Glancestyle Care Homes Limited

Southleigh Community Independent Hospital

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	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as good because:

- Patients told us they felt safe. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The multidisciplinary team included or had access to a range of specialists required to meet the needs of patients. Managers ensured that these staff received training, supervision and appraisal. The 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.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service worked to a recognised model of mental health rehabilitation.

However,

- NEWS2 charts were not being completed correctly and there were gaps in recording. There was no system in place for auditing the charts.
- Cleaning records for the clinic room did not show when physical health equipment had been cleaned.
- There were a high number of nursing and support vacancies that were covered by bank and agency staff.
- There were some gaps in the provision of the specialist training that all staff needed to work with the current patient group, for example, on topics such as epilepsy and diabetes. Records of emergency scenario simulation training were not available.
- The service did not always escalate concerns to clinical governance meetings and the risk register.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Good 	Please see overall summary.

Summary of findings

Contents

Summary of this inspection

Background to Southleigh Community Independent Hospital

Southleigh Community Independent Hospital is part of the Inmind Hospital Healthcare Group.

Southleigh Community Independent Hospital provides care, treatment and rehabilitation for people with severe and enduring mental health problems. The service offers community rehabilitation for up to 27 male and female patients with complex needs with an overall aim of moving most patients on to supported accommodation. At the time of the inspection the service was looking after 2 patients with a learning disability and patients who had comorbidities and complex physical and mental health needs.

The service consists of a ward over three floors and 6 semi-independent flats. The service receives referrals from NHS organisations inside and outside of London. There is a registered manager in place.

Southleigh Community Independent Hospital is registered to provide:

• assessment or medical treatment for persons detained under the Mental Health Act 1983

• diagnostic and screening procedures; and

• treatment of disease, disorder or injury.

The service has a registered manager. There have been two previous inspections at the service since 2015. The last inspection was in May 2019. At that inspection the service was rated as good.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

What people who use the service say

We spoke with 8 patients to gather feedback about the service. Patients told us they were listened to and felt safe. All patients reported that they were involved in their care and had access to activities within the service and the community. They told us they were supported to maintain contact with family members.

Patients said staff treated them well and behaved kindly. One patient told us “It’s one of the best places I’ve been to. They really care about patients”. Another described the staff as being “very good and understanding my needs”.

We spoke with 4 family members or carers. Three of the 4 spoke very positively about the service. Three carers reported that staff communicated very well with them. One carer told us that they were not always kept updated and communication could be improved. All carers reported that their family member was safe and well looked after. They told us they were involved in meetings, tribunals and discussions about discharge. Comments included “they [staff] are amazing, very caring and I have nothing but praise for them”. “This is the best that my relative has been, they have been to other places and this is far the best”.

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with the hospital director and 12 other staff members: including consultant psychiatrist, nurses, occupational therapist, healthcare assistants, occupational therapy assistants, physical health lead, clinical psychologist and mental health act administrator.
- spoke with an independent advocate
- spoke with carers four carers. Interviews with carers were completed by telephone. Our final carer interview was on 21 September 2022
- looked at five care and treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service
- attended a handover meeting, patients' community meeting and weekly ward round.

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 to improve:

- The service must ensure that staff NEWS2 charts are completed accurately and that regular audits are carried out. Regulation 12 (1)(2)(a)(b)

Action the service SHOULD take to improve:

- The service should ensure that cleaning records for the clinic room indicate when physical health equipment had been cleaned
- The service should have a system in place to cover fire alarm testing when the responsible person is absent
- The service should ensure records are maintained of emergency scenario simulation training
- The service should strive to achieve a better balance between permanent and temporary staff to improve continuity of care
- The service should ensure that all staff have training to meeting the needs of patients, particularly training in epilepsy and diabetes

Summary of this inspection

- The service should ensure that all areas of concern are escalated to clinical governance meetings with the risk register

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	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. However, staff were not consistently completing and recording checks and observations of patients' physical health.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff carried out a health and safety check of the ward environment on each shift.

Staff could not easily observe patients in all parts of the ward due to the layout of the building. This risk was mitigated through regular observations. Convex mirrors were in place to improve visibility at potential blind spots.

Where individual patients were identified as being at risk, increased observations, including one-to-one, were used.

