Willows Green Healthcare Limited

Willows Green 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	Inadequate
Are services safe?	Inadequate
Are services effective?	Insufficient evidence to rate
Are services caring?	Inadequate
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated it as inadequate because:

- The service did not provide safe care. The service did not have enough, appropriately skilled staff to meet people's needs and keep them safe. There were insufficient staff to provide breaks while conducting one to one observation. There were insufficient female staff to support the patients.
- Patients did not always receive kind and compassionate care from staff and patient's privacy and dignity was not always observed. Two male members of staff supervised female patients for long periods of time. On our observations staff attempted no therapeutic activity whilst conducting observations.
- People's risks were not assessed and reviewed regularly. We saw risk records had not been updated after incidents. Managers did not complete investigations into incidents in a timely manner.
- The service did not provide care, support and treatment from trained staff able to meet people's needs. We were not satisfied mandatory training records of staff were accurate. Staff had not received the correct safeguarding training and were not qualified to conduct high level safeguarding investigations.
- The service was not well led, and the governance processes did not ensure incidents were reported and investigated appropriately. Duty of candour processes were not followed. There was no evidence that staff were held accountable for their actions and that managers took disciplinary action where inappropriate holds were used. Routine audits such as food safety were not completed resulting in out of date food being kept in the kitchen.

However:

- The ward environments were safe and clean.
- There was a full range of specialists required to meet the needs of patients on the wards.
- Managers ensured that staff received supervision.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Willows Green Hospital

Willows Green Independent Hospital provides long term rehabilitation care and treatment. The hospital opened in March 2022. There are four wards but three are currently closed.

At the time of our inspection there were two patients both on the same ward.

Before the inspection the registered manager had become the deputy manager and relinquished their registration. The new manager had applied to become the registered manager.

The provider was registered to provide the following regulated activities:

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

What people who use the service say

We spoke to both patients and their carers.

Patients told us they felt that the staff did care about them but they expressed frustration at their current placement with patients wanting to be discharged into a community setting.

Carers told us that the hospital was slow to respond to queries and that they had made informal complaints about different issues. Carers felt that they were not always told about incidents that had occurred with one referring to an incident that the commissioner had spoken to them about before the hospital staff had.

How we carried out this inspection

We inspected this service in response to safety concerns that had been raised about the care and treatment of people using the service. We examined all five key questions and visited the hospital on one evening and the following day.

The team that inspected the service included two CQC inspectors, one medicines inspector and one occupational therapist advisor.

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for feedback or information about the service.

During the inspection visit, the inspection team:

- Looked at the quality of the environment and observed how staff were caring for people using the Short Observational Framework (SOFI) tool
- Spoke with both patients who were using the service and one advocate
- Spoke with both carers of people who were using the service
- Spoke with the manager and the nominated individual.

Summary of this inspection

- Spoke with eight other staff members; including nurses, support workers, occupational therapist, psychologist, caretaker and the consultant psychiatrist
- Spoke with two commissioners
- Looked at both patient care and treatment records
- Carried out a specific check of the medicine's management; and
- 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 provider must ensure there is sufficient mix of male and and female staff at all times to meet the needs of the patients. (Regulation 9, (1)).
- The provider must ensure staff conducting obesrvations have the training and understand the therapeutic opportunity to engage with the patient. (Regulation 9, (1),)
- The provider must ensure the environment meets the needs of the patient, for example ensuring the noise of closing doors does not affect the wellbeing of the patients. (Regulation 9, (1)),
- The provider must ensure that all staff receive appropriate training in safeguarding adults and children suitable to their role so that staff can identify and take action when safeguarding's occur. (Regulations 13 (2)(4)(b)).
- The provider must ensure that there are enough suitably qualified, skilled and experienced staff to meet the patient's needs. (Regulations 18(1)).
- The provider must ensure that staff receive an induction which is appropriate to meet the needs of autistic people within a specialist autism service. (Regulations 18(1);17(1)(2)(a)).
- The provider must ensure that patients' risk assessments accurately reflect patients' risks and that these are reviewed and updated in line with the providers policy. (Regulations 12(2)(a)).
- The provider must ensure that care plans are contemporaneous, accessible, personalised, holistic and strengths based and reflect the assessed needs of the patient.(Regulations 17(1)(2)(a)(c); 9(3)(b)).
- The provider must ensure that prescribed observations are delivered in a way that meets best practice guidance. (Regulations 17(1)(2)(a)).
- The provider must quickly investigate, review and reflect on incidents of restraint to ensure that patients are kept safe. (Regulations 17(1)(2)(a).
- The provider must ensure that lessons learnt on safeguarding, incidents, complaints and reflective practice is shared with staff. (Regulations 17(1)(2)(a).
- The provider must ensure that governance processes operate effectively at team level and that performance and risk are managed well. (Regulations 17(1)(2)(a)(b)(f)).

Action the service SHOULD take to improve:

- The provider must ensure minimum maximum medicine fridge temperatures are completed and recorded.

Summary of this inspection

- The provider should continue to work on creating open, positive working relationships with external teams and organisations.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Insufficient evidence to rate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate
Overall	Inadequate	Insufficient evidence to rate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Insufficient evidence to rate
Caring	Inadequate
Responsive	Insufficient evidence to rate
Well-led	Inadequate

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

Inadequate

We rated it as inadequate.

The service did not provide safe care.

The service did not have enough, appropriately skilled staff to meet people's needs and keep them safe. The service did not regularly review its staffing levels and mix of skills to make sure they are able to respond to people's changing needs, managers did not ensure national guidance on staff observations were being followed.

