Three Valleys Hospital

Quality Report

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Date of inspection visit: 27 to 30 November 2017
Date of publication: 24/01/2018

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated Three Valleys Hospital as **good** because:

- Safety was a high priority for the service and the measurement and monitoring of safety was a robust and continual process of improvement. Patients had detailed and thorough risk assessments in place which staff updated regularly. There were clearly defined and embedded systems and processes in place to keep patients safe and safeguard them from abuse. People received their medicines as prescribed and medications and equipment were stored safely. When incidents occurred staff recorded them well, investigated them appropriately and they utilised the learning of lessons to ensure improvements in safety.
- Staff planned and delivered care and treatment to patients in line with national best practice guidance. A clinical improvement schedule was in place to monitor practice and ensure improvements were made. Where audits identified a need for improvement we saw that staff made changes. Patients had comprehensive and holistic assessments of the entirety of their needs and the service gave high priority to the monitoring of patient's physical healthcare needs. Staff used legislation such as the Mental Health Act and Mental Capacity Act appropriately and monitoring systems were in place to measure and improve their use. The service supported staff to deliver effective care and treatment by providing them with supervision, appraisal and opportunities for reflective practice. The service had a strong multi-disciplinary team who worked together to produce holistic care and treatment plans for patients.
- Feedback from patients and carers was positive about the why staff treated people. We observed care that was kind and compassionate and saw that staff knew the patient group well. Patients on the rehabilitation wards were encouraged to become active partners in their own care and in the running of the service. In the rehabilitation services staff used a variety of ways to encourage patients to give feedback about their care and treatment. In the specialist dementia service we saw examples of exceptional care where staff had gone the extra mile to provide comfort and care to patients.
- The service was responsive to the individual needs of patients and made reasonable adjustments for patients with specific needs. People had discharge and recovery plans in place to support effective discharge and the service was focussing on a renewed focus for discharging patients more quickly where it was appropriate to do so. The service needed to continue to ensure this focus was embedded to enable us to see sustained improvement in the discharge of patients from the hospital. Patients on the rehabilitation wards were not restricted and staff gave them opportunities to enhance their skills for independence. Patients on all wards were able to access a variety of activities, which were planned to meet their individual needs, interests and support their recovery plans.
- The service was well led. The senior leadership team were experienced and qualified and had robust governance systems in place to manage, monitor and maintain the safety of the service. The service had a clear statement of its vision, values and its strategy for the future. Senior leaders were aware of the challenges faced by the service and had implemented plans to meet these challenges and prevent them from having an impact on the care and treatment of patients. The leadership team modelled the culture of the service which was one of openness and transparency. They embedded least restrictive practice for patients and a sustained focus on driving improvement by learning lessons from incidents and complaints. There was a clear pathway from ward level governance to organisation wide governance and a clear system for reporting from ward to board and back to the staff teams. Staff told us that their managers were approachable and that morale within the service was increasing. The management team had responded quickly to staff morale concerns on Oakwroth ward and made significant improvements.

However,

- The service was not always able to provide facilities which promoted the comfort, dignity and privacy of patients. However, the hospital director explained that the service was due to start a period of renovation

which the provider supported and that these renovation plans would address all of these concerns within the next twelve months. Work had already begun on the replacement of doors on Oldfield ward.

- The service did not always follow best practice guidance in relation to the use of do not attempt cardio pulmonary resuscitation forms on Oakworth ward. They were also unable to provide adequate psychological therapy services due to an ongoing vacant post for a qualified psychologist. Staff used a risk assessment tool which did not meet the needs of the patient groups.
- Patients in the specialist dementia service were not asked to give feedback about their care and it was difficult to ascertain how they and their families had been involved in the planning of their care. Oakworth ward was not discussed in the service's admission leaflet and therefore specific information was not available to patients and their carers.
- Although the service was safe we found that staff needed to make improvements in their recording. Particularly in relation to the planning of leave, and the recording of patient physical health observations. service needed to ensure that local and national policy in the provision of emergency drugs on site were clear to staff to reduce the risk of error.

Summary of findings

Contents

Summary of this inspection

Page

Background to Three Valleys Hospital 6

Our inspection team 6

Why we carried out this inspection 6

How we carried out this inspection 7

What people who use the service say 7

The five questions we ask about services and what we found 9

Detailed findings from this inspection

Mental Health Act responsibilities 14

Mental Capacity Act and Deprivation of Liberty Safeguards 14

Overview of ratings 14

Outstanding practice 47

Areas for improvement 47

Good

Three Valleys Hospital

Services we looked at:
Long stay/rehabilitation mental health wards for working-age adults; Wards for older people with mental health problems.

Summary of this inspection

Background to Three Valleys Hospital

Three Valleys Hospital has been registered with the Care Quality Commission since August 2013 to carry out the following regulated activities:

- Assessment and treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

Three Valleys Hospital is a community inpatient locked rehabilitation service. It is a registered location of Elysium Healthcare Ltd. Prior to December 2016 another provider managed this location.

The service provides care for a maximum of 43 male and female patients across five wards:

- Ingrow is a 12 bed female rehabilitation ward.
- Winfield is a four bedded 'step down' ward designed to provide support for patients from Ingrow who are closer to discharge. At the time of the inspection, 11 patients were admitted to Ingrow ward and two to Winfield.
- Oldfield is an 18 bed male rehabilitation ward.
- Steeton is a six bedded 'step down' ward, which is designed to provide support for patients from Oldfield ward who are closer to discharge. At the time of the inspection, eight patients were admitted to Oldfield ward and three to Steeton.
- Oakworth ward provides a nine bed male only service which specialises in dementia care. At the time of the inspection, nine patients were admitted to the service.

The Care Quality Commission has not previously inspected Three Valleys Hospital provided by Elysium Healthcare Ltd.

Our Mental Health Act Reviewers have also visited the following wards; Ingrow (November 2017), Oakworth (May 2017), and Oldfield (December 2016). At these visits, the reviewer raised concerns about; the information available to patients, staff informing patients of their rights in a timely manner, a lack of observation panels on patient bedroom doors, activities for patients, and the discharge focus. We reviewed these concerns during this inspection.

The hospital had a registered manager. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and the associated regulations including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010.

Our inspection team

The team that inspected the service comprised three CQC inspectors which included the team leader, a CQC assistant inspector, and three specialist advisors; two mental health nurses and one occupational therapist.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

Summary of this inspection

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all three wards at the service, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 10 patients who were using the rehabilitation service, and four patients using the ward for older people with mental health problems
- spoke with three carers or relatives of people using the rehabilitation service and four carers or relative of people using the ward for older people with mental health problems
- carried out a short observational framework for inspection on Oakworth ward
- spoke with the hospital director, clinical governance lead, two ward managers and both consultant psychiatrists
- attended activities with patients
- spoke with 23 other staff members including nurses, healthcare support workers, psychologists, occupational therapists, activity co-ordinators and administration and ancillary support workers
- spoke with 21 staff at two staff focus groups
- spoke with three patients at one focus group
- looked at the care and treatment records of 15 patients
- carried out a specific review of the management of medicines at the service

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 14 of the 33 patients admitted to the hospital during one to one discussions and a focus group. We offered to speak with all patients, but not everyone wanted to speak with us or was able to share their views with us.