All patients had their own bedrooms. There were three separate floors within the main building and six individual flats. The first and second floors accommodated male patients and the third floor accommodated female patients. At the time of our inspection there were two female patients being accommodated on the second floor which was for male patients. Both patients had an ensuite shower room. CCTV cameras covered this area. A risk assessment had been carried out for both patients and was reviewed regularly by the MDT. The hospital manager reported that additional observations were carried out by staff when these two rooms were occupied by female patients. Plans were in place to move both patients when bedrooms became available on the third floor. Patients only had keys to access their own floor. Each bedroom had an individual toilet with a handbasin. Each floor had shared bathroom and toilet facilities. Patients in the flats had their own space, including a private bathroom and toilet.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe, for example, by using observation, engagement and individual risk management plans for each patient. The service had a ligature risk assessment. Ligature point audits were up to date and action plans were in place to mitigate any risks identified. There were ligature cutters on each floor and staff confirmed these were easily accessible.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff did not always have access to a personal alarm. At the time of our inspection the service was waiting for a delivery of personal alarms. Three staff reported that an alarm was not available as they were broken or had been sent for repair. This meant that there was a risk that staff would not be able to summon emergency assistance if required. The layout of the building meant there were times when a staff member was, in effect, lone working on a floor. There was no system in place to check or record that staff on duty had a personal alarm allocated when they were working directly with patients. Nor was there a system in place to ensure that personal alarms were tested regularly. We raised these concerns with the registered manager during the inspection. The registered manager acted promptly to address these concerns. Two-way radios were available in nursing office for staff who did not have a personal alarm.

Issues relating to staff personal alarms had been raised at team meetings and the June 2022 clinical governance meeting. These concerns had not been escalated to the service risk register and a risk assessment and risk management plan had not been initiated whilst the service waited for new alarms to be delivered.

Patients had easy access to nurse call systems. These were available throughout the building, in communal areas, individual bedrooms and bathrooms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. An environmental action plan was in place and this detailed the works planned for the ward which included, a larger clinic room, new visitors' room, new flooring, redecoration and refurbishment of the communal areas. The service was supported by an internal maintenance team shared with the provider's other two hospitals. Maintenance issues were addressed within a reasonable timeframe.

Staff made sure cleaning records, other than those for the clinic room, were up-to-date and the premises were clean. Housekeeping staff were seen cleaning high touch areas throughout the day. Patients were supported to clean their bedrooms as part of their rehabilitation programme.

Staff followed infection control principles including appropriate handwashing techniques, use of personal protective equipment (PPE) including aprons, masks, gloves, and hand sanitiser was readily available. Staff accessed infection control training. Training was compliant at 100%.

Fire safety arrangements were in place, although there had not been full compliance with these. All drills, testing and servicing was recorded in a fire folder. We saw that there had been some gaps in weekly and monthly testing in the months of April, May and June 2022. However, regular tests had been carried out from July 2022. The hospital manager told us that the absence of the hospital's maintenance person had impacted on testing.

Personal emergency evacuation plans (PEEPS) had been completed for all patients. These plans detailed the assistance required for each patient to leave building in an emergency. Staff completed fire safety training as part of their role. At the time of the inspection 98% of staff had completed fire awareness, and 82% had completed service-specific fire evacuation training.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked daily.

All equipment was visibly clean, in working order and calibrated. The clinic room was well ordered. Cleaning records were available, however there were no records to demonstrate that clinic room equipment had been cleaned. However, staff did not maintain cleaning records for the clinic room and equipment. Staff told us they did clean the equipment, but we did not see any recorded evidence of this.

Staff recorded daily clinic room temperatures and fridge temperatures and knew the actions to take if these were out of range.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, there were a high number of nursing and support vacancies that were covered by bank and agency staff. Patients received care from many staff, including some staff they were not familiar with

Nursing staff

With the use of bank and agency staff the service had enough nursing and support staff to keep patients safe and to provide the right care and treatment. Staffing levels were reviewed each day at the daily handover.

At the time of the inspection the service had vacancies for 4 registered nurses. Three support workers had recently been appointed but were not yet in post. The service was actively recruiting into vacant posts. This included undertaking recruitment overseas. Vacant support worker vacancies had been recruited to and these staff were going through an onboarding HR process.

Staff vacancies were covered by bank and agency staff who were mainly familiar to the service. Ad-hoc agency staff were booked to cover one-to-one observations. Permanent staff told us that there were many different agency staff that came to the service alongside regular agency staff. They told us that these agency staff did not always know how to respond to the individual needs of each patients. For the month of June 2022 48% of shifts were carried out by 20 different agency support workers; in August 2022, 32% of shifts were carried out by 31 different agency support workers. We saw that patients had complex needs and levels of acuity were high. We observed an incident in the garden when staff did not respond promptly to a patient exhibiting distressed behaviour.

There was a high reliance on agency staff due to the vacancy rate as well as the need to cover enhanced levels of observations. At the time of our inspection 3 patients were on one-to-one observation. The hospital manager had reported at the August 2022 clinical governance meeting that there was a potential for the number of incidents to increase as a result of the lack of continuity of staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service had an induction checklist for agency staff which included information on topics such as fire procedures, location of emergency equipment and ensuring they were aware of health and safety and safeguarding procedures.

Over the past six months the turnover rate for the service was 24%.

Managers supported staff who needed time off for ill health. At the time of our inspection 3 support workers were on long-term sick leave. Over the past 6 months the sickness rate for the hospital had been 14%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

Long stay or rehabilitation mental health wards for working age adults

Good

The hospital manager adjusted staffing levels according to the needs of the patients. Additional staff were booked if patients required a higher level of observation or there were pre-booked activities which affected staffing, such as trips and community activities.