Where staff had training about how to keep people safe, including how to involve other professionals under safeguarding procedures, they often do not act on this which put people at risk.

The practice in the service put people at risk of harm or did not protect them from actual harm. Risks were not effectively managed and staff caring for patients were not adequately trained to keep people safe.

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safe and clean care environments

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The ward consisted of a long corridor, off which were all the bedrooms and communal spaces such as lounge or dining area. Staff nursed patients in separate area's of the ward for clinical reasons and the wishes of the patient.

Staff could observe patients in all parts of the wards.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

There was no mixed sex accommodation. All patients were female. However, staff completing observations were not always of the preferred gender. Several male staff were seen to be observing female patients. During our inspection we saw patients observed with two male staff members for long periods of time. For example, there were five healthcare assistants on the ward only one of which was a female. We were told that female members of the multi disciplinary team would supplement as required. We did not observe this during our inspection.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems. Patients were observed by two members of staff.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. However, the door to the nurse's station did not "soft close" which resulted in a noisy bang every time it was used. All patients were highly sensitive to noise and mentioned this.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. Visitors were reminded to wear appropriate personal protective equipment and use hand sanitiser before entering premises. Posters were displayed around buildings to advise staff and others of good hand hygiene and masks were being worn inside the premises.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff recorded daily room temperatures and fridge temperatures. However, from June 2022 only a single temperature was being monitored and not min/max. All recorded temperatures were within range 2-8 degrees, but we were unable to verify this was throughout the 24 hours.

Room temperature was being monitored on the same sheet and was recorded as being above 25 degrees on two occasions on 11/08 and 12/08. There was no record on the chart as to what actions staff had taken, if any. There was conflicting written guidance to staff as to whether staff should take action when the maximum room temperature exceeded 25 or 30 degrees.

Staff checked, maintained, and cleaned equipment. Nurses had access to equipment for monitoring physical observations which was regularly clean and maintained.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support workers to keep people safe. There was one nurse and five health care assistants on duty for both days and nights. Four of these staff members were on observations which meant they could not leave the patient they were allocated to support. There was one additional health care assistant. We saw this meant that the staff were on observations for more than two hours continuously. We saw the registered nurse take on

observation duties so that members of staff could have a short comfort break. At mealtimes, a member of staff had to prepare meals for patients because the service did not have a chef. This meant there was no extra staff to provide cover for even the shortest of breaks for those observing. National Institute for Health and Care Excellence (NICE) guidance recommends staff should not be on continuous observations for more than two hours.

There were also insufficient numbers of female staff. We observed female patients being observed by two male staff members in their bedrooms at the same time. When the two female patients needed to tend to their personal care or use the toilet, it was not clear how patients personal care could be supported with staff of the same gender with the small number of female staff. The provider stated that other female staff such as members of the multi-disciplinary team, manager and assistant manager who were all female provided cover. We did not witness this.

The service had high rates of bank and agency support staff. The service used its own agency to staff the service and fill the staffing gaps. Managers said that where possible, they used agency and bank staff that were familiar with the patients in the service. Of the four nursing posts, two were covered by bank.

We reviewed a selection of rotas from 4 July 2022 to 17 August 2022. This covered 45 days of both the day and night rota. During this period there were six shifts that had an extra health care assistant on duty raising staff levels to one nurse and six health care assistants.

However, the nursing role was covered by bank or agency staff 11 times on the day shift and 24 times on the night shift. On one occasion 23 July 2022 the entire day shift was bank and agency staff, and this occurred on six occasion on nights, once for three consecutive nights.

On eight days shifts and five night shifts there was only one permanent member of staff on duty. On seven of those occasions that member of staff was a health care assistant.

During the 45 days we examined on days, 50% (135) of all shifts and on nights 54% (147) of all shifts were covered by bank or agency staff.

We did see evidence that the provider was attempting to recruit new staff and we saw they had appointed new staff and were awaiting the completion of employment checks before appointing more staff.

The service also had a psychologist, occupational therapist and an assistant occupational therapist.

Managers made sure all bank and agency staff had an induction and were familiar with the service before starting their shift. All agency and bank staff were expected to complete the same training and induction as permanent staff. New starters had five days of classroom learning followed by one week of shadowing before working on the wards.

The service had no turnover of staff since it opened in March 2022.

The manager could adjust staffing levels according to the needs of the patients. The service had their own agency and managers told us they could always access additional staff at short notice.

Levels of sickness were low. The current level of sickness was less than 1%.

The provider reported that escorted leave or activities were not cancelled, even when the service was short staffed. One patient had even been horse riding and was attending a community course. However, patients and family told us escorted leave had been cancelled due to a lack of trained drivers.

The service had enough staff on each shift to carry out any physical interventions safely. As the provider used their own agency staff, they and permanent members of staff attended the same Management of Aggression or Potential Aggression (MAPPA) training course.

Staff shared information to keep people using the service safe when handing over their care to others. The service had a handover booklet covering information such as mood, food and fluid intake, medicines taken, risk, incidents, physical health and trips out. We checked this information against incidents that had occurred. In particular an incident on the 11 July 2022 when a patient had been carried back into the hospital using inappropriate holds. The handover record for that shift did contain information about the incident in that the patient had been returned to the hospital, but it was not an accurate account of the incident leaving out any mention of inappropriate restraint.

The Care Quality Comission had received a notification about this incident but it did contain this information. Managers stated they were unaware of the inappropriate restraint until the patient disclosed this information to a visiting commissioner. Managers had failed to investigate the incident fully, and had not reported to safeguarding as they should have done.