The majority of patients told us that they felt safe at the hospital and that staff were kind and friendly. Patients told us that staff treated them with dignity and that they felt involved in their care. Patients valued the support of the advocates which was available to them at the service. Patients spoke highly of the activities available to them and showed us the things they had achieved during their stay such as artwork and gardening projects. However, three patients from the rehabilitation wards told us that there were not always enough staff to escort them on planned leave.

Patients gave us mixed views regarding the environment on the rehabilitation wards. They told us that the wards had recently been decorated which had made an improvement, but three patients said that the wards were not always clean. Two patients told us that they had experienced having their belongings taken from them by other patients.

We spoke with seven carers or relatives of people using the service. All of the carers and relatives told us that they felt their relative was safe and well cared for. They said that staff were kind, polite, welcoming, caring and compassionate. They said that they felt comfortable talking to staff and making complaints.

However, all of the carers we spoke with told us that they felt that the service could improve communication with them. They said that there was a high staff turnover and so they did not always know who their relatives named

Summary of this inspection

staff member was, and didn't feel that they had always been involved in care planning and long term planning for their relative. They did tell us that staff always invited them to care programme approach meetings but that they had little contact with the service outside of this.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because:

- Staff adhered to infection control and hand hygiene procedures. Staff had undertaken environmental and ligature risk assessments and the service managed fire safety well, undertaking regular fire evacuation tests.
- All wards had access to emergency and disaster grab bags and staff had access to emergency equipment such as defibrillators and ligature cutters.
- Although staffing had been a challenge for the service, shifts ran at safe establishment levels the majority of the time, and the clinical governance lead had a robust system in place to monitor this.
- Patients were able to have regular one to one with staff and there was adequate cover from doctors and to respond to incidents.
- Medication management and record keeping and storage was good, other than one medication omission on Oldfield ward. Pharmacists visited all wards regularly and carried out detailed audits and we saw improvements as a result of these audits.
- All patients had risk assessments in place which staff updated regularly and the system for assessing and mitigating patient risk was clear and well managed.
- Staff were up to date with mandatory training.
- The use of restrictive interventions was low across all wards. Staff did not use prone (chest down restraint) and all other restraints we reviewed used only low level restraint such as low level arm holds. Staff had not used seclusion or rapid tranquilisation with any patients. The hospital had a least restrictive culture and staff were skilled in de-escalation. When staff used restrictive or physical intervention they recorded it appropriately and the management team reviewed all incidents.
- All staff knew how to report incidents, and senior members of the team reviewed these. Senior managers always shared lessons learned with staff and following a serious incident we saw that staff had implemented changes to practice. The

Summary of this inspection

system which the provider used for reporting incidents merged with the patient daily record which meant that patient records and risks were continually updated and could be reviewed by staff.

- The senior leadership team had responded promptly when staff raised concerns about morale and patient care being affected by staffing levels.

However:

- The clinic room on Oakworth ward was not entirely clean and was also disorganised. Clinic rooms on all wards were small and did not contain examination couches for patients.
- The hospital did not entirely follow guidance regarding the management of do not attempt cardio pulmonary resuscitation notices because they were photocopies which did not contain the original signature.
- Ligatures risks in communal bathrooms were not included in the ward's ligature risk assessment.
- The service used the historical clinical risk (20) assessment tool with all patients. This tool did not support the risk assessment of the patient group and is widely used in forensic services.
- The service had a local policy for the use of emergency drugs with patients, which did not entirely match with the provider's national policy. This may cause confusion for staff in emergency situations.
- Less than 75% of staff on Oakworth ward had been trained in the management of violence and aggression. However, the provider had a plan to manage and improve this, and an interim management plan to ensure the safety of patients.

Are services effective?

Good

We rated effective as **good** because:

- The service employed a registered general nurse who was responsible for ensuring patients' physical healthcare needs were met. The physical health of patients was high priority for staff and underpinned by a physical health strategy.
- The service provided patients with care in line with national best practice guidance, and monitored patient outcomes using recognised ratings scales.
- Staff had up to date appraisals and received regular clinical supervision. They were also able to participate in regular reflective practice sessions on all wards.

Summary of this inspection

- The service had a good system in place for the management of the Mental Health Act and Mental Capacity Act and Deprivation of Liberty Safeguards. All staff had received training in both Acts and were able to explain their principles.
- Staff had completed capacity assessments and undertaken best interests discussions when patients did not have capacity to make specific decisions about their care and treatment.
- A highly skilled on site multi-disciplinary team worked collaboratively with patients to produce detailed care plans for patients.

However:

- Care plans did not always reflect the involvement of relatives and carers in the patient's care and treatment.
- The air locked door on Oakworth ward meant that not all informal patients were able to leave at will and the provider had introduced this as an additional safety measure but were not entirely clear that this was the least restrictive option for all patients.
- There was a vacant post for a lead psychologist at the service, this meant that patients were unable to access all psychological therapies and the service lacked a long term psychology model. However, the provider continued to make efforts to employ a qualified lead psychologist.

Are services caring?

Good

We rated caring as **good** because:

- Patients, and their relatives and carers spoke positively about the care staff provided and described them as kind, compassionate and responsive.
- Staff were caring, and we saw kind and compassionate interactions between patients and staff. Staff treated and spoke about patients in a dignified manner.
- Care delivered ensured the entirety of patients' needs was equally important.
- Patients had access to the support of advocacy. Advocates were highly visible around the hospital and visited all wards at least once per week.
- Where patients had made advance decisions about their care and treatment staff had worked with these patients to ensure they could meet their needs and wishes.

However:

Summary of this inspection

- Community meetings on Oakworth ward for older people with mental health problems were not in place at the time of the inspection.
- Carers told us that they did not always feel involved in the care of their relative, particularly on the rehabilitation wards, and communication from staff outside of planned meetings was not always good and impacted by the use of temporary staff on Oakworth ward.
- The hospital admission leaflet did not include information about Oakworth ward to support patients and their carers.

Are services responsive?

Good

We rated responsive as **good** because:

- Staff planned all discharges and admissions to the service thoroughly and involved the input of the patients, their commissioner and the entire multi-disciplinary team.
- Patients were not restricted; they were able to access facilities such as skills kitchens and communal patient laundries on the rehabilitation wards in order to prepare them to build their skills for independence.
- Patients were able to make drinks and snacks throughout the day and night and had personalised bedrooms.
- The service was able to meet the needs of all people who used the service by providing access to outside spaces, access for those with mobility needs and onsite catering facilities which could meet the needs of patients with specific dietary needs.
- Staff had gone the extra mile on Oakworth ward to meet patient's individual needs by considering their history, needs and wishes to ensure they were able to maintain a good quality of life and be cared for in a manner in which they chose.
- Patients had access to a wide range of activities which were highly individualised to meet their needs with the support of the occupational therapy team.