There were sufficient staff available to enable patients to have regular one-to-one sessions with their named nurse.

Patients rarely had their escorted leave or activities completely cancelled. Patients confirmed that leave could sometimes be delayed. The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. Staff held a handover meeting at the start of each shift. Staff used the handover to discuss any incidents that had occurred and update patient risk information. Staff completed a comprehensive handover document which included detailed risks with a risk rating, observation levels, physical observations, leave and activities taking place. This ensured that information was passed onto staff coming onto shift and that staff were aware of the individual risk rating of each patient.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The ward had an assigned consultant psychiatrist and specialty doctor. Patients were seen and monitored in a timely way. The service operated an on-call system for out of hours. Cover for the consultant was in place when they were not available.

Mandatory training

Staff had completed and mostly kept up to date with their mandatory training to ensure they had the appropriate knowledge and skills to carry out their roles safely. The service had a mandatory training programme. This included training on basic life support, intermediate life support and recording observations of patients' vital signs. Managers monitored mandatory training and alerted staff when they needed to update their training, through individual supervision and team meetings.

Overall compliance was at 94%. Compliance rates for physical interventions – breakaway training was at 79% and physical holds training at 70%. Training compliance and areas where improvements were required were discussed at the monthly integrated clinical governance committee meeting.

Assessing and managing risk to patients and staff

Staff assessed and managed some risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. As a result, they used restraint only after attempts at de-escalation had failed. However, the risk of physical health deterioration was not fully mitigated due to poor compliance with NEWS2 requirements.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised risk assessment tool, and reviewed this regularly, including after any incident. Where patients had a forensic history, the service completed Historical Clinical Risk Management-20 (HCR-20) to assess risk. For other patients, staff used the Short-Term *Assessment* of *Risk* and Treatability (*START*) assessment tool.

Long stay or rehabilitation mental health wards for working age adults

Good

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Most staff we spoke with had a good understanding of each patient and the risks they posed. Patient risk assessment and management was discussed in the daily handovers and in the weekly ward round. This enabled staff to focus on the current risks and review the effectiveness of management and mitigation plans. All care records for patients had up-to-date risk assessments.

The clinical psychologist had developed positive behavioural support plans for all patients to guide staff on how to manage predictable situations. The psychologist spent time with staff supporting them to deal with patients' behaviour.

Staff identified and responded to any changes in risks to, or posed by, patients. For example, additional observations were carried out or additional staff were rostered on shift when required. However, we found that five NEWS2 charts had gaps in their recording.

The hospital used the National Early Warning Score (NEWS2) track and trigger system. NEWS2 is a tool used to score a patient's vital signs to identify those at risk of physical deterioration. We reviewed four NEWS2 charts and found that staff were not using NEWS guidance correctly. For example, a patient had a NEWS score of 4, but checks of their vital signs had not been repeated as per guidance. For another patient, their NEWS score was 2. Staff acknowledged that monitoring was therefore required every 4-6 hours. There was no evidence of the vital signs checks being repeated. We found that NEWS charts were not being completed correctly, some charts had no date or time of observations recorded. This meant that it was difficult to ascertain when monitoring had been carried out. The physical health lead and hospital manager reported that NEWS2 audits were not being carried out. We could not identify any impact on patients due to the incorrect use of guidance but it was a risk.

We observed a morning a morning handover. Members of the multidisciplinary team and senior staff attended these meetings each morning. Staff discussed individual patient risk, observation levels, any incidents that had taken place, individual physical health needs and staffing levels.

Staff followed procedures to minimise risks where they could not easily observe patients. Patients were checked in line with the observation levels set by the clinical team. These ranged from one-to-one continuous observation, to intermittent and general observations.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff and patients were aware of these procedures.

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. There were no reported incidents of seclusion or long-term segregation.

In the 12 months before the inspection there had been 13 incidents involving restraint. Of these, 5 incidents involved patients being restrained in a seated position and 8 involved restraint in a standing position. There had been 5 incidents requiring the use of rapid tranquilisation. Staff followed National Institute of Health and Care Excellence guidance when using rapid tranquilisation. All incidents of restraint and rapid tranquilisation were reviewed at the clinical governance meeting.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff understood the Mental Capacity Act definition of restraint and worked within it. For example, we saw that staff had carried out a restraint in order to take blood samples in the best interests of the patient.

Staff applied blanket restrictions on patients' freedom only when justified. Blanket restrictions were proportionate to the requirement to maintain safety, as well as a supportive environment, within a locked rehabilitation service. For example, the front door to the unit was kept locked. Most patients were under section and were either permitted escorted or unescorted leave. Informal patients could ask staff to unlock the front door and exit or enter the building as they wished. Smoking was allowed in the garden area only.

