Langford Clinic Limited

The Langford Centre

Inspection report

55-65 De La Warr Road
Bexhill on Sea
East Sussex
TN40 2JE
Tel: 01372744900
www.bramleyhealth.co.uk

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

Summary of findings

Overall summary

The Langford Centre is an independent mental health hospital providing care and treatment to working-age adults with severe mental illness. The service provides one low secure forensic ward, two high-dependency mental health rehabilitation wards and two acute mental health wards for adults of working age. The two acute mental health wards for adults of working age had recently opened during 2021 and this was the first time we had inspected these wards.

On 15 May 2022, a few days after the inspection, a patient sadly died after fixing a ligature to the sash-style window in their bedroom on Cooden ward, an acute mental health ward.

Due to the concerns we identified during this inspection, we used our powers under section 31 of the Health and Social Care Act to take immediate enforcement action and placed a number of conditions on the provider's registration. This meant that the provider could not admit patients to Fairlight or Cooden wards, the two acute mental health wards for adults of working age, without seeking written permission from the CQC. The CQC also required the provider to make improvements to how ligature risks were identified and managed on Cooden and Fairlight wards, and to how individual patient risks were assessed on Fairlight ward.

The urgent conditions were subsequently lifted and the provider was able to admit patients to Fairlight and Cooden wards from 9 June 2022. This was because the provider had taken prompt action to make improvements to keep patients safe. The provider worked in collaboration with the local mental health NHS trust to make some immediate improvements to the service.

Our rating for The Langford Centre went down. We rated it as requires improvement because:

- Each of the three core services were rated as requires improvement overall. Although immediate improvements were made in relation to the assessment and management of ligature risks and assessment of individual patient risk on the acute wards for adults of working age, these improvements needed to be sustained and embedded. We also identified a range of other areas for improvement during the inspection.
- The leadership and governance of the service needed to be improved. We received some reports of a poor leadership culture with some staff feeling that they had not been involved in discussions about recent service changes and unable to speak up due to fear of retribution. The provider needed to recruit to the ward manager posts on Seaford and Balmoral wards.
- Most of the issues we identified during the inspection were not known to the provider because they had not been identified by their own internal governance assurance processes. Staff recorded patient clinical information on both paper and electronic records, which posed a risk that all the information they needed to deliver safe care and treatment would not be accessed.
- The service was not safely staffed. This was because the provider relied heavily on temporary staff to cover vacancies, who were less familiar with patients' needs and the way the service operated. Leaders did not properly assess staff skill mix to ensure temporary staff had the right skills and experience to safely meet the needs of patients. The provider had started to make some progress with international nurse recruitment, but vacancies still needed to be filled.
- Potential ligature anchor points existed across the wards. Although the provider had a programme of works planned to minimise the presence of potential ligature risks, these works were not yet complete. A ligature anchor point is

anything that could be used to attach a cord or other material for the purpose of hanging or strangulation. We took urgent enforcement action because ligature risks had not been appropriately assessed and managed. The provider acted promptly to improve their approach to assessing and managing ligature risks, but this improved approach needed to be sustained and embedded.

- Initial patient risk assessments were not sufficient on the acute mental health wards for adults of working age. Initial risk screens were completed by the doctor on duty during admission but were not routinely accessible to staff. Risk assessments were not always developed in collaboration with the range of multidisciplinary team members, and some patients did not have an initial risk assessment in place for up to 11 days, meaning that staff were not suitably equipped to safely manage individual patient risks, such as suicide and self-harm. We took urgent enforcement action because the provider's approach to individual patient risk assessment was unsafe. The provider acted promptly to improve their approach to assessing patient risk, but this improved approach needed to be sustained and embedded.
- We identified a range of other safety concerns. On the acute mental health wards for adults of working age, staff completed patient observations at set times, rather than intermittently. This meant that it was possible that patients could predict when staff would next check that they were safe. Staff had not been trained to safely search patients for prohibited items, posing a risk that items that could cause harm could be brought onto the wards. Staff did not ensure that the physical health of one patient on Seaford ward who had received rapid tranquilisation was robustly monitored to minimise the side effects of the medication which put them at significant risk of physical health deterioration. Clinical waste on Balmoral ward was not safely managed, which posed a risk of injury and infection.
- Patients did not receive the appropriate support to develop their daily living skills and one occupational therapist was working across the entire hospital. This was not enough occupational therapy cover to meet the needs of patients, particularly on the high-dependency rehabilitation and low secure forensic wards, where patients needed to be supported for discharge to community settings after long stays in hospital.
- Although the provider operated two high-dependency rehabilitation wards, this service did not adhere to this model because the multi-disciplinary team cover, including consultant psychiatry and occupational therapy, was not enough to meet the needs of patients. Patients had stayed at the service for up to ten years, while patients requiring support from a high-dependency rehabilitation service should stay for up to one year.
- The provider did not ensure patients could easily access an independent mental health advocate (IMHA) and IMHAs were not routinely able to access the wards to meet with and introduce themselves to patients.
- We identified that many patients across the hospital did not have access to their care plan. On Fairlight ward, patients had not been involved in decisions about their care and treatment.
- Patients' privacy and dignity was not maintained on the acute mental health wards for adults of working age because bedroom doors either had peep-holes that anybody in the corridor could use to observe patients in their bedrooms, or viewing panels that were left in the open position by staff.

However;

- Permanent staff received support from ward managers, including those who were covering two wards because of ward manager vacancies. They had access to clinical supervision and appraisals.
- Patients were generally positive about their experience using the service and the provider was working to improve the quality of meals in collaboration with patients.
- Staff understood their roles in relation to the Mental Capacity Act 2005 and the Mental Health Act 1983 (MHA) and the application of the MHA was monitored closely by MHA administrators.
- Staff understood their responsibilities in relation to safeguarding and knew how to identify issues of potential abuse and how to escalate these.
- Staff managed medicines well and know how to report incidents.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	We rated forensic inpatient or secure wards as requires improvement because: • Potential ligature anchor points existed throughout the ward. These were not always assessed and managed appropriately to help manage the risk to patients. • Some patients could not access support to develop their daily living skills. There was limited occupational therapy support available to patients at the time of the inspection because the ward occupational therapist post was vacant. Some patients who were ready to prepare and cook their own meals were unable to do this because there was not enough space in the ward kitchen. • Independent Mental Health Advocates (IMHAs) did not routinely make themselves available to patients on the wards because their access was restricted. Therefore, they were not visible to patients. Instead, patients needed to ask staff to meet with the IMHA at a location elsewhere in the hospital. • The service relied heavily on temporary staff because vacant staff posts needed to be recruited to. This meant that patient leave was sometimes cancelled or changed with short notice. • Although staff felt very well supported by their ward manager, some reported that the hospital had a poor overall leadership culture and felt unable to raise concerns. • Essential clinical information was not always managed and stored appropriately. The provider used both paper and electronic records and ward staff did not routinely access electronic records, such as the doctors initial clerking in documentation and patient risk screen. However:

Summary of findings

- The ward was clean, staff followed infection, prevention and control procedures and since the last inspection staff had acted to ensure all clinical equipment was safe to use.
- Although there were staff vacancies these were normally filled by temporary staff and permanent staff worked hard to support them to work safely on the ward, providing them with a comprehensive induction.
- Staff had good therapeutic relationships with patients and supported them using verbal de-escalation if patients exhibited distressed behaviours. Consequently, patients did not often experience restrictive interventions such as restraint or rapid tranquilisation.
- Staff managed medicines safely and knew how to report and learn from incidents.
- Staff on the ward were supported in their roles. They attended regular team meetings and received regular managerial supervision. Staff spoke about how their career development had been supported whilst working at the service.
- Systems were in place to ensure the Mental Health Act 1983 (MHA) was applied in a lawful and appropriate way.
- Staff involved patients in decisions about their care. Patients were also asked to contribute to discussions about the service at weekly community meetings and a patient represented the ward at the hospital's patient council meetings.
- Staff worked closely with colleagues outside the organisation, including the provider collaborative and other healthcare providers, to support patients' transfer between services.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

- Although the provider reported that the service followed a high-dependency rehabilitation unit model, this was not appropriately adhered to. Patients stayed at the service for much longer than the anticipated maximum of 1 year for this type of service and lots of patients were experiencing delayed discharges because the

Summary of findings

rehabilitation model was not clear enough. Patients did not have access to the appropriate amount of multi-disciplinary specialist support required by a high-dependency rehabilitation service. The consultant psychiatry and occupational therapy cover was not appropriate to meet the needs of patients.

- Staff did not ensure that the physical health of one patient on Seaford ward who had received rapid tranquilisation was robustly monitored to minimise the side effects of the medication These patients would be at heightened risk of significant physical health deterioration. Staff did not have access to the necessary medicines to use in the event of a physical health emergency resulting from rapid tranquilisation.
- Potential ligature anchor points existed throughout the wards. These were not always assessed and managed appropriately to help manage the risk to patients. The ligature risk assessments were not robust enough and the ligature maps had not been updated on Seaford ward.
- Clinical waste was not safely managed. We identified an overflowing sharps bin on Balmoral ward that presented a risk of needle-stick injury and infection.
- The service had a high number of nursing staff vacancies which led to patients' Section 17 leave sometimes being cancelled. One registered nurse worked on each shift which left the wards without a nurse on duty if they went for a break or left to attend a meeting. There were some shifts where a registered nurse was not working on the ward and where nursing staff from other wards had to assist with tasks such as administering medication. The registered nurses working on the wards were not always registered mental health nurses.
- Patients access to their bedrooms was restricted because staff were not able to provide patients with bedroom keys, despite some being assessed as safe and capable of having their own key.

Summary of findings

- Patients were not routinely offered copies of their care plans and care plans did not demonstrate that patients and relatives had commented on aspects of their care and treatment where appropriate.
- The provider informed us that Seaford ward had recently been refurbished. However, the furnishings in the lounge looked tired and needed updating. We also saw loose electrical connections in a patient's bedroom next to the shower room.
- Patients could not easily access independent mental health advocates (IMHAs) because they were not routinely allowed to access the wards. Some patients did not know the role of an IMHA or how to contact them.
- Improvements needed to be made to the leadership and governance of the service. Both wards had vacant ward manager posts and the local governance processes had not identified that staff did not routinely complete physical health monitoring for patients who had received medicines via intramuscular rapid tranquilisation.
- Essential clinical information as not always managed and stored appropriately. The provider used both paper and electronic records and ward staff did not routinely access electronic records, such as the doctors initial clerking in documentation and patient risk screen.

However;

- The ward environments were clean and staff followed good practice with respect to safeguarding.
- Staff received training, supervision and appraisal. The ward staff worked well together as a team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity,

Summary of findings

and understood the individual needs of patients. Patients reported that staff were genuinely kind, they made them feel safe and supported them emotionally.

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

Requires Improvement

This core service had not been previously rated We rated it as requires improvement because:

- The ward environments were not safely managed because staff did not adequately assess and manage potential ligature anchor points, including sash-style bedroom windows. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Some staff did not know how to find and use ligature cutters.
- Staff did not safely observe patients. Patients were routinely observed by staff at different frequencies dependent on individual clinical risk. However, these observations were completed at set times rather than intermittently, meaning patients could predict when staff would observe them. Staff observed patients in some bedrooms using spy-holes, rather than viewing panels. This presented blind spots and meant that staff could not easily observe all parts of patient bedrooms.
- Managers did not ensure there were enough staff with appropriate skills rostered to work on each shift to ensure that all patients need could be met. We identified that only one staff member working the night shift on Fairlight ward during the week of the inspection had received training in preventing and managing incidents of violence and aggression. This presented a potential risk of harm to patients if restraint was required, because staff did not have the skills to safely restrain patients.
- Staff did not adequately assess patient risk on admission. Initial risk screens were completed by the doctor on duty, but these were not made routinely accessible to staff. On Fairlight ward we identified that three patients had not been subject to a timely multi-disciplinary risk assessment after their admission. The minutes

Summary of findings

of handover meetings between staff, where they discussed how to manage patient risk, were stored electronically and not routinely accessed by staff.

- Patients experienced blanket restrictions and the provider did not have a robust process for these restrictions to be reviewed. For example, patients did not have keys to their own bedrooms, could only smoke and access the ward garden at set times and did not routinely access to drinks and snacks.
- Staff had not been trained to safely search patients for contraband items that may pose a risk of harm to patients. Some patients reported that they felt unsafe because the process for staff searching patients for contraband items was not robust.
- Essential clinical information as not always managed and stored appropriately. The provider used both paper and electronic records and ward staff did not routinely access electronic records, such as the doctors initial clerking in documentation and patient risk screen.
- Patients were not always involved in planning their care. On Fairlight ward we identified that care plans were updated regularly by staff without the involvement of patients, and patients were not given copies of their care plans.
- Patients could not access the appropriate amount of support from an occupational therapist and could not access occupational therapy activities at weekends. Most patients reported feeling as though there was not enough to keep them occupied. One occupational therapist worked across the entire hospital.
- Staff did not use any clinical outcome measures to review improvement or progress patients have made whilst in the acute wards.
- Some staff reported that they had not received specialist training to equip them to carry out their roles successfully, particularly in managing the needs of the acute mental health patient group.

