Turning Point

Turning Point - Pendlebury House

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	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We undertook an inspection of Turning Point – Pendlebury House as part of a random selection of services rated good and outstanding to test the reliability of our new monitoring approach. We only looked at two of our key questions; how safe and how well-led is the service?

Following this inspection our rating of safe, well-led and the overall rating of this location went down. We rated it as requires improvement because:

- Areas of the environment were dated and in need of refurbishment. These areas included the rehabilitation kitchen, communal bathroom and the ensuite patient bathrooms. The fire doors had also been identified by the service for replacement, but this had not yet been completed. The service did not have a specific maintenance or refurbishment plan, although managers had identified areas of the hospital that they felt needed refurbishment. The service also had maintenance jobs that were pending and had not yet been completed.
- The service's processes for reviewing and monitoring the environment and maintenance were not always completed in line with the provider's expectations. There were gaps in some of the weekly environmental checks for the service. It was also not clear that these processes identified every issue or how issues identified in these audits were monitored to ensure they were addressed in a timely manner. The processes did not ensure that managers had appropriate oversight of all the identified issues and how they were being monitored and addressed.
- The hospital's governance processes and checks had not ensured that all issues in the service were identified and addressed. There were out of date items in one of the first aid kits. One of four risk assessments checked had not been reviewed in line with the provider's expectations. Two of the five prescription cards checked had missed signatures for medication. The service had written a recent police incident notification form but had not submitted it to CQC. All staff were not aware of the location of the ligature cutters in the hospital. The service had some low compliance rates for mandatory training courses.

However:

- The service provided safe care. Staff generally assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. Patients gave positive feedback about the service, staff and management.
- Despite recent challenges in respect of staffing and vacancies in the service, staff and managers were passionate about their jobs and attempted to limit the impact on the care and treatment of patients.

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	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Turning Point - Pendlebury House

Turning Point Pendlebury House is a mental health rehabilitation service for people with enduring mental health problems who have been assessed as having the potential to improve their level of functioning and independence. It is a 10-bedded facility for males and females over the age of 18. The service previously admitted male patients only. This was changed in 2020 as the service had identified that the hospital was often not at capacity and there was an identified need in the local area for more female rehabilitation beds.

There was a registered manager at the time of our inspection and had an identified controlled drugs accountable officer.

Turning Point Pendlebury House is registered for the following regulated activities:

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

Turning Point Pendlebury House has been registered with CQC since 08 February 2011. There have been three previous inspections carried out at Pendlebury House; the most recent was conducted on 11 April 2016. Pendlebury House was rated as outstanding overall at the 2016 inspection. The caring and responsive domains were rated outstanding with the other three domains rated as good.

The most recent Mental Health Act Monitoring visit was on 20 March 2019. At that visit, we found good adherence to the Mental Health Act and Mental Health Act code of practice with no issues raised.

We undertook this inspection as part of a random selection of services rated good and outstanding to test the reliability of our new monitoring approach. This inspection was focused on the safe and well-led key questions. The effective, caring and responsive key questions were not inspected and so the ratings for those key questions remain the same.

What people who use the service say

We spoke with three of the nine patients at Pendlebury House on the day of our inspection and observed interactions between staff and patients. Patients gave positive feedback about the service and the care and treatment that they received from staff. Patients felt safe on the unit and described the atmosphere as being calm and laid back. Patients described staff as being respectful and noted that staff were always approachable and friendly. Patients felt that there were enough activities that took place and that staff kept their family and carers involved in their care and treatment.

How we carried out this inspection

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

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the environment and observed how staff were caring for patients;
- spoke with three patients who were using the service;
- spoke with the registered manager and the head of service;

Summary of this inspection

- spoke with five staff members including a nurse, health care assistants, the Mental Health Act administrator and the catering manager / music therapist;
- looked at four care and treatment records of patients and five prescription charts;
- attended a morning meeting for patients;
- looked at a range of policies, procedures and other documents relating to the running of the service.