However:

- The facilities available to patients at the hospital did not always promote comfort, dignity and confidentiality. Four patient bedroom windows did not have privacy film. However the hospital director showed us a plan for renovations at the hospital to take place within the next twelve months, which they confirmed would address all of these issues identified and which they senior leadership were already aware of.

Summary of this inspection

- Although patients and carers knew how to make complaints and the service had a clear system for managing them. Staff did not always keep patients updated about delays, and did not always ensure that were investigated fairly and independently.

Are services well-led?

Good

We rated well-led as **good** because:

- The overall governance of the service ensured the safe management of the hospital. There was a clear pathway between ward level governance, hospital level governance and provider wide governance.
- The leadership team had a clear strategy for the service, and were aware of concerns and risks within the service. Where we identified issues during the inspection, the service had already recognised these areas and had plans in place to manage them.
- Staff felt supported and valued and spoke positively about the leadership team and the provider as a whole. Staff felt able to raise concerns without fear of victimisation.
- The service used a variety of tools and audits to measure the quality of the service and identified themes and trends from this data to continually improve the service.
- The service was aware of their own risks and challenges. All areas of concern drawn from the measurement of data and key performance indicators had action plans in place to improve quality and safety.

However:

- Accurate and contemporaneous records were not always kept for all patients, such as in regards to their physical health observations and in leave planning.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

At the time of the inspection 94% of staff across both core services had received training in the Mental Health Act and this training was mandatory for staff. Staff had a good working knowledge of the Act and its principles and several were able to explain its principles, particularly the principle of least restriction.

The service had systems in place to ensure the proper implementation and administration of the Mental Health Act and Code of Practice. They carried out regular audits to ensure continued compliance.

All patients had the relevant paperwork in place which was well organised and staff made appropriate referrals for a second opinion doctor when required for patients who lacked capacity to consent to their treatment.

Care records evidenced that staff routinely explained to patients their rights under the Mental Health Act.

We reviewed the provider's 'working with the Mental Health Act' policy (April 2017). The policy was detailed and thorough and referenced relevant legislation including the Mental Health Act Code of Practice (2015).

Patients were allocated section 17 leave by the responsible clinician in weekly multi-disciplinary team meetings. Staff documented leave appropriately. All patients had leave care plans. However in three patient records we saw that patients had more than one leave plan marked as current which could cause confusion for staff.

All patients admitted to the service who lacked capacity to consent where referred to an independent mental health advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of the inspection 93% of staff across both core services had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards and this training was mandatory for staff. Staff had a good understanding of the Act and its principles and were able to explain these to us during the inspection.

We reviewed the provider's policy for the Mental Capacity Act and Deprivation of Liberty Safeguards (August 2017). The policy was thorough and contained all relevant guidance including updates from the 2014 supreme court judgement in relation to Deprivation of Liberty Safeguards.

Staff had made applications for the use of Deprivation of Liberty Safeguards for patients on all wards, when their needs did not meet criteria for detention under the Mental Health Act and they lacked capacity to make a decision about their own care and treatment.

Staff were aware that they should assume capacity. They had undertaken specific two-stage capacity assessments and best interests meetings in relation to specific decisions which were highly complex. These assessments gave a clear rationale and senior members of staff had undertaken them. Where staff had completed best interests meetings all relevant parties were involved including the patient, their advocate and any external professionals involved. However staff did not always strongly represent the voice of the patient in the recording of these meetings.

All patients had access to the support of an independent mental capacity advocate, who visited the wards on a weekly basis. Staff automatically referred patients who lacked capacity for the support of an advocate.

A number of patients had outstanding applications for Deprivation of Liberty Safeguards which continued to await approval from the relevant local authority. The service continued to document and record following these applications up for assessment.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Long stay/rehabilitation mental health wards for working age adults

Good

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

The rehabilitation service consisted of four wards.

- Ingrow; a 12 bed female rehabilitation ward
- Winfield; a four bedded 'step down' ward designed to provide support for patients from Ingrow who were closer to discharge
- Oldfield, an 18 bed male rehabilitation ward
- Steeton; a six bedded 'step down' ward which is designed to provide support for patients from Oldfield ward who are closer to discharge.

At the time of the inspection, 11 patients were admitted to Ingrow ward and two to Winfield, eight were admitted to Oldfield ward and three to Steeton.

We checked the whole of the environment to consider whether it was safe and clean.

The ward layout on Oldfield and Steeton wards allowed clear lines of sight for staff to observe patients. The ward was located on one long corridor, with the staff office placed centrally between the two wards. The staff office was glass fronted and looked onto the communal lounge and skills kitchen.

The ward layout on Ingrow and Winfield wards did not allow staff clear lines of sight to observe patients in all areas. However, the staff office looked out onto the communal lounge.

Staff mitigated risk regarding lines of sight on both wards through the use of patient observations. One member of staff was allocated at each shift handover to observe patients throughout the day and night. Observation levels were determined by the level of risk presented. Staff would monitor a patient who had an increased risk of self-harm more closely. The multi-disciplinary team reviewed patient observation levels on a weekly basis and staff discussed them daily in handover meetings.

All areas of the service contained ligature points (a ligature point is something which a patient intent on self-harm could use to tie something to in order to strangle themselves). The ward manager had undertaken a ligature risk assessment on all wards in October 2017 which identified ligature risks in all areas of the service. However the unlocked communal bathroom on Oldfield ward contained specialist bathing and moving and handling equipment which had not been included in the ward ligature risk assessment. This meant that staff were not aware of all the ligature risks. The risk was increased because patients accessed this unlocked room without supervision. The hospital director agreed to rectify this immediately after the inspection and advised that the additional ligature points were moveable equipment which staff had stored incorrectly.

The wards were separated and provided accommodation to either male or female patients and therefore were compliant with guidance on same sex accommodation provided in the Mental Health Act Code of Practice, and Department of Health guidance in eliminating mixed sex accommodation.

Oldfield and Ingrow wards had a clinic room in which staff stored medication and equipment to support physical

healthcare needs. Neither clinic room had an examination couch for staff to examine patients because they did not have enough space to fit them in. Staff examined patients in their bedrooms.

The equipment stored in the clinic room such as blood pressure monitor and weighing scales was clean and well maintained. Ingrow ward's clinic room did not have a fridge to store medications and shared the fridge on Oldfield ward. Both clinic rooms contained emergency resuscitation bags with up to date required equipment. Both wards had a defibrillator and ligature knife which were stored in the staff office.