Summary of findings

- Patients could not easily access independent mental health advocates (IMHAs) because they were not routinely allowed to access the wards. Some patients did not know the role of an IMHA or how to contact them.
- Patient privacy and dignity was compromised because bedroom door viewing panels were left in the open position by staff. Bedrooms with spy-holes in their doors could also be observed by anyone in the bedroom corridor.
- Patients relied on support from staff to lock their bedroom doors and there was no lockable space in patient bedrooms to secure personal items.
- The provider did not have appropriate local governance systems in place to effectively assess, monitor and improve the quality and safety of the service. Issues with a defibrillator not being in working order, a lack of patient involvement in care planning, complaints documentation not being stored appropriately and inconsistencies between the way ligature risks had been assessed on each ward had not been identified by the provider.

However:

- The service had appropriate medical cover which included access to out of hours doctors. Each ward had a junior doctor located on the ward, working Monday to Friday to support patients and to manage new admissions.
- Each ward had safeguarding champions and these champions met on a monthly basis with the senior leadership team to review all safeguarding issues across the wards
- Each patient had their own bedroom with an en-suite bathroom. Patients personalised their bedrooms with pictures and personal items.

Summary of findings

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Summary of this inspection

Background to The Langford Centre

The Langford Centre provides low secure forensic, high-dependency rehabilitation and acute inpatient mental health services to adults. Most patients are detained under the Mental Health Act (1983).

The service is provided by Bramley Health Limited.

The hospital is purpose built and provides sixty-seven beds over five wards:

- Seaford Ward (9 beds) is a high-dependency rehabilitation ward for males,
- Balmoral Ward (11 beds) is a high-dependency rehabilitation ward for females,
- Fairlight Ward (16 beds) is a 16 bed female acute ward
- Cooden Ward (15 beds) is a 15 bed male acute ward,
- Pevensey Ward (16 beds) is a 15 bed male low secure forensic ward,

The Langford Centre is registered to provide:

1. Treatment of disease, disorder or injury
2. Assessment or medical treatment for persons detained under the Mental Health Act 1983
3. Diagnostic and screening procedures

The Langford Centre was last inspected in October 2020. This inspection consisted of a visit to Camber ward, which was a ward for people with a learning disability or autism. This ward closed in 2021 and the hospital opened two new acute wards, Fairlight and Cooden, these beds are funded directly by the local MH trust for local patients.

We last inspected all core services at the hospital during a comprehensive inspection in June 2018. The hospital was rated as good in all key questions and therefore was rated good overall.

The site visit of the inspection took place on 10-12 2022, however during our inspection window, while we were continuing to review evidence as part of the inspection process, a death sadly took place on 15 May. Subsequently we took urgent civil enforcement action against the provider. Concerns were in relation to how ligature risks were assessed and managed, and how individual patient risks were assessed on Fairlight and Cooden wards.

On 15 May 2022, a few days after the inspection, a patient sadly died after fixing a ligature to the sash-style window in their bedroom on Cooden ward. As a result of this patient's death and our feedback following the inspection, the provider decided to commission a programme of works to replace all sash-style bedroom windows across the hospital. The provider locked all bedroom windows to manage this risk in the immediate future.

The CQC issued a Notice of Decision under Section 31 of the Health and Social Care Act 2008 on 18 May 2022. The Notice of Decision imposed conditions on the provider's registration and was specifically related to the acute wards.

We took this urgent action because we believed a person would or may have been exposed to the risk of harm.

The conditions imposed required the provider to:

Summary of this inspection

- seek written permission from CQC before admitting or readmitting patients to Fairlight or Cooden wards at the hospital
- ensure that a suitably qualified and experienced person undertakes a comprehensive environmental risk assessment of Fairlight and Cooden wards. This must include identification of all ligature anchor points and details of a clear process for managing these, if they cannot be removed and that a copy must be provided to CQC
- ensure that a suitably qualified and experienced person undertakes a comprehensive risk assessment of every service user at Fairlight and that a copy must be provided to CQC

These conditions were subsequently removed on 9 June 2022 because the provider had taken prompt action to improve and keep patients safe. They worked in collaboration with the local mental health NHS trust do make the immediate improvements to the service.

How we carried out this inspection

The team that inspected the hospital comprised two CQC inspection managers, five CQC inspectors, three specialist advisors and one expert by experience.

Before the inspection visit, we reviewed information that we held about the hospital and recent inspection reports.

During the inspection, we looked at the quality of the ward environments, observed how staff were caring for patients and spoke with 31 patients.

We spoke with a range of staff members including ward managers, consultant psychiatrist, nurses, occupational therapists, occupational therapy assistants, healthcare support workers and an assistant psychologist.

We reviewed 20 sets of care records and 28 medicine records and reviewed a range of documents relating to the running of the hospital.

We also looked at the medicines management on both wards including medicine charts and associated Mental Health Act 1983 documentation and physical health monitoring following administration of rapid tranquilisation.

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 the service MUST take to improve:

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

- The provider must ensure improvements to how ligature risks are safely assessed and managed are sustained and embedded, and that ligature risk assessments continue to be developed by a suitably trained person. **Regulation 12 (2) (d)**

Summary of this inspection

- The provider must ensure patient observations are completed intermittently rather than at set times. **Regulation 12 (1) (2) (b)**

- The provider must ensure nursing staff with the appropriate skills are rostered to work on each shift to safely meet the needs of patients, and that staff receive the necessary specialist training to ensure they are skilled and competent to carry out their roles. **Regulation 18 (1)**

- The provider must ensure improvements to assessing patient risk in a comprehensive and timely manner are sustained and embedded. **Regulation 12 (2) (a) (b)**

- The provider must ensure staff are trained to safety search patients to keep them safe from risks posed by contraband items. **Regulation 12 (1) (2) (b)**

- The provider must ensure blanket restrictions are systematically reviewed and appropriate for patients based on clinical risk, and that patients can secure their personal items in a lockable space independently. **Regulation 13 (1) (4) (b) (c) (5)**

- The provider must ensure all essential clinical information is appropriately managed and routinely accessible to staff. **Regulation 17 (1) (2) (c)**

- The provider must ensure patients are involved in planning their care and treatment. **Regulation 9 (1) (c) (3) (a) (c) (d) (g)**

- The provider must ensure that patients can access an appropriate amount of occupational therapy led therapeutic activities, including during evenings and at weekends. **Regulation 9 (1) (a) (b)**

- The provider must ensure patients can easily access independent mental health advocates (IMHAs) on the wards. **Regulation 9 (1) (3) (c) (d) (f)**

- The provider must ensure appropriate governance systems are in place to assess, monitor and improve the quality and safety of the service. **Regulation 17 (1) (2) (a)**

Long stay or rehabilitation mental health wards for working age adults

- The provider must ensure ligature risks are safely assessed and managed and that ligature risk assessments are developed by a suitably trained person. **Regulation 12 (2) (d)**
- The provider must ensure clinical waste including used sharps are managed safely to minimise the risk of injury and infection. **Regulation 12 (1) (2) (h)**
- The provider must ensure staff safely monitor the physical health of patients who have received medicine by intramuscular rapid tranquilisation to help identify significant potential physical health deterioration, and that staff have access to the necessary emergency medicines to manage a physical health emergency. **Regulation 12 (1) (2) (b) (f)**
- The provider must ensure patients can easily access independent mental health advocates (IMHAs) on the wards. **Regulation 9 (1) (3) (c) (d) (f)**
- The provider must recruit to the ward manager posts on Seaford and Balmoral wards. **Regulation 18 (1)**

Summary of this inspection

- The provider must operate effective governance systems to enable the provider to assess, monitor and improve the quality and safety of the service. **Regulation 17 (1) (2) (a)**
- The provider must adhere to an inpatient rehabilitation model and ensure the anticipated length of stay, patient discharge plans and multidisciplinary staffing provision, including occupational therapy and consultant psychiatry, align with this model. **Regulation 9 (1) (3) (a)**
- The provider must ensure that each patient has a plan for their discharge from the service. **Regulation 9 (1) (3) (b)**
- The provider must ensure patients have access to a key to their own bedroom where this is clinically appropriate. **Regulation 13 (1) (4) (b) (c) (5)**
- The provider must ensure all essential clinical information is appropriately managed and routinely accessible to staff. **Regulation 17 (1) (2) (c)**

Forensic Wards

- The provider must ensure ligature risks are safely assessed and managed and that ligature risk assessments are developed by a suitably trained person. **Regulation 12 (2) (d)**

- The provider must ensure patients have the appropriate support to develop their daily living skills, including the ability to cook and prepare meals with appropriate support from an occupational therapist. **Regulation 9 (1) (a) (b) (2) (3) (b)**

- The provider must ensure patients can easily access independent mental health advocates (IMHAs) on the wards. **Regulation 9 (1) (3) (c) (d) (f)**

- The provider must ensure all essential clinical information is appropriately managed and routinely accessible to staff. **Regulation 17 (1) (2) (c)**

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 hospitals.

Action the service SHOULD take to improve:

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

- The provider should ensure patients privacy and dignity is respected by ensuring bedroom door viewing panels are kept in the closed position.

- The provider should ensure patients receive an appropriate induction and orientation to the wards when they are first admitted.

- The provider should ensure informal patients are aware of their right to leave the ward.

- The provider should embed outcome measures to assess and record the effectiveness of its interventions for patients.

Long stay or rehabilitation mental health wards for working age adults

Summary of this inspection

- The service should consider making improvements to the ward environments and furnishings to make them feel more homely.
- The provider should ensure that the current registered nursing vacancies are recruited to. The provider should ensure that it deploys enough suitably qualified, skilled and competent nursing staff on every shift, across all the wards who knew the service well to ensure consistency of care.
- The provider should ensure patients are offered copies of their care plans and that care plans reflect patients' personal goals and that patients and carers are involved in developing care plans where possible.

Forensic Wards

- The provider should continue with its work to recruit to vacant nursing staff posts and ensure patients can access their Section 17 leave as agreed.
- The provider should consider how to improve the leadership culture of the hospital and ensure that staff feel able to raise concerns without fear of retribution.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Requires Improvement

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

Safe and clean care environments

The wards were clean well equipped, well furnished, well maintained and fit for purpose but improvements were needed to the way that staff identified and managed ligature risks.

Safety of the ward layout

Potential ligature anchor points existed throughout the ward. These were not always assessed and managed appropriately to help manage the risk to patients. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. For example, sash style windows in patients' bedrooms had been scored as low risk on the ward ligature risk assessment which did not reflect the potential risk they posed to patients. The ward manager had not been trained or given support by the provider to assess ligature risks in the environment.

Staff could easily observe all areas of the ward. Blind spots were checked regularly by staff and the nursing office was situated in the centre of the ward which meant that most areas could be directly observed form this point with ease. The provider had installed mirrors and closed-circuit television cameras to improve observation. We observed that a staff member was always present in the communal areas. Staff checked all bedrooms and communal areas for any contraband items or items that posed a risk to patients.

The service complied with guidance from Department of Health and Social Care guidance on eliminating mixed-sex accommodation in hospitals as they only admitted male patients.

Staff carried personal alarms to call for assistance if required and patients had access to call bells to call for help.

Maintenance, cleanliness and infection control

The ward was visibly clean in all areas, well maintained, furnished and fit for purpose.

Staff made sure cleaning records were up to date and domestic staff visited daily to clean all areas.

Requires Improvement

Forensic inpatient or secure wards

The service had a policy in place regarding infection prevention and control and staff followed the policy including hand washing and wearing the appropriate personal protective equipment to help limit the spread of Covid-19. Hand sanitiser dispensers were available for staff and visitors to use before entering the ward.

Staff reported that maintenance issues were easy to report and were fixed in a timely manner.

Clinic room and equipment

During the last inspection in June 2018, we identified that clinical equipment was not always in date, calibrated and safe to use. At this inspection, we identified that this had improved and equipment was in date, calibrated and safe to use. Out of date equipment was removed and disposed. The clinic room was fully equipped, and equipment was clean and checked regularly.

Emergency drugs were available to the relevant registered staff, and staff checked and audited stock medicine weekly. Staff monitored room and fridge temperature daily and all medicines were labelled and were in date.

Safe staffing

The service was operating with some staff vacancies that were being filled by temporary staff.

Nursing staff

We reviewed the nursing and care vacancies on the ward and identified that there were three vacancies for registered nurses and four vacancies for therapeutic support workers. The provider was in the process of completing pre-employment checks for therapeutic support workers and nurses and expected to have the new staff in post soon. We identified that patients' agreed leave under Section 17 of the MHA was sometimes re-arranged at short notice because staff were too busy. The provider did track whenever leave was cancelled. However, they didn't always give the rational as to why leave had been cancelled or rearranged.

The provider had taken steps to recruit nurses from overseas following the introduction of overseas nursing programme by the UK government. For example, the provider had recruited eight pre-registered nurses who were ready to sit the Observational Structured Certificate Examination (OSCE) in the coming months and would become registered nurses if they passed the exams.

The ward manager could adjust staffing levels according to the needs of the patients.

The service relied heavily on agency staff. Most of these agency staff regularly worked on the ward and knew the patients and permanent staff provided a comprehensive induction to temporary staff during their first shift. Twenty-two percent of registered nurse shifts were covered by agency staff between February and April 2022, and 47% of all nursing support worker shifts were covered by agency staff during the same time frame.

Each patient had an allocated named nurse and named therapeutic support worker and patients spent appropriate amounts of time with their allocated staff members.

At the time of this inspection, the provider was investigating a complaint about staff sleeping during night shifts.

Medical staff

The service had appropriate medical cover and a doctor could attend the ward quickly in an emergency. We reviewed the staffing structure and saw that the ward had a consultant forensic psychiatrist who worked one and half days a week and was contactable outside their working day for advice.