Safeguarding

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

Staff we spoke with understood safeguarding arrangements in the service and could give examples of safeguarding concerns they had identified and raised. Staff felt confident that if they did raise concerns they would be listened to and action taken.

Staff received training on how to recognise and report abuse, appropriate for their role. We saw that the service raised safeguarding concerns with the local authority safeguarding team. The hospital manager was the designated safeguarding lead for the service. The service used a tracker to monitor all safeguarding referrals made to the local authority.

At the time of the inspection 100% of staff were up to date with their adult safeguarding training and 93% of staff were up to date with their child safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, staff described the strategies they had used to support a homosexual patient.

Managers took part in serious case reviews and made changes to procedures or practice based on the outcomes.

Staff access to essential information

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

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.

Records were stored securely.

Long stay or rehabilitation mental health wards for working age adults

Good

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

The service used systems and processes to safely prescribe, administer, record and store medicines. In line with guidance from the National Institute of Health and Care Excellence taff regularly reviewed the effects of medicines on each patient's mental and physical health. This took place at the weekly ward round meeting. Systems were in place to check controlled drugs.

The pharmacist carried out weekly visits and undertook monthly medicine audits. Results of the audits were sent to the service and any shortfalls were discussed at the integrated governance meeting. Any medicine incidents, including errors, were reviewed by the responsible clinician and hospital manager. Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. For example, when patients had 'as required' medicines prescribed a PRN protocol was available with the prescription chart.

Where patients were on a high dose antipsychotic monitoring forms were in place. The physical health lead ran a clozapine clinic at the service. They took blood samples and carried out electrocardiograms (ECGs). We found that the service had not implemented a bowel monitoring chart for one patient as agreed with the multidisciplinary team (MDT). This was in place by the second day of our inspection.

Track record on safety

The service had a good recent track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service managed patient safety incidents well. All staff knew what incidents to report and how to report them using the electronic incident reporting system. Staff told us that they would report any incident of harm, potential harm and/or risks to safety.

Staff told us incidents and never events were discussed in handover, in reflective practice, supervision and staff meetings. When a patient was involved in an incident, the multidisciplinary informed their commissioner. The service invited the commissioner to the multidisciplinary team meeting to discuss the incident.

Learning from incidents was discussed at the daily handover, monthly staff meetings, supervision and integrated clinical governance meetings. Staff also received lessons learned bulletins. All incidents were analysed and any themes and trends discussed with the staff team.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour incidents were reviewed and discussed at the monthly integrated clinical governance meetings. We saw that the hospital manager had apologised to a patient following a medicine error.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers debriefed and supported staff after any serious incident. Staff felt well supported and were offered the opportunity to debrief immediately following incidents and in regular reflective practice sessions. Patients were also supported to debrief following an incident.

Staff received feedback from investigation of incidents and there was evidence that changes had been made as a result of feedback, for example, random searches had been increased following an incident where a knife had gone missing.

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

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-orientated.

There was a holistic approach to assessing, planning and delivering care and treatment to patients. A small number of patients were not well enough to benefit from a recovery approach and the service was working with commissioners to find placements better suited to their needs.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. This included a mental state examination and an assessment of any risk the patient presented.

The psychologist completed functional behaviour assessments for patients with a learning disability. Some patients had a detailed positive behaviour support plan and staff were required to use a positive behaviour approach when supporting them.

All patients had their physical health assessed on admission and regularly reviewed during their time at the service. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring and electrocardiograms.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic, recovery-orientated and tailored to meet the needs of each patient. Care planning documentation clearly reflected the patient's voice and involvement.

Staff regularly reviewed and updated care plans when patients' needs changed. The multidisciplinary team reviewed every patient and regularly updated each patient's care plan with the patient's involvement actively encouraged and supported.

Long stay or rehabilitation mental health wards for working age adults

Good

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a wide range of care and treatment interventions suitable for patients who required rehabilitation. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence.

Patients had access to individual psychology sessions addressing a range of patients' needs and risks. For example, the psychologist used cognitive behavioural therapy to support patients with their social skills and community integration. Patients were supported with their care and treatment at a pace that was comfortable to them and met their individual needs.

Patients were able to access a comprehensive and varied activity programme. Patients could access groups on anger management, timekeeping, art therapy, sleep hygiene, cooking, budgeting and self-care. The occupational therapist had also developed individual timetables for patients to meet their specific needs.

At the time of our inspection there were 2 patients with a learning disability who had been admitted to the service. Four patients required additional support for distressed behaviour. We saw that the service had also been admitting patients who experienced severe and complex mental ill-health that impacted on their recovery journey. Clinical governance meeting minutes identified most recorded incidents were attributed to patients with complex needs. Staff reported that the therapeutic environment and character of the hospital had altered due to the recent changes in the profile of patients admitted.