The emergency resuscitation bags did not contain any of the emergency medications stated in the Elysium Healthcare policy, except for an epi-pen. The registered general nurse explained that a local risk assessment for the service identified that the wards would not hold emergency medications because staff did not use these medications regularly and the service was located within five minutes of the general hospital. Staff followed the local protocol detailed in the previous provider's policy, which they were all familiar with that stated that staff would sustain life using immediate life support techniques whilst emergency paramedics arrived. However this did not fit with the provider's own national policy and we were concerned that this may cause confusion for staff.

The service did not have a seclusion area.

The wards were clean and furnishings were in good condition. Domestic staff were present on the wards throughout our visits and the wards were clean and tidy. However three patients told us that the wards were not always clean.

Staff adhered to infection control principles including handwashing and we saw that hand wash was available to staff, patients and visitors throughout the hospital. Staff wore personal protective equipment when they carried out cleaning tasks and the handling of food. Staff carried out regular infection control audits to monitor the cleanliness of the environment.

The health and safety manager had undertaken environmental and situational risk assessments on each ward alongside the ward manager on 15 November 2017. These were detailed and available to all staff on the ward. The hospital had a fire risk assessment completed on 23 November 2017. Fire extinguishers and equipment we checked were in date and an external provider had inspected the alarms and certificates were in place. Patient personal evacuation plans were stored in a 'disaster grab bag' on each ward. We saw that the hospital undertook regular fire evacuation practices.

Staff carried personal alarms to alert colleagues should they require assistance in an emergency. During the inspection we saw these alarms sound and staff responded to them quickly and appropriately. The service had a policy in place for the checking and monitoring of both alarm systems which included recording monthly maintenance checks. Patients had access to nurse alarm call systems in their bedrooms and on communal corridors.

Safe staffing

Prior to the inspection the hospital submitted data regarding their staffing levels. The whole hospital had 81 substantive staff in total including clinical, managerial, administrative and ancillary staff. This included 12 whole time equivalent qualified nurses and 29 whole time equivalent healthcare support workers. The data provided showed that there were no staff vacancies at the time of the inspection on the rehabilitation wards.

The wards had an average sickness rate between 1 September 2016 and 31 August 2017 of 3.8% which was slightly higher than the provider's own target of 3%.

The rehabilitation wards had experienced a high turnover of staff between 1 September 2016 and 31 August 2017. There were ten staff leavers on Ingrow and Winfield wards and eight on Oldfield/Steeton ward. The hospital understood that the staff retention was a challenge and the potential impact on the continuity of patient care and had implemented a staff retention policy. This included actions such as a culture of care survey and a review of staff exit interviews to analyse themes and trends and provide support to staff to improve retention.

The hospital director used an in-house tool to estimate the numbers of staff required per shift on each ward. The wards were staffed with two shifts running from 7:30am to 8:00pm during the day and 7:30pm to 08:00am at night. Each ward was staffed by two qualified nurses and three healthcare support workers.

Long stay/rehabilitation mental health wards for working age adults

Good

In addition to the above, a multi-disciplinary team supported the rehabilitation wards. This included sufficient medical input into the service from; two consultant psychiatrists and occupational therapy and psychology teams.

The service had a clear governance structure to manage staffing. Daily staffing numbers were reviewed by the clinical governance lead each morning, and staffing across the hospital was reviewed three times per week in the hospital's morning meeting.

We reviewed safer staffing reports from 30 June 2017 to 16 November 2017. We found that staffing met establishment levels on all shifts during this period other than on six occasions when the wards ran with one less staff member than planned. However a senior leadership team member had reviewed all reports and made comments of planned actions or reasons when staffing levels fell below establishment levels. The service reported that there were seven shifts on Oldfield/Steeton ward which were not filled to establishment levels due to sickness or vacancies and eight on Ingrow / Winfield. This amounted to 4% of the total shifts available. However on these occasions the wards were not running at full bed occupancy levels and other members of the multi-disciplinary team outside of staffing numbers stepped into shifts to support the teams as needed.

The ward manager was able to request the support of temporary bank or agency staff as required in response to unplanned events such as sickness or changes in patient's risk.

The service used temporary bank and agency staff appropriately. Between 1 June 2017 and 31 August 2017 bank staff were used on 65 of 184 shifts (35%). On Oldfield/ Steeton ward and 64 of 185 shifts on Ingrow/Winfield ward (35%). Agency staff were used on the same number of shifts.

Ward managers told us that if additional staff were required, they utilised overtime from permanent staff or support from in house bank staff prior to requesting agency staff. Managers monitored the use of agency staff and safer staffing reports highlighted in amber when agency use rose above 25%. This was to ensure that the service never filled shifts entirely by agency staff. If agency staff were used, managers would spread the use across the wards to ensure it was equitable and provided consistency of staff to patients.

Qualified nursing staff were available and visible to patients on the ward throughout our visit. Patients told us that there was enough staff available to allow them to spend one to one time with them. Staff and patients explained that the wards held patient protected time during a specific period each day. This time was designated to ensure staff that staff were on the ward spending time with patients on activities or care planning.

The service did not record information regarding how often ward activities or patient leave was cancelled due to staffing shortages. Three patients told us that there was not always enough staff available to facilitate leave from the ward. Staff told us that when this happened, they always rearranged leave. Two staff members told us that patient's leave was sometimes cancelled due to staffing shortages. The hospital director said that this had occurred due to previous staff vacancies but was improving.

There were enough staff to carry out physical interventions with patients should they be required. Each day the hospital had a designated management of violence and aggression team which consisted of five trained staff members. They, along with the clinical governance lead attended all incidents as required.

There was adequate medical cover day and night. Two full time consultants supported the wards during the day. At night there was an on call rota for this and other local hospitals in the group. The consultant psychiatrist told us that a doctor could reach the hospital in an emergency within 40 minutes.

Prior to the inspection we asked the service to provide us with evidence of staff training. Staff carried out mandatory training in; moving and handling, suggestions, ideas and complaints, information governance, equality, diversity and human rights, fire safety, health and safety, safeguarding children level one, safeguarding adults Level 1, infection control level one and two, breakaway, the management of violence and aggression, basic and immediate life support, Mental Capacity Act and Deprivation of Liberty Safeguards, Mental Health Act Code of Practice, food hygiene, and the safe administration of medication.

Long stay/rehabilitation mental health wards for working age adults

Good

Elysium Healthcare Ltd had a training compliance target of 95%. Over 88% of staff had achieved compliance with mandatory training.

The lowest level of training for staff was in relation to management of violence and aggression at 88%. The hospital director told us that since the changeover of provider, the training has changed to require training in a new method. The manager was concerned about the risks of training staff in different techniques. They had a structured plan to deliver training on each ward from January 2018 and no longer sent staff for refresher training on the old method to reduce the risk of confusion. In the interim hospital had developed a five person management of violence and aggression team who were up to date and complaint with all training and attend all incidents as the first responders to ensure consistency and mitigate any impact of those staff who had not received refresher training. All staff were trained in breakaway techniques.

