food was "really bad", another patient told us that the quality of the food was "not great," Patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Staff did not have access to a full range of rooms and equipment to support treatment and care. We found that space on the ward was limited. Wards did not have a quiet room for patients who may not want to sit in the television room, and there were no interview rooms on the ward for staff to meet with patients.

The service did not have quiet areas and a room where patients could meet with visitors in private. However, 2 patients told us they used the garden, and 2 patients told us they used a room off the ward.

Patients told us that the service did not offer a variety of good quality food. Of the 6 patients interviewed, 3 told us the food was good. One of the 3 patients who were not happy with the quality of the food told us that the food was "really bad", another patient told us that the quality of the food was "not great."

However, each patient had their own bedroom, which they could personalise. Patient bedrooms were of a good size and had ensuites.

Patients had a secure place to store personal possessions.

Patients could make phone calls in private. Most patients had access to mobile phones. In addition, patients could make a private call using a ward phone.

The service had an outside space that patients could access easily. The hospital is situated in the countryside and has access to extensive grounds. However, the hospital is a distance away from main facilities in the local town. Staff and patients could access local facilities via 1 of the 4 vehicles provided by the hospital.

Patients could make their own hot drinks and snacks and were not dependent on staff. We found that patients had access to hot and cold drinks and snacks on each of the wards.

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

Inadequate

Patient's engagement with the wider community

Staff did not consistently support patients with activities outside the service, such as work, education, and family relationships.

Staff helped patients to stay in contact with families and carers and encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service.

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The ward was on the ground floor and had easy access.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. During inspection we saw a range of notices on patient notice boards. Notices included how to complain, information on advocacy, treatment, and activities.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us that they were able to access interpreters or signers when needed and that the hospital had a contract in place for this.

The service could access information leaflets available in languages spoken by the patients and local community.

Patients had access to spiritual, religious, and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. However, the service had not evidenced learning.

Patients, relatives, and carers knew how to complain or raise concerns. Of the 6 patients on the ward who spoke to us about complaints, 3 patients (50%) told us they had not made complaint, 2 patients told us they did not feel listened to, and 1 patient told us they had asked to move closer to home.

During the six-month period January to June 2023, the provider (across all 6 wards), had received 5 complaints. The highest number of complaints received per month was in March 2023 when 3 patient complaints were submitted. Two patient complaints related to peer conduct, one staff complaint related to replacement equipment for staff, one was a staff-to-staff complaints (which was reclassified) and one patient complaint related to staff talking in a language other than English.

The service clearly displayed information about how to raise a concern in patient areas. Patients were given a patient's handbook on admission. This contains information on how to complain, how to provide feedback via 'I want great care'. Staff had also displayed posters on how to complain or raise a concern on notice boards in patient areas.

Staff understood the policy on complaints and knew how to handle them. All staff interviewed were aware of what actions were needed and what to do if a patient complained.

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

Inadequate

Staff protected patients who raised concerns or complaints from discrimination and harassment.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. The provider shared lessons learned for each of the complaints, which were shared with staff through the provider's learning from incident reporting system, with any trends being reported to the executive team. However, learning from complaints had not always been embedded in practice.

The service used compliments to learn, celebrate success and improve the quality of care. In the three-month period April to June 2023 the hospital (across all 6 wards) received 16 compliments. The highest number of compliments received was in June 2023 when 11 compliments had been received.

Is the service well-led?

Inadequate

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

This key question was last rated in October 2021.

Leadership

Not all leaders had the skills, knowledge, and experience to perform their roles. They did not have a good understanding of the services they managed; however, they were visible in the service and approachable for patients and staff.

Leaders had not always ensured that services were safe. There had been a high number of incidents, and during inspection 12 patients told us that they did not feel safe. Between 1 April and 17 July 2023 across the hospital, there had been 132 incidents of violence and aggression toward staff and 84 against patients.

While leaders were committed to the service and service improvement, they were not always aware of all aspects of their roles. Leaders did not have a good understanding of the services they managed. Leaders could not clearly explain how the teams were working to provide high quality care. They could not explain clearly how the teams were working to provide high quality care, however, did have immediate access to information relating to key information including staffing, patient observations, incidents, safeguarding referrals, and notifications to the Care Quality Commission.

Leadership development opportunities were not always available, including opportunities for staff below team manager level.

Vision and strategy

Staff were able to outline some of the provider's vision and values and how they applied to the work of their team. The provider has six core values in place. These were 'people first, passion for care, pursue diversity, progressive, partnership and positivity'.

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

Inadequate

While the provider's senior leadership team had communicated their vision and values to the frontline staff in this service; there was limited evidence that these values had been translated into practice.