Staff identified patients' physical health needs and recorded them in their care plans. Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. All patients at the service were registered with a general practitioner (GP) and could access other specialists such as optician, dentist, dietician and chiropodist. The service had a dedicated physical health lead who worked closely with the local GP in monitoring patients' long-term physical health problems. A comprehensive severe mental illness assessment was completed in conjunction with the GP. All patients received an annual health check through the GP service. The GP also attended ward rounds when they could and had been involved in best interests decisions.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The service could access support from the community speech and language therapist and a dietician. The dietician supported patients with individual dietary advice and provided input into the menu. These specialists worked with staff and patients to fully understand patients' nutrition and hydration needs.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Where required the dietician supported individual patients with healthy eating and weight reduction plans. The service facilitated healthy eating groups and a walking group. Staff supported patients with smoking cessation with support from the GP.

Staff used recognised rating scales such as Health of the Nation Outcome Scales (HONOS), to assess and record the severity of patients' conditions and care and treatment outcomes. Staff measured patients' progress and the effectiveness of treatment at each ward round and against individual recovery goals.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff conducted clinical audits of the quality of records, incidents, care plans, risk assessments and medicines management. Managers used results from audits to make improvements by implementing and monitoring action plans. Audit results were discussed at clinical governance meetings, team meetings and at individual supervision.

Skilled staff to deliver care

The ward team included or had access to a range of specialists required to meet the needs of patients on the ward. Most staff were skilled and qualified and had the right skills and experience to meet the needs of the patient group. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. They also provided an induction programme for new staff. However, staff did not have access to specialist training to ensure they could meet the full range of needs of individual patients.

The team included a range of specialists required to meet the needs of patients on the wards. The psychologist had undertaken training in neuro-cognitive assessments that assisted in diagnosing autistic patients. One nurse was registered as a specialist nurse for people with learning disabilities. Patients had access to a range of professionals through multidisciplinary working, including medical, psychology, occupational therapy, non-nursing and nursing staff. Domestic, catering and administrative staff supported the service. At the time of our inspection the hospital social worker had recently left. The service was in the process of recruiting into this post.

Managers gave each new member of staff a full induction to the service before they started work. New staff were able to access an employee handbook and the provider's policies and procedures.

Managers supported staff through regular, constructive appraisals of their work. Managers carried out annual appraisals of staff each year.

Managers supported medical staff through regular, constructive clinical supervision of their work. Staff confirmed they received regular supervision sessions and an annual appraisal to discuss their learning and development, work performance and any issues they had about their role at the service. Staff confirmed that they used supervision to discuss the current patients, to reflect and learn from practice, incidents and for personal support and professional development. Staff supervision records reflected these discussions.

Managers made sure staff attended regular team meetings and passed on information from those they could not attend. Where staff were unable to attend meeting minutes were available.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

In August 2022, managers started to implement training on learning disability and autism as this is now mandatory for all services receiving NHS patients. Staff were also being offered relational security training. However, 5 staff reported that they had not received other specialist training to improve their skills and knowledge of all the conditions experienced by patients on the ward. For example, 2 patients had epilepsy and several patients had type 2 diabetes. Epilepsy is a leading cause of early death for people with learning disabilities.

The hospital manager reported that they carried out emergency scenario simulation training. However, they were unable to provide any written records of when and who was involved and whether there were actions to be taken forward.

Long stay or rehabilitation mental health wards for working age adults

Good

The hospital manager reported that there were plans to develop a preceptorship programme for newly qualified registered nurses, tailored to develop the skills and knowledge required to work in long term mental health rehabilitation services.

Managers recognised poor performance, could identify the reasons and dealt with these through supervision and performance management plans.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary team meetings to discuss patients and improve their care. All members of the multidisciplinary team and other staff worked together to understand and meet the range and complexity of patients' needs. Patients were invited in to discuss their care and treatment. The meeting room had a large screen linked to the hospital IT system so that external people could join the meeting. This enabled professionals, commissioners, family and carers to easily participate which benefited the patients by supporting smoother discharge planning.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. The service had daily handover meetings each morning which discussed staffing, incidents, referrals, admissions, planned discharges, diary appointments and any other relevant issues. These were attended by the hospital manager and the wider clinical team. Each shift held a handover where incidents, patient care and risk were discussed.

Staff worked effectively together and with other health and social care professionals to deliver effective care and treatment. Care co-ordinators regularly attended care programme approach meetings. Staff reported that they had good relationships with commissioners, local authority social services, the GP practice and other mental health providers.

Ward teams had positive working relationships with external teams and organisations. There were effective working relationships with other health and social care professionals. The staff team participated in formal care and treatment reviews for patients with learning disabilities. These meetings were facilitated by the patient's Clinical Commissioning Group (CCG). Staff also participated in regular placement meetings with the CCGs. Staff worked closely with the local safeguarding team and patients' care coordinators in their local areas to facilitate effective discharge planning and follow-up care.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. 100% of staff had completed the Mental Health Act training.

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

Staff knew who their Mental Health Act administrators were and when to ask them for support.