Assessing and managing risk to patients and staff

Between 1 March 2017 and 31 August 2017 staff had used restraint once with one patient on Oldfield ward and five times with two patients on Steeton ward.

In the same time period staff had used restraint on ten occasions with two patients on Ingrow ward and six times with two patients on Winfield. None of these restraints were carried out in the prone (chest down) position. None of the restraint incidents had involved the use of rapid tranquilisation (medication used to rapidly calm patients).

We reviewed the risk assessments of 10 patients admitted to the rehabilitation wards. Staff used recognised risk assessments such as an in-house risk assessment matrix, the short term assessment of risk and treatability and the historical clinical risk management (20). This type of risk assessment is mainly used with patients with a forensic background and there are more suitable assessment tools for use with this patient group. Staff also completed a detailed risk care plan. All 10 patients had a current risk assessment which staff had completed within the last six months. Staff had updated all patient risk assessments every six months or sooner if an incident occurred.

Staff reviewed risk care plans for all patients monthly in the multi-disciplinary team meeting. The provider had an 'assessment and management of clinical risk' policy, which was written in June 2017. Staff had not entirely followed this policy, which stated that they should complete a short term assessment of risk and treatability assessment for each patient within seven days of admission (or at pre-admission). For patients admitted to the ward within the last twelve months staff had completed a risk assessment within one month of the patient's admission date. It was not possible to check these dates for other patients due to a change in the provider's electronic system. However staff had completed a historical clinical risk management (20) within the first 12 weeks of admission and reviewed all risk assessments at a minimum of six monthly which was in line with the provider's own policy. All patients who were admitted to the service had a pre-admission assessment carried out with staff.

The service did not have blanket restrictions in place. A blanket restriction is a rule which a provider puts into place for all patients regardless of their risk level or detention status. The provider reviewed blanket restrictions thoroughly and completed a blanket restriction audit. We saw open access for patients to all rooms within the wards, including access to the laundries and skills kitchens to ensure patients were able to enhance their skills for independent living.

At the time of the inspection there was one informal patient admitted to Ingrow ward. The remaining patients were detained under the Mental Health Act. Both wards contained advice and signage for informal patients to ensure they were aware of their right to leave.

The search policy clearly stated that searches were only undertaken with patient consent and when there was a risk indication that a patient may have brought banned items into the ward. Staff did not undertake room searches unless there was a clinical reason for doing so. There had been a recent increase in patient searches due to the hospital implementing a smoke-free environment including in the hospital grounds. Patients had brought cigarettes and lighters onto the wards.

The hospital also had a local protocol in place for the use of a breathalyser and substance misuse urine testing kits held on site. Staff were only able to use these with patient consent and in direct response to a risk (such as a patient returning from unescorted leave appearing to have consumed alcohol or substances which may have an effect on their medication).

Patients were allocated differing observation levels dependent on the risk they presented at the time. Qualified

nurses were able to increase observation levels should they be concerned about the risk a person was presenting. Patients had a maximum of hourly observations on the ward as per the ward risk assessment to manage the environmental risks. However according to risk assessments, patients on Winfield or Steeton step down wards could have further reduced observations. We saw that when staff increased patient observations due to risk, they quickly reduced them when safe to do so to ensure a least restrictive approach to care.

Staff and patients told us that physical interventions were rarely used on the wards and we saw evidence of this in the data shown to us by the provider. Staff used talking, distraction, and de-escalation techniques to reduce the need for physical interventions. Staff had a good awareness of the least restrictive principle and the hospital had a culture which promoted the use of none physical interventions.

Staff had not used restrictive practices such as seclusion and rapid tranquilisation in the last twelve months.

Between 1 March 2017 and 31 August 2017 staff had used restraint once with one patient on Oldfield ward and five times with two patients on Steeton ward. We asked the provider why there had been restraint on a ward designed for patients ready for discharge and they explained that these patients had become unwell and one of them had moved to a psychiatric intensive care unit following these incidents.

In the same time period staff had used restraint on ten occasions with two patients on Ingrow ward and had not used restraint on Winfield ward. None of these restraints were carried out in the prone (chest down) position. None of the restraint incidents had involved the use of rapid tranquilisation (medication used to rapidly calm patients).

We reviewed five incidents of restraint which had taken place on the wards in November 2017. All five incidents noted aggression from patients towards staff or other patients. Staff recorded all incidents clearly with details of what de-escalation actions they had taken prior to the use of restraint. Staff recorded all five restraint incidents as either 'friendly come along or low level forearm holds.

Between 31 October 2016 and 31 October 2017 the service had notified the Care Quality Commission of 33 safeguarding concerns at the location.

We reviewed the last 12 safeguarding referrals which the service had made to the local authority between 31 May 2017 and 15 November 2017. These were four on Oldfield, four on Ingrow and four on Steeton ward. These referrals evidenced that staff had correctly identified safeguarding concerns when incidents had occurred on the ward and had made appropriate referrals to the local authority safeguarding team and the Care Quality Commission.

The service had also undertaken a serious incident investigation alongside one safeguarding investigation where a patient made allegations against a member of staff. This showed that the service had taken these concerns seriously and listened to the patient's concerns.

We saw good practice in staff's understanding and recording of safeguarding. In one incident the patient had not told staff about an assault from another patient and staff explained to the patient the importance of reporting concerns so that staff could protect them appropriately.

The service had a thorough system in place for the monitoring and reporting of safeguarding. Where staff had made referrals to the local authority, the clinical governance lead kept a log of these until the local authority had made a final decision on any outcome from their investigation.

The service had an overall safeguarding lead and a designated safeguarding lead per ward. Patients and staff knew who they were and posters and details to contact them were located throughout the hospital. Staff knew about safeguarding procedures and could give examples of when to report and what to report.

During the inspection we checked the arrangements for managing medicines at the service. Medicines were stored securely according to the manufacturer's instructions in locked clinic rooms on both wards. The pharmacist visited the wards weekly and carried out a specific check of medication storage and the quality of medication cards. The pharmacist reported back to ward and senior managers on a number of areas such as; prescription errors, recording omissions, and medications above recommended limits. They also completed reviews when patients had refused medications. We reviewed the medications audits for April to June 2017 and found that staff had made improvements from then to the July to September 2017 audit which showed a significant reduction in errors. In addition, the pharmacist produced a

detailed medicines management audit report every three months. This audit reported against specific standards including ensuring that the service was compliant with controlled drugs regulations and that weekly equipment and medication checks were taking place along with daily recordings of fridge temperatures.

We reviewed the medication records of all patients admitted to the wards. In all records checked we found one error in the medication cards where staff had not signed that they had given a nasal spray on one occasion.

We discussed prescribing with the lead consultant psychiatrist as we noted that six patients were prescribed more than one anti-psychotic medication and one patient was prescribed over the recommended limit. The lead consultant psychiatrist stated that for these patients the team continually reviewed the potential risks against the benefits of the medication. Regular physical health checks were undertaken to monitor these patients. All patients had valid consent to treatment recorded and kept with their medications card.

