Active Adult Limited

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

Summary of findings

Overall summary

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

- Staff did not always escalate physical health concerns appropriately. This meant there was a risk that deteriorating patients may not receive timely medical support.
- Staff did not always follow the procedure for seclusion set out in the Code of Practice.
- Blood glucose machines were not regularly calibrated. This meant that the machines could give incorrect readings that could lead to staff giving incorrect doses of medicines.
- Staff did not always follow NICE guidance when using rapid tranquilisation. For example, we identified one record of rapid tranquilisations where staff did not record the patient's physical health observations 4 times within the first hour as per NICE guidance.
- Governance processes were not sufficient to ensure all risks were identified and managed.
- Cleaning records were not fully completed by all staff.
- Staff did not always store and manage all medicines and prescribing documents safely. On Barnes ward we identified 3 different types of medicines that had exceeded their expiry date. When patients were discharged with short notice, medicines for the patient to take away with them did not come with important warning labels.
- The wards were previously psychiatric intensive care units and the ward environments reflected this. The ward environment lacked colour and had limited furnishings.
- We identified one record where a patient was deemed to not have capacity however the evidence behind this decision was not recorded.

However:

- The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. Staff followed good practice with respect to safeguarding.
- Staff provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Holybourne Hospital

Holybourne Hospital is provided by Active Adult Limited which is part of the Active Care Group. It is registered to provide the following regulated activities:

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

• Accommodation for persons who require nursing or personal care

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury

The service provides 41 adult acute beds. Barnes ward provided care and treatment for up to 9 male patients. Richmond ward provided care and treatment for up to 10 male patients. Osman ward provided care and treatment for up to 13 female patients. Kingston ward provided care and treatment for up to 9 female patients.

This service was registered by CQC on 5 March 2021. This service has not been inspected before.

There was a registered manager in place at the time of inspection

What people who use the service say

We spoke to 10 patients as part of the inspection. Patients described most staff members as kind and caring. Some patients did tell us that members of staff could sometimes be abrupt.

Patients told us that the food was good and varied. Patients reported that any complaint or concerns they raised were listened to and taken seriously. They felt able to speak up.

All patients that we spoke to told us that there were enough activities during the day, patients that we spoke to had recently attended dance therapy and art therapy.

How we carried out this inspection

The inspection was led by a CQC inspector with another inspector and 2 specialist advisors.

During this inspection, the inspection team:

- visited 4 wards
- conducted a review of the environment on each ward and observed staff supporting patients
- spoke with 2 ward managers
- spoke with 19 staff including registered nurses, support workers, consultant psychiatrists and assistant psychologists
- spoke with the hospital director, medical director, head of therapies and head of nursing and quality
- spoke with 10 patients

Summary of this inspection

- spoke with 8 family members and carers
- reviewed the records for 14 patients
- reviewed the medication charts for 10 patients
- attended daily operations management meeting and multidisciplinary team meetings
- reviewed other documents, performance data and polices 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 provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure that staff understand when to escalate physical health concerns and follow up and clearly document actions taken in response to elevated early warning signs. (Regulation 12(2)(b))
- The provider must ensure that staff understand when an episode of seclusion has occurred and that these are reviewed in line with the Mental Health Act Code of Practice. (Regulation 13 (2))
- The provider must ensure staff complete the necessary physical health monitoring of patients who receive intramuscular rapid tranquilisation medicines, to protect them from significant physical health deterioration post administration. (Regulation 12(2)(b))
- The service must ensure that blood glucose monitoring devices are calibrated regularly. (Regulation 12(2)(e))
- The provider must ensure that governance systems that are in place are sufficient to ensure all risks are identified and managed. (Regulation 17(1))

Action the service SHOULD take to improve:

- The provider should review the process for providing medicines to patients when they are discharged from the hospital to ensure they receive safety information.
- The provider should continue their recruitment drive and reduce the number of vacant posts across the hospital and reduce its reliance on temporary staff to improve the continuity of care of patients.
- The provider should ensure that all cleaning records are up-to-date and complete.
- The provider should improve the therapeutic nature of the ward environments.
- The provider should ensure that medicines administration records are complete and that out of date medication is disposed of correctly.
- The provider should ensure that mental capacity decisions are documented fully.
- The provider should ensure that the use of enhanced observations are appropriately assessed on an individual basis.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

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

Requires Improvement

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

Is the service safe?

Requires Improvement

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

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished and fit for purpose. However, blood glucose monitoring devices were not regularly calibrated and some cleaning records had not been comprehensively completed.

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. Daily checks of the environment were carried out by a designated member of staff.

Staff could observe patients in most parts of the wards. There were some areas on the wards that staff were unable to observe from the nursing office. Staff were aware of the blind spots that were present on the wards and mitigated the risk by being present in the communal area at all times. At the time of the inspection, we observed patients who were unobserved whilst in the garden. The garden contained several ligature risks and there was a possible risk of absconsion. Senior leaders took rapid, appropriate action to mitigate risks when this was raised, for example a bench was secured to the floor.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The service had completed a ligature audit. The last update was in February 2023. The assessment was comprehensive, covering all areas of the ward. There were anti-ligature fittings in the bathrooms.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff alarms were tested and issued at the beginning of each shift.