Long stay or rehabilitation mental health wards for working age adults

Good

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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There was a dedicated advocate who visited the service one day per week to support patients with tribunal hearings, ward rounds and complaints.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

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. All section 17 leave was risk assessed beforehand by the multidisciplinary team.

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

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the hospital freely and the service displayed posters to tell them this. We saw that informal patients could come and go as they liked.

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. The mental health act administrator completed monthly audits of the Mental Health Act. The results were discussed at the monthly integrated governance meeting.

Good practice in applying the Mental Capacity Act

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. Ninety-four percent of staff had completed mandatory training on the Mental Capacity Act.

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

Long stay or rehabilitation mental health wards for working age adults

Good

When a patient lacked capacity for a specific decision, the multidisciplinary team, with the patient's input, would discuss the issue and make a decision in the patient's best interests that took into account the patient's wishes. For example, we saw that a best interests decision had been taken for a patient who refused to have blood taken in relation to Clozapine medicine management.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Regular audits of patients' capacity to consent to treatment were carried out and reviewed at the monthly integrated clinical governance meeting.

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

Good

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We observed a range of interactions between staff and patients on the ward. Staff were discreet, respectful, and responsive when caring for patients. We saw instances where staff spoke with patients to discuss their daily activities, discharge and concerns where patients were involved in making decisions.

Staff gave patients practical help, emotional support and advice when they needed it, for example, we observed a staff member supporting a patient who had mobility difficulties in the dining room. Patients told us they felt they were treated with dignity and respect, could speak to staff and that they felt listened to and supported.

Staff supported patients to understand and manage their own care treatment or condition. For example, medical staff provided support so that patients could understand their medicines and their side-effects.

Patients said staff treated them well and behaved kindly. One patient told us "It's one of the best places I've been to. They really care about patients". Another described the staff as being "very good and understanding my needs".

Staff understood and respected the individual needs of each patient. The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights. They also spoke about the complexity of patients' mental illness and co-morbidities.

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

Staff followed policy to keep patient information confidential. Staff maintained the confidentiality of information about the patients. Patient information could only be accessed by staff authorised to do so. Any patient discussions were held in offices and meeting rooms to ensure patient confidentiality.

Long stay or rehabilitation mental health wards for working age adults

Good

The service had received 15 compliments within the last six months. These included compliments from patients, family members, commissioners and care co-ordinators.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured 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 service had a welcome pack that included key information about the hospital and the services provided.

Staff involved patients in care planning and risk assessment. All patients were involved in the development of their care plans and risk assessments. All care plans we viewed were person centred and reflected the individual patient's voice.

Staff made sure patients understood their care and treatment, for example a patient described how the consultant had discussed plans to reduce a prescribed medicine. The multidisciplinary team held meetings with patients each week where their care and treatment was discussed. Staff held regular individual sessions with patients. Staff also involved patients in their Care Programme Approach (CPA) meetings. We saw that no decisions were made about any aspect of care or treatment without the involvement of the patient.

Staff involved patients in decisions about the service, when appropriate, for example patients were involved in staff recruitment interviews.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients participated in regular community meetings and where they had opportunities to input their suggestions, give feedback and raise any concerns. The minutes of these meetings indicated that the patients felt confident in raising any concerns about the hospital.

The patient representative also attended the monthly clinical governance meeting and fed back the views of the patients to the meeting. There was a patient representative for the service. The patient representative regularly attended the clinical governance meeting and was involved in interviewing potential new staff for the service.

Staff made sure patients could access advocacy services. We spoke to the advocate for the service. They told us that the patients had their contact details. The patients were supported by the advocate at ward rounds, CPA meetings, Mental Health Act Tribunals, to make complaints, raise safeguarding concerns and provided feedback to the advocate about their care and treatment.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families and carers appropriately. Staff explained how they maintained contact with families and carers during each patient's stay at the service.

Long stay or rehabilitation mental health wards for working age adults

Good

We spoke with 4 family members or carers. Three carers reported that staff communicated very well with them. One carer told us that they were not always kept updated and communication could be improved. All carers reported that their family member was safe and well looked after. Comments included “they [staff] are amazing, very caring and I have nothing but praise for them.” “This is the best that my relative has been, they have been to other places and this is far the best”.

All carers reported that they were involved in care programme approach meetings, ward rounds discharge planning and Mental Health Act tribunals, in accordance with the wishes of their family member.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Good

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

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients’ moves out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave. However, the service had recently accepted patients with more complex needs and high levels of acuity.

The service worked closely with the South London Partnership provider collaborative and other commissioning teams in respect of admissions to the service. There was a clear admissions criteria and process. Clinical staff assessed patients before they were accepted into the service. Pre-admission assessments were carried out to ensure that the level of risk presented by the patient could be managed.