Culture

Our findings from other key questions in this report and a review of recent incidents, including whistleblowing reports, suggest that there were indications of a closed culture at the hospital. We found evidence of ongoing issues and lack of cohesive working between different ethnic groups at the hospital. The inspection team discussed this with the provider who immediately carried out a full review of the culture in the hospital and introduced various training and awareness sessions to address any cultural issues. We received assurances that where any issues had arisen senior managers had dealt with these in a timely manner.

The overall scoring for the staff survey within the previous 12 months (July 2023) was good.

While staff told us they felt respected, supported, and valued, and could see there had been an improvement in the culture of the hospital over the previous 6 to 12 months. They also identified areas that still needed further improvement. Comments from staff included the need to employ more permanent staff, the need for improvements in relation to rehabilitation care planning that "promotes and encourages independence to assist in budgeting, healthier eating, laundry, tidying the bedroom with assistance, and cooking." Other comments focused on how agency staff were being treated by permanent staffing adding that "they don't treat agency staff like their colleagues."

Staff felt positive about working for their provider and team. Staff felt able to raise concerns without the fear of retribution. Staff knew how to use the whistleblowing process and the role of the speak up guardian.

Managers had dealt with poor staff performance when needed. Teams worked well together and were there were difficulties managers dealt with them appropriately.

The provider recognised success within the service. Awards included caring excellence, clinical excellence, rising star and behind the scenes ward.

Governance

Our findings from the other key questions showed that governance processes had not always operated effectively at team level or that performance and risk were managed well.

The service was not adequately mitigating risk to patients and supporting a pathway to recovery. Our findings from the safe key question showed that governance processes did not always operate effectively at ward level and that performance and risks were not always managed well. Although policies were in place at the service to ensure that visual observations were undertaken post rapid tranquillisation (when patients had refused to have their physical observations undertaken), observations had not always been recorded. The provider conducted audits which showed that not all staff were compliant with this requirement. However, the provider had not ensured that managers had acted on the outcome of these audit results. Therefore, effective audit and adequate governance systems were not in place.

Leaders had not ensured a safe environment for patients. Staff had completed ligature risk assessments of all ward areas; however, managers had not taken steps to remove or reduce the identified ligature risks. Some of the identified ligatures were had been rated as green, which indicated that the risk was adequately mitigated. This was not the case.

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

Inadequate

The identified mitigation for these risks was 'closed circuit television' (CCTV), which is not an alternative to staff presence. CCTV can only be used to augment, but never replace, monitoring. Mitigation for the risks identified would require additional staff observations both via mental health and zonal observations. These were not identified as mitigation. The fence surrounding the ward was too low and did not reduce the risks of patients absconding.

Leaders did not have sufficient oversight of infection, prevention, and control measures. We found that some staff were wearing jewellery, were not bare from the elbow and were wearing nail varnish. We found several concerns regarding the maintenance, cleanliness, calibration of medical equipment. Leaders had not ensured that there was adequate oversight in these areas to ensure that any concerns were highlighted and resolved at an early stage.

Management of risk, issues, and performance

While teams had access to the information, they needed to provide safe and effective care, however had not always used that information to good effect.

However, staff maintained and had access to a risk register for the organisation. Staff at ward level could escalate concerns to senior managers when needed. Staff concerns matched those on the risk register. The provider had five areas of risk on the risk register. These included qualified nurse vacancies, concerns re potential access to reception, a lack of vision panels in bedroom doors, a high use of agency staffing, and the risk associated with the height of the perimeter fence. The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Information management

While staff collected and analysed some data about outcomes and performance and engaged actively in local quality improvement activities, these findings were not used to ensure sustainable high standards of care.

While the service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. We found clinical audits and monitoring were not always effective as demonstrated by missing emergency equipment, identified gaps in the requirements for emergency equipment, the lack of clinic and clinical equipment cleaning records.

Although the provider had closed circuit television (CCTV) in place in general ward areas. However, we did not see any evidence that patients had been informed that CCTV was in use. We did not see evidence of any appropriate signage placed around the ward areas to inform patients that they may be under surveillance. Making individuals aware that their information was being collected is critical because individuals have a right to make enquiries or submit a complaint if they feel their privacy has been breached.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well, and helped to improve the quality of care. Information governance systems included confidentiality of patient records. Information was in an accessible format, and was timely, accurate and identified areas for improvement. However, inspectors found that patient records were and not easy to find. Patient records were ward based. Patient stays on other wards were archived, therefore were not immediately accessible.

Engagement

Managers engaged actively with other local and national health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the patients.

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

Inadequate

Learning, continuous improvement and innovation

The provider is currently working with the East Midland Collaborative group and are currently working on reducing restrictive interventions. To date the provider has introduced a change idea form for both patient and staff debrief. The aim is to review how the incident was dealt with, who was involved and the outcome they wish to achieve. However, this should have been standard practice.