Maintenance, cleanliness and infection control

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

Requires Improvement

Ward areas were clean, well maintained, well furnished and fit for purpose.

Most staff made sure cleaning records were up-to-date and the premises were clean. All the premises we observed appeared clean, however cleaning records that were completed by staff were not always comprehensive. For example, the servery daily cleaning schedule was partly completed. The elements that the housekeeper was responsible for was fully completed and signed. However ward based staff and kitchen staff had not completed the cleaning records.

Staff followed infection control principles including appropriate handwashing techniques, use of equipment including aprons and gloves, and hand sanitiser was readily available. Handwashing audits were carried out monthly. Sharp bins were available to staff however the sharps bin on Barnes ward was not labelled.

Clinic room and equipment

Most clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. At the time of inspection, Richmond ward did not have a defibrillator on the ward. If required staff would use the defibrillator held on Barnes ward. A new defibrillator had been ordered for Richmond ward. The emergency bag on the wards were checked daily.

Staff checked, maintained, and cleaned most equipment. Cleaning records were maintained and up to date. However, blood glucose monitoring machines were not calibrated regularly. For example, on Richmond ward we saw evidence that the machines were calibrated once in February 2023. We could not see evidence that the blood glucose monitoring machines were calibrated in January 2023 or March 2023. This meant that the machines could give incorrect readings that could lead to staff giving incorrect doses of medicines.

Room and fridge temperatures were checked each day. On Richmond ward, the fridge temperature was out of range on 3 days in March. Maintenance was informed following the third day the temperatures were out of range. An incident was raised following this.

On Osman ward an oxygen cylinder was available in the clinic room for use in an emergency. There was no spare cylinder present in the clinic room, there was a spare oxygen cylinder located on the same floor in the Hospital Matrons office. Spare oxygen cylinders were available on all the other wards.

Safe staffing

The service had enough nursing and medical staff, who knew the patients. The service was recruiting staff to fill vacant posts. The use of regular bank and agency staff promoted consistency of care. Staff received basic training to keep people safe from avoidable harm. Some improvements were need to ensure all patients received regular one to one's with their named nurse that were recorded.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Managers had calculated the number and grade of nurses and healthcare assistants required. The ward managers could adjust staffing levels according to the needs of the patients. Staff told us that if there was high acuity on the wards or a high number of patients on the wards

they would be able to allocate extra members of staff. The service had recently changed the number of staff working on shifts across the hospital. The staffing levels per ward were reduced by 1 healthcare support worker, this was following the change in service provision. The wards were previously psychiatric intensive care units and were now acute wards. Psychiatric intensive care units typically have more staff per patient due to higher acuity.

At the time of inspection, the service had a 50% vacancy rate for nursing staff, there were 17.4 vacant posts at the service. Eleven of these posts were due to be filled in the coming months, 9 international nurses had been recruited. The international nurses were due to start work on the wards as senior health care support workers until they had obtained their NMC pin number.

At the time of inspection, the service had 6 healthcare support worker vacancies, this was an overall vacancy rate of 14%. Senior leaders told us that health care support worker recruitment had been paused as a temporary measure because the international nurses that were due to arrive would be working as health care support workers initially.

In January 2023, 50% of nursing shifts were covered by agency staff and 42% of duty nursing shifts were also covered by agency staff. The duty nurse role was an additional nurse that covered all the wards and would provide onsite support as and when required. Senior leaders were aware of the risks represented by high agency use. Most of the agency staff were contracted and had worked with the service for several years. They knew the patients, staff, policies and procedures, which supported consistency of care. The provider had a main agency provider.

In January 2023, 10% of health care support worker shifts were covered by agency staff and 14% of shifts were covered by bank staff.

The service had low turnover rates. Overall staff turnover was 4.3% in February 2023.

Managers supported staff who needed time off for ill health. In January 2023, on 64 occasions nurses and support workers were unable to attend their shift due to sickness. This accounted for 6.1% of all shifts.

Most patients had regular one to one sessions with their named nurse. However, two patients told us that they did not have regular one to one sessions with their named nurse. Staff told us that they would regularly meet patients on a one to one basis however this was not always recorded.

Staff shortages did not result in staff cancelling escorted leave or ward activities. Some staff that we spoke to told us that they felt the reduction in support workers on each ward had made it more challenging to facilitate section 17 leave.

There were enough staff to carry out physical interventions (for example, observations, restraint and seclusion) safely and staff had been trained to do so. All staff had received training in the use of physical intervention. None of the staff we spoke with said there had been insufficient staff to carry out physical interventions when required.

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. As of February 2023, there were 7.3 WTE medics employed by the service and there were no vacancies. On call out-of-hours cover was provided by the ward doctors and consultants. This was through a 7 day on call rota.

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

Requires Improvement

Managers had a process in place to get locum cover if this was needed.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. At the time of inspection, the overall training compliance was 88%. Training compliance was monitored weekly by the senior management team and department leads. Improvements in compliance were achieved through the provision of additional courses. For example, basic life support and search training. New training courses were also provided when additional training needs were identified. For example training in basic autism awareness and learning disability awareness had recently been rolled out for staff. Senior leaders told us that there had been a recent focus on mandatory training for bank staff. Staff were required to be compliant with their mandatory training as a requirement for working in the hospital and being retained on the bank.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training courses included fire safety, infection control and basic life support. There were some mandatory training courses that were role specific, for example managing medications and search training.