Four patients displayed behaviour that challenged. Two of these patients had learning disabilities. The consultant reported that approximately 90% of referrals received were for people with a mild learning disability as a co-morbidity and that those with a mental illness presentation were more acutely unwell than in the past. Not all referrals were accepted. The service was working towards supporting patients stabilise their symptoms and help them gain or regain the skills and confidence to live successfully in the community.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Some patients had been at the service for several years. The average length of stay for the service was 621 days between the period 1 August 2021 to 28 September 2022. The service was working with commissioners and care co-ordinators to find suitable placements for longer-stay patients.

Managers and staff worked together to make sure they did not discharge patients before they were ready. For example, for one patient we saw a detailed transition plan with overnight stays planned at the new service. When patients went on leave there was always a bed available when they returned.

Staff did not move or discharge patients at night or very early in the morning unless they were acutely physically unwell and needed an emergency acute hospital admission.

Long stay or rehabilitation mental health wards for working age adults

Good

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed. The delays were mostly due to the complexities of funding and the lack of suitable placements. There had been 2 delayed discharges for the period 1 August 2021 to 28 September 2022 and 8 discharges from this service.

Staff carefully planned each patient's discharge and worked with care managers and coordinators to make sure this went well. The service held a weekly multidisciplinary meeting where discharges were discussed. We attended the weekly ward round and heard staff discussing patient discharges there too, as well as the work taking place to support people with very complex mental, physical and social needs. Moving on happened gradually so that patients had time to adjust before they were discharged. Plans for transition and discharge included section 117 after-care.

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 patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and 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. All bedrooms were ensuite with a toilet and handbasin. Each floor had an accessible bathroom and laundry room.

Patients had a secure place to store personal possessions. Patients had their own key to their bedroom and semi-independent flat. Each bedroom contained locked cabinets for patients to securely store their belongings.

Staff used a full range of rooms and equipment to support treatment and care. These included an occupational therapy kitchen and an activity room.

The service had quiet areas and a room where patients could meet with visitors in private. There was a small visitors' room. Plans were in place as part of the service development plan to develop a new visitors' room. The service was waiting for board approval and funding.

Patients could make phone calls in private. Patients use of mobile telephones was risk assessed. The service had a patient phone in the main hallway. Patients could also access a cordless phone which they could take into a separate room if they did not have their own mobile and wished to have a private conversation.

The service had an outside space that patients could access easily. There was a spacious garden area at the rear of the main building. This was mainly used as a smoking area but it was large enough to accommodate patients who did not smoke and wanted to distance themselves from the fumes.

Patients could make their own hot drinks and snacks and were not dependent on staff.

Long stay or rehabilitation mental health wards for working age adults

Good

The service offered a variety of good quality food. All food was freshly prepared. We saw healthy meal choices on offer and a relative told us staff had promoted healthy eating to help their family member lose weight. There was a choice of meals which patients selected each day. Patients in the semi-independent flats were able to cook and prepare their own meals. They also had an option of eating within the main dining room.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff supported patients with activities outside the service, such as work opportunities, education and family relationships. Therapeutic programmes specific to rehabilitation included self-care, cooking, budgeting, social skills, self-medication and healthy living. Patient participation in programmes varied dependent on their mental health.

Patients accessed the local community as part of their rehabilitation treatment programme. Patients who were well enough could also undertake small jobs within the service which they were paid for.

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

A drama and music group visited the service and provided activities. Both groups were funded by the local authority.

Meeting the needs of all people who use the service

The service met the needs of most 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. A lift was available for patients to each floor. All bathroom and garden areas were accessible for patients with limited mobility. Staff regularly assessed patient's mobility needs. The service provided patients with documents in a format that was easier to read and understand.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The information provided was in a form accessible to the particular patient group according to each patient's needs, for example, the complaints procedure was available in pictorial form. Staff made information leaflets available in languages spoken by patients if requested.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. Staff responded to individual requests for support in these areas.

Staff were supportive of patients who were LGBT+. Staff were able to describe the support they offered to a patient with their sexuality and how they had worked with other patients to ensure that they were protected from any bullying and harassment. Information on LGBT+ and services was displayed on patient notice boards.

Long stay or rehabilitation mental health wards for working age adults

Good

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.

Patients and carers we spoke with understood how to make a complaint and told us they would feel comfortable doing so. During the previous 12 months, the service received five complaints. The service used a tracker to log all complaints and complaint outcomes.

The service clearly displayed information about how to raise a concern in patient areas. Complaints were regularly discussed at community meetings. Patients were also able to raise complaints through the advocate. There was a complaints and comments box in the main reception area.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. All complaints were discussed at the monthly clinical governance meeting and any themes or trends identified shared with the wider team.

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 service used compliments to learn, celebrate success and improve the quality of care.

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

Good

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

Leadership

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

Leaders had the skills, knowledge and experience to perform their roles. The registered manager had been in the post since November 2021. The registered manager was an occupational therapist. They had experience of working in mental health rehabilitation settings.

Leaders had a good understanding of the services they managed. They could explain clearly how the team were working to provide high quality care. During our inspection the registered manager demonstrated a good understanding of patients, the staff team and all matters relating to the provision of rehabilitation care services.