Track record on safety

The service reported that they had not had any serious incidents take place in the last twelve months. No adverse events had taken place.

Reporting incidents and learning from when things go wrong

Staff used an electronic system to record and report incidents. The system was clear and logical and used by all designations of staff. Staff understood what they should report and how to use the system. The incident system joined up with the patient record system which meant that once staff had signed off an incident it recorded in the patient's daily records to highlight risks and concerns.

When incidents didn't meet the criteria for a serious incident, but evidenced potential learning points for staff, senior managers carried out investigations of these incidents in order to share and enhance learning opportunities to increase quality and safety. Managers had undertaken investigations of five such incidents between 6 April 2017 and 17 November 2017. These included patients absent without authorised leave, an assault, a medication error and a Mental Health Act paperwork error. Each investigation report was highly detailed, explained the incident, the findings of the investigator and detailed lessons learned for staff and immediate actions taken.

Staff reported incidents onto the system and ward managers reviewed these initially. Senior managers reviewed these further, and signed them off at the hospital's morning meetings. Staff also discussed all incidents involving patients at their multi-disciplinary meetings to ensure that they updated care plans and risk assessments in response to changes in risks.

Staff were able to explain to us how they received feedback when incidents had taken place. They said that this took place in team meetings and supervision sessions and also in reflective practice sessions undertaken with the support of the psychology team. Staff were able to give clear examples about how things had changed following an incident. For example they told us that they had an increased awareness and revised policy on contacting out of hours managers and the police when patients left the hospital in emergencies following one specific incident. Where serious incidents with learning opportunities had taken place, all staff we spoke with were aware of what happened and the outcome, which evidenced that lessons were learned and information was shared across the hospital.

The Duty of Candour regulation explains the need for providers to act in an open and transparent way with people who uses services. It sets out specific requirements that providers must follow when things go wrong with care and treatment. The service had embedded a culture of openness and transparency and we saw in incident reports and staff recordings that senior staff had considered use of the regulation in response to incidents. Staff also noted in recordings that they provided feedback and had been open and honest with patients and their families when things had gone wrong.

Long stay/rehabilitation mental health wards for working age adults

Good

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed the care records of ten patients. All patients had a comprehensive group of care plans which staff had completed with patients, within one month of their admission to the service.

The monitoring of patients physical health care needs was high on the agenda for the service. Staff used a national early warning scores system to record patient's physical health observations on a weekly basis. Staff repeated these if a patient was unwell or had a long term condition which meant closer monitoring was required. Where patients had long term conditions they had specific care plans to ensure staff could meet these needs.

Staff updated patient care plans at least monthly in multi-disciplinary team meetings. Care plans were holistic and discussed the entirety of a patient's needs such as; finances, leave, rehabilitation, discharge, physical health and mental health insight.

Care plans were personalised and discussed the patient's history, likes and dislikes and any decisions they had made about their care. We saw evidence that staff carried these out collaboratively with patients as care plans contained direct quotes from patients about their needs and wishes. One patient had a specific care plan for contact with families and friends and there were documents for 11 other patients such as best interests meetings, care programme approach meetings and discharge planning meetings where patient's families and carers had been invited and involved in decision making.

All information required to plan and deliver care to patients was accessible and kept within a secure electronic system.

Best practice in treatment and care

The service embedded national guidance in staff practices and patient treatment. They ensured that patient care plans referred to guidance from the National Institute of Health and Care Excellence and the Mental Health Act and Mental Capacity Act Codes of Practice. In addition to this, all working policies and procedures referenced the relevant guidance, such as National Institute of Health and Care Excellence (10) regarding the management of violence and aggression. Staff we spoke with were aware that each ward had a reference folder which contained copies of all relevant guidance. Staff told us the organisation communicated changes in policies and national guidance via staff meetings, email and newsletters.

Patients had limited access to psychological therapies due to a vacant post for a lead psychologist which the service had struggled to recruit to. However in order to reduce the impact of this for patients, a locum psychologist had been employed by the service. They worked one day per week and offered advice and support in weekly multi-disciplinary team meetings on individual patient care. They were also completing a service review to make plans for a renewed focus for the psychology team once the new post holder was employed.

The service employed two assistant psychologists; they delivered some direct therapies to patients using a cognitive behavioural therapy approach. They also supported staff by assisting them to complete historical clinical risk management (20) risk assessments, formulating risk and behaviour management plans and running group supervision and reflective practice sessions with staff.

Access to physical healthcare was high on the agenda for the service. A physical health strategy was in place to follow the service initiative to integrate better physical health care for patients. This strategy included a health promotion element such as 'mission fit,' and delivery elements including physical health champions on each ward and a hospital wide health and wellbeing group. The service employed a registered general nurse in a leadership role to manage and support this strategy and to enhance the skills of the staff group to support patients with long term conditions. The registered general nurse attended all patient multi-disciplinary team meetings to highlight risks and offer support and enhance specific care plans for patients with complex or long term physical health conditions. They also visited each ward daily to review physical health needs and support staff to meet patient needs. They maintained a liaison with patient's GP's which has enhanced and developed these relationships.

Long stay/rehabilitation mental health wards for working age adults

Good

The service had a large occupational therapy department which was led by a senior occupational therapist. They managed two occupational therapist, two occupational therapy assistants and three activity co-ordinators. The activity co-ordinator posts were recently added to ensure occupational therapists could spend more time being therapy rather than activity based. The occupational therapy department used tools and pathways for assessment such as self-catering pathways, independent transport assessment, road safety assessments and community integration assessments. They used the model of human occupational screening tool to measure outcomes against patient's own long term and immediate measurable goals. The purpose of their work was to continue to focus on goal setting and skills development to prepare patients for independence. We saw an example of a patient identifying their goal for independent travel and being supported to achieve this

During the inspection, we did not see that any patients required specialist nutrition or hydration support. However the service was able to provide this and staff told us how they would address any additional hydration or nutritional needs within patients' individual care plans.

Staff also used other rating scales to assess and record severity and outcomes for patients, including the malnutrition universal screening tool, the health of the nation outcome scale and the national early warning score system.

Staff participated in a range of audits to monitor the quality and safety of the service. These included infection control audits, ligature and environmental audits, Mental Health Act and Mental Capacity Act audits, a culture of care barometer, medication audits and equipment audits, information governance audits, a high dose antipsychotic audit, and patient and carer surveys. The hospital had a clinical improvement schedule in place which listed the variety of audits taking place and dates for completion.

Skilled staff to deliver care

The service had experienced and qualified staff, and managers ensured they supported professional development. For example; the provider had seconded two healthcare support workers to complete their mental health nursing qualification. In addition to mandatory training the provider had trained staff in a variety of additional skills. These included phlebotomy, electro-cardio grams, leadership and management, sensory integration and dementia mapping.