Assessing and managing risk to patients and staff

Staff assessed and managed most risks to patients and themselves well. However,staff did not always record patients' physical health monitoring in a way that was clear when escalation was required or what actions, if any, were taken in response to elevated warning signs. Staff had not recognised that preventing a patient from leaving the de-escalation room on one ward had meant that they were subject to defacto seclusion. This meant that the safeguards, set out in statutory guidance, to protect the rights and safety of patients in seclusion were not followed.

Assessment of patient risk

Staff completed a risk assessment for each patient on admission, and reviewed this regularly, including after any incident. The services electronic patient records had been disabled by a cyber-attack in August 2022. This had caused extensive disruption to the service. At the time of the inspection staff were still recording information in separate documents. Risk was reviewed and the outcome recorded during the weekly multi-disciplinary team ward round meetings. Staff would also discuss risk at every handover. The consistent recording of risk had been adversely affected by the outage of the electronic patient record system. The medical director told us that a standardised risk assessment tool would be rolled out shortly.

Staff completed a risk assessment for all patients before they went on section 17 leave. This included a risk score and a written comment on the patient's mental state. Staff recorded each episode of leave, including details of what the patient was wearing when they left the ward.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff recorded observations of patients on a standardised form. This included details of what the patient was doing each time they were observed. Intermittent observation took place 4 times each hour at unpredictable intervals.

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

Requires Improvement

Staff did not always escalate physical health concerns appropriately. Staff were using a national early warning signs (NEWS) form to record checks of patients' vital signs daily. The form is used to record the physical health of a patient. Staff collect a range of indicators to produce a score. This shows when a patient's health may be deteriorating. Depending on the score, staff should escalate to the nurse in charge, a doctor, or emergency services.

As part of the inspection, we reviewed 6 NEWS charts on Barnes ward. We identified 1 record where there was no evidence to suggest high NEWS scores were escalated to the appropriate professional. On 2 consecutive days a service user had scored 5 or 6, these scores were calculated incorrectly however escalation was still required as they had scored 2 and 3. There was no written evidence to suggest this had been escalated. On Osman ward a NEWS chart identified that a service user had low blood pressure. This was not escalated to the duty nurse or consultant as the ward round notes from the following day noted there were no physical health concerns. This meant there was a risk that patients may not receive timely medical support.

Staff identified and responded to any changes in risks to, or posed by, patients. If staff were concerned about a change in a patient risk they would increase the level of observation. Staff also told us they would move a patient closer to the nursing office if their risks were escalating.

Staff could observe patients in most areas of the wards from the nursing office. Where observation wasn't possible a member of staff would always be placed on the ward floor.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff searched patients for prohibited items when they returned from leave. This involved asking patients to empty their pockets and allow staff to look in any bags. Staff could also check for concealed metal items using a handheld metal detector. Staff told us that they would conduct random searches of patients' bedrooms if they were concerned about possible contraband on the ward.

Personal emergency evacuation plans (PEEP) were in place for all patients in the hospital. The aim of a PEEP is to provide people who cannot get themselves out of a building unaided with the necessary information and assistance to be able to manage their escape to a place of safety and to ensure that the correct level of assistance is always available. We identified 1 plan that referenced a patient should only be on the ground floor when they were living on the first floor. The ward manager told us that this was a mistake and the plan was reviewed and updated.

Use of restrictive interventions

As part of the inspection, we reviewed the CCTV footage from 7 incidents. Overall, CCTV footage showed staff responding to patients' needs appropriately. However, we reviewed CCTV footage of 1 patient placed in the de-escalation room on Kingston Ward who was under close observation from staff. We noted that the patient attempted to leave the room on 8 occasions. On each occasion, they were prevented from doing so by staff. This meant the patient was secluded. Staff did not follow the procedure for seclusion set out in the Code of Practice. This meant that the safeguards, set out in statutory guidance, to protect the rights and safety of patients in seclusion were not followed.

The provider monitored the use of restrictive interventions. Between January 2022 and January 2023 there had been 181 incidents of restraint and the ward with the highest number of restraints was Barnes ward. The number of restraints had reduced from earlier in the year, between September 2022 and January 2023 there was an average of 8 restraints per month. The ward manager on Osman ward told us that he recollected about 10 instances of rapid tranquilisation on Osman and 14 instances on Kingston in the last 6 months.

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

Requires Improvement

Staff participated in the provider's restrictive interventions reduction programme. A quality improvement project was underway to reduce the number of incidents related to vaping. Service users were able to smoke whilst on escorted or unescorted leave. Specialist vapes were purchased by the hospital which would allow service users to vape on the ward safely, a maximum number of vapes was individually risk assessed. Staff reported that this had helped de-escalate incidents and there were less incidents around asking for section 17 leave to vape. At the time of the inspection, this project had been in place for 6 months. Staff reported that there had been a 30% decrease in vaping related incidents since the project had been introduced. A coproduced review of the project was also undertaken to further improve the programme and patient experience.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. All staff that we spoke to told us that restraint would only be used as a last resort. During the inspection we saw staff use distraction techniques to de-escalate incidents of aggression.