The ward was also covered by a junior doctor each working day. A consultant psychiatrist always worked on-call across the hospital. Each patient was registered with a GP.

Mandatory training

Staff had received and were up to date with most appropriate mandatory training.

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

The provider had set 23 training sessions as mandatory training and 87% of the staff were up to date with their training.

Leaders monitored mandatory training compliance and alerted the ward manager and staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed a risk assessment for every patient on admission and updated these regularly including after any incident. We reviewed four care records and found that staff used recognised risk assessment tools to assess all patients on admission. Each patient had a Historical Clinical Risk Management (HCR20) in place. This is a structured tool for assessing each patient's risk to others. Staff updated the HCR20 regularly including after any incident.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. For example, some patients required close supervision while using e-cigarettes.

Staff followed the provider's policy on the use of observation and searching patients. Patients were searched on return from Section 17 leave and bedrooms were searched only if staff had reason to suspect a contraband item was hidden. Items such as cutlery were checked and counted at various points throughout the day to ensure these were being stored securely and safely in the right place.

Staff applied blanket restrictions to patients only when necessary. For example, a carefully considered list of contraband items was in place, including items such as aerosol sprays and razor blades, which were stored safely by staff and used under staff supervision because they posed a risk of harm to patients. The restricted items list was subject to a routine review where staff considered whether the list of contraband items was an appropriate restriction on patients.

During the last inspection in June 2018, we identified that patients with high modified early warning system scores (NEWS2) were not always referred to a nurse or doctor for further investigation. During this inspection we found that staff monitored the physical health of patients regularly using the observation chart for the (NEWS2) and referred patients to a nurse or a doctor for investigation where necessary. NEWS2 is a tool that aids the detection and response to clinical deterioration in adult patients. Staff were trained in the use of the NEWS2 chart to identify deteriorating patients. Staff said they were confident about using the tool and escalating issues as appropriate. We reviewed NEWS2 forms and found they were filled in appropriately in line with the providers policy.

Staff knew where the emergency equipment was kept, and it was checked by a nurse on each shift to ensure all components were present and safe to use.

Use of restrictive interventions

During the last inspection in June 2018, blanket restrictions were not always assessed and reviewed to ensure they were in a patient's best interest. During this inspection, we identified that this had improved and staff used blanket restrictions only when it was necessary. Staff took an individual approach to restrictions on patients and ensured they were in patients' best interests. For example, some patients had been identified as being safe to keep their own bedroom keys, whilst other patients required support from staff to access their bedrooms because it was not clinically appropriate for them to have a set of keys.

The provider had an incident reporting system, staff discussed and learnt from incidents including the events that led up to episodes of restraint. However, there was not yet a formal reducing restrictive interventions programme in place which aimed to track and analyse themes/ trajectories in relation to the use of restrictive interventions such as restraint and rapid tranquilisation.

The ward had three episodes of restraints, no use of rapid tranquilisation and no seclusion in the last 12 months.

Staff were competent at using skilled de-escalation techniques. This helped minimise the need for restrictive interventions such as restraint.

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

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.

The ward had a safeguarding vulnerable adult protocol in place and all staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff had face to face training relevant to their role in safeguarding adults and children. Ninety three percent of staff had completed this training.

Staff gave clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff followed clear procedures to keep children visiting the ward safe. There was an allocated visitors room away from the ward.

Staff access to essential information

Most patients' care and treatment records were kept in paper files. These were well organised, stored securely and accessible to staff. However, the initial clerking in documents completed by the doctor on admission were stored electronically and not routinely accessed by staff. Staff reported that they did not routinely have access to computers. This posed a risk because the duplicate system of using electronic and paper records meant staff could miss checking risk information on the electronic records because they did not routinely have access to computers on the ward.

The provider had plans to develop electronic care and treatment records in the future. The ward staff had access to two shared computers and staff reported that it was difficult to access these computers due to demand.

Medicines management

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

We reviewed 15 medicines records and saw that staff prescribed and administered medicines safely. Medicines were prescribed in line with National Institute for Health and Care Excellence guidelines and staff monitored the physical health of patients receiving high dose antipsychotic medicines. Staff used the NEWS2 template to do this.

Medicines records were accurate and up to date. T2 consent to treatment forms were attached to the cards and with the renewal of section dates noted on all charts. Second opinion appointed doctor T3 certificates were attached to the charts where appropriate.

Ward staff could access advice from a pharmacist who attended the ward once a week.

Staff who worked out of hours could access the provider's on-call pharmacy service for medicines advice. Ward rounds took place fortnightly depending on patient's need and medicines were discussed and reviewed.

Posters were displayed advising patients about common medicines prescribed on the ward, including why they were prescribed, what the common side effects were and who to contact to discuss them.

The ward also had daily ward huddles where urgent medicine concerns could be raised amongst staff.

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. Incidents were investigated and lessons were shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew how to report incidents using the providers incident reporting forms. Incidents were discussed by staff at team meetings and at staff handovers.

Staff learnt from incidents. For example, following an incident of violence and aggression involving one patient, a clinical decision was made for female staff to de-escalate similar incidents of distress in future, because the patient did not normally respond well to male staff.

Staff described incidents in 'incident huddles' to debrief and identify any initial learning following incidents.

The ward had no serious incidents on the ward in the 12 months prior to the inspection.

Staff understood the duty of candour and talked about being open and transparent with patients when things went wrong.

Requires Improvement

Forensic inpatient or secure wards

The ward manager investigated incidents thoroughly. Patients and their families were involved in these investigations. For example, the ward manager showed us details of communication between them and a family member relating to an incident that they were investigating.

Are Forensic inpatient or secure wards effective?

Requires Improvement

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans that were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, were personalised, holistic and recovery oriented. They included specific safety and security arrangements.

We reviewed four patient care and treatment records and identified that staff completed a comprehensive assessment of physical and mental health needs of patients on admission to the ward.

Staff developed a recovery focused, personalised care plan with patients and reviewed these regularly at multidisciplinary team meetings.

Best practice in treatment and care

Our findings were quite mixed. Some patients said that there weren't enough activities for evenings and weekends. However, some of the activities that were available to patients who did have section 17 leave, included litter picking, car valeting, horticulture, bricklaying, garden maintenance, purchasing magazines, and building and construction.

The provider was trying to recruit to the occupational therapist post for the ward but in the meantime, there was only one OT across the hospital therefore the impact on patient was that they didn't have easy access to one -to-one or group sessions with the OT. The ward kitchen was small and crowded. The manager received numerous complaints about patients wanting to cook their own food but had to wait longer to access the kitchen. Therefore, some patients who had been assessed as being able and ready to develop their living skills by budgeting, preparing and cooking their own meals, were unable to do this. Some patients reported there were not enough activities to keep them occupied during at evenings and weekends.

However, some patients who were granted Section 17 leave and therefore able to access the hospital grounds were involved in building a chicken coup and aimed to start looking after chickens soon. Patients were supported to grow vegetables in the hospital grounds and take on paid roles such as car valeting and litter picking.

Staff facilitated an on-site gym session for patients once a week. One patient reported that there were not enough opportunities to take part in exercises within the hospital, which particularly affected patients who did not have much section 17 leave and could not use the local gym or swimming pool in the community.

Requires Improvement

Forensic inpatient or secure wards

Patients had access to psychology interventions. These interventions included one-to-one sessions in distress tolerance, anxiety management, dialectical behavioural therapy, anger management and violence reduction. An ex-patient was supported by psychology staff to visit the ward and run group mindfulness sessions.

Staff used outcome measures for each psychological intervention to help identify whether the intervention had been beneficial to the patient.

Physical health checks took place at least weekly for all patients. One of the registered nurses had a lead role in ensuring patients' physical health needs were met. This included linking up with GPs and ensuring the service complied with the Commissioning for Quality and Innovation (CQUIN) target to assess document and act on cardiometabolic risk factors in patients with psychosis including schizophrenia.

Staff made efforts to support patients to lead a healthy lifestyle. For example, patients accessed smoking cessation advice and equipment such as nicotine patches to help them reduce their smoking.

Staff used recognised rating scales to including Health of the of the Nation outcome scales to assess and monitor outcomes for patients.

At the time of the inspection staff were involved in quality compliance audits. For example, NEWS2 audit, emergency bag audits, first aid box audits infection control audits and fire safety audits.

Skilled staff to deliver care

The ward team had access to some specialists to meet the needs of the patients on the ward. They included a consultant psychiatrist, psychologist, nurses and therapeutic support workers. Physical health nurses also attended the ward when required. There was one OT covering the whole hospital at the time of the inspection and the service was in the process of recruiting to the ward OT post.

Staff mostly had the right skills, knowledge and experience to meet the needs of patients. However, leaders did not always assess the skill mix of temporary staff who were rostered to work on the ward.

Each new staff member received a full induction to the service before they started work.

Staff received supervision in line with the provider's policy. Eighty seven percent of staff were up to date with their supervision over the past four months. Staff also participated in weekly reflective practice sessions led by the clinical psychologist. The ward manager conducted an annual appraisal of each member of staff's work performance and 93% of the staff had received an appraisal in the last year.

The ward manager supported staff with their professional development. For example, we spoke to two staff members who were supported to develop their skills and experience on the job and had secured more senior positions such as senior therapeutic care workers. The provider agreed to fund specialist training courses for staff where appropriate. For example, an existing therapeutic care worker had been supported by the provider to undertake training to become a clinical psychologist.

The ward manager explained how they supported staff through periods of poor performance.

Requires Improvement

Forensic inpatient or secure wards

Multi-disciplinary and inter-agency teamwork

Staff from different disciplines worked together as a team to benefit patients. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff worked closely with other teams within the organisation and external organisation such as local authorities and commissioners of healthcare services. A social worker worked across the hospital. However, staff reported that this post had been vacant until recently and they were pleased that patients were now receiving appropriate support with their finances.

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 but patients could not easily access support from an Independent Mental Health Advocate (IMHA) because they did not routinely attend the ward.

All staff had received, and kept up to date, with training on the Mental Health Act (MHA) 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.

Staff knew who their Mental Health Administrators were 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.

The service needed to improve the accessibility of the Independent Mental Health Advocate (IMHA). The IMHA was not routinely allowed to access the ward. This meant that patients did not often see the IMHA on the ward. Instead, patients obtained their details from a poster and approached staff to make a request to schedule a session with the advocate elsewhere away from the main ward. Patients were not routinely introduced to the IMHA when they were first admitted to the service.

Staff explained patients' rights under the MHA to them in a way that they could understand, repeated the process as necessary and recorded these attempts clearly in the patient's clinical record.

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

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. For example, Section 17 leave forms were kept in order in the nursing office and staff completed risk assessments before patients went on Section 17 leave, which included a self-assessment by patients.

The ward did not have informal patients.

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

All patients had care plans which included information about understanding their detention under the MHA.

Staff ensured the service applied the MHA correctly by completing audits and discussing the findings.

Requires Improvement

Forensic inpatient or secure wards

Good practice in applying the Mental Capacity Act

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

Staff demonstrated a good understanding of the Mental Capacity Act (MCA). For example, 87% of the staff had received training in MCA training. Staff presumed patients had capacity to make decisions unless there was reason to consider otherwise.

At the time of inspection, no patient was subjected to the Deprivation of Liberty Safeguards. However, staff knew how to make an application.

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

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Doctors undertook capacity assessments when necessary. For example, one patient had been subject to a capacity assessment around whether they could safely decide and weigh up a decision around whether to take their medicines.

Staff made decisions in patients' best interests where necessary and involved relatives where possible. For example, staff had followed the best interest decision process to support a patient to be transferred to an appropriate placement when they were discharged.

Are Forensic inpatient or secure wards 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.

Patients said staff treated them well and were kind. Staff were discreet, respectful, and responsive when caring for patients. For example, two patients told us staff were respectful and showed empathy towards them. However, other patients felt differently. Two patients told us staff were not always polite to them.

Staff supported patients to understand and manage their own care treatment or condition. For example, patients we spoke to felt staff involved them in their care planning process and had copies of their care plans given to them if they wanted them. Patients also reported that they attended their ward round and were able to contribute to discussions about their care and treatment with doctors.

Requires Improvement

Forensic inpatient or secure wards

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

Patients reported that the quality of food had improved. The chef had visited the ward to consult with patients about potential menu changes and feedback on how food could be improved was actively sought during morning planning meetings with patients. However, two patients told us the food was not always good.

Patients had access to an activity room where they had access to a computer tablet to browse the internet or to play games. However, one patient reported needing to wait a long time to access a tablet device as there were only two of them available.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.

Involvement of patients

Staff introduced patients to the ward during the admission process.

Patient views were included in their care plans and staff offered each patient a copy of their care plan. However, we received mixed feedback from patients about how involved they felt in their care planning. For example, one patient told us he had not seen a copy of his care plan before.

Staff supported patients to attend weekly community meetings where patients were able to give feedback and raise any concerns about the service. A daily planning meeting also took place where patients discussed their individual plans for the day including personal appointments and leave arrangements.

Some patients were members of the patient council. The patient council provided a voice for patients and carers in the design, development and delivery of the provider's services. The council met periodically to discuss a range of views with management and fed back to patients during community meetings.

During the last inspection in June 2018, we identified that patients did not always receive feedback on their comments and suggestions. During this inspection, we identified that patients received feedback on their comments and suggestions. For example, patients filled in food feedback forms and the findings were discussed and documented in the minutes of community meetings. Staff acted on issues that were raised in community meetings as quickly as possible.