Leaders were visible in the service, approachable and accessible for patients and staff.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff reported they could raise any concerns they had with them. We saw that managers responded immediately to rectify urgent issues that emerged during the inspection.

Vision and strategy

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

The provider's values were culture, integrity, quality, growth, safety and encouragement. Leaders incorporated the values in all aspects of the running of the service. We saw that there was a strong focus on recovery, collaborative working with the patients and person-centred care.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected, supported and valued. They could raise any concerns without fear. Staff respected and valued the roles of different professionals and supported each other, through reflective practice and debriefs.

We observed that staff spoke with patients with respect. Staff responded to patients' frustration, anger and agitation in a calm manner, providing explanations.

We received mixed feedback about morale at the service. Staff reported that there was a high use of agency staff, and an increase in the number of incidents where patients had behaviours that challenged and some said the change in patient profile had impacted the morale within the service.

Staff had access to a whistleblowing policy. Staff were aware of the organisation's Freedom to Speak Up Guardian and how to contact them. Posters were displayed on speaking up.

Managers dealt with poor staff performance appropriately when needed. Performance issues were initially addressed during to one-to-one supervision sessions and goals and objectives were introduced for staff whose performance needed to be improved.

Staff had access to support for their own physical and emotional health needs. The organisation provided an employee assistance programme where staff could access counselling, legal and financial advice. Staff also accessed the provider's occupational health services when needed.

The service had an employee of the month programme.

Governance

Our findings from the other key questions demonstrated that there were some gaps in governance processes. NEWS2 audits were not in place, issues with staff personal alarms had not been escalated to the risk register and there were other issues.

Managers ensured that there was a clear governance structure in place with processes, policies and systems to ensure that the service ran effectively to provide high quality care to patients. Staff were clear about lines of accountability. Patients were cared for in a clean environment, environmental risks were adequately mitigated using routine

environmental observations. There were sufficient staff on duty to meet the assessed needs of patients safely and additional staff could be rostered if needed. Staff had completed most current mandatory training; they were supervised and appraised appropriately. Staff worked to ensure positive patient outcomes and clinical effectiveness. However, NEWS2 audits were not in place, issues with staff personal alarms had not been escalated to the risk register and mitigations were not in place, patients did not receive consistent care due to the high use of temporary staff, staff did not receive specialist training for their role and there were some gaps in the recording of fire checks.

Managers reviewed the performance and effectiveness of the service at the monthly clinical governance and at the corporate governance committee meeting. They looked at mandatory training and supervision rates, incidents, infection prevention and control, patient feedback, complaints, staffing and lessons learned. There was a clear framework for communication, this enabled staff to be kept updated about the service, incidents, safeguarding, complaints and essential information through regular team, clinical governance, and daily handover meetings.

Regular audits were carried out in most key areas and action plans developed where shortfalls had been identified.

The hospital director told us learning was cascaded to staff. All staff members had a work email account and updates were sent to staff via email.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. However, staff were not always equipped to deal with new patients' needs from the first day of their admission.

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

There was an effective process to identify, understand, monitor and address current and future risks, including risks to patient safety. For example, following a number of incidents where the front door had been left unlocked the service was in the process of implementing a fob system.

Staff were aware of the main risks in relation to the service they were providing. The service had a risk register. For each risk entry current mitigations and action plans to address the risk were in place. However, safety concerns regarding personal alarms had not been escalated onto the risk register.

The risk register was reviewed at the monthly clinical governance meeting.

The service had plans for emergencies, for example, adverse weather or a flu outbreak.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service collected information about outcomes and performance. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. This data was reviewed at clinical governance meetings and regular reports were sent to commissioners.

Long stay or rehabilitation mental health wards for working age adults

Good

The service was preparing to transition to an alternative electronic patient records system in October 2022. Plans were in place for staff training on the new system.

Information governance systems included the confidentiality of patient records. The service provided information governance training and 98% staff had completed it.

Staff knew when they needed to make notifications to external bodies, including the Care Quality Commission.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided.

Staff received regular updates about the work of the provider through intranet emails and team meetings.

Patients and carers were encouraged to provide feedback about the service using surveys and patients could provide feedback during weekly patient community meetings. Results collated from the carers survey carried out in May 2022 showed that 100% were happy with the care and treatment offered to family members at the service.

The hospital completed an annual staff survey and had regular meetings where staff could discuss their concerns. The 2022 staff survey had a response rate of 25%. Where staff had provided feedback the manager had developed an action plan which included running the survey every three months.

Staff worked effectively together and with other health and social care professionals to deliver effective care and treatment. Care co-ordinators regularly attended care programme approach meetings. Staff reported that they had good relationships with commissioners, local authority social services and the patients' GP.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that NEWS2 charts were completed accurately. Regular audits of the NEWS2 charts were not being carried out. Regulation 12 (1)(2)(a)(b)