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 trust 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.

Action the service MUST take to improve:

- The service must ensure that actions are taken to improve the environment as planned by the service. (Regulation 15(1)).
- The service must ensure that environmental checks are robust and that actions are taken to address any issues in a timely manner. (Regulation 15(1)).
- The service must ensure that processes and systems are effective at monitoring issues identified or areas of work that are pending. (Regulation 17(1)(2)).
- The service must ensure that processes provide managers with appropriate oversight and awareness of any ongoing issues within the service. (Regulation 17(1)(2)).
- The service must ensure that mandatory training is completed in line with the provider's expectations and guidance. (Regulation 18(2)).

Action the service SHOULD take to improve:

- The service should ensure that the first aid kits are checked regularly and that any expired items are removed and replaced. (Regulation 12(2)).
- The service should ensure that patient risk assessments are reviewed and updated as per the provider's expectations. (Regulation 12(2)).
- The service should ensure that all staff are aware of the location of ligature cutters in the service along with any other essential health and safety information. (Regulation 18(2)).
- The service should ensure that medication cards are signed and checked to ensure there are no gaps. (Regulation 12(2)).
- The service should ensure that CQC statutory notifications are sent to CQC and that processes ensure that these are submitted. (Care Quality Commission (Registration) Regulation 18(1)(2)).
- The service should ensure that they review how the temperature of the clinic room can be managed and regulated in hot temperatures. (Regulation 12(2)).

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	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe	Requires Improvement
Well-led	Requires Improvement

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

Staff did not always complete environmental audits regularly and did not take action to remedy the issues identified. The environment was not always well maintained and the outside area was littered. However, the ward was clean, well equipped, well furnished and fit for purpose.

Safety of the ward layout

Staff did not always complete and regularly update thorough risk assessments of all ward areas and did not remove or reduce all the risks they identified. The service had a ligature risk assessment which had been last reviewed on the 20 August 2021. The service had further environmental checks to monitor and manage the environment, including a weekly room check and bed audit and a monthly housekeeping checklist. The weekly room check and bed audit was last completed on the 16 July 2022. The previous audit had been completed on the 25 June 2022. Issues that had been identified on the 25 June audit remained on the 16 July, such as a bathroom fan in one of the bedrooms that required maintenance. This meant that staff had not completed the audits as regularly as they should and had failed to ensure action had been taken to remedy all the issues identified. It was also not clear that the audits identified all the environmental issues within the service and how staff monitored and managed them.

The service had further environmental audits and checks including a housekeeping checklist, bathrooms and toilets audit and a legionella management check. The last bathroom and toilet audit had been completed on the 17 July 2022 with the one previous completed on 26 June 2022. The last legionella management check was completed on 28 June 2022. Staff had last completed the housekeeping checklist on the 17 July 2022. Where issues were identified from the checklist, no specific action plan was created to monitor and ensure these issues were being addressed. The registered manager noted that the staff member completing the checklist would escalate any identified issues to them.

Staff could not observe patients in all parts of the wards. Staff mitigated risks using risk assessments of the patients in the service and with regular observations.

The service complied with guidance on mixed sex accommodation. Since our last inspection in 2016, the hospital had changed to admitting both male and female patients. All the bedrooms within the hospital were ensuite. The service had an identified female corridor with three bedrooms specifically for female patients. A fourth bedroom could be used for either a male or female patient and was currently occupied by a male patient. The service had adapted the conservatory to be the female-only lounge.

There was a magnet on the door to the female corridor that meant it would stay open unless the release mechanism was manually triggered. The manager noted that the service would expect the door to be shut but that sometimes it remained open because of this.

The dining room was also on the female corridor. Staff would be present when the dining room was in use and the door to the dining room was at the top of the corridor. This meant that no male patients had to pass the female bedrooms to access the dining room.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Although on the day of the inspection, two members of staff did not know where the ligature cutters were located in the service. This was escalated to the management during the inspection. The provider amended the health and safety induction checklist following the inspection to ensure that all staff are shown where the ligature cutters are located and how they should be used. The service had not had any ligature incidents and did not admit patients that were a current risk of ligaturing or self-harm.