The provider had information about accessing IMHA, but the IMHA did not routinely make themselves available to patients on the wards because their access was restricted.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff helped families to give feedback on the service using a carers survey. Some families and carers attended Care Practice Approach meetings and ward round meetings.

Are Forensic inpatient or secure wards responsive?

Requires Improvement

Forensic inpatient or secure wards

Good

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

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

All beds were full at the time of the inspection. Patients who were granted overnight leave always had a bed to return to. The Kent, Sussex and Surrey provider collaborative (South East) for low and medium secure services met on Thursdays to discuss bed occupancy and patient progress against discharge goals in local services. All patients were from the local area covered by the provider collaborative.

Staff worked to make sure they did not discharge patients before they were ready, and patients were only transferred to other similar services based on clinical need.

Discharge and transfers of care

The ward did not have any patients whose discharge had been delayed at the time of the inspection.

Staff planned for patients' discharge, including good liaison with care managers/coordinators. For example, the ward manger told us they held discharge planning meetings with the MDT, community teams, case managers and care managers to discuss how and when to discharge patients at a safe time. Most patients were discharged to community supported living settings.

Staff supported patients during referrals and transfers between services. For example, if they required treatment at an acute hospital or temporary transfer to a psychiatric intensive care unit.

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.

Patients had access to their own mobile telephones where clinically appropriate. The ward had a payphone that patients could use to make calls in private. The ward had quiet rooms available for patients to use at any time.

Patients had access to ward garden. However, this was only accessible with support from staff at times that were arranged in advance because it was shared with another ward. Patients who had Section 17 leave granted could access the wider hospital grounds and take part in activities such as gardening and building a chicken coup. These activities in the hospital grounds were often done in collaboration with patients from other wards.

The ward had a large lounge, activities room and small group room that patients could access. A de-escalation room was also available for patients to spend quiet time if they wished.

Patients could access the kitchen under staff supervision and could make snacks and hot drinks as they wished. However, the kitchen was too small to accommodate more than two patients at a time.

There was also lockable storage in patients' bedrooms in their bedside cabinets. Some patients also had a safe in their room to store their possessions.

Patients were encouraged to maintain contact with their families and staff ensured they facilitated this where appropriate.

Patients' engagement with the wider community

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

Patients who were granted Section 17 leave were encouraged to integrate into the wider community. For example, staff supported patients to access a local swimming pool and with walks to local nature reserves and the seafront. Some patients were involved in playing guitars, gardening and brick laying. Patients engaged in paid work such as litter picking and car/van cleaning. One patient had recently completed college.

Staff supported patients to keep in touch with people who mattered to them. For example, staff proactively supported patients to speak with relatives on the telephone, especially when they lived too far away to visit them regularly.

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 met the needs of all patients who used the service including those with a protected characteristic. The ward had personal emergency evacuation plans in place for patients who required them, which meant that staff knew how to safely evacuate patients with mobility needs in an emergency.

Staff provided patients with communication, cultural and spiritual support. For example, staff reported supporting patients with their religion by escorting patients to places of worship when appropriate and by arranging places on the ward for patients to pray without being disturbed.

Staff provided access to spiritual support when required. For example, one patient told us they used their section 17 leave sometimes to go to church on Sundays.

The provider displayed information about services, including advocacy, clearly on noticeboard on all the ward.

The staff could access an interpreter service for a patient on the ward whose first language is not English. An interpreter was arranged for their ward round and care programme approach meetings and could be contacted at short notice.

Staff supported patients with specific communication needs. For example, one patient had a communication passport for staff to refer to. This enabled staff to communicate in an effective way that the patient was comfortable with.

Staff worked closely with the kitchen staff to ensure patients' dietary needs including the need for culturally appropriate foods were met. Patients could choose from available options such as vegetarian, vegan and halal options.

Requires Improvement

Forensic inpatient or secure wards

Listening to and learning from concerns and complaints

Staff provided information leaflets on how to make complaints and displayed them on the notice boards. Staff could arrange for these to be provided in easy read format or different languages if needed.

Patients we spoke with knew how to complain and staff supported them to do so.

Are Forensic inpatient or secure wards well-led?

Good

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

Leadership

The ward manger had the skills, knowledge and experience to perform their role. They had a good understanding of the service they managed and were visible on the ward and approachable for patients and staff.

Staff on the ward spoke highly of the manager and felt supported at ward levels.

At the time of the inspection, the ward manager was covering for the ward manager vacancy on Seaford ward, which provided treatment to patients requiring long stay/rehabilitation treatment. This meant they spent more time away from the ward than usual.

Vision and strategy

Not all staff were familiar with the provider's vision and values and how they applied to the work of their team. Although staff had not participated in discussions about the vision and strategy of the service, senior leaders did want to prioritise involving staff in these discussions in future.

Culture

We received mixed feedback about the overall leadership culture of the hospital. Some staff reported they didn't always feel listened to and didn't feel as if their feedback about the service was welcome. They also explained that there was a culture of blame when things went wrong or when staff raised concerns. Some staff also explained that leaders had not involved them in discussions about service changes. In recent months, some wards in the hospital had changed purpose and lots of staff had moved to work in different teams.

However, ward staff got along well with each other, supported each other and worked well as a team.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level.

The provider had a clear framework of what was discussed at governance meetings and how this was fed back to staff. Team business meetings were available for all staff to attend. These involved discussions about learning and reflective practice.

The provider had a programme of audits which provided assurance about the performance of the service. Staff acted on findings following audits. A clinical records audit was completed by a senior nurse. MHA administrators routinely checked records to help ensure detention paperwork was kept in order and in date.

Requires Improvement

Forensic inpatient or secure wards

Management of risk, issues and performance

During the last inspection in 2018, we identified that the hospital risk register did not include all identified risks. During this inspection, we found that hospital now had an up to date risk register in place. The ward had contingency plans for emergencies, and this was reviewed as part of their risk register with action plan to mitigate identified risks. The ward carried out regular health and safety checks including regular fire drills. The ward team reviewed the risks for the wards every day. The ward teams knew the patients well and could defuse situations effectively before they escalated.

Information management

Staff collected analysed data about outcomes and performance.

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

The ward manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. They received information from the central administrative team who monitored mandatory training and alerted the staff when they needed to update their training.

Staff had access to equipment and technology needed to do their work. However, staff we spoke with told us the ward had access to only two laptops which made it difficult for staff to complete their records on time.

Staff knew the process for sending notifications to outside bodies, such as the CQC, and did so promptly.

Engagement

Patients and carers had opportunities to give feedback on the service, either informally at multidisciplinary reviews or through patient satisfaction questionnaires. Wards had patient

representatives who attended a monthly patient council meeting to provide feedback to senior manager from the service.

Learning, continuous improvement and innovation

The service was accredited by the Royal College of Psychiatrists quality network. As part of the accreditation process, staff working on the ward had the opportunity to join reviews of similar local services.

The trainee clinical psychologist was undertaking evidential research into interventions used to address patients with history of sexual offences. This research aimed to identify the most appropriate interventions to use with people who had committed sexual offences and who presented with mental health conditions.

The provider started a project to acquire specialist vapes which are safe to use on secure wards. The project is at its trial stage and awaiting final approval by management.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

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

Requires Improvement

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

Safe and clean care environments

The ward environments were not safely managed. There were multiple fixed ligature points across both wards that were not always assessed appropriately.

Safety of the ward layout

Potential ligature anchor points existed throughout the wards. These were not always assessed and managed appropriately to help manage the risk to patients. For example, the dining area on Balmoral ward had curtain rail hooks which could be used as a fixed ligature anchor point. The toilet roll holder in the patients' toilet on Balmoral ward could also be used as a fixed ligature anchor point.

Ward managers were required to complete ligature risk assessments, but they had not been supported adequately by the provider to complete these safely and accurately. We also saw that the ligature map on Seaford ward which was supposed to show where the ligature risks were and locations of the ligature cutters had not been updated.

There were CCTV cameras that operated across the wards. Staff told us that the CCTV was used to help staff review ward incidents.

The wards complied with the Department of Health and Social Care guidance on eliminating mixed-sex accommodation in hospitals. Balmoral ward was a female only ward and Seaford ward was a male ward.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean and fit for purpose. While we saw that the furnishings in the lounge on Seaford ward required updating, the provider informed us that these were taken from other parts of the hospital and that new furniture had been ordered for the wards.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff made sure cleaning records were up-to-date and the premises were clean. Staff and patients informed us that the wards were always clean.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

The wards had clinic rooms which were used to store medicines and medical records. Resuscitation and other emergency equipment bags were stored in the nursing office.

If physical examinations or procedures were required these took place in the patient's bedroom.

Improvements needed to be made to ensure clinical waste was managed safely. Both wards had waste and sharps bins in the clinic room. However, on Seaford ward, we saw that the waste bin was left open and on Balmoral ward the sharps bin was overfilled which posed a risk of needle-stick injury and potential infection.

Safe staffing

The service did not have sufficient full time registered nurses to provide consistent care for patients. However, the provider was actively recruiting to the vacant registered nursing posts

One registered nurse worked on each ward during each shift. If the nurse needed to leave the ward for any reason for example, ward rounds, this left the wards without a registered nurse. Although leaders reported that staff could call on a nurse from another ward to assist when the registered nurse was absent.

Managers, staff and patients reported there were occasions where there were no registered nurses on a shift on a ward. The provider informed us that if there were no registered nurses, for example, when a booked agency registered nurse did not turn up for a shift, they would try to get nurses from other wards to cover a shift. Staff told us that they could also book extra healthcare support workers to cover a shift where required. When this happened registered nurses from other wards would administer patient's medicines. None of the permanent registered nurses across the service were registered mental health nurses.

The service relied heavily on agency staff because most registered nursing posts were vacant. Ninety percent of registered nurse shifts were filled by agency staff on Seaford ward, and 75% were filled by agency staff on Balmoral ward. Although Balmoral ward had some regular agency nurses who knew the patients well, Staff reported that on Seaford Seaford ward they could not always get regular agency nurses who were familiar with the service. One patient also reported that there were always new faces.

Some patients had agreed section 17 leave for up to four times a week, and records showed that most patients utilised leave. However, one patient told us that their leave had been cancelled and had to wait for the next day because the ward was very busy.

There was a 14% turnover rate for nursing support workers and registered nurses across the service.

The sickness rates were 1% for both wards. Managers supported staff who needed time off for ill health.

Patients reported they had regular one- to-one sessions with their named nurse.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Medical staff

Patients had access to associate doctors who worked full time for the service. Balmoral ward had a full time consultant psychiatrist who is also the medical director and Seaford ward had a consultant psychiatrist who worked one day a week. However, one patient on Seaford ward told us they were only able to speak to the ward consultant at ward rounds and they were concerned this was causing delays to their discharge. The medical director informed us that they also supported Seaford ward, and if patients had any concern this will be reviewed and escalated to the designated consultant psychiatrist.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. The training comprised of online learning and face to face training including safeguarding, basic and immediate life support and Prevention and Management of Violence and Aggression (PMVA). However, some agency staff had not completed PMVA training and leaders did not systematically assess the skill mix of staff rostered to work on each shift to ensure a suitable number of staff had received the appropriate amount of training to safely meet the needs of patients.

Managers monitored mandatory training and alerted permanent staff when they needed to update their training.

Assessing and managing risk to patients and staff

While staff assessed patients risks on admission, and regularly reviewed patients physical on most occasions, we did not see records of post rapid tranquilisation monitoring for a patient who had been given rapid tranquilisation.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. All patients received a short-term assessment of risk and treatability (START) risk assessment on admission.

Patient risks were discussed regularly at ward round and reviewed.

Management of patient risk

Staff did not always robustly monitor the physical health of patients who received medicines via rapid tranquilisation, who were at heightened risk of significant physical health deterioration. One patient had received medicines via intramuscular rapid tranquilisation on six occasions and had not been subject to the required post-dose physical health monitoring.

Staff did not always record their rationale for using rapid tranquilisation and it was not clear what steps staff had taken to de-escalate incidents of distressed behaviour before resorting to using rapid tranquilisation.

One patient who was prescribed a high-dose antipsychotic medicine at 110% above British National Formulary (BNF) limit, did not have a plan in place for how staff would monitor and manage the patient's physical health risks caused by their medicine. This type of high-dose medicine increases the likelihood adverse effects including extrapyramidal side effects (EPSE), tachycardia, postural hypotension, sedation, hyperprolactinaemia and risk of seizures.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff checked that patients were physically well enough before going out on leave. For example, staff ensured that diabetic patients' blood sugars were within safe range before going out on leave to avoid a hypoglycaemic episode. Staff also ensured that patients who had mobility problems were able to get around safely.

Staff identified and responded to any changes in risks to, or posed by, patients. We saw that patients who presented a risk of aggression to others were placed on enhanced monitoring when needed.

Staff completed routine patient observations to help manage potential patient risks. Enhanced observations were used where clinically appropriate to mitigate individual patient risks. There were also allocated fire marshals, first aiders and emergency responders in case of an emergency. Staff followed the provider's policy when they needed to search patients or their bedrooms to keep them safe from harm. Staff reported they would only search patients with known risks. For example, staff searched patients that concealed lighters to minimise the risk of them smoking in their bedrooms and prevent them setting a fire.

Use of restrictive interventions

All permanent staff had completed a five-day intensive PMVA training. Staff reported they would always use verbal de-escalation first and would only use restraint as a last resort.