Staff did not always follow NICE guidance when using rapid tranquilisation. For example, we identified 1 record of rapid tranquilisations where staff did not record the service user's physical health observations 4 times within the first hour as per NICE guidance. This was not consistent with the providers policy for rapid tranquilisation. During the inspection it was also identified that the staff member did not sign the document. When patients refused these observations, staff did not always record the patient's respiration and note whether they were alert and conscious.

Seclusion rooms were not in use at this service. A de-escalation room was available. The staff used the de-escalation room for managing patients exhibiting volatile behaviour.

All patients on Richmond ward were observed 4 times each hour, it was not clear from speaking to staff if this was a risk-based decision.

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 received training on how to recognise and report abuse, appropriate for their role. Staff gave details of when they had raised safeguarding concerns. For example, a service user had alleged that an agency member of staff had fallen asleep. The Local Authority and CQC were informed within 24 hours. Following the incident, the member of staff was no longer employed within the service.

Staff kept up-to-date with their safeguarding training. Safeguarding training was mandatory for all staff. Ninety-five percent of staff were up to date with safeguarding children and safeguarding adults training.

Staff could give 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 followed clear procedures to keep children visiting the ward safe. The hospital had a family room that was off the ward, this would be used for visiting children and families. People under the age of 16 were not allowed onto the ward.

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

Requires Improvement

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Flowcharts were visible in the nursing offices on how to escalate safeguarding concerns. Between January 2022 and January 2023, 79 safeguarding records had been created by staff. The number of referrals had reduced between September 2022 and January 2023 (12 were raised). Staff told us that this was reduction was due to a few unwell service users being transferred to other services. All safeguarding concerns were discussed in the daily professionals meeting.

Managers took part in serious case reviews and made changes based on the outcomes. All safeguarding matters were discussed in clinical governance meetings.

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 however staff could not always access them easily. The provider's electronic patient records had been disabled by a cyber-attack in August 2022.This had caused extensive disruption to the service. At the time of the inspection each entry onto a patient's records was recorded in an individual document. These entries were detailed and comprehensive however it took staff a lot of time to find information as they would have to search through each individual document. This issue had affected the whole provider and the senior leadership team were actively working to find a solution.

Records were stored securely. Staff accessed the electronic patient record system using a personal username and secure password.

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 most medicines safely. Nurses administered medicines and signed prescription charts to show they were given as intended.

We reviewed 10 medicine administration charts. Of these, 2 did not have the allergy box completed. This meant that staff may be unaware of patients' allergies. Staff added allergy information immediately after this issue was raised. We also identified 1 record that said intramuscular promethazine was administered however staff told us that they were given the medication orally. Staff told us that this was an error and an incident would be raised. The pharmacy provider offered training to hospital staff, staff told us that additional training on the recording of medicines charts would be provided soon.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Carers and patients that we spoke to told us that they felt well informed about the medications administered by staff.

Staff did not always store and manage all medicines and prescribing documents safely. On Barnes ward, we identified 3 different types of medicines that had exceeded their expiry date. These medicines were destroyed once they were identified to be out of date by the inspection team. We identified no other out of date medication on the other wards.

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

Requires Improvement

The system for providing patients with medicines when they were discharged did not always meet best practice requirements. This was the case when patients went on home leave or were discharged. Medicines for the patient to take away were then dispensed by the ward doctor and a registered nurse. However, the medicine boxes did not have the required warning labels, such as for not operating machinery, or to be taken after food. This meant that the risks associated with medicines were not minimised. Staff told us that patients would be placed on short scripts to ensure that local GPs or community mental health teams took over responsibility for prescribing.

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. We reviewed ten medication charts, all patient medication was within BNF limits.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Side effects of medicines were monitored through regular checks of patients' pulse, blood pressure, respiration and oxygen saturation. Any side effects were discussed at the daily multidisciplinary team handover.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff reported all incidents that they should report. Staff across the hospital reported incidents such as medicines errors, patients going absent without leave and incidents of self-harm. Staff recorded the details of incidents on the electronic incident record. For example, between December 2022 and March 2023 there were 202 incidents reported, 151 resulted in no harm or injury, 37 resulted in minor injury, 12 were near misses and 2 were resulted in moderate harm. The most common type of incident were Security(other) (22), Covid self isolation (13) and physical aggression (13). Security other included incidents of patients being in other patients bedrooms, vapes being used that were not approved for use on the wards and some incidents of violence and aggression toward staff. There were 9 incidents of self harm between December 2022 and March 2023 and 10 incidents were in relation to medication errors.

Staff understood the duty of candour. They were open and transparent, and they gave patients and families a full explanation when things went wrong. For example, an apology was provided to a patient and their family following a patient-on-patient assault.

Managers debriefed and supported staff after any serious incident.

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. for example, a quality newsletter was sent out on a bi-monthly basis which shared learning from safety incidents. In the January/February newsletter learning on epilepsy management was shared following a seizure related fall in a supported living service.