Staff did not carry personal alarms. Staff and patients had easy access to nurse call systems that were throughout the location. In the event of an emergency, staff could use the nurse call system for assistance when needed.

Maintenance, cleanliness and infection control

The environment was not always well maintained and the outside area was littered. Areas of the service were dated and in need of refurbishment. However, the ward was clean, well equipped, well furnished and fit for purpose.

During the tour of the outside of the service, the garden area had two ashtrays full of cigarette ends and litter across the ground including several empty cigarette packets and some empty cans.

The toilet in the communal bathroom was out of order. This had not been recorded in the provider's maintenance log for the landlord, although had been noted in the service diary. The toilet was identified as being out of order on the 2 July 2022 and reported to the landlord on the 4 July 2022. Maintenance had been scheduled for the 7 July 2022 although this did not go ahead. There were no further notes recorded to confirm that this had been escalated further or re-booked. However, patients did have access to toilets in their ensuite bathrooms.

There were other environmental issues throughout the hospital including some of the radiators in the hospital that had been damaged with the ends of the covers coming away and there were minor areas of chipped paint and damage to some of the walls in the corridors of the hospital.

In one of the patient's ensuite bathrooms, a section of the wood covering the pipework of the shower was missing. It was not clear that this had identified by the provider or that action was being taken to address this.

We reviewed the last four minutes from the community meetings held by the service. In the "repairs needed" section of the minutes, there were repairs that remained on all four meeting minutes. The actions for these stated that the issues were on-going and had been reported but the issues were not being addressed in a timely manner.

Managers told us that there were plans to update and refurbish areas of the hospital, including the rehabilitation kitchen, the ensuite bathrooms, the garden area and the fire doors. Managers had made proposals for some of these

areas but did not have specific timelines for when the work would be completed. The doors throughout the service made loud bangs if they were not held when being shut. The rehabilitation kitchen and the ensuite bathrooms were both dated and in need of updating and refurbishment. The environment did not reflect a quiet, positive and modern environment to support rehabilitation.

Staff made sure cleaning records were up-to-date and the premises were generally clean. An external company was employed to carry out the routine cleaning of the service.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The service had audits and checks in place to ensure that the clinic room was being managed safely and regularly cleaned. All checks were being completed and were up to date on the day of the inspection. We saw that a sharps bin in the clinic room had been opened but the date of opening had not been recorded.

On the day of the inspection, the temperature of the clinic room was above the recommended temperature range for the safe storage of medicines at 27.5 degrees celsius. The inspection was undertaken during a week when outside temperatures were high, however, the clinic room had no windows, air conditioning or ventilation aside from a small fan. The nurse in charge had escalated the issue and received advice from pharmacy that the room temperature at that level did not pose a risk to the integrity of the medicines so they could still be used. The temperature of the clinic room did not regularly exceed the recommended range for the safe storage of medicines. Managers stated that they would explore options that could help them to better regulate the temperature of the clinic room when temperatures were high.

Staff checked, maintained, and cleaned equipment.

During the tour of the location we were informed that first aid kits were kept in the staff office and clinic room. Both first aid kits were in the staff office on the day of the inspection. Whilst checking one of the first aid kits we observed that there were assorted waterproof plasters, single plasters and sterile cleaning wipes that were past the expiry date listed on them. This was highlighted to the registered manager.

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.

Nursing staff

The service had enough nursing and support staff to keep patients safe. The service was able to meet its minimum requirements for staffing on each shift. Managers reported that this could be pressurised at times due to vacant posts and sickness within the team. The registered manager reported that the service rarely met the location's planned staffing level for each shift although never felt the hospital's staffing levels were not safe.

Patients reported feeling safe in the service and felt that there were enough staff each day. Patients did not report any impact of staffing levels on their care and treatment.