There had been 17 episodes of restraint in the last 12 months across the two wards, and none of these were in the prone position. Staff reported they would always try verbal de-escalation before restraining a patient.

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

There service reported no seclusion or long-term segregation in the last 12 months.

Staff monitored and regularly reviewed any blanket restrictions, and restrictions were specific for each patient and was in the patient's best interest.

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 safeguarding champions attended a monthly meeting that was led by the hospital manager. We reviewed two safeguarding records and saw that appropriate referrals were made, investigated and lessons learned. The provider also supported patients and staff throughout the safeguarding process.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff mostly kept up-to-date with their safeguarding training. All staff on Balmoral had completed their mandatory training and 89% of staff on Seaford ward had completed their safeguarding training.

Staff followed clear procedures to keep children visiting the ward safe. There was a visitor's room next to reception away from the ward where patients could meet with their visitors including children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding lead and staff reported they could access them easily.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

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

Staff access to essential information

Most patients' care and treatment records were kept in paper files. These were well organised, stored securely and easily accessible to staff. However, the initial clerking in documents completed by the doctor on admission were stored electronically and not routinely accessed by staff. This posed a risk that some staff may not be familiar with a patient's initial risks when they were first admitted to the service. Some staff reported that the use of paper and electronic record systems meant their workload was increased because of duplication and they sometimes found it challenging to locate clinical information.

Leaders reported they had plans to move all records to an electronic system and they were working with software companies to develop this.

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

Paper records were stored securely in individual folders in the nurse's office and medicine records were stored in the clinic room.

Medicines management

The service used systems and processes to safely prescribe and store medicines.

Staff followed systems and processes to prescribe medicines safely, and they provided information and advice to patients about their medicines.

Staff stored patient's medicines appropriately. Patients had their individual medicine box. Staff ensured liquid medicines had a date of opening. The wards had stock medicine cupboard, and all stock were within date.

Staff disposed of medicines appropriately. The service used a denaturing kit for safe disposal of old medicines including controlled drugs. The wards also had clearly labelled green bins for the safe disposal of medicines, and staff kept these up to date.

Staff ensured patients had the correct medicines when they were admitted or if they moved between services.

Although staff mostly kept medicines related records up to date, however, we saw on one occasion that a patient's consent to treatment form had not been completed.

Staff informed us they did not have access to Flumazenil, which is a benzodiazepine antagonist that acts to reverse the effect of some rapid tranquilisation medicines in an emergency.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Track record on safety

Reporting incidents and learning from when things go wrong

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

The service used an incident reporting and debrief form to report incidents and this included triggers, intervention, what went well, and lessons learned.

Staff knew what incidents to report and how to report them. However, staff did not always ensure patient related incidents were recorded in their notes. For example, for one patient on Seaford ward, there were no records of the incidents in the patients notes which led to staff administering intramuscular rapid tranquilisation.

Staff knew what incidents met the serious incident criteria and how to report them in line with the provider's policy.

The service had no never events.

Staff understood the duty of candour. Staff told us it was about being open and honest, and giving patients and families a full explanation when things went wrong.

There was a process to ensure staff and patients received a debrief after a serious incident.

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

Staff received feedback from investigations into incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. We saw examples of learning from incidents. For example, staff made appropriate referrals to speech and language therapy teams following a choking incident. Staff were now monitoring patients with known risks of choking at mealtimes to keep them safe.

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

Requires Improvement

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

Assessment of needs and planning of care

Although patients had individualised care plans in place, staff did not always record whether patients were offered copies of their care plans.

Six of the seven patients whose care and treatment records we reviewed had not been offered copies of their care plans. Staff were not clearly documenting when patients had reviewed, signed or refused copies of their care plans.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff did not always record whether family or carers wanted to be involved in the patient's care. Three care plans we reviewed showed minimal family or carer involvement, and staff did not record whether family or carers wanted to be involved.

Patient care plans did not always capture the patients views and goals, and some patient care plans showed minimal patient involvement. Staff told us that patient care plans were reviewed and updated following ward rounds. The provider informed us that patients often did not wish to be actively involved in their care plans and refused to engage with staff completing them. The Royal College of Psychiatry Standards for Inpatient Mental Health Rehabilitation Services 2016 6.10 recommends that the practitioner must develop the care plan collaboratively with the patient and their carer (with patient consent).

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Each patient had a Short-Term Assessment of Risk and Treatability assessment (START) on admission which identified potential risks such as risk of violence, self-harm, and substance use.

Most patients had positive behaviour support plans and any psychology or occupational therapy interventions were detailed in patient care plans. The psychological interventions included strategies to manage distressed behaviour.

Patients had their physical health assessed soon after admission. Staff reported that the doctors were required to carry out weekly physical health monitoring for patients.

Best practice in treatment and care

Staff provided a range of treatment and care for patients, although this was not enough to meet the needs of patients requiring treatment at a high-dependency rehabilitation unit. Access to specialist multi-disciplinary team members including occupational therapists was limited. However, some patients on Balmoral ward reported that they met with an occupational therapy assistant who provided them with meaningful support with cooking and budgeting skills. The occupational therapy assistants also carried out kitchen assessments each week to ensure patients were safe to use the kitchen and prepare their own meals. They also facilitated activities such as poetry, art and gardening.

Patients had access to individual psychotherapy and group therapy sessions. Some patients had weekly sessions with a clinical psychologist.

Staff formulated a treatment plan for patients soon after admission which included a psychology and occupational therapy treatment plan. Although the occupational therapy activity plans were very detailed and individualised for some patients, for others they were generic and lacked meaningful therapeutic activities. Managers and staff reported that the service would benefit from a full-time occupational therapist as there was only one qualified occupational therapist who supported the whole hospital and they are quite stretched.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used Health of the Nation Outcome Scales (HoNOS) which measured the health and social functioning of people with severe mental illness and (World Health Organisation's disability assessment schedule) (WHODAS) which was used to assess factors such as cognition, disability, self-care, and social skills in adult patients.

Staff ensured patients had access to physical health care, including specialists as required. The ward doctors were responsible for patients' physical health monitoring including early warning scores which in most cases was completed weekly.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients reported staff gave them information on how to stay healthy. We observed staff giving a diabetic patient advice on how to manage their diabetes by following a healthy diet.

Staff used technology to support patients. Patients had access to their own mobile phones. They could access the ward computers with staff support.

The service was not currently involved in any clinical audits, benchmarking, or quality improvement initiatives.

Skilled staff to deliver care

The service did not have a full-time occupational therapist (OT). The CQC brief guide on inpatient mental health rehabilitation services – assessment, treatment and care, states that each team should include one full time OT. The service did not provide OT provision in line with this guidance. This meant that detailed activity plans were not always in place for all patients on the ward. Leaders reported that they were in process of recruiting to this role and patients were being supported by the lead OT for the hospital. However, they supported patients on all wards across the hospital so were not able to provide the necessary amount of OT support to patients on these wards.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. All staff had an annual appraisal.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. The qualified nurses were responsible for the clinical supervision the senior support workers who were in turn responsible for the supervision of the other health care support workers. Ninety percent of staff supervision sessions went ahead as planned in the last 12 months.

Managers made sure staff received any specific training required for their role. For example, staff reported they had just completed one day trauma training which they found very useful.

Managers recognised poor performance, could identify the reasons and managed episodes of poor staff performance in a supportive way.

Multi-disciplinary and interagency teamwork

Staff worked together to benefit patients and had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The service had a weekly ward round where the team formally reviewed patients' care and treatment including their MHA status, rights, and medicines and patients were present at these meeting.

Staff made sure they shared clear information about patients and any changes to their care during handover meetings. The shift handovers were comprehensive and detailed, and included information about each patient's mental and physical health.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Ward teams had effective working relationships with other teams in the organisation. Staff told us sometimes when they were short of staff, they could get support from other teams. Each ward had an allocated member of staff that was on hand to respond to any potential emergencies in the hospital.

Ward teams had effective working relationships with external teams and organisations including commissioners, care coordinators, local authority safeguarding teams and the police.

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

The provider did not ensure that patients had easy access to Independent Mental Health Act advocates (IMHAs). However, 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.

Patients we spoke with told us they could not always access an IMHA. The IMAH did not routinely access the ward and relied on staff to support patients to refer themselves to the IMHA. Some patients told us they did not know the role of an IMHA and that staff had not explained this. Some patients reported they would not know how to contact an IMHA if they needed one.

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.

Staff knew who their Mental Health Act administrators were 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.

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

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

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

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

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

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

Good practice in applying the Mental Capacity Act

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of 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.

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Leaders monitored how well the Mental Capacity Act was followed and acted when they needed to make changes to improve. We saw that capacity assessment were completed regularly. However, staff did not ensure certificate of consent to treatment and second opinion for T2 was always updated contemporaneously.

Are Long stay or rehabilitation mental health wards for working age adults 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 patient's privacy and dignity. They understood the individual needs of patients and supported them to understand and manage their care, treatment or condition.

We spoke with six patients across both wards who felt all felt staff were compassionate and caring. Staff treated patients well and behaved kindly towards them.

Patients reported that staff gave them help, emotional support and advice when they needed it. We saw a member of staff discussing a patient's concerns with them and the staff member followed up with them afterwards to ensure the patient was happy with the outcome.

Staff respected patients' privacy and dignity. Staff knocked on doors and sought permission before going into patient bedrooms.

When staff interacted with patients, they were discreet, respectful and were responsive when caring for them. For example, we saw a member of staff invite a patient into the nursing office when they needed to discuss a private matter. The staff member was attentive, listened to their concern, respected their wishes and provided assurance.

Staff supported patients to understand and manage their own care treatment or condition.

Staff addressed patients by their preferred names.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff directed patients to other agencies such as mental health support charities and peer support groups.

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

Staff followed the provider's policy to keep patient information confidential. Paper records were kept securely in folders and the electronic systems were password protected.

Patients on Seaford ward reported that it was difficult for them to contact the ward consultant who worked one day per week on ward round days.

Some patients reported that staff could be quite loud, and they found it difficult to cope with this.

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients reported they were offered information packs about the service on admission.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties, although not all patients received copies of their care plans. Patients told us staff regularly discussed their care and treatment with them. Some patients felt the doctors took time to explain patient's medication, addressed any concerns they had and informed them when their medication changed. However, one patient informed us they were not always given a choice of treatment that it was rather prescriptive, and they did not always feel listened to. Another patient reported they had been placed on a specific medication which they took three times a day, but the doctors had not explained it to them.

Some patients reported that staff involved them in decisions about the service.

Involvement of families and carers

Staff told us they informed families and carers in decisions about a patients care where appropriate. However, staff did not document clearly when there were no family or carer involvement in patients' care. Three out of seven care plans we reviewed did not show carer involvement.

Although families and carers were not allowed on the wards, there was a family room off the ward next to reception where patients could meet with their visitors.

Staff helped families to give feedback on the service through the friends and family survey.

Staff gave carers information on how to find the carer's assessment.

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

Requires Improvement

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Access and discharge

Although the service was designated as a high-dependency rehabilitation unit, the provider did not follow this service model appropriately and some of the patients admitted to the wards had complex needs which did not make them appropriate for this type of service. This had led to inappropriate admissions and delays to patients' discharge.

Staff felt that some of the patients currently at the service were not suitable for the model of care being provided. The provider reported that the service was a high-dependency rehabilitation unit, but some patients had long-term complex needs that would require more long-term treatment by a service providing a different rehabilitation model. Out of 15 patients at the service, six of them have been at the service for over 2 years. This meant that many patients had been staying on the ward for extended periods of time. The high dependency unit specification as outlined in the CQC's brief guide states that the length of stay should be up to one year.

The move on plans for most patients were either to community rehabilitation unit or supported living accommodation. However, we saw on Seaford ward that a patient was being referred to a psychiatric intensive care unit (PICU) due to their mental health deterioration.

We reviewed the length of stay for patients and this showed that patients were staying longer at the service which was not in line with the rehabilitation model for a high dependency unit. One patient had been with the service for up to 10 years. Another patient who has been in the service for a number of years informed us they were not happy because there were no clear discharge plans which was frustrating for them, and that they would like to move on. One patient told us the service was not doing enough discharge patients. We raised this as a concern following the inspection and the provider informed us that some of the patients had complex mental health needs which required extended lengths of stay in hospital. They informed us that they were working with commissioners, social services, charities, community mental health teams and other stakeholders to ensure that some of these patents could be discharged successfully.

Facilities that promote comfort, dignity and privacy

Staff did not ensure that patients had keys to their bedrooms. Two patients reported that they did not have keys to their bedrooms. We did not see clearly documented risk assessments and care plans for why these patients could not have keys to their bedrooms. However, each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. The food was of good quality and patients could make hot drinks and snacks at any time.

While the provider informed us that Seaford ward had newly been refurbished, we saw that some aspect of the environment still required improvement in other to meet the needs of people using the service. For example, Seaford ward did not have a cooker although one patient reported they would like to do their own cooking. The lights in the corridors flickered consistently. Staff told us they were motion sensor lights. There were loose electrical connections in one of the patient's bedroom. The sofa in the lounge on Seaford ward could do with a refresh. The provider informed us this was brought in from another ward and that they had ordered new furnishings for the ward. We spoke with two patients on Seaford ward who reported that the environment could do with more decorations.