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 psychiatrist worked full time for the provider, working four days at another location and one day a week at Willows Green. They could respond to incidents and provided on call cover and lived a short distance away.

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

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The provider reported a 94% compliance rate across all mandatory training modules. However, they had recently only added mental health capacity and Deprivation Of Liberty Safeguards to their online training program and only 5% of staff had completed that training.

The mandatory training programme did not meet the needs of patients and staff and it was not clear how managers monitored mandatory training. We examined 91 staff profiles provided after the inspection, the patients have complex caring needs. Staff had an autism and learning difficulties training session as part of their induction training. We were not satisfied this training met the needs of staff or patients to deliver good quality care. We had concerns about the providers record keeping. The records recorded that eleven staff had competed all their training in one day, which included MAPPA training and a total of up to 20 courses.

We saw on nearly all staff profiles, autism training was recorded as being delivered on the same day as MAPPA training. During the inspection we were provided with seven staff profiles, all these profiles showed the staff were MAPPA trained but had not received training on autism spectrum conditions. We cross referenced these with the ones provided after the inspection. Five of the profiles provided at the time of inspection now showed autism training on the same day as MAPPA training.

One of these five originally showed MAPPA training on 20 May 2022, on the one submitted by the provider after inspection it showed MAPPA training on 10 June2022 and autism training on 9 June 2022 completed alongside 15 other courses.

Two out of the six staff profiles we had were not in the 91 provided.

We were provided with nine more comprehensive training records which included certificates issued by a regulated training provider. Three of these did not include the certificate covering autism training.

We were not assured that Willows Green had the correct information about what training its staff, including bank and agency had received and the competency of its staff.

We could find no evidence of staff receiving any specialist training to meet the needs of the patients.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. They did not always achieve 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. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and but these were not reviewed regularly, including after any incident. We reviewed the patients risk assessments which had been updated on 9 August 2022 and found evidence that showed these had not been updated after each incident. Following each incident, staff completed a handwritten incident report and gave this to the nurse in charge who forwarded those to the manager.

We found nine reports in a tray and were told they were then added to the hospitals incident recording record on an ad hoc time by admin. These were dated from 1 August to 10 August and included incidents such as ligature, assault on staff and one where police had been called to attend.

The last incidents added to one risk assessment was 5 July 2022 and for another patient, it was 25 July 2022. This meant that the patients risk assessments were not up to date with all the information on patient risk.

Staff used a recognised risk assessment tool. The hospital used the Salford Tool for Assessment of Risk (STAR).

Management of patient risk

Staff did not always know about any risks to each patient. We observed a staff handover. The nurse on days gave a verbal briefing to staff. There was a written handover sheet but this was presented to staff. The information given revolved around how the patient had been over the last shift.

Staff were not told what risks were associated with what patient. Each team member was just allocated who was on which observations and who was the float health care assistant. We were not assured that new bank staff would understand why a patient was being observed and the risks they were there to prevent.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

We had concerns about the skills and knowledge of staff on duty in relation to the patients they were caring for. Staff undertaking observations were not provided with important information they needed to keep patients safe and provide the care they needed. For example, one patient had prohibited articles as they used them to self harm. We saw incidents recorded where they had gained possession of such items and used them to self harm.

Staff did not identify and respond to any changes in risks to, or posed by, patients. We saw that risk assessments were not reviewed following incidents, even when the incidents had included the help of the police to return a patient who had absconded and staff had used inappropriate holds to carry the patient from the vehicle into the hospital. We examined the handover sheet for shift in which this incident occurred. There was a summary of this incident under a section labelled overall presentation, but it was neither comprehensive nor accurate.

The front sheet of the assessment was ticked for no change in risk and no incidents during the shift was also ticked. The incident had in fact been recorded.

Staff could observe patients in all areas.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. They only conducted such searches if they believed there was a risk to the patient.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme. Each patient had a restrictive practice assessment for the use of metal cutlery, ceramic dining plates, glass cups and use of kettle. These had also been reviewed on the 11 and 15 August. They also had a more comprehensive restrictive practice assessment covering other areas of restrictions such as sec 17 leave, money, other contraband items, possession of mobile phone and observation levels. These had been assessed by the multi disciplinary team on 9 August 2022.

We saw that staff made efforts to avoid using restraint by using de-escalation techniques however, there had been several incidents of restraint. Staff had made formal complaints of assault to police and safeguarding were investigating incidents which patients had brought to their attention. We read incident reports which had resulted in restraint where staff had described de-escalation techniques prior to the physical intervention.

Staff followed NICE guidance when using rapid tranquilisation.

There was no seclusion facility.

There was no use of long term segregation.

Safeguarding

Staff did not know how to protect patients from abuse and the service did not work well with other agencies to do so. Staff had training on how to recognise and report abuse, but it was not appropriate for staff needs.

Staff did not receive training on how to recognise and report abuse, appropriate for their role.

The provider reported a 100% staff completion rate for safeguarding training. However, this was an online module only. Best practice guidance stipulates that e-learning is appropriate for levels one and two but for levels three and above, it is expected that at least 50% of indicative education, training and learning time is of a participatory nature. For example, formal teaching/education, conference attendance and group case discussion.

Additionally, the service did not provide safeguarding children training to staff as part of its mandatory training package in line with best practice guidance.

For example the appointed safeguarding lead for the hospital and all nurses had only completed the on line module. They were not qualified to complete safeguarding enquiries. A safeguarding lead would be expected to have completed level 4 safeguarding training.