The service followed robust human resources policy and procedure. We reviewed three staff files for Ingrow ward and three staff files for Oldfield along with the staff files for the consultant psychiatrists. Staff files contained all recruitment checks in line with the Elysium Healthcare recruitment policy with the exception of evidence of tuberculosis immunisation. This was specified in the recruitment policy as part of employment checks for nursing and healthcare workers in line with Department of Health guidance. Staff files contained all relevant information such as evidence of disclosure and barring service checks, reference checks and right to work checks.

All staff received an appropriate corporate and local induction programme. Bank staff and permanent staff received the same induction. All new permanent staff also had a week where they were not included in planned staffing levels for orientation, shadowing and mandatory training when they started. Staff also received a ward specific welcome pack. All new staff were managed by an experienced staff member until their induction was signed off.

The hospital also had an induction process for agency staff including the completion of an agency induction checklist upon commencement of their shift.

Staff received regular supervision and appraisal. Between 1 September 2016 and 31 August 2017 84% of staff on Ingrow/Winfield wards all staff on Oldfield/Steeton had received clinical supervision. By October 2017 all staff on all wards had received clinical supervision which exceeded the provider's supervision compliance target of 95%.

Staff also received managerial supervision and reflective practice sessions with the support of psychology staff where it was appropriate to their role. The reflective practice sessions we reviewed demonstrated staff sharing ideas and learning, and peer support, around care planning and providing treatment and care for patients with more complex needs.

The provider showed us data which evidenced that 79% of staff had received an annual appraisal. This was lower than the provider's own target of 95%.

Long stay/rehabilitation mental health wards for working age adults

Good

Managers informed us that there was no poor staff performance requiring additional management in the last twelve months. However the hospital director had worked within the human resource procedures to manage and support staff through periods of sickness and absence.

Multi-disciplinary and inter-agency team work

There was a range of professional disciplines available at the service which made up the multidisciplinary team. This included psychiatry, psychology, nursing and occupational therapy.

The team had weekly multi-disciplinary meetings on site to discuss patient needs. We observed a multi-disciplinary meeting during the inspection. All professionals involved in the patients' care attended the meeting. Staff also invited the patient, their carer or relative, and any relevant professionals from outside of the service to the meeting. The consultant psychiatrist chaired the meeting. Staff discussed a range of issues for each patient, including physical healthcare, best interest decisions and mental capacity, discharge and future placements, section 17 leave, detention under the Mental Health Act, and any changes in medication. We saw that the meeting gave all professionals the opportunity to give a view on the patient and their progress. Staff spoke about the patients respectfully at all times. Where patients did not wish to attend the meeting the nursing staff provided feedback to questions the patient had completed in preparation.

The service had effective working relationships with professionals outside of the service. The hospital director sent weekly update reports on all patients to their relevant commissioner and had regular discussions with them regarding the discharge plans for patients. The team also worked closely with the local GP. Staff had made referrals to other professionals to support patients with ongoing physical health problems which required specialist support. The occupational therapy team accessed facilities in the local community to meet patient's needs such as with dog walking volunteering opportunities and local art projects.

There was a handover meeting twice daily at the start of each shift, including the nurse in charge of both shifts and the healthcare support workers beginning the new shift. We observed two handover meetings during the inspection and found them to be of good quality. The staff member in charge of the current shift discussed each patient in turn including their behaviour and mental state, leave, incidents, sleep and eating habits and any change in risk and the need for enhanced physical health monitoring. In addition to this, the senior leadership team met three times per week at a morning meeting to discuss incidents, risks and staffing.

Adherence to the MHA and the MHA Code of Practice

At the time of the inspection 94% of staff had received training in the Mental Health Act. This training was mandatory for staff.

The service had an onsite Mental Health Act administrator. Staff knew who this member of staff was and told us that they were accessible and offered advice to staff. They had recently delivered some updated training to the staff teams to enhance knowledge and improve practice.

The Mental Health Act Administrator organised and scrutinised paperwork on admission. monitored tribunals and renewals and provided reminders to psychiatrists when action was required They also completed regular audits to ensure the Mental Health Act documentation was being completed appropriately and the Act was being applied as required.

Staff had a good working knowledge of the Act and the application of its principles in their practice, for example the principle of least restriction.

We reviewed the provider's 'working with the Mental Health Act' policy (April 2017). The policy was detailed and thorough and referenced relevant legislation including the Mental Health Act Code of Practice (2015).

We reviewed the Mental Health Act paperwork of ten patients during the inspection. Paperwork was stored electronically and in good order. All patients had valid consent to treatment forms stored with medication cards. All patient records contained a copy of their detention papers and relevant approved mental health practitioner report other than in two records. All patients other than two patients had their rights explained to them under the Act at the appropriate time. Staff displayed patients' rights information around the units, and informal patient notices were visible around the hospital. We saw that for patients lacking capacity, staff had requested a second opinion

Long stay/rehabilitation mental health wards for working age adults

Good

doctor at the appropriate time. All patients had a capacity assessment undertaken in relation to their capacity to consent to treatment and this was stored with patient medication cards.

Patients were allocated section 17 leave by the responsible clinician in weekly multi-disciplinary team meetings. Staff documented leave appropriately. All patients had leave care plans. However in three patient records we saw that patients had more than one leave plan marked as current which could cause confusion for staff.

All patients admitted to the service who lacked capacity to consent where referred to an independent mental health advocacy service.

Our Mental Health Act Reviewer last visited this service in November 2017 (Ingrow ward), and visited Oldfield ward in December 2016. At these visits, the reviewer raised concerns about the information available to patients, staff informing patients of their rights, a lack of observation panels on patient bedroom doors, activities for patients, and a limited focus on discharge.

We reviewed these concerns during this inspection and found that all the issues had been resolved, except the lack of observation panels in patient doors which meant that staff had to open the bedroom door to check on the patient in line with their required level of observations. However, this issue was included on the refurbishment plan for the hospital and completion planned within the next 12 months and none of the patients we spoke with raised concerns about this.

Good practice in applying the MCA

At the time of the inspection 93% of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This training was mandatory for staff.

We reviewed the provider's policy for the Mental Capacity Act and Deprivation of liberty safeguards (August 2017). The policy was thorough and contained all relevant guidance including updates from the 2014 supreme court judgement in relation to Deprivation of Liberty Safeguards.

Staff had a good understanding of the Act and its principles and were able to explain these to us during the inspection. Staff were aware that they should assume capacity. They had undertaken specific two-stage capacity assessments and best interests meetings in relation to specific decisions which were highly complex such ongoing complex physical healthcare needs where there was an indication that the patient lacked capacity to make that decision. These assessments gave a clear rationale and senior members of staff had undertaken them. Where staff had completed best interests meetings all relevant parties were involved including the patient, their advocate and any external professionals involved.