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

Requires Improvement

Staff met to discuss the feedback and look at improvements to patient care. As part of the inspection, we reviewed minutes of team meetings held on the wards for the previous 3 months. Lessons learnt was a standing agenda item for all of the meetings. Lessons learnt in the last 3 months included intermittent observations should not be at predictable fixed times. Learning in relation to referrals was also raised as for the month of December 2 patients were accepted from a PICU service and they were soon identified as not appropriate for the service.

There was evidence that changes had been made as a result of feedback. For example, in November 2022 there was an increase in incidents on Osman Ward staff told us this was due to referrals containing limited information. These concerns were followed up with the referring trust to improve the information provided. Senior leaders told us that the information shared by the trust had greatly improved following this.

Is the service effective?

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Most care plans were reviewed regularly through multidisciplinary discussion and were person centred. Most care plans reflected patients' assessed needs.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. When patients were admitted they were reviewed by a doctor for an initial assessment, which included an assessment of their risk.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff carried out blood tests and electrocardiogram tests shortly after a patient was admitted to the ward. We identified 1 service user who had not had an electrocardiogram following their admission. Physical health assessments that were completed on admission were audited monthly.

Most care plans were personalised, holistic and recovery-oriented. However, we found that five care plans did not reflect the specific plans in place for the patient to achieve their goal or the care plan did not clearly record the patient's involvement in the planning process. Staff told us that some patients only remained at the service for short time periods and engagement was challenging when patients were unwell.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported 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.

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

Requires Improvement

Staff provided a range of care and treatment suitable for the patients in the service. Most patients were admitted to the wards with psychosis, schizo-affective disorder, bi-polar affective disorder or schizophrenia. Some patients were experiencing an emotionally unstable personality disorder. Treatment predominantly involved the use of medicines. The therapy team had increased in size following the change from a PICU service to an acute service. Therapies offered included art therapy, music therapy and CBT.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, staff provided patients with nicotine replacement therapies such as e-cigarettes. Service users were also encouraged to utilise their leave, patients would go on walks in Richmond Park which was a short distance from the service.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes including Core-10 and National Early Warning Scores.

Staff used technology to support patients, teleconferencing facilities were used during ward rounds to ensure family and community teams remained involved in patient care. At the time of the inspection, the wards were having an electronic observation system installed to record physical health checks carried out on patients.

Staff took part in clinical audits. Monthly audits were undertaken on each ward with different staff responsible for particular audits. Regular audits undertaken included safeguarding, physical health and care plans. Findings from these audits were discussed during clinical governance. For example, a restrictive practice audit was undertaken in February 2023 where it was identified that some patients did not have a rapid tranquilisation plan in place. Staff were reminded to complete these and the implementation of the care plans would continue to be audited. Senior leaders had identified that further work was needed to better document the positive work staff were doing with patients. A two-week review was planned for the end of March to look at how care plan documents and progress note tools and templates could be improved.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the patients on the wards. Each ward team included a ward manager, registered nurses, support workers, a speciality doctor and a consultant psychiatrist. The wards also had access to occupational therapists, psychologists, assistant psychologists and activity co-ordinators.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. All staff that we spoke to told us that they had received a comprehensive induction before starting on the ward. Managers had a system in place to ensure that agency staff members had received an induction.

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

Requires Improvement

Managers supported staff through regular, constructive appraisals of their work. Staff were required to have a formal appraisal once a year. As of March 2023, the overall appraisal rate for the hospital was 82%. Kingston ward had the lowest appraisal rate at 78%. Senior leaders told us that the department leads would ensure that any appraisals yet to be completed were booked and due to be completed by the end of March 2023.

Managers supported staff through regular, constructive clinical supervision of their work. At the time of the inspection the overall supervision rate was at 93%. Most staff that we spoke to told us that they had received clinical supervision. Staff told us that supervision covered any recent incidents, training, competencies and wellbeing. However, 2 bank staff members that we spoke to said they were not receiving regular supervision.

Weekly reflective practice sessions were provided to the multidisciplinary staff members by the hospital in collaboration with a nearby university. However, some ward staff that we spoke to told us that reflective practice was not happening consistently.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. These team meetings followed a fixed agenda. At the meetings, staff discussed incidents, lesson learnt, physical health, patient feedback and complaints and compliments.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had received additional training in autism and learning disability. Some staff told us that they would like further training on supporting service users with autism as several patients on the wards were autistic.

Managers recognised poor performance, could identify the reasons and dealt with these.

Managers recruited, trained and supported volunteers to work with patients in the service. The service employed an expert by experience who held groups for service users.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Each multidisciplinary team met to formally review each patient at least once a week. These meetings were attended by the consultant psychiatrist, speciality doctor, assistant psychologists and a member of the nursing team. These meetings were chaired by the consultant psychiatrist. At the meetings we observed, staff gave clear information about patients and ensured any changes in their care was shared, both within the team, and with other teams external to the organisation.

Ward teams had different working relationships with external teams and organisations. A local NHS trust had a contract in place with the hospital. A member of staff from the trust was based at the hospital to try and ensure there were no barriers to discharge. Staff told us that they felt this contract was functioning well. Staff told us that they mostly had good links to patients' care co-ordinators in the community and they would always be invited to attend ward rounds.

All wards had access to a psychologist. Assistant psychologists also provided support to patients on the wards, including 1 to 1 and group sessions. Patients also had access to occupational therapists, music therapists and art therapists.