Staff did not know how to recognise adults and children at risk of or suffering harm and work with other agencies to protect them. The safeguarding lead had not recognised when safeguarding incidents should be referred. They took telephone advice from a social worker not connected to the appropriate referral pathway who told them that they did not need to refer an incident because the police attended. This incident involved an allegation of staff assault and is now subject to a safeguarding investigation. The provider formally reported this incident to safeguarding ten days after it occurred.

Commissioners had contacted the Care Quality Commission about incidents reported by patients alleging mistreatment by staff, the hospital had been slow to contact the appropriate safeguarding body to report these incidents. They were only made aware of the correct procedure to report safeguarding when the area safeguarding team visited the hospital.

Managers did not take part in serious case reviews or make changes based on the outcomes. At the time of inspection, the provider had still not completed its investigation into the inappropriate holds used to carry a patient back into the hospital. When the incomplete daily handover sheet, which had omitted this information was pointed out, managers had still not interviewed the nurse to establish why the entry was incomplete.

Staff access to essential information

Staff had easy access to clinical information.

Patient notes were accessible, and all staff could access them easily. The provider kept a daily notes system online but had paper records for all other records such as risk assessments and care plans. These were kept in a large lever arch file in the nurse's office.

Records were stored securely.

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.

Staff followed systems and processes to prescribe and administer medicines safely. However, physical health monitoring after the administration of an anti-psychotic medicine via injection was completed on one occasion but not another. The prescribing of an oral anti-psychotic medicine continued with an increase in dose despite the medicine not being administered on four out of seven possible occasions.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Prescription charts for patients were completed with allergy status and weights. All prescription charts were fully completed with no missing signature of administration. However, one patient's chart showed the stock of a medicine used to treat psychosis was not available for the patient's first three doses. The change in dosage strength was still completed despite this and the patient refusing a further one dose. It was unclear what impact that might have had on the patient's mental health.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff completed medicines records accurately and kept them up-to-date. There was a weekly medication and stock balance check completed by staff and a monthly medication audit completed by the manager. These indicated that a topical lotion was out of stock for a patient. The audit included checks on prescription charts, storage of medicines, incident reports, missed doses for example. However, they did not reference the antipsychotic medicine being unavailable for three days before the patient able to commence treatment. Mental Health Act detention documents corresponded to the patients' prescribed medicines and were retained with their prescription charts.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored securely, however fridge temperature monitoring was completed as a single temperature measurement. This did not reflect the temperature of the fridge over the previous 24 hours. Staff would have been unable to tell if had been out of the required manufacturers recommended temperature range during this time.

The emergency bag was available for use and a weekly audit completed which showed medicines and equipment were in date and appropriate for emergency use. This included a defibrillator.

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. Prescription charts for both patients included reference, to which of the "when required medicines" should be administered to help manage patients distress which could result in violence and aggression. There was also, detailed guidance available to staff, to ensure the administration of medicines was appropriate and in line with the prescriber's intentions.

Staff did not review the effects of each patient's medicines on their physical health according to NICE guidance. Physical health equipment was available for appropriate physical health monitoring. There was evidence of regular checks including full blood tests and weigh measurements. However, the patients' physical health charts were not fully completed on four occasions. There was no evidence of any additions of the scores on one chart.

One of the patients had been administered a medicine to assist them in managing their distress, the physical health monitoring was completed according to NICE guidance on one occasion but not on another occasion.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers did not always investigate incidents and share lessons in a timely manner. When things went wrong, staff did not apologise and give patients honest information and suitable support.

Staff did not know what incidents to report and how to report them. Although the hospital kept an incident record, this was a spreadsheet updated in an adhoc manner from a written proforma completed by staff immediately after an incident. The record was not up to date.

Commissioners had reported incidents to the managers of the hospital, and they had not been recorded by staff as incidents prior to commissioners informing them. However, staff had reported incidents where patients had assaulted staff and staff had made complaints to the police.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The service had no never events but we saw no evidence that managers shared learning with their staff about never events that happened elsewhere.

Staff did not understand the duty of candour. The provider had not complied with their obligations to write to patients to apologise following incidents that required a duty of candour response.

Managers did not investigate incidents thoroughly. Staff members had still not been fully interviewed over a month after one incident. Patients and their families told us they were not always involved or informed fully about these investigations, often learning about incidents from other sources such as commissioners. However, the hospital psychologist did review each handwritten incident proforma and they completed a record attached to the proforma to say they had completed a session with the patient where they discussed the incident.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw no evidence that the psychology debrief of the patient was used to inform staff about how to better care for the patient.

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

Insufficient evidence to rate

We did not rate effective as there was insufficient evidence.

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 not always reviewed regularly through multidisciplinary discussion and updated as needed.

Care plans did not always reflect patients' assessed needs, and they did not contain the detailed instructions staff needed

Staff had completed a mental health and physical health assessment of each patient either on admission or soon after. Both patients had a pre-admission screening assessment document in place as well as doctor's admission documentation which covered circumstance prior to admission, the patient's presentation, patient history, physical health, medication and risks.

Staff developed a care plan but did always keep these up to date for each patient that covered a broad spectrum of patient's needs. These covered, areas such as observations, managing mental health, physical health, relationships, managing mental health, social networks, responsibility, communication, identity and self-esteem and dysphagia. However, these care plans did not prescribe the care that should be given. For example, in each observation care plan it noted that patients were under two to one observation but did not inform those providing the care why. There was a no mention within the care plan of what restricted items the patients should be denied, we found incidents where patients had taken possession of items which were prohibited.

Also, the observation care plan for one of the patients made no mention that the patient had absconded.