The service had reducing vacancy rates. The service had one registered nurse vacancy and three support worker vacancies at the time of the inspection. The service was actively recruiting to these posts.

The service also had vacancies in the multi-disciplinary team including for the occupational therapist and assistant psychologist. This had impacted on the service due to other members of staff having to take on additional duties and roles. The occupational therapist and assistant psychologist roles had been recruited to and the new members of staff were due to be starting in the coming months. Managers expected that this would reduce pressure on the staff team.

The service used bank and agency nurses and nursing assistants to support staffing numbers. Managers monitored the use of bank and agency staff. In the three months prior to the inspection, the service used 324.75 hours of agency staff which equated to 5.76% of the total hours available.

Where possible, managers limited their use of bank and agency staff and requested staff familiar with the service. Managers explained that they had a core group of bank staff that they would use that were familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service had role specific inductions for staff and a health and safety induction checklist that would be completed with staff.

The service had a 25% turnover rate for the 12 months prior to the inspection which equated to five staff leavers. The figure was high due to the service having a small staff team.

Managers supported staff who needed time off for ill health. Managers described how they supported staff during periods of sickness and on their return to work.

Levels of sickness had increased in the three months prior to the inspection, with the average level of sickness being 11.65%. The average level of sickness in the service for the 12 months prior to the inspection was 6.72%. Managers were aware of the recent increase in sickness levels and were monitoring this for any themes or concerns. Managers noted that the vacancies within the multi-disciplinary team had impacted on the whole staff team due to them having to attend to additional responsibilities and activities.

Managers accurately calculated and reviewed the number and grade of nurses and nursing assistants for each shift. The manager could adjust staffing levels according to the needs of the patients. The registered manager explained how and when they would access additional staff if they were required at the service and reported no issues with increasing staffing levels.

Patients had regular one-to-one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients reported that staff were always available to speak to and that there were enough activities in the service.

Staff shared key information to keep patients safe when handing over their care to others.

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. Staff reported that the doctor was accessible, and that cover was always in place.

Mandatory training

Staff had mostly completed and kept up-to-date with their mandatory training. Some mandatory training compliance figures were low.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

We reviewed the provider's mandatory training data as of July 2022. The provider had low compliance rates for safeguarding level 2 training which was 32% and understanding positive behaviour support which was 53%. These two courses were face-to-face and staff attendance for these courses had been impacted by the COVID-19 pandemic. The provider was awaiting dates for both courses to enable staff to attend. Some further training courses also had slightly lower compliance rates, including basic life support at 75%, food hygiene awareness at 68% and infection prevention control awareness at 74%.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received regular updates regarding training levels in the service to support them in having oversight, although noted that this information could include staff that had not started or had been incorrectly allocated to their numbers. Managers were aware of this and took this into account when reviewing the data.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour.

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 reviewed four patient records. One of the four risk assessments had last been reviewed in April 2022 and the proposed review date was June 2022. This had not been reviewed at the time of the inspection. The other three risk assessments had been reviewed in line with the provider's expectations which was every two months or if new risks were identified. The risk assessments contained detailed information about each patient.

The service did not admit patients who had a current risk of self-harm and risk of ligaturing.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff knew the patients that they were caring for and described that they were told any important information when attending each shift.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff described how they monitored patients and how they would escalate any concerns that they identified.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff were aware of their responsibilities regarding observations and the procedures to keep patients safe.

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

Use of restrictive interventions

The service did not use restraint and staff were not trained in restraint. Staff could explain how they were able to verbally de-escalate patients when required.

The service had a protocol if de-escalation was not working or a patient was becoming violent, which would be to contact the police and to ensure that the other patients and staff were out of the way and safe. There had been one incident in the six months prior to the inspection where the police had been called to respond to an incident. The patient was verbally deescalated when the police attended and no further restrictive intervention was required.

Pendlebury House did not have facilities for seclusion and seclusion was never used. There was no use of other restrictive interventions including long-term segregation or rapid tranquilisation.