There were no quiet rooms on the ward for patients who needed quiet area to relax. Staff told us due to covid-19, visitors were not allowed on the wards. However, staff informed us patients could meet with their visitors off the ward in the general visitor's room next to reception. Patients could use their bedroom if they needed quiet space to relax.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Balmoral ward was located on the ground floor with outside space which patients could access easily. We observed that patients could go out to the garden freely and the doors were left open to let in light and fresh air. However, the provider informed us that Balmoral ward was moving upstairs to a newly refurbished unit. While some patients felt that the new unit would offer more cooking spaces as it had a bigger kitchen with more cookers, some patients and staff expressed concerns that patients might not be able to access outside space as easily.

Each patient had their own bedroom, which they could personalise. However, three patients reported that they did not have keys to their bedrooms and therefore could not lock their bedroom doors despite being able to safely manage their keys. Staff told us they were in the process of getting new locks for the doors and keys for these patients.

Patients had a secure place to store personal possessions. Some patients reported they could store their possessions in their bedrooms. Items that were valuable or restricted items such as cigarette lighters were locked securely in a locker in the nurses' office, which only staff could access.

Patients generally felt the food was of good quality and there were variety of options. However, some patients on Seaford ward reported that they would like to cook their own food at times, but the ward did not have a cooker and patients were unable to develop their daily living skills in relation to preparing and cooking meals.

Patients could make their own hot drinks and snacks and were not dependent on staff. There were patient cupboards on the in the kitchen where they could store their own food and snacks.

Each ward had a laundry room where patients could to their laundry at allocated times. There were weekly supplies of clean, fresh linen and bedding.

We saw that patients were in possession of their own mobile phones, unless staff had identified risks relating to a patient having a mobile phone following a risk assessment. Patients had access to the ward phone. Patients reported that they could make phone calls privately in their bedroom.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. The provider regularly advertised paid and volunteer opportunities for patients. Staff supported patients to write CVs and also to apply for these roles.

Staff helped patients to stay in contact with families and carers. For patients with active carer involvement in their care, staff encouraged them to stay in touch.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Some patients reported they go out to the garden centres and also meet up with peers.

Meeting the needs of all people who use the service

The service could support and make adjustments for patients with disabilities and those with communication or other specific needs.

Staff made sure patients could access information on treatment, local services such as mental health support charities, drug and alcohol services, their rights and how to complain.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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. However, on Seaford ward some patients told us they would like to do their own cooking, but the ward did not have a cooker.

Patients had access to spiritual, religious and cultural support. There was information on the notice board about local places of worship. However, one patient reported that they told staff they would like to go to church on Sundays, but this had not been facilitated.

Listening to and learning from concerns and complaints

Patients, relatives and carers knew how to complain or raise concerns.

Information about how to make a complaint was displayed on an information board on entering the ward.

Staff understood the policy on complaints, and they knew how to acknowledge and handle complaints.

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

Managers investigated complaints and identified themes. They shared feedback from complaints with patients and staff following investigation of the complaint, and learning was used to improve the service. For example, following the complaint by patients about poor communication from some staff, managers reminded staff to be professional when they spoke to patients.

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

However, it was not always clear how concerns were reviewed and the actions the provider took to address them. For example, minutes from community meetings on Balmoral ward showed that a patient had reported they did not feel safe on more than one occasion. However, there were not records of actions the provider had taken to address their concerns.

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

Requires Improvement

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

Leadership

Both Seaford ward and Balmoral wards had ward manager vacancies at the time of our inspection. Senior leaders reported that they were recruiting to these ward manager posts, and in the interim the service and staff were being supported by ward managers from the acute and low secure forensic wards.

The interim managers understood the service and its challenges. However, they informed us that due to high demands on the other wards they could not always be present on the rehabilitation wards and were not always able to attend meetings.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff reported that they could contact the ward managers by telephone, and they offered support when needed.

Vision and strategy

The vision and strategy for the Seaford and Balmoral wards were not clearly defined. While the provider had advertised that the service was a high dependency rehabilitation unit, we saw that the client group, staffing requirements, focus, length of stay, and recovery goals were not aligned to this type of service specification. For example, the length of stay for an inpatient mental health high dependency rehabilitation unit is up to one year. However, a number of patients had been with the service for over 10 years.

Culture

Staff felt respected, supported and valued by the managers who oversaw the two wards. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression.

Staff felt there was an open culture and found their immediate managers approachable. Some staff reported that change could be quite slow. For example, staff and managers had raised concerns that the current workload for registered nurses was unmanageable due to the current staffing arrangements and this has been a concern for a long time. The provider informed us they were actively trying to recruit to the vacant posts and have successful recruited eight international nurses who were awaiting their nursing exams in the next couple of months

Staff felt very positive about the opportunities for growth and career progression. For example, a graduate psychologist was being supported to become fully qualified, and another senior health care support worker reported the provider had made a commitment to fund and support their nursing associate degree. The provider was also working towards developing and supporting its own staff to take on more senior leadership roles.

Governance

The provider needed to improve its governance assurance processes. The provider's systems and processes for monitoring and assuring the quality of the service had not identified a number of the issues we identified during the inspection.

Leaders including the hospital director and those directly overseeing the wards were not aware that staff did not always safely monitor the physical health of patients who were at risk of significant physical health deterioration because of their high-dose antipsychotic medicines or medicines administered un-planned via rapid tranquilisation.

Staff could not provide us minutes of teams meetings during our inspection. This illustrated that staff who might want to refer to the meeting minutes would be unable to do so.

The ligature risk assessments were completed by ward managers who had not received specific training on how to complete them. We saw that there were numerous ligature points throughout the wards, but the risk management plans were not robust enough to mitigate against the risks.

However, there was a monthly hospital-wide clinical governance meeting which was attended by staff at all levels including hospital managers, ward managers, nurses, support workers and other staff. The meetings had a standard agenda where issues such as staffing, complaints, safeguarding, incidents, outcomes of medicines audits and service level risks such as patient absence without official leave (AWOL) and security breaches were discussed. Information from the meetings were shared with staff who could not attend during handovers, MDT meetings and via emails and newsletters.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Management of risk, issues and performance

During the last inspection in 2018, we identified that the hospital risk register did not include all identified risks. During this inspection, we found that hospital now had an up to date risk register in place. Staff told us that service level risks were escalated to managers who in turn informed the senior leadership team. The corporate risk register included two identified risks: the high use of agency staff due to staff vacancies and COVID-19.

There was a clear plan to address the risks around the high use of agency staff and a COVID-19 protocol. For example, the provider had recently recruited eight overseas nurses who were waiting to take their professional nursing exams, and the provider was also recruiting to the ward manager posts. However, managers and staff were concerned about the current ward staffing levels and the impact on the wellbeing of staff, but this had not been recorded as a risk.

The service had a business continuity plan for emergencies.

Information management

The service used systems to collect data from wards.

Staff had access to equipment and technology to do their work. Staff used a combination of electronic and paper records. However, staff reported that the combination of paper and electronic recording led to duplication and was burdensome for them.

The provider used an online training system. Managers could monitor staff compliance with their mandatory training and performance.

Staff had their personal log in credentials to ensure patient information was kept confidential. Each staff member an email address where they received updates from the provider.

Engagement

Staff had access to up to date information through handovers, meetings and the intranet.

Staff informed us they actively encouraged patients to be involved in service developments at a patient-led meeting.

The provider regularly gathered feedback from staff, patients and carers via surveys to learn about the service and identify areas where they could make improvements.

The provider was carrying out a staff survey at the time of our inspection.

Patients and carers had opportunities to give feedback using the friends and family survey. The feedback from the most recent friends and family test in December 2021 showed that staff were friendly and committed. Patients also reported that one area of improvement would be for there to be more activities in the evenings and weekends.

Learning, continuous improvement and innovation

The interim ward managers informed us that there were ongoing discussions about getting a national accreditation for rehab service for people recovering from mental health problems.

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

Requires Improvement

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

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

Requires Improvement

We rated safe as requires improvement.

Safe and clean care environments

The ward environments were not safely managed. There were multiple fixed ligature points and blind spots across both wards that were not assessed and managed safely.

Safety of the ward layout

The ward environments were not safely managed. Although ward ligature risk assessments were in place, these were basic, inconsistent across the two wards and did not identify the primary ligature risks such as the bedroom windows and en-suite doors on Cooden ward as presenting a high risk to patients. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The National Safety Alert issued in September 2018 from the Central Alerting System (CAS) identifies actions that all providers of mental health service should take in the assessment of ligature anchor points. All ligature anchor points should be assessed as presenting a high risk. On Fairlight ward the risk rating for windows was scored as 18 and presenting a low risk. On Cooden ward the risk rating for windows was scored as nine and presenting a low risk. We were told by a ward manager that the ligature risk assessments were completed by each individual ward manager and they had not received specific training in how to assess ligature risks. A few days after the inspection site visit, a patient sadly died shortly after being admitted to Cooden ward because they tied a ligature to their bedroom window.

The ward staff could not clearly articulate how they were working to manage identified environmental risks. Not all staff knew where to access ligature cutters to use in an emergency. This presented a risk of a delayed response if a patient tied a ligature and needed help, increasing the likelihood of them sustaining significant harm or death.

Staff did not safely observe patients to ensure they were safe. Patients were observed by staff at different frequencies depending on their clinical risks. However, staff completed enhanced patient observations at set times rather than intermittently. This presented a significant risk that patients would accurately predict when staff would next check they were safe.

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

Requires Improvement

Staff could not always safely observe patients in their bedrooms. This was because some bedroom doors were fitted with spy-holes rather than observation window panels, this meant there were blind spots and also compromised privacy and dignity because they could not be secured in the closed position by patients.

The CQC used its urgent powers under Section 31 of the Health and Social Care Act 2008 and imposed urgent conditions on the provider's registration on 18 May 2022. These conditions prevented the provider from admitting new patients to the two acute wards and instructed the provider to improve its approach to assessing and managing ligature risks and individual patient risk assessments.

These conditions were subsequently removed on 9 June 2022 because the provider had taken action to ensure it made improvements required to keep patients safe. The provider had committed to replacing all sash-style bedroom windows across the hospital. In the meantime, all windows were locked to protect patients from the significant risks they posed. The provider also deployed a suitable qualified team of assessors to complete comprehensive assessments of the ligature risks on both wards.

Staff could safely observe the communal areas of the ward from the nursing office and convex mirrors were used to mitigate blind spots in communal areas.

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

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

During the last inspection in June 2018 we identified that bedrooms on Cooden ward were not always kept clean. Although Cooden ward had changed purpose since the last inspection, improvements were still needed to ensure bedrooms were kept clean. One patient's bedroom was visibly dirty, and their bedsheets had not been cleaned. On Fairlight ward we identified urine on the floor of one bedroom. We raised this with staff during the inspection, who took action to clean these areas.

Cleaning schedules were in place and dedicated cleaning staff were allocated to each of the wards. Staff made sure cleaning records were up-to-date and the communal areas of the wards were visibly clean.

Infection, prevention and control processes were managed well in relation Covid-19 and protective equipment was available to staff.

Clinic room and equipment

During the last inspection in June 2018, we identified that staff did not routinely check that clinical equipment was in date, calibrated and safe to use. This continued to be an issue at this inspection. Clinic rooms were equipped with the necessary medical equipment. However, there was not a robust system to ensure staff checked that clinical equipment was clean and safe to use. For example, on Fairlight ward we identified that the defibrillator was not working despite recorded weekly checks indicating it was working, and parts of the defibrillator had been opened and went out of date in February 2022. We raised this with leaders who ensured a new defibrillator was brought to the ward immediately.

Hospital management staff were able to show us audit records showing us that medical devices had been calibrated.

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

Requires Improvement

Safe staffing

The service had enough nursing and medical staff. However, wards were heavily reliant on agency staff, particularly at night. Agency staff were not always trained to the same standard as permanent staff.

Nursing staff

Across both wards, seven out of 12 registered mental health nurse (RMN)were vacant however the provider had recruited into these posts and were in the process of awaiting their formal registration as they were workers from outside the UK.

Three of the 28 nursing support worker posts were vacant. However, the provider had already recruited to this role with overseas staff presently going through pre-employment checks. Staff vacancies featured on the service risk register. When we reviewed the staffing vacancies, we could see that the organisation had made significant effort to recruit nurses from overseas and were supporting their transition into the organisation. There were eight pre-registered nurses ready to sit their transitional training within the next three months. We saw evidence of local recruitment days begin undertaken that were designed to attract support workers and that the organisation had a package designed to retain staff.

Agency staff were used to fill vacant shifts. Nurses from the agency were familiar with the wards and knew the patents. When they started working on the wards, they completed a local induction. However, some of the agency support workers we spoke with were not familiar with local procedures around management of ligature risks and were not trained in prevention and management of violence and aggression (PMVA).

Sickness levels were low across the acute wards and ranged from 1-2% in the months between November 2021 to March 2022.

Managers used a formula to work out the number and grade of nurses, nursing assistants and healthcare assistants for each shift and this was dependent on the number of patients on enhanced observations. Rotas indicated that the service was always able to cover these numbers.

Leaders did not ensure staff with an appropriate skill mix were rostered to work on each shift. For example, during the night shifts on Fairlight ward during the week of the inspection only one staff member had received training in PMVA. This meant that the staff team working during that shift did not have the right skills to safely manage incidents of violence and aggression and could potentially cause harm to patients if they needed to use restraint.

Agency staff reported feeling well supported by ward managers

Patients told us they were not having regular one to one time with their primary nurse and could not identify who their primary nurses were.