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

Requires Improvement

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. At the time of inspection 88% of staff had received training in the Mental Health Act Level 1 and 97% of staff had received training in the Mental Health Act Level 2.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for 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. An advocate would attend the wards once a week. The advocate produced a monthly site report. This report was reviewed during the clinical governance meeting.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

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

Informal patients knew that they could leave the ward freely, however the service did not clearly display posters telling them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. A new audit had been rolled out by the provider's corporate team in February 2023. The first audit had identified that staff were recording section 17 leave inconsistently across the wards, learning was shared at the monthly clinical governance meeting.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed however capacity assessments were not always recorded clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of the inspection, 91% of staff were trained in the Mental Capacity Act.

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

Requires Improvement

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff told us that they knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff assessed and recorded capacity to consent clearly most times a patient needed to make an important decision. We identified 1 service user who was deemed not to have capacity on admission however there was no documentation to say how this decision was evidenced.

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

As part of the inspection we spoke to 10 patients.

Staff were discreet, respectful, and responsive when caring for patients. During our observations of the wards, we noted that patients approached staff on several occasions to talk to them. On each occasion, staff responded immediately, kindly and positively. We saw a member of staff and a patient enjoying a game of table tennis together on Barnes ward. The overall atmosphere of the wards was calm and felt therapeutic.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Doctors discussed patients' care and treatment with them in weekly ward rounds. Doctors also talked to patients about the potential side effects of their medication.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff understood and respected the individual needs of each patient. Staff across all the wards showed a good understanding of patients' needs, their illnesses and their social circumstances outside the hospital. At ward round and the daily planning meeting, staff discussed patients' personal preferences, risks and physical health needs.

Most patients understood how to make a complaint about their care, including speaking with their named nurse, the ward manager, or asking for support from an advocate to make a formal complaint. Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. For example, patient information written on white boards in the nurses' offices could not be seen from outside the office.

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

Requires Improvement

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. Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. However, there was some variability in the recording of patients' views across the wards. Some care plans had little in the way of patient views recorded, even when insight and the ability to express views had improved over the course of their admission.

Staff involved patients and gave them access to their care planning and risk assessments. Patients were able to attend ward rounds and their views were recorded when they did so. Carers and relatives were actively encouraged to attend ward rounds this could be done remotely or in person with the permission of the patient involved.

Staff made sure patients understood their care and treatment and found ways to communicate effectively. Staff told us that they would use an interpreter where appropriate.

Staff enabled patients to give feedback on the service they received, for example, by completing surveys, and attending community meetings on each ward. Community meeting records indicated that patients spoke up about issues of concern to them, ranging from food, hygiene, staff support and activities. For example, patients raised in January 2023 that they would like a new net and paddles for the table tennis table. These were in place at the time of the March 2023 inspection. Patients had also fedback that there were not enough activities. Following this the hospital had invested in more activities for the wards to increase engagement between patients and staff during their admission. New board games and computer games were present on each ward at the time of inspection.

An Expert by Experience worker provided extra support to patients on the wards, assisting them with activities and leave, with the benefit of having experience of using similar services themselves.

Staff made sure patients could access advocacy services. An advocate attended the hospital on a weekly basis, feedback from the advocate was reviewed as part of the monthly clinical governance meeting.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

During the inspection we spoke to 8 relatives and carers. Most relatives told us that staff had supported them and involved them in the care of their loved ones. Family and carers were always invited to ward rounds where appropriate. Relatives told us that it was relatively easy to contact the wards and speak to a member of staff however others told us that they had a more mixed experience. Relatives told us that staff would be flexible and accommodating with visiting times and rooms would be arranged promptly for children to visit their parents.

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

Requires Improvement

Is the service responsive?

Good

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

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

All patient placements were funded by NHS trusts. Referrals were accepted from across the country, but most patients were referred from services in London and the South East. The hospital had an agreement in place with a local NHS trust for 18 beds. A monthly compliance report was submitted to the trust to inform the trust of performance. The report reflected a variety of care delivery indicators which were discussed at the monthly contract meetings.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. In January 2023 the average length of stay was 48 days.

Managers and staff worked to make sure they did not discharge patients before they were ready. However, as the beds were funded by NHS trusts they were able to call back patients back within area with short notice. This had happened on a few occasions in the last year, staff told us that this was rare and the vast majority of patients would only leave the hospital when they were ready for discharge into the community. Several relatives that we spoke to also felt that their loved ones were discharged too early in their opinions.

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

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. For example, a patient was recently moved due to incidents related to another patient.

Staff did not move or discharge patients at night or very early in the morning. However, one relative told us that their partner was admitted in the early hours of the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. There was a total of 6 patients reported as delayed discharges in February 2023. These patients were discussed in the daily morning hospital operational planning meeting and with the referring trusts. Barriers to discharge were reviewed with clinical teams within Holybourne, and with the community services of referring trusts. The most common barrier to discharge was in relation to finding suitable accommodation.

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

Requires Improvement

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. There was a daily pathway call with a local NHS trust to review discharges, admissions and overall patient flow, as well as a weekly clinical review meeting with another NHS trust which was consistently the second largest referrer of patients to Holybourne. Care co-ordinators were regularly invited to the weekly ward round meetings to offer their input and provide updates on any possible barriers to discharge.