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 mostly received training on how to recognise and report abuse, appropriate for their role. Staff received training in safeguarding level 1 which was safeguarding awareness and safeguarding level 2 which was a safeguarding workshop.

At the time of the inspection, the compliance rates for safeguarding training were 100% of all current staff for safeguarding level 1 training and 32% for safeguarding level 2 training. The provider was awaiting course dates for the level 2 training.

The registered manager was the safeguarding lead for the service.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff were aware of their responsibilities regarding safeguarding and described how they would escalate any concerns that they had.

Staff followed clear procedures to keep children visiting the ward safe. The service had a procedure that would be followed if children were to visit the ward and ensured that patients and their families were aware of this.

The service had made no safeguarding referrals in the 12 months prior to the inspection. Staff knew how to make a safeguarding referral and who to inform if they did have any concerns.

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. The service used electronic patient records which were stored securely.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The service used systems and processes to safely prescribe, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. However, there were issues with medicines that staff had not signed for on two prescription cards.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed regular checks and audits on medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients felt supported with their medication and could ask staff any questions that they had about them.

Staff did not always complete medicines records accurately and keep them up-to-date. We reviewed five patients' prescription cards. Three were completed accurately and with no issues identified. Two of the prescription cards had some missed signatures for medication; one card had three missed signatures and the other had one missed signature. This meant that it was unclear whether staff had administered these medicines to patients when they should have. There were no further issues identified with the prescription cards.

Staff stored and managed all medicines and prescribing documents safely. Staff followed processes and checks for managing medicines safely and in line with the provider's policies and expectations.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

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.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff completed regular physical health checks and monitoring on patients.

Track record on safety

The service had a good track record on safety.

The service had a low number of incidents and staff were confident in being able to manage any incidents if they occurred.

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. However, there was an incident of police involvement that the provider had not notified us of.

Staff knew what incidents to report and how to report them.

Staff explained about a recent incident in the service that had required police involvement. The incident had been managed appropriately and debriefs had been completed following the incident.

This incident had not been reported as a statutory notification to CQC. The statutory notification had been completed and uploaded to the provider's incident reporting system however, a copy had not been sent to CQC. Managers were not aware as to why this had not been sent to CQC.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff reported serious incidents clearly and in line with the provider's policy.

The service had no never events.

Staff understood the duty of candour. No incidents had met the threshold for the duty of candour in the service. Staff explained how they would be open and transparent, and give patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff confirmed that debriefs would take place if an incident occurred which would review the circumstances and any learning that could be identified.

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

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. The service held regular team meetings that staff could attend and discuss recent incidents or situations that may have impacted on patient care.

There was evidence that changes had been made as a result of feedback. Managers noted an incident from the previous year where staff had been delayed in accessing out of hours medication. The service accessed this medication from an external organisation and agency staff in that organisation were not aware of the process. This had resulted in the delay. Managers had reviewed this incident and ensured a service level agreement was in place with the external organisation. Managers noted there had been no further issues since this incident.

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

Requires Improvement

Our rating of well-led went down. 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 service they managed and were visible in the service and approachable for patients and staff.

The hospital had an experienced registered manager who understood the service and patient group. At the time of the inspection, the registered manager was working across two services which had reduced the amount of time that they were on site at Pendlebury House. It was expected this would continue until September 2022.

Leaders in the service were passionate about the care and treatment they were providing to patients, although noted that there had been recent challenges that the service had faced.

Leaders felt supported in their roles and that there were opportunities to develop in the organisation.

Leaders engaged with patients and were approachable.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Vision and strategy

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

Staff understood the vision and values of the organisation. Managers described how the provider's vision and values were considered as part of the recruitment process to ensure that new staff entering the service represented the qualities expected of the organisation.

Culture

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

Staff felt supported within their roles and that they could raise any concerns if they had them. Although there were staffing pressures within the service, staff maintained a positive approach to work and were committed to ensuring patients received appropriate care and treatment.