One observation care plan had been updated on 20 July 2022 with the note "care plan updated to include use of PRN". There was no update on the use of PRN and no instructions given about how to use PRN or which PRN to use.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff did not always review and update care plans. We saw patients care plans had been reviewed monthly. However, on the day of the inspection we found that one patient had not had physical health, relationship, addictive behaviour, trust and hope, identity and self-esteem and observation care plans updated since 18 June 2022 while the other care plans had been updated on 12 August 2022. One patient also had five care plans not updated since 21 June 2022. We saw no evidence that care plans were reviewed following incidents.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for patients based on national guidance and best practice.

However, there was 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 did not deliver all aspects of care in line with best practice and national guidance (from relevant bodies e.g. NICE). The service used a high number of staff from an agency, we were sent 91 staff profiles. This meant there were regularly new staff. During our observation of staff on the ward, we saw no interaction between the patients and the two staff observing them. One patient had a dysphagia care plan in place which included instructions to staff about mealtimes. Staff should support the patient by encouraging them to take small sips of a drink while they ate. Staff should wherever possible eat and drink with them to model an appropriate speed for eating and drinking. The patient should also be encouraged to sit for 30 minutes after eating. We did not observe staff demonstrating these behaviours or encouraging the patient to model the behaviours recommended.

Staff identified patients' physical health needs and recorded them in their care plans. Patients had physical healthcare plans. They were individualised and reflected the physical health needs of the patients covering the different conditions such as hay fever or constipation that affected the patients.

Staff made sure patients had access to physical health care, including specialists as required. The patients were registered with a local doctor's surgery, dentist and optician and we saw that they had accessed these services.

Staff did meet patients' dietary needs and assess those needing specialist care for nutrition and hydration. Patients dietary needs were discussed in multi-disciplinary meetings. Each patient had a dietary requirements assessment and food allergies were recorded.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. One patient attended horse riding lessons and physical health checks were conducted.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the Liverpool University Neuroleptic Side-Effect Rating Scale (LUNSERS) to monitor medication-induced side effects. They also used Salford Tool for Assessment of Risk, a mental capacity assessment tool, Health of the Nation Outcome Scale (HoNOS) and the recovery star.

Staff used technology to support patients. Patients had access to tablets and mobiles.

Staff took part in clinical audits, benchmarking and quality improvement initiatives but they did not always identify issues, errors or omissions. The managers conducted weekly audits which covered the emergency bag and hand

hygiene. Bi-weekly clinical audits of medication. Monthly audits covered infection control, ligature risks and mattresses. Every quarter patient care files and the Restraint Reduction Network audit tool were audited. There was a monthly clinical governance meeting where these audits were discussed. However, care plans and risk assessments which were out of date or not updated had not been identified.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers did not make sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision but there were no opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. There was a psychiatrist, psychologist, occupational therapist and an assistant occupational therapist.

Managers did not ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The hospital had no staff records and managers could not assure themselves of the identity of staff being provided by the agency nor the skill base of the agency staff. On the days of our inspection they were unable to provide staff records for the staff working.

Managers gave each new member of staff a full induction to the service before they started work. Staff received an induction and training package at another location and were given a short period of shadowing once they had completed their induction.

The hospital had opened in March 2022, so no appraisals had taken place but 89% of staff had had regular supervision meetings with managers.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers had not identified the training needs their staff had. For example, the provider did not know that safeguarding leads required additional training and had only just arranged for the safeguarding lead to attend level four training.

Managers did not provide staff with any specialist training for their role. No member of staff could give an example of specialist training they had received.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We examined several minutes from multidisciplinary meeting since the hospital had been open. These were short and brief. However, prior to our inspection a new format had been introduced and this was more comprehensive and informative providing more commentary on the patients progress with clear actions to be followed.

Staff did not have clear information about patients and any changes in their care, including during handover meetings. We examined handovers, attending one handover from days to night. The nurse on days had completed a written

handover sheet but staff were briefed verbally. There was no information about risk, other than the risk level had not changed. It was not clear how staff on observation were to identify what the risks were to the patient and to themselves, there had been incidents where staff had been assaulted and patients had gained possession of prohibited items. There were no instructions on staff behaviour and how staff should interact with the patients.

There was no information on dysphagia and how the patient should be presented with food and how staff should support the patient at mealtimes.

The hospital did not have effective working relationships with external teams and organisations. Commissioners told us they would ask for information from the provider and would have to wait for a reply often having to chase up the request. They told us they had initially been refused access to view cctv of an incident. However, commissioners did attend multidisciplinary meetings and did communicate with their patients regularly.

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 and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The service had a Mental Health Act administrator, that staff knew, who was easily accessible and provided support.

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. The advocate attended the wards regularly and had a good working relationship with staff and patients in the service.

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. Assessments were in place to record a patient's capacity to consent to treatment.

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. Section 17 leave was discussed at every multidisciplinary team meeting with patients encouraged to leave the hospital to engage in activities.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw in records that these were requested.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. The Mental Health Act administrator made sure the service applied the Mental Health Act correctly by completing audits and sharing the findings.

There were no informal patients on the wards.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Good practice in applying the Mental Capacity Act

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

The provider had only just introduced training in the Mental Capacity Act; however, we did see mental health capacity assessments which showed a good understanding of at least the five principles.

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. Record keeping indicated that staff had a good understanding of the five principles.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw each patient had completed their own profiles listing likes and dislikes informing staff how they liked to be addressed and treated.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Patients were assessed as having capacity and when they declined medication or treatment sessions these were recorded in the daily notes and on handovers.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

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

Inadequate

We rated it as inadequate.