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

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality.

The wards were previously psychiatric intensive care units and the ward environments reflected this. The ward environment lacked colour and had limited furnishings. The senior leadership had identified this and were reviewing what could be added to the wards to make them more homely for patients.

Patients had their own bedrooms and did not sleep in bed bays or dormitories. Patients could personalise their bedrooms and request for staff to lock their bedrooms for them to help keep their possessions safe.

Staff used a full range of rooms and equipment to support treatment and care. Each ward had a dedicated clinic room where patients were examined or received their medications. Outside space was readily accessible. A therapies corridor was situated on the ground floor and was shared by patients from different wards. The corridor contained an occupational therapy kitchen, group therapy room, a gym for exercise, areas for art therapy to take place and a multi-faith room.

Patients could either meet with visitors in meeting rooms on the wards or in a relative's room off the ward, which was routinely used when children visited the hospital.

Patients could make phone calls in private. Ward phones were available on the wards but most patients had access to their own mobiles. Access to mobile phones was individually risk assessed.

Patients reported that the food was of good quality and that they could access healthy food options.

Patients relied on staff to make hot drinks on all wards. This appeared to be a legacy issue from the wards previously being a PICU where access to hot water would not be appropriate. This issue had been identified by the reducing restrictive practice group and staff were working to resolve it.

Patients' engagement with the wider community

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

Some patients only remained at the service for short time periods before being transferred back to their local area. Whilst occupational therapy staff and psychology staff supported patients to develop essential living skills, due to the length of time patients spent on the wards education and work opportunities were more limited.

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

Requires Improvement

Staff helped patients to stay in contact with families and carers. Staff told us they were proud that they made every attempt to keep patients connected to their families and carers. Most carers and relatives that we spoke to, told us that they felt suitably informed about their loved ones care and treatment.

Meeting the needs of all people who use the service

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

The service made adjustments for patients who had a disability. Patients with reduced mobility were assessed on an individual basis and were admitted if the service could meet their needs. All areas of the building were accessible by lift.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Patients that we spoke to told us that they were aware of how to raise a complaint and were aware of their rights.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed.

Patients' dietary requirements were met. As well as vegetarianism, staff could source food that met religious dietary needs, such as halal meats.

Patients had access to spiritual, religious and cultural support. Staff explained that they had previously supported one patient to attend a local church.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The service provided patients with information on how to complain. Information about the provider's complaints procedure was also detailed in the patient welcome booklet and leaflets were available.

Patients told us they felt confident to approach staff for advice about the complaints procedure if they needed to.

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

Staff knew how to deal with complaints and there was an established system for ensuring complaints were responded to. This included informing the person who had complained of the timescale when they would receive a response.

When patients complained or raised concerns, they received feedback. Whenever possible, the ward manager dealt with informal complaints straight away and gave patients feedback.

The service had received 6 complaints between December 2022 and February 2023. Three complaints were not upheld, 2 were partially upheld and one was still in progress.

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

Requires Improvement

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

Managers investigated complaints and identified themes. Senior leaders told us that there has been a focus on strengthening the responsiveness regarding patient complaints. The Hospital Director introduced mid-way update meetings with complaint investigators to provide support and ensure that the investigation and complaint response was on track.

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

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was discussed in monthly clinical governance meetings.

The service used compliments to learn, celebrate success and improve the quality of care. For example, in October 2022 a newsletter was sent to all staff which contained a compliment from the wife of a patient. This complement was also shared with the senior executive team at the provider. To celebrate the success of the complement, the hospital director provided doughnuts to all staff and patients.

Is the service 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 services they managed and were visible in the service and approachable for patients and staff.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Throughout our engagement meetings and during our inspection the registered manager demonstrated a good understanding of patients, the staff team and all matters relating to the provision of acute mental health services.

Leaders were visible in the service and approachable for patients and staff. The Hospital Director had also developed and implemented the monthly Together We Are Stronger Group. This group was set up to increase involvement of hospital staff. There was a representative of each team and department at the meeting.

Leadership development opportunities were available, including opportunities for staff below team manager level. Managers supported staff to develop their skills and take on more senior roles. For example, one health care support worker had been supported to complete their nurse training.

The service employed 2 ward managers at the hospital. Each ward manager was responsible for 2 wards. Some staff members told us that it could be challenging when the ward manager wasn't visible on the ward.

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

Requires Improvement

Vision and strategy

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

Staff understood and demonstrated the provider's vision and values. Throughout our inspection we saw how both staff and leaders applied the provider values of being 'kind and honest' and 'fair and inclusive' in their day to day work. These values were demonstrated in staff members' respectful and inclusive interactions and behaviours with patients.

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.

Most staff were positive about the culture and morale on their wards, and the support they received from their teams.

Senior leaders told us they were focused on building a culture at Holybourne reflecting the Active Care Group behaviours, and had been developing this and staff awareness with a view to this being evident in all that they do in terms of patient and staff experience.

The annual staff survey took place in February 2023, with Holybourne Hospital achieving a 43% response rate (against a 45% provider average response rate) and 73% engagement score, detailing likelihood of staff intending to remain with the hospital (against a 60% provider average engagement score). At the time of inspection, the senior leadership team was analysing the results and creating an action plan.