The service had undertaken a staff survey in October 2021. Ten staff had completed the survey anonymously. The results of the survey were mixed although positive about being able to speak with managers about any concerns, issues or questions. Two responses indicated that there was a concern regarding one patient's suitability for the service and the impact on staff.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not always managed well.

The service's processes for monitoring and addressing environmental and maintenance issues were not always effective. The provider had various environmental checks to be completed on a regular basis, although these were not always being completed at the intervals required in line with the provider's expectations and environmental issues identified had not been addressed promptly. This meant that the processes in place did not provide managers appropriate oversight or monitoring of any ongoing issues.

The toilet in the communal bathroom had been out of order since 2 July 2022 and governance systems and processes had not ensured that it had been reported and followed up for repair appropriately.

Systems did not ensure that the service notified CQC of all relevant incidents. Despite a notification form being written for a recent incident that had required police involvement it had not been sent to CQC and the provider was not aware as to why the notification had not been submitted.

There were other findings during the inspection that indicated that processes did not always operate effectively. There were issues with a risk assessment not being reviewed regularly and two staff members were not aware of the location of the ligature cutters in the service and it was not clear that the induction process had ensured that staff were told this information. The provider amended the health and safety induction checklist following the inspection to ensure that the location of the ligature cutters and how to use them was included on this checklist.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

However, the service had a clear organisational governance structure. On a local level, the service held a business meeting and a combined clinical governance meeting on a rotating basis each month. Issues from these meetings fed into a senior governance meeting that was attended by the registered manager. This meeting was part of the organisational governance structure that meant issues could be escalated to senior managers of the organisation.

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.

The service had a local risk register which had last been reviewed on the 05 July 2022. The risk register was reviewed on a quarterly basis. No changes had been made to the risk register during the last review. Two risks were recorded on the register around nursing vacancies and retention and the risk of outbreaks of COVID-19. The risk register listed the mitigating actions for these two risks. The risk register was not comprehensive because it did not include any risks in relation to the environment or maintenance of the service.

Staff described feeling confident and able to raise any concerns or risks identified within the service to managers.

Information management

Staff collected analysed data about outcomes and performance.

There was an electronic patient record system. We observed staff using the system and they were all comfortable and were able to easily find information when requested.

Staff noted that access to computers in the service could be an issue at times as both desktop computers were not working. Staff did have access to three laptops for the service.

Managers had access to performance reports and data which supported them in their awareness of risks and in understanding areas requiring improvement.

Engagement

The service held weekly community meetings for patients to give them the opportunity to provide feedback on the service or to raise any concerns or issues. Staff could also provide updates to patients during these meetings.

The service had patient, carer and staff survey forms that could be completed and submitted anonymously. Managers received the results of these surveys and used the results to consider any improvements or changes that were required.

Managers shared themes from feedback and reflected on the survey results within team meetings.

Learning, continuous improvement and innovation

The service was not participating in any research, national audits or accreditation.

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 15 HSCA (RA) Regulations 2014 Premises and equipment • Areas of the environment were dated and in need of refurbishment. These areas included the rehabilitation kitchen, communal bathroom and the ensuite patient bathrooms. • The fire doors had been identified by the service for replacement, but this had not yet been completed. • The service did not have a specific maintenance or refurbishment plan, although managers had identified areas of the hospital that they felt needed refurbishment. • The service had maintenance jobs that were pending and had not yet been completed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had low compliance rates for safeguarding level 2 training which was 32% and understanding positive behaviour support which was 53%.

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 service's processes for reviewing and monitoring the environment and maintenance were not always completed in line with the provider's expectations. There were gaps in some of the weekly environmental

This section is primarily information for the provider

Requirement notices

checks for the service. It was also not clear that these processes identified every issue or how issues identified in these audits were monitored to ensure they were addressed in a timely manner.

- The hospital's governance processes, and checks had not ensured that all issues in the service were identified and addressed.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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