Some staff were taking part in research, and some innovations had taken place in the service. Staff had access to hand devices to record patient information in real time. Staff did not take part in national audits relevant to the service.

The provider had created a safeguarding accreditation for services to work towards. The award has been designed to reward the services for reaching compliance in safeguarding across 3 different levels: bronze, silver, and gold award. Broomhill is currently working towards Bronze across all seven wards.

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 ensure that it had effective governance structures and processes to provide oversight and assurance of all aspects of service delivery, to be able to identify and improve practice in a timely manner and sustain that improvement. (Regulation 17). This was an area of concern in September 2020 and February 2021. • The provider did not ensure the confidentiality of all patient's identifiable information. (Regulation 17). • The provider did not ensure that de-briefs following incidents of violence and aggression were undertaken and recorded in a timely way. (Regulation 17) • The provider did not ensure that all patients received a comprehensive assessment and treatment plan in a timely manner. (Regulation 17) • The provider did not ensure that food was of a good quality. (Regulation 17)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • The provider did not ensure that staff treated patients with kindness, privacy, dignity, respect, compassion, and support at all times. (Regulation 10) This was an area of concern in 2021. • The provider did not ensure that there was access to visiting facilities for patients and their carers, including a family visiting room. (Regulation 10)

This section is primarily information for the provider

Requirement notices

- The provider did not ensure that staff did not talk in languages other than English in front of patients unless it was the patient's native language (Regulation 10). This was an area of concern in July and September 2020.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider did not ensure that clear mitigation was in place for all identified ligatures, and that appropriate actions were taken to address blind spots on the wards. (Regulation 12). This was an area of concern in February 2020. • The provider did not ensure that staff followed National Institute for Health and Care Excellence guidelines when undertaking enhanced patient observations. (Regulation 12). This was an area of concern in February and September 2020. • The provider did not ensure that the correct techniques were used when restraining patients. The provider did not always aim to reduce the number of restraints. (Regulation 12). • The provider did not ensure the oversight of rapid tranquillisation administration and monitoring. The provider did not ensure a competent professional maintained oversight of rapid tranquillisation administration and monitoring. That non-contact observations were undertaken post rapid tranquillisation, when patients refused to have their physical health observations undertaken. (Regulation 12). • The provider did not ensure that staff adhered to the hospital's infection prevention and control policy. The provider did not ensure acceptable food hygiene and storage procedures were in place across the hospital, and that the current problems with mice infestation were safely managed and any traps were not placed in patient areas. (Regulation 12).

This section is primarily information for the provider

Requirement notices

- The provider did not ensure that clinical equipment was checked and cleaned regularly and that clean stickers were in place. (Regulation 12) This was an area of concern in July 2020.
- The provider did not ensure that staff adhered to the hospital's policy and procedure when bed rails were used. That all electrical equipment was placed in safe areas on the ward and that patient risks were fully assessed. (Regulation 12).
- The provider did not ensure that all patient medication was prescribed within British National Formulary limits unless there was a clear rationale for doing so and a second opinion in place. The provider did not ensure that all patient medication were covered in the patient's consent to treatment form. (Regulation 12).
- The provider did not ensure that all medical equipment was calibrated as per manufacturers guidance. The provider did not ensure that staff regularly check the emergency grab bags and defibrillators. (Regulation 12).
- The provider did not ensure that staff met all aspects of the available mandatory training requirements. (Regulation 12). This was an area of concern in February 2020.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider did not ensure a recognised rehabilitation model of care was embedded within the rehabilitation wards to meet patient's needs. The provider did not ensure patients had regular access to activities that promoted rehabilitation such as employment and education opportunities. (Regulation 9) • The provider did not ensure that all patients were fully involved in the development and ongoing monitoring of their care plans, patients were not always given a copy of their care plan, which was evidenced within the patient's clinical records. (Regulation 9) • The provider did not ensure that staff did not copy and paste from one patient's record into another. (Regulation 9)

This section is primarily information for the provider

Requirement notices

- The provider did not support staff to provide an environment where staff can de-escalate patients in a way that supports the patient's privacy and dignity. (Regulation 9)

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 ensure that patients were always properly safeguarded. That patients felt safe on the ward and were protected from harm, this included patient on patient assaults, sexual vulnerability and how any known allergies were managed. The provider did not ensure that they monitored the numbers of assaults and altercations between patients. (Regulation 13). This was an area of concern in February 2021.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider did not ensure that all ward areas were fully clean and that any ripped, dirty, or broken furniture and fittings were discarded. (Regulation 15). • The provider did not ensure that all corridors were kept clear to enable safe exit from the ward in the case of an emergency. (Regulation 15).