There is a lack of continuity of staff, so they were not familiar with the person they are caring for. Staff routines and preferences took priority and staff had little understanding of the wellbeing and needs of people using the service.

Staff communication with patients was poor. Staff dId not understand the different methods of communication that could be used. We saw little or no interaction between staff observing patients and therefore we observed no kindness, respect or compassion from observing staff.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were not always discreet, respectful, and responsive when caring for patients.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We conducted two observations, one in the evening and one during the day.

On both observations we saw two staff on constant observations sat outside the patient's room. There were five health care assistants (four observing) and a nurse on both occasions. We did not see staff proactively communicate with patients, and mostly staff talked amongst themselves. At no time did we see staff on observations attempt any therapeutic activity with the patient.

One patient who had been the victim of past trauma and abuse was constantly observed by two male observers. On one observation we saw four male staff and one female member of staff performing observations. We were told that female members of the multidisciplinary team would supplement when required to support patients address personal hygiene. We did not see any member of the multidisciplinary team assist in this way and on evening they were not on duty.

We observed a period where the only staff on the ward were the four staff observing the patients. One patient asked about lunch and why it was late. The other health care assistant had left the ward to prepare the meal as there was cook in post. None of the staff could leave their observation duties to assist the patient by enquiring how much longer the meal would be.

Staff did not always give patients help, emotional support and advice when they needed it. Patients said that staff did sometimes engage them in activities but mostly staff just sat at the door.

Staff did not support patients to understand and manage their own care treatment or condition. For example, we observed mealtimes and patients were presented with the meal in their room. No effort was made by staff to encourage patients to leave their room and use the dining area.

Staff directed patients to other services and supported them to access those services if they needed help. One patient had been supported to attend an external college for life skills lesson.

Patients told us they believed that staff were caring, but both wanted to go to another hospital.

Staff did not understand the individual needs of each patient.

We had concerns about the skills and knowledge of staff on duty in relation to the patients they were caring for. Staff undertaking observations were not provided with important information they needed to keep patients safe and provide the care they needed.

All staff members undertaking observation with patients did not know the individual risks relating to the patient they were supervising. When asked staff told us they were there to prevent self-harm, however they had no personal knowledge of the patients.

Staff were unable to tell us what may trigger a patient they were observing to self-harm, how they may self-harm and what actions/interventions they should take to reduce the risk of them self-harming.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All staff told us they knew how to raise concerns.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff followed policy to keep patient information confidential.

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. Each patient had been provided with a welcome pack.

Staff did not always involved patients and gave them access to their care planning and risk assessments. We saw that patients had a one-page profile and when care plans were updated the patient had signed the care plans. Patients attended multi-discipline meetings where care plans were discussed with them. However, outside of the multi-discipline meeting staff who worked on the ward were unaware of risks or plans to engage patients in a therapeutic way.

Staff involved in clinical decisions within the multi-discipline meeting made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties) within the multi-discipline meeting. One patient was selectively mute and staff either communicated with her by writing in a journal she kept or through email. However, staff such as health care assistants had no knowledge of decisions or understood how to engage with the patients to support that process.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. The provider held community meetings monthly. Various issues about daily life on the ward were discussed as standing items. At the last community meeting patients had raised concerns about a lack of female staff.

Staff supported patients to make decisions on their care.

Staff made sure patients could access advocacy services. The advocate attended meetings with the multidisciplinary team and spoke regularly with people using the service.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always support, inform and involve families or carers. We spoke with both patients' families. Both families felt that the care had improved recently but one complained that their daughter had not been allowed to take medication with her on trips outside the hospital. Another family when asked about the incident involving inappropriate restraint had not been informed fully about the incident and only discovered the full extent from the commissioner. Both families felt there was a lack of communication.

Staff helped families to give feedback on the service. We saw that families attended multidisciplinary meetings either in person or online and were able to give their feedback.

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Insufficient evidence to rate

We did not rate responsive as there was insufficient evidence.

Access and discharge

Staff planned for patient discharge. There had no discharges since the hospital had opened.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. There were long term plans for the patients to be discharged into community care.

The service had no out-of-area placements. Patients came from the North West of England.

Managers and staff worked to make sure they did not discharge patients before they were ready. There had been discharges since the hospital had opened.

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.

Discharge and transfers of care

Managers had plans to monitor the number of patients whose discharge was delayed, however at the time of inspection there had been no delayed discharges.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

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 but patients could not make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw that patients had personalised their rooms.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. There was a dedicated occupational therapy room but no occupational therapy kitchen. One of the patients complained they could not cook their own food.

The service had quiet areas and a room where patients could meet with visitors in private. Visitors met patients outside the ward environment in a dedicated meeting room.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patients could make phone calls in private. Patients had mobile phones and used them whenever they wished.

The service had an outside space that patients could access easily. The ward had a large outdoor space.

Patients could not make their own hot drinks and were dependent on staff. This had been risk assessed individually with a clear rationale to keep patients safe. Staff were available to bring patients snacks and drinks.

The service offered a variety of good quality food. We saw that diet preferences were discussed in community meetings with patients requesting individual food types. However, at the time of the inspection the position of cook was vacant. The fridge in the kitchen contained products that were either out of date or did not have dates recorded when they were opened. The provider did remove all items when they were informed of this.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. We saw patients could go out on trips and had taken part in activities such as horse riding, visits to football stadia and attended college.

Staff helped patients to stay in contact with families and carers. Patients and families were in regular contact with each other.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service did not always meet the needs of all 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.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. There were clearly displayed posters providing information to patients about their rights.