Medical staff

The service had appropriate medical cover which included access to out of hours doctors. Each ward had a junior doctor located on the ward, working Monday to Friday to support patients and to manage new admissions. Each ward had an allocated consultant psychiatrist available to act as responsible clinician and to oversee the patients care, two days per week on Cooden ward and three days per week on Fairlight ward. The staff teams felt this level of medical input was suitable and felt they could contact the consultants outside of their working hours if needed. Cooden ward had a locum junior doctor at the time of the inspection but plans were in place to recruit to this position.

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

Requires Improvement

The service had a clear rota for cover for out of hours consultants and staff knew how to contact them when required.

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

Mandatory training

Staff were mostly up to date with their mandatory training. Managers monitored mandatory training compliance and alerted staff when they needed to update their training. All training figures were above 85%, which was the provider's target.

Staff felt the mandatory training programme was comprehensive, but it was mostly online and not face to face. Two staff had recently completed train the trainer training in prevention and management of violence and aggression (PMVA) to ensure the face to face PMVA training was delivered to all staff regularly.

Assessing and managing risk to patients and staff

Patient risk assessments were not multi-disciplinary and were not completed promptly after admission. Risk assessments were saved electronically and the most up to date versions were not routinely reviewed by staff. Staff had not been trained on how to search patients to reduce the risk of contraband items being brought onto the ward. Patients experienced blanket restrictions and these restrictions were not kept under review by the provider.

Assessment of patient risk

The initial risk screen that was completed by the doctor who oversaw each patient's admission was not routinely accessible to staff. This was because it was stored on an electronic system that staff did not routinely access. Risk screening assessments were not always available in the paper patient record folders that staff accessed for any of the patients.

Patient risk assessments were not completed promptly after admission. We identified three occasions on Fairlight ward where staff completed the first risk assessment after 11, six and five days respectively. All completed patient risk assessments had been completed by a therapy technician and had not been formulated by the wider multi-disciplinary team. This posed a risk that individual patient risks may not have been formulated appropriately.

A few days after the inspection a patient sadly died shortly after they were admitted to Cooden ward. We identified that this patient's initial risk screen, completed by the doctor on admission, had been saved electronically and was not readily accessible to ward staff. Although an initial risk assessment followed soon after, this was completed by a therapy technician and healthcare support worker. Other multi-disciplinary team members had not been involved in this risk assessment process. The patient's risk of suicide had been inappropriately downgraded from high to medium during the risk assessment process, without agreement with other multidisciplinary team members including a doctor.

The CQC used its urgent powers under Section 31 of the Health and Social Care Act 2008 and imposed urgent conditions on the provider's registration on 18 May 2022. These conditions prevented the provider from admitting new patients to the two acute wards and instructed the provider to improve its approach to individual patient risk assessments as well as assessing managing ligature risks.

These conditions were subsequently removed on 9 June 2022 because the provider had taken action to ensure it made improvements required to keep patients safe. Initial risk assessments were now completed collaboratively by multi-disciplinary team members, and a review had been undertaken of each patient risk assessment.

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

Requires Improvement

Management of patient risk

Patient risk was discussed in each handover meeting between shifts. Notes from these meetings were stored electronically and staff working on the wards did not routinely access electronic records. This posed a risk that staff would not access this information to assist them in safely managing individual patient risks.

Patient risk assessments and management plans were normally reviewed during weekly ward meetings with the multi-disciplinary team, when any incidents were discussed and changes were made.

Some patients reported not feeling safe on the ward and felt that they were able to bring items into the ward to self-injure with if they chose to. The patients felt that the processes for checking for contraband items was not robust enough. We checked this with the ward staff and reviewed their process for admission to the ward. There was a clear list of contraband items and the staff used a metal detector to assist in searching, but staff were inexperienced and had received no formal training in searching patients.

Blanket restrictions were in place that were not regularly reviewed by the provider to ensure they were appropriate. For example, no patients had keys for their bedrooms, there were set smoking times, restricted access to the kitchens on the wards, restricted access to the garden on Cooden ward and restricted access to hot and cold drinks.

Senior managers told us there was a reducing restrictive practices committee and we reviewed quarterly audits that had been completed as part of the quality assurance framework for the hospital. However, these audits showed little evidence of a review of restrictive practices and were generic for both wards. Although senior leaders explained that each ward had a reducing restrictive practices file to guide staff, these could not be located by ward staff.

Use of restrictive interventions

Episodes of physical restraint and rapid tranquilisation were low across the acute wards and 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.

Staff used de-escalation skills to manage conflict and normally de-escalated incidents of violence and aggression before the need for physical intervention. Use of physical restraint was low over the 12 months prior to the inspection, twenty-six episodes of physical restraint had taken place on Fairlight ward, and one episode had taken place on Cooden ward. None of these restraints had used the prone position.

Rapid tranquillisation is the use of medicine to help calm a person who is extremely distressed and is at risk of harm to themselves, or possibly those around them. Use of rapid tranquillisation was low across the acute wards with staff on Fairlight ward using it 16 times and staff on Cooden ward using it once in the 12 months prior to the inspection.

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 kept up-to-date with their safeguarding training and training compliance was overseen centrally by the rota manager to ensure all staff were booked onto training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them.

There were dedicated visiting rooms elsewhere in the hospital designated for children who visited, and the staff encouraged patients to go out with their family members as much as possible.

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

Each ward had safeguarding champions and these champions met on a monthly basis with the senior leadership team to review all safeguarding issues across the wards and ensure actions were picked up and lessons were learned and fed back to the wards.

Staff access to essential information

Staff did not always have easy access to clinical information.

Staff used a mixture of paper and electronic records, which posed a risk that staff would not be up-to-date with essential clinical information. For example, doctors used an electronic form to clerk the patients into the wards and screen their individual clinical risks. We were told these should be copied and put into the paper file but on Fairlight ward these had not been printed and attached to patient records for staff to refer to. Also, we found that records of MDT meetings containing discussions about patient risks were stored electronically and not easily accessible to staff.

Leaders reported they had plans to move all records to an electronic system and they were working with software companies to develop this although there were not yet timescales for this work to be complete.

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.

We reviewed 19 sets of patient medicine records and saw that staff followed the correct procedure for prescribing and administering medicines.

An external pharmacy company completed regular audits of the use of medicines and how safely they were managed. Any actions suggested by the pharmacist were communicated with the nursing staff and the prescriber. The pharmacist visited the hospital weekly and checked that staff had acted on advice given and fed back to the senior management team.

Room temperatures and fridge temperatures were recorded and audited regularly. The clinic rooms all had labelled containers for the safe disposal of medications which was signed for securely by two nurses. The management of controlled drugs was safe and in line with national guidance.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Whilst there was learning from the incidents occurring on the acute wards, staff were not able to describe what they had learnt from incidents across other parts of the hospital.

Staff reported all incidents using a paper-based incident reporting system.

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. Serious incidents were initially discussed at the morning managers handover meeting. From here it was decided what immediate action should be taken and a member of the clinical team was allocated to investigate the incident. The incident review then fed into the patient safety meeting, which was held monthly, where representatives from all the wards reviewed all serious incidents and lessons learned. Incidents were also discussed at clinical governance meetings. We could see how lessons learned from an incident where a patient had gone absent from hospital without leave were followed up and correctly reported to the police and the local safeguarding teams.

Managers and members of the senior management team debriefed and supported staff and patients after serious incidents.

Weekly multi-disciplinary team meetings also reviewed serious incidents for individual patients and showed evidence of discussion. However, as these were only available electronically it was not clear how this was shared with the ward staff. Staff weren't able to give examples of how local incidents or accidents across the hospital as a whole had affected the way they worked.

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

Requires Improvement

We rated effective as requires improvement.

Assessment of needs and planning of care

Doctors assessed the physical and mental health of all patients on admission. They developed care plans which were reviewed and updated regularly by the multidisciplinary staff team.

Each patient had a care plan in place. Mental health care plans were generic and followed a standard format. Physical health care plans were individualised to the patients' health needs.

Eight patients we spoke with across both wards told us that they did not feel involved in their care planning and had not been given a copy of the plan.

On Fairlight ward we reviewed six patient care plans. These were in date and regularly reviewed. However, four of these patients had not been involved in developing their care plans. All patients on Fairlight ward had a psychology treatment plan but there was no evidence that the patients had seen and agreed with these plans. Care plans for patients on Cooden ward were of a higher quality and staff had involved patients in planning their own care and treatment. For example, patients' particular needs around wound care and managing their diabetes had been well documented.

The service benefitted from having junior doctors based on the wards throughout the week who were able to focus on physical health and we saw evidence of good physical health monitoring on Cooden ward. Staff made sure patients had access to external physical health care, including specialists as required.

Staff completed audits of care plans and clinical notes every month. However, this audit process had not identified the need for action to be taken to involve patients on Fairlight ward in their care planning.

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

Requires Improvement

Best practice in treatment and care

Patients did not have appropriate access to occupational therapy support. There was one lead occupational therapist in place across the whole hospital. On the acute wards the therapy programme was run by therapy technicians who had a dual role and were also assistant psychologists. The therapy programme was not in line with National Institute for Health and Care Excellence (NICE) guidelines which recommend meaningful and culturally appropriate activities seven days a week and not limited to 9am to 5pm. Staff delivered an occupational therapy activity programme every day during the day from 9-5 and two evenings in the week. There was no timetable for planned weekend activity and no occupational health staff available on Saturday or Sunday.

We reviewed current activity timetables on both wards that included a range of individual and group work. However, most patients felt that there was not enough to do, that they felt bored and the activities that were available were not suitable for their individual needs or to support their recovery. Four patients reported that the occupational therapy activities had not been explained to them and they were not sure what activities were available.

Staff identified patients' physical health needs and recorded them in their care plans and made sure patients had access to physical health care, including specialists as required.

Managers took part in a programme of clinical audits which fed directly into the quality assurance framework of the hospital. These audits were monitored by the ward managers using a dashboard system which was reviewed regularly by the compliance team at the hospital. Managers used results from audits to make improvements.

Staff did not use any clinical outcome measures such as HONOS (Health of the Nation Outcome Scales) to review improvement or progress patients have made whilst in the acute wards.

Skilled staff to deliver care

Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers supported all staff to develop through yearly, constructive appraisals of their work.

Staff also accessed regular clinical supervision of their work. Long-standing agency staff were not entitled to this same level of support.

Some staff reported that they did not have access to appropriate specialist training to equip them to meet the needs of the acute patient group, However records were supplied to the inspection team after the inspection indicating that specialist training was available for staff working with acute patients .This includes training on: Admissions/discharge process, Understanding acute service users, Care plan writing and Risk assessment writing.

Agency support workers staff we spoke with had limited experience of working on an acute ward and nurses reported the level of knowledge and experience within the staff teams needed to be strengthened.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. The ward teams had effective working relationships with other relevant teams within the hospital and with relevant services outside the hospital.

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

Requires Improvement

Staff held twice weekly multidisciplinary ward meetings on Fairlight ward and twice weekly on Cooden ward to discuss patients care and develop multi-disciplinary care plans. In these meetings staff collaborated in their approach to patient care.

Daily handover meetings were clear and structured. The senior management team also had a senior handover meeting each morning to review any risk or safeguarding activity across the hospital and to check staffing arrangements across the wards.

Ward teams had positive working relationships with external teams and organisations. The bed manager form the local mental health trust attended weekly ward round meetings virtually to oversee the clinical management of patients.

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 (MHA) and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them. Informal patients were not all aware that they had the right to leave the ward. The provider did not ensure that patients had easy access to Independent Mental Health Act advocates (IMHAs).

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

Informal patients were not aware they could leave the ward freely and were told by staff that if they tried to leave without staff support, they could be detained under the MHA. There were no signs on the doors in the corridor of Fairlight or Cooden wards informing informal patients they were able to leave the ward. This was brought to the attention of the managers immediately who made sure these were in place before the end of the inspection.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who the Mental Health Act administrator was and when to ask them for support.

The wards had access to advocacy services but this was on a referral basis. The advocate did not routinely access the main ward environment and met with patients who had made an appointment elsewhere in the hospital. Patients were not all clear about the process for accessing support from independent mental health advocacy. One patient told us they had to be referred but did not know the process and one patient told us they did not know who the advocate was and had not met them. There was no information in relation to accessing the advocate service on information boards on the wards.

Staff took time to speak with each detained patient about their rights under the MHA in a way that they could understand. They repeated this as necessary and recorded it in the patient's notes each time. There was a form that was completed for informal patients to record that a conversation had happened in relation to their rights.

Staff received and kept up-to-date with mandatory training on the Mental Health Act and the Mental Health Act Code of Practice and established staff could describe the Code of Practice guiding principles.

Discharge care plans did not include information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

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

Requires Improvement

Good practice in applying the Mental Capacity Act

Nurses and managers understood the provider's policy on the Mental Capacity Act 2005 and the multi-disciplinary team reviewed capacity to consent to treatment in ward rounds. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. There was a policy on Mental Capacity Act and deprivation of liberty safeguards, which staff knew how to access. Staff received and kept up-to-date with mandatory training in the Mental Capacity Act and had an understanding of the five basic principles.

Paper records had evidence that assessment of capacity to consent to treatment had happened and was reviewed when necessary.

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

Requires Improvement

We rated caring as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always respect patients' dignity and some patients reported that communicating with staff was sometimes a challenge. Patients were not always involved in their care.