Staff felt able to raise concerns without fear of retribution. Staff said they would feel comfortable in raising any concerns with their colleagues and managers. Most staff felt their views and opinions would be listened to and acted on. Staff knew how to use the whistle-blowing process. Posters detailing who to contact if staff needed to speak up were on display in staff areas.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at senior level. Further work was required to ensure all performance and risk issues were managed well.

There were issues that we identified during the inspection where it was not clear how these concerns were escalated or what governance systems were in place to identify these issues. For example, we identified issues with medical equipment and medication management. It was not clear how these concerns were escalated and actioned. Senior leaders were aware of some of the areas of concern that we identified. These issues had been identified through the governance processes at the provider. Senior leaders were trying to resolve these issues as quickly as possible. For example, senior leaders had identified a need for care plans and progress notes to be more patient-centred and reflective of practice, engagement and interventions. Plans had been developed to provide new templates for care planning and progress notes to support staff to better evidence patient care. The governance systems within the hospital were relatively new and further work was required to ensure governance systems were fully embedded.

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

Requires Improvement

There was a clear framework of what must be discussed at a team level in team meetings to ensure that essential information, such as learning from incidents, was shared and discussed.

The service held a range of meetings at which staff shared issues and concerns, identified actions and monitored progress. Agendas for meetings were standardised across the service and covered learning from incidents, complaints and safeguarding cases.

Staff were not always clear about their roles and responsibilities. For example, we identified some concerns in relation to the clinic room, it was not always clear from the staff whose responsibility it was to monitor the clinic room. Senior leaders that we spoke to told us that they had identified that the ward leadership could be strengthened and they were reviewing the different roles and responsibilities of staff on the ward. For example, the introduction of senior support workers and lead nurses that led on specific areas on the wards.

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.

Managers maintained a risk register for the hospital. The risk register for the hospital included details of the risk, a risk rating and an action plan explaining how the risk was being addressed and a deadline for the completion of these actions. At the time of the inspection there were 9 risks identified on the risk register. These included nurse vacancies, high use of agency staff and documentation and record keeping.

Staff concerns matched those on the risk register. Staff spoke to us about risks relating to low numbers of permanent staff and frustrations with the outage of the electronic patient record system.

Daily operations planning meetings were held every morning. These involved ward managers and senior managers. The purpose of these meetings was to assess occupancy, risk, acuity, safeguarding and staffing.

Leaders within the service were actively working on mitigating risks. For example, significant progress had been made in recruiting more permanent nurses.

Information management

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

The loss of the electronic patient record in August 2022 had caused enormous difficulties. The wards had acted quickly to establish interim measures for recording patients' notes. However, it was very difficult for staff to access information about patients' care and treatment because patient information was saved in separate documents. Some staff were concerned that progress on resolving the problems was taking a long time.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff said they had sufficient computers to carry out their roles.

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

Requires Improvement

Information governance systems included confidentiality of patient records. All computer systems were assessed by individual usernames and passwords.

Staff made notifications to the relevant external bodies as needed. Staff sent notifications in a timely manner to the Care Quality Commission in relation to patients sustaining injuries, allegations of abuse and incidents reported to the police.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff were engaged in decision making about the ward through discussions at team meetings and clinical governance meetings.

The hospital had an agreement in place with a local NHS trust for 18 beds. A monthly compliance report was submitted to the trust to inform the trust of performance. The report reflected a variety of care delivery indicators which were discussed at the monthly contract meetings. The hospital also had a daily bed planning meeting with the trust to review upcoming referrals and possible discharges. Staff at the hospital thought this agreement was working well.

Learning, continuous improvement and innovation

The hospital management team were clearly committed to continuous improvement of the service. There had been a particular focus on the recruitment of permanent staff. Work had also taken place to enhance engagement with patients to co-produce and develop services at the hospital. Patients that were involved in the development of the service were rewarded with a certificate that demonstrated their involvement in the future of the service. This work resulted in the hospital being nominated for a national award.

A quality improvement project was underway to reduce the number of incidents related to smoking. Staff told us that they were keen to begin further improvement project in the future. For example, increasing links with services available in the community.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not always escalate physical health concerns appropriately. This meant there was a risk that deteriorating patients may not receive timely medical support. Blood glucose machines were not regularly calibrated. This meant that the machines could give incorrect readings that could lead to staff giving incorrect doses of medicines. Staff did not always follow NICE guidance when using rapid tranquilisation.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Governance processes were not sufficient to ensure all risks were identified and managed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment As part of the inspection, we reviewed the CCTV footage from 7 incidents. Overall, CCTV footage showed staff responding to patients' needs appropriately. However, we reviewed CCTV footage of 1 patient placed in the de-escalation room on Kingston Ward who was under close observation from staff. We noted that the patient attempted to leave the room on 8 occasions. On each

This section is primarily information for the provider

Requirement notices

occasion, they were prevented from doing so by staff. This meant the patient was secluded. Staff did not follow the procedure for seclusion set out in the Code of Practice. This meant that the safeguards, set out in statutory guidance, to protect the rights and safety of patients in seclusion were not followed.