The service had information leaflets available in languages spoken by the patients and local community. While the service had not had any patients for which English was not their first language, however the provider did have arrangements to provide translation services.

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.

Listening to and learning from concerns and complaints

The service did not always treat concerns and complaints seriously, investigate them and learned lessons from the results, and shared these with the whole team and wider service.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patients, relatives and carers knew how to complain or raise concerns. Patients and families told us they had complained about incidents and commissioners had also raised concerns about incidents regarding staff treatment of the patients. At the time of the inspection there had been two safeguarding enquiries into allegations of staff assault. Both had been instigated by commissioners who were informed about the incidents by the patients.

While patients, carers and commissioners told us they had complained, none of these complaints had been recorded formally.

The provider had only recorded one complaint and that was about uncivil behaviour at a doctor's surgery.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff told us about the complaint system and that they would expect managers to investigate complaints raised.

Managers did not always investigated complaints and identified themes. Managers did not act quickly to investigate complaints or allegations. When questioned about incidents that had occurred, they said they were waiting to interview staff about those incidents. At the time of inspection, one investigation from 11 July had still not been completed.

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 told us they shared feedback from complaints with staff and learning was used to improve the service. Staff told us they were informed about complaints and incidents in handovers, supervision and team meetings. However, we examined team meeting minutes for May and June. In May there was no reported safeguarding's but in June there was two safeguarding's. There was no information within the minutes about those safeguardings or learning related to them. Neither record had any learning from any incidents except information about staff who had been assaulted.

The service had not received any compliments.

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

Inadequate

We rated it as inadequate.

Leaders did not have the skills, knowledge and experience to perform their roles. They did not have a good understanding of the services they managed.

Leadership within the service was inconsistent. Managers did not immediately investigate incidents and hold staff accountable, instead they allocated these tasks to others.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Roles and responsibilities within the service are not clear. The manager and other senior managers did not know the deputy had failed to report safeguardings appropriately.

Management and staff do not understand the principles of good quality assurance therefore staff were not given the information they needed.

Safeguarding matters are not dealt with in an open, transparent and objective way.

Leadership

When the hospital opened in March 2022 there was a registered manager in place. At the time of our inspection that manager had become the deputy manager with a new manager appointed who was waiting to be registered by the Care Quality Commission.

Managers at the hospital and more senior staff from the provider had been unaware that they had not been reporting incidents regarding safeguarding through the correct channels until just before the inspection. The now deputy manager who was the safeguarding lead was not sufficiently trained to fulfil that role. At the time of the inspection training had been arranged.

At the time of our inspection the new manager was on leave and was interviewed when they returned. Despite commissioners and safeguarding authorities rising concerns about the investigation into inappropriate holds we were told this investigation had been handed to a new deputy manager who had replaced the previous one. We were told that the manager had missed the use of inappopriate holds due to concentrating on the fact the patient had been allowed to leave the hospital through the front door.

The inconsistencies in the nurse's handover sheet were pointed out to the manager, but the nurse had still not been challenged by the leadership team. We were told the new deputy manager would be interviewing them. Leaders did not take the intiative but seemed to allocate tasks downwards.

Staff and patients told us that managers were visible and supported them.

Vision and strategy

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

Staff know and understand the vision and values of the team and organisation.

Staff had the opportunity to contribute to discussions about the strategy for their service.

The provider's vision and values were displayed on team meeting minutes and there were posters on the premises. Staff we spoke with told us these were included in the induction program.

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.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff felt respected, supported and valued. All staff told us they felt respected and that they were supported by managers. There had several incidents of assault on staff and racist abuse. Staff told us managers had supported them when they had reported such incidents to the police.

The service responded proactively to bullying and harassment cases. All staff told us they felt the service had an open culture where they could raise concerns without fear. Those that had raised concerns felt listened to and that action had been taken. This was reflected in team meeting minutes. Staff were aware of the whistle-blowing process and where to find the policy.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Most staff worked for an agency which was associated with the owners of the provider. Managers referred to these staff as flexible workers. This made up most of the staff who worked at the hospital. These staff told us they enjoyed the flexibility of these arrangements and they were happy in their role without looking for career progression.

As a new service they had not yet commissioned a staff survey.

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 managed well.

There was a clear framework of what must be discussed at a facility, team or senior management level. We saw that all governance meetings had a structured agenda followed on all occasions. However, this structure not been effective in ensuring staff training was recorded correctly, incidents were investigated appropriately and staff were held to account for their actions and that staff were correctly trained for their post.

Staff had not implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. We found no evidence that the provider had come to any conclusions about investigations and actions that should be brought to the attention of staff. Investigations were still on going after several weeks and we saw no evidence of these incidents being formerly discussed within governance or team minutes. Within the clinical governance minutes there was a list of incidents, but no recorded discussion, analysis or formulated plan recorded.

Staff undertook or participated in local clinical audits. However; audits did not always identify issues when they should have done. For example, the hospital was without a cook at the time of inspection. We found out of date opened food in the fridge and the audit sheet showed that staff had failed to audit the contents and cleanliness of the kitchen.

Data and notifications were not always submitted to external bodies and internal departments as required. Staff did not always respond to the needs of external agencies. Incidents were not always reported to external bodies when required. The service commissioners we spoke with confirmed managers did not keep them up to date with appropriate information about incidents. Commissioners were often the first to raise issues or identify incidents had occurred and told us they then had to wait for the information often having to recontact the service. Commissioners told us they were often told one version of events to be told another version later.

Management of risk, issues and performance

Staff did not always have the information they needed to provide safe and effective care.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

There was a clear quality assurance management and performance framework in place with clinical governance meetings monthly. However, systems in place did not equally record all the information therefore staff may not have the right knowledge regarding risk.