Although we observed that staff interacted with patients in a positive way during the inspection, patients' privacy and dignity was not always respected. Some bedroom doors had spy holes for staff to observe patients in their bedrooms, which could be operated by anyone using the bedroom corridor. Other bedroom doors had staff-operated vision panels to provide staff with clear visibility into patient bedrooms when they needed to undertake observations. Four patients reported that their vision panels were left open by staff. During the inspection we observed that all the vision panels on bedroom doors were left in the open position.

Eight patients we spoke with across the two wards told us that they did not feel involved in their care planning and had not been given a copy of the plan after admission or after it had been reviewed in the ward round.

On Fairlight ward we reviewed six patient care plans. These were in date and regularly reviewed. However, in four sets of patient notes there was no evidence that the patients had been involved in developing their care plans. The care plans were generic and not specific to the individual patients care needs or treatment pathway. All patients on Fairlight ward had a psychology treatment plan but there was no evidence that the patients had seen and agreed with these plans.

Patients did not feel the staff team supported their needs well and reported problems in expressing their personal needs, particularly overnight where patients felt there were less experienced agency staff on duty. One patient told us they were not able to communicate to the staff that they wanted a hot drink and another told us that they felt the staff avoided them and ignored them.

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

Staff made every effort to keep patient information confidential, patient information folders were kept in the staff office.

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

Requires Improvement

Involvement in care

Staff did not routinely involve patients in care planning and risk assessment and did not always actively seek their feedback on the quality of care provided.

Involvement of patients

Patients did not always feel involved in their care planning on either of the acute wards. We spoke with 13 patients across the two wards. Eight patients told us they had never seen a copy of their care plan and two patients told us it was a document they had been asked to sign but they did not know what it contained. None of the patients could show us a copy of their care plan.

We reviewed 12 sets of care plans across the two wards. Eleven patients had care plans present in their paper files. The standard of the care plans was found to be inconsistent. In all six patient care plans we reviewed on Fairlight ward the involvement of the patient was minimal. The care plans were written from the staff member's viewpoint and not from the patients. For example, we saw some patients had an informal leave care plan which identified what the staff would do to support a patient, but not what action the patient would take to keep themselves safe.

On Cooden ward we identified better examples of patients being involved in their care planning and that patients were having regular discussion about discharge planning and a discharge plan in place where necessary.

We found all patients had a psychology treatment plan completed by the therapies technician who was also an assistant psychologist. However, there was no evidence the patients had seen or agreed with the plans and the section for service user sign off was not completed. We were told this was an introductory document and not a care plan and was used for review in the ward rounds.

Two patients told us on admission they had not been shown around the ward and they felt this had left them feeling apprehensive about being on the ward.

Patients could give feedback on the service and their treatment and staff supported them to do this through regular weekly community meetings and monthly peoples' council meetings which were attended by representatives from each ward. This meant for the acute wards the action required in relation to acting on patients' feedback was being met.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff told us that they had regular contact with families and carers. We could see from the patient ward round records that family members were invited if patients gave consent.

Staff sought patient consent to share information with relatives before sharing information. Three patients told us that their families and carers were involved in their care.

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

Requires Improvement

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

Requires Improvement

We rated responsive as requires improvement.

Access and discharge

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

Bed management

Patients were not discharged before they were ready. Staff did not move or discharge patients at night or very early in the morning. All admissions were planned and coordinated with the local mental health NHS trust who block booked the beds.

When patients went on leave there was always a bed available when they returned. During the inspection there were patients on community leave and their beds were available for when they returned.

Managers worked with discharge planners from the local mental health NHS trust and regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Staff liaised with colleagues at the local mental health NHS trust to ensure that in the event of a patient requiring a more enhanced level of care such as in a psychiatric intensive care unit (PICU), they were able to move the patient to the appropriate setting promptly.

Following the inspection, the acute wards were closed to admissions because the CQC urgently imposed a condition to stop the provider admitting new patients to the ward because of significant concerns around how the provider managed individual patient risk and ligature risks.

Discharge and transfers of care

The multi-disciplinary teams reviewed the discharge arrangements for the patients who were ready to leave hospital and had oversight of these patients' discharge plans. We reviewed the records for one patient who was being discharged on the day of the inspection and observed that their primary nurse had recorded one-to-one sessions where they had made post discharge plans with the patient and discussed what support the patient required.

In ward rounds the multi-disciplinary teams monitored the number of patients whose discharge was delayed, they knew which ward had the most delays, and took action to reduce them.

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

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

Requires Improvement

Facilities that promote comfort, dignity and privacy

Patients were not able to lock their bedroom doors without assistance from staff and patients did not have lockable space in their bedrooms to store personal items. One patient told us they stayed in their bedroom to look after their possessions.

Patients on Fairlight ward had access to a ward garden that they could access easily, the door to this garden was kept open so patients could walk in and out freely when they wanted fresh air. On Cooden ward, as it was on the second floor, patients could not access an outside space freely and required staff escort to enable them to use the stairs to access the garden. This was recorded as a restrictive practice on the ward audit but the audit showed no plans on how to review this restriction.

Each patient had their own bedroom with an en-suite bathroom. Patients personalised their bedrooms with pictures and personal items.

Three patients on Cooden ward and two patients on Fairlight ward told us that hot and cold drinks were not freely available and they needed to ask staff for these. Although drinks had been put out on the day of the inspection, we were told this was not normal practice and sometimes it was difficult to ask staff to assist because they were often busy.

Patients were able to use their own personal mobile phones if this had been risk assessed by the clinical team and most patients we spoke with had their own phones with them on the wards. If patients did not have a suitable mobile phone, they were able to use the ward phone to take incoming calls.

Meeting the needs of all people who use the service

Patients felt that the food available did not always meet their dietary needs. One patient had specific religious need for particular food and they told us this was not being met, another told us they were vegetarian and the choice was poor. Leaders had identified this as an issue and had arranged for the head chef to attend some of the community meetings to discuss this with the patients.

Ten out of the 13 patients we spoke with were unhappy about the quality of the food provided by the hospital and we could see from the minutes of the clinical governance meetings that this was something the hospital were already aware of and were working to address in collaboration with patients.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us that they could access translation services when needed.

Patients could make phone calls in private. Patients also had access to their own mobile phones, which was risk assessed on an individual basis.

The ward had personal emergency evacuation plans in place for patients with mobility needs who required them. We identified two patients who had clear plans in place to ensure staff supported them to leave the building promptly in an emergency.

Listening to and learning from concerns and complaints

Patients and staff understood how to use the provider's formal complaints process. Patients knew how to complain or raise concerns. Twenty-four patients out of 29 reported understanding how to make a complaint when asked in a patient satisfaction survey in December 2021. Posters detailing how to follow the complaints process were displayed on both wards.

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

Requires Improvement

Although complaints and compliments were routinely discussed monthly during a clinical governance meeting, leaders did not have an effective system to assure themselves that the complaints policy was being followed correctly.

We reviewed three complaints during the inspection. Leaders responded to complaints within the five day target. However, we identified that the documentation relating to one complaint was missing and had not been stored correctly. The response letters for the other two complaints were dated incorrectly and there was no reference number at the top of the letter which made it difficult to keep track of the complaint process.

The service had oversight of complaints but it was not clear how they were consistently investigated and how learned lessons from the results were shared with the ward teams and wider service.

Full time staff understood the policy on complaints and knew how to handle them. Agency staff we spoke with would refer patients to the full time staff in the first instance to report a complaint.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

Ward Managers had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

There had been an ongoing challenge in recruiting to the registered manager post. Because of this, one of the provider's directors filled the role and split their time between managing the service and their senior leadership duties for the provider.

We identified a disconnect between senior leaders and the ward teams around procedures on the wards. Senior leaders felt that systems and processes such as the reducing restrictive practices and paper risk assessment forms were embedded in the wards and functioning, but this was not reflected by staff at ward level.

The ward managers had the skills and experience to perform their roles well. They had a good understanding of the services they managed and staff we spoke to felt they were visible on the wards.

Vision and strategy

The providers senior leadership team had not communicated the organisations vision and values effectively so staff were not able to inform us of the providers vision or describe how these should be applied in the process of their work.

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

Requires Improvement

Culture

Most staff felt respected, supported and valued within their teams. Staff spoke about there being different cultures across the two wards and that staff on Cooden ward had a clearer understanding of their roles and responsibilities. Staff felt Cooden ward was more settled and organised despite having a newly appointed ward manager at the time of the inspection.

Staff told us they could raise any concerns to the ward manager on both wards without fear but did not always feel that they were able to make changes to the running of the wards.

At the time of the inspection, managers told us no grievance procedures were being pursued within the wards and there were no allegations of bullying or harassment.

Staff felt there was a heavy reliance on agency staff and this sometimes made permanent staff feel undervalued.

The provider carried out an annual survey which was last completed in February 2021, when three staff completed the survey. The themes that were identified from the survey were addressed by an action plan which identified that staff felt that managers were not supportive in managing stress levels, career development and following up on appraisal development. The provider had developed an action plan to address these areas but the 2022 survey was not available to determine if these actions had been successful.

Ward managers had human resource dashboards which helped them to keep track of staff sickness, training and performance. Sickness levels were low across the acute wards and ranged from 1-2% in the months between November 2021 to March 2022.

Staff felt they had suitable levels of supervision and felt that ward managers were approachable and available for ad-hoc supervision.

Governance

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

The provider did not have robust internal assurance processes which meant that many of the issues identified during the inspection were unknown to the provider. The defibrillator that was not in working order on Fairlight ward had not been picked up through the provider's assurance processes. We identified that patients were not routinely involved in developing their care plans on Fairlight ward despite a care record audit being in place that had not identified this. Some of the complaint documentation was either incomplete or not stored appropriately and the provider had not identified this through an internal assurance process. The ward ligature risk assessments were inconsistent because the same risk had been scored differently across both wards and this had not been identified by the provider.

Staff working on the two acute wards did not have access to team meetings. Although staff could give feedback or raise concerns directly with senior leaders directly or via the staff survey, there was no clear and consistent way of capturing and escalating feedback and concerns from the ward staff teams. The provider had plans to re-introduce team meetings soon.

A hospital-wide clinical governance meeting took place, although identified actions were not given timeframes for completion and were not always reported on during subsequent meetings.

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

Requires Improvement

Management of risk, issues and performance

During the last inspection in June 2018, we identified that the hospital risk register did not identify the key risks to the service. During this inspection, we found that the hospital now had a risk register in place that reflected the risks associated with using agency staff and the Covid-19 pandemic.

Information management

Staff collected data about outcomes and performance.

The provider planned to develop an electronic care records system but no plans had been formalised at the time of the inspection and there were no timescales for this work to be complete.

The ward managers and the quality team had dashboards in place to support them in their role. This included information on staffing, supervision and appraisals, training and hospital performance data.

Staff were aware of the requirements to refer to external bodies such as the CQC when required to report incidents and safeguarding issues.

Engagement

Patients had the opportunity to give feedback about the service via the patient weekly community meetings which happened on both wards. Also, the service had a patient annual survey. The last patient survey happened in December 2021 that gave rise to mostly positive feedback, although some patients did not always feel like they were being treated with care and respect. The survey did not have an action plan attached so we were unable to review whether the actions had been allocated and resolved.

Patients and carers had opportunities to give feedback on the service as an annual carers survey was carried out.

The acute wards regularly met with external stakeholders and commissioners of the service through engagement meetings. These had been happening more recently via video conferencing due to the Covid-19 pandemic however restarted prior to the inspection.

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 9 HSCA (RA) Regulations 2014 Person-centred care • The provider did not ensure patients could easily access independent mental health advocates (IMHAs) on the wards. • The provider did not ensure patients were involved in planning their care and treatment. • The provider did not ensure that patients could access an appropriate amount of occupational therapy led therapeutic activities, including during evenings and at weekends. • The provider did not adhere to an inpatient rehabilitation model and ensure the anticipated length of stay, patient discharge plans and multidisciplinary staffing provision, including occupational therapy and consultant psychiatry, aligned with this model. • The provider did not ensure that each patient had a plan for their discharge from the service. • The provider did not ensure that patients have the appropriate support to develop their daily living skills, including the ability to cook and prepare meals with appropriate support from an occupational therapist.

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 did not ensure ligature risks were safely assessed and managed. • The provider did not ensure assessment of patient risk was done in a comprehensive and timely manner. • The provider did not ensure patient observations were completed intermittently rather than at set times.

This section is primarily information for the provider

Requirement notices

- The provider did not ensure staff were trained to safety search patients to keep them safe from risks posed by contraband items.
- The provider did not ensure staff safely monitored the physical health of patients who have received medicine by intramuscular rapid tranquilisation.
- The provider did not ensure clinical waste including used sharps were managed safely to minimise the risk of injury and infection.

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 did not ensure blanket restrictions were systematically reviewed and that patients could secure their personal items in a lockable space independently. • The provider did not ensure patients had access to a key to their own bedroom where this was clinically appropriate.

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 did not ensure nursing staff with the appropriate skills were rostered to work on each shift to safely meet the needs of patients, and that staff received the necessary specialist training to ensure they were skilled and competent to carry out their roles. • The provider had not been able to recruit to the vacant ward manager posts on Seaford and Balmoral wards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

- The provider did not ensure all essential clinical information was appropriately managed and routinely accessible to staff.
- The provider did not ensure appropriate governance systems were in place to assess, monitor and improve the quality and safety of the service.
- The provider did not operate effective governance systems to enable them to assess, monitor and improve the quality and safety of the service.