We examined the governance minute meetings and the data used at that meeting and cross referenced that with the risk management plan available to staff on the ward within the patient profile file.

For example, the minutes looking at June describe incidents relating to one patient as being 11 in total with five resulting in restraint. The incidents included eight assaults on staff, and a ligature attempt. The risk management plan, available to staff on the ward, did record the threat of danger to staff within the formulation of risk but the incident record form (record of incidents) had recorded only one incident. Another patient had three incidents of staff assault but within the register only one incident was recorded in which property was damaged and staff threatened, there was no recording of assault.

The service had a local risk register to capture operational issues relevant to the location. Staff could escalate issues to a regional and national risk register as appropriate.

Incidents were not always reported, and appropriate notifications were not always made to external bodies when required. The service commissioners we spoke with confirmed managers did not keep them up to date with appropriate information about incidents. Commissioners were often the first to raise issues and told us they then had to wait for the information often having to recontact the service. Commissioners told us they were often told one version of events to be told another version later.

Information management

Staff collected analysed data about outcomes and performance.

The service used systems to collect data that related to patient care such as staffing levels, incidents, restraints and complaints. The service had identified the need for additonal manager support and had recently appointed a new hospital manager replacing the previous one who had become the deputy hospital manager.

Staff had access to the equipment and information technology needed to do their work. There was an electronic daily notes record system. Other records such as care plans and risk assessments were paper records. All staff had access to the system.

The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Engagement

Managers engaged actively with other local health and social care providers to ensure they meet the needs of the patients.

Patients were registered and had accessed to local health care provision. There was a clear relationship with other health care professionals such as commissioners who we witnessed attending multidisciplinary meetings.

Learning, continuous improvement and innovation

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The service included quality improvement information within its governance meeting structure.

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The provider must ensure that all staff receive appropriate training in safeguarding adults and children suitable to their role so that staff can identify and take action when safeguarding's occur. (Regulations 13 (2)(4)(b)).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider must ensure that there are enough suitably qualified, skilled and experienced staff to meet the patient's needs. (Regulations 18(1)). • The provider must ensure that staff receive an induction which is appropriate to meet the needs of autistic people within a specialist autism service. (Regulations 18(1);17(1)(2)(a)).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must ensure that care plans are contemporaneous, accessible, personalised, holistic and strengths based and reflect the assessed needs of the patient.(Regulations **17(1)(2)(a)(c); 9(3)(b)).** • The provider must ensure that prescribed observations are delivered in a way that meets best practice guidance. (Regulations **17(1)(2)(a)**).

This section is primarily information for the provider

Requirement notices

- The provider must quickly investigate, review and reflect on incidents of restraint to ensure that patients are kept safe. (Regulations **17(1)(2)(a**).
- The provider must ensure that lessons learnt on safeguarding, incidents, complaints and reflective practice is shared with staff. (Regulations **17(1)(2)(a**).
- The provider must ensure that governance processes operate effectively at team level and that performance and risk are managed well. (Regulations **17(1)(2)(a)(b)(f)).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider must ensure there is sufficient mix of male and and female staff at all times to meet the needs of the patients. (Regulation 9, (1)). • The provider must ensure staff conducting obesrvations have the training and understand the therapeutic opportunity to engage with the patient. (Regulation 9, (1),) • The provider must ensure the environment meets the needs of the patient, both patients complained about the door to the staff office and the noise when it closed and how it affected their wellbeing. The door did not close softly and the loud bang could be heard in all areas of the ward. (Regulation 9, (1))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must ensure that patients' risk assessments accurately reflect patients' risks and that these are reviewed and updated in line with the providers policy. (Regulations 12(2)(a)).

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.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	S29 Warning Notice Regulation 9, (1), Person-centred care, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Patients were observed by staff of the opposite sex for long periods of time, and there were insufficent staff to repsond to the needs of the patients. Staff on observastion did not engage with the patients at anytime or attempt any therapuetic activity. The ward, where Patient 1 and Patient 2 were being cared for had a nurse's office. The door to the office banged loudly when closed freely. Staff were not aware of the environment and how noise can affect patients, particularly those with autism. One of the patients complained about this to the inspector.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	S29 Warning Notice Regulation 17, (2), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A incident occurred on 11 July 2022, and the registered provider had not written to the patient to fulfil its obligation under duty of candour. The registered provider was unable to provide records relating to people employed. There were no completed induction checklists to show that staff had been inducted into the service and understood key information about the running of the service including safety.

This section is primarily information for the provider

Enforcement actions

The registered provider did not have effective systems and processes to ensure it had understood its responsibilities for safeguarding and the training of staff in line with national guidelines on safeguarding. The training program for safeguarding did not recognise what level of training it provided. The hospital lead for safeguarding was not trained to a suitable level of safeguarding training for their role.

The registered provider did not have suitable management of health and safety processes in place. The chef had left before July 2022 and staff were now making meals. We saw the fridge and cupboards contained out of date food, food passed the use by date and unlabelled opened food. These food products were being provided to patients to eat. Staff had not completed any updates on food hygiene or health and safety audits for the kitchen.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	S29 Warning Notice Regulation 12, (1) (2), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were five health care assistants on duty. Four of these staff members were on observation which meant they could not leave the patient they were allocated to support. This meant there was no extra staff to provide cover for even the shortest of breaks for those observing. National Institute for Health and Care Excellence recommends staff should not be on continuous observations more than two hours. Patients risk assessments were not up to date with all the information on patient risk.