At the time of inspection, the service had made one application under the Deprivation of Liberty Safeguards and this continued to await approval from the relevant supervisory body. This was in relation to one patient who refused support with personal care, was deemed to lack capacity but did not meet criteria for detention under the Mental Health Act. This demonstrated that the service understood the interface between the two pieces of legislation and had used the least restrictive option for the patient who lacked capacity to make one decision but could consent to the remainder of her care as an informal patient.

All patients had access to the support of an independent mental capacity advocate, who visited the wards on a weekly basis. Staff automatically referred patients who lacked capacity for the support of an advocate.

The Mental Health Act Administrator organised and scrutinised paperwork relating to the Mental Capacity Act and Deprivation of Liberty Safeguards, and renewals and provided reminders to staff when action was required. They also undertook audits to ensure documentation was being completed appropriately.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

We spoke with ten patients during our inspection and three patients prior to the inspection in patient focus groups. We offered all patients the opportunity to speak with us, but some patients chose not to. We also spent time with two patients during activities they were completing outside the hospital.

Long stay/rehabilitation mental health wards for working age adults

Good

We observed staff when they were working directly with patients. We saw that they were kind, compassionate and gentle in their approach. Staff took time to listen to patients about their needs and wishes; particularly around the activities and leave they wished to take part in.

Patients said that staff treated them with dignity, for example by knocking before entering their bedrooms. Patients also described staff as 'friendly', lovely' and 'kind'. All patients apart from two said that there was always enough staff available to support them. They said that staff always responded when patients needed them. Patients said that staff supported them and made them feel safe. A number of patients told us that they had spent time in other hospitals and that this was the best ward they had stayed in. One patient from Ingrow ward told us that '**"**I've never been looked after like this in all my life".

Staff had a good understanding of the individual needs of patients and this was reflected in the individualised care we observed and patient's individualised care plans, for example each patient had a 'playlist for life' which staff had helped them to choose and which they played on the wards in turn. Every patient had an individualised activity and leave timetable compiled with the support of occupational therapists. Staff were able to meet patient's needs quickly and appropriately and this meant that incidents were often quickly de-escalated.

The involvement of people in the care they receive

The service had a robust admission process supported by an admission checklist for staff to complete with each new patient. We observed staff planning for a new admission to Oldfield ward and saw that planning was detailed, with staff spending time preparing for the arrival of the patient. Each patient was allocated to a member of staff on arrival who orientated them to the ward. Patients were also provided with a detailed admission booklet.

Patients were involved in the planning of their care where they wanted to be involved. We saw that staff included the patient's voice in individual care plans. Patients worked with staff on an individual recovery plan, a recovery star, and a 'my recovery journey' file which detailed what they wanted to achieve with actions in accordance with their discharge. These plans were extremely person centred. One patient told us that the doctor involved them in their care plan and listened to what they wanted for the future. Two patients told us that they did not understand their care plan and had not received copies of this. However they said that they knew staff would discuss this with them in multi-disciplinary meetings.

Staff supported patients to voice their choices and opinions about their care in a variety of ways. Each morning all patients participated in a planning meeting where patients discussed what they wished to achieve that day. In addition to this both wards had weekly community meetings where patients shared their opinions about the ward and their care.

When patients did not feel comfortable to attend meetings, such as their multi-disciplinary team meetings, staff supported them to voice their needs and wishes by completing a questionnaire which staff could take to the meeting on the patient's behalf. Each ward also had comments and complaints boxes which patients could use to express their opinions.

Staff had completed a patient satisfaction survey with patients in February 2017. They collected 21 responses which was 68% of patients. Ten percent of patients had rated their care as excellent, 29% as very good, 31% as good, 5% (1 patient) as poor, and 19% of patients (four) didn't answer this question. The service had analysed the results of the survey and completed a report and action plan in response with a timeline for completion. Areas for improvement were; increasing information on admission, increasing the awareness of voluntary and work opportunities, increasing patient access to information about medication and their treatment, and supporting patients to remain in touch with their family and friends.

Advocacy support was embedded in the service. The advocate visited the wards twice weekly and patients we spoke with knew who they were and how to contact them.

We spoke with three carers of patients admitted to the service. Carers said that they felt their relative was safe and well cared for by staff that were polite, friendly and caring. Carers told us that they were always invited to meetings and we saw evidence of this in patient's documentation. However they all reported a high turnover of staff on the wards and felt that this was why they did not have a named person to speak with when they contacted the service. All carers told us that they would like more updates and involvement from the service regarding the care and progress of their relative.

Long stay/rehabilitation mental health wards for working age adults

Good

All of the carers we spoke with told us that they would feel comfortable approaching staff or the service manager should they wish to raise a concern or make a complaint.

Patients were encouraged to become involved with the running of the service via community ward meetings. Also all patients were invited to a whole service 'your voice' meeting once per fortnight to discuss the service and any improvements needed. Staff recorded actions and updated this at the following meeting in the minutes we reviewed. Some patients became service user representatives to ensure staff listened to the needs and voices of the patient group. The occupational therapy team had involved patients in the designing of therapy groups. Patients were involved in the recruitment of staff including attendance on the interview panels and also preparing questions to use in the interview with applicants for the posts.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

At the time of the inspection there were 24 patients admitted to 34 beds across the two rehabilitation wards. Between 01 March 2017 and 31 August 2017 average bed occupancy ranged from 82% on Winfield ward to 88% on Steeton ward.

The available beds within the service meant that the service was able to provide support to the local population if required.

We saw that patients sometimes had periods of overnight leave as a transition to a new care setting. The service did not use these beds for newly admitted patients until staff had fully discharged that patient.

Staff sometimes moved patients to another ward during an admission, for patients to move into the step down areas of the wards. In order to ensure continuity of care, should a patient's condition deteriorate staff increased their observation levels and enhanced staffing levels. This reduced the need for patients to transfer to other more intensive service provisions unless the risk presented became more unmanageable.

All patient discharges involved long term planning; usually to an alternative care setting. This meant that staff never discharged patients at an inappropriate time of the day or night.

The service reported that between 1 September 2016 and 31 August 2017 the average length of stay was 867 days (Oldfield), 527 days (Steeton), 985 days (Ingrow) and 688 days (Winfield). The service did not report any delayed discharges during this period. However, these figures for the average length of stay were skewed by the longer patient stays. The longest patient stay was six years and eleven months because there remained a need for them to continue to receive hospital care whereas other patients had been admitted to the service for one to two years.

The hospital director was aware of the long length of stay for some patients and discussed that the model of care offered to these patients was a slower stream of rehab which offered long term care and rehabilitation to patients with chronic long term mental illness, focussing on quality of life care as well as rehabilitation. All patients had a discharge and recovery plan in place with measurable and achievable goals for discharge. Staff talked to us about the service being discharged focussed and how this focus had increased in the last twelve months. The rehabilitation services manager had implemented monthly development meetings for the service which included discussions about the development of a recovery hub and we saw that changes had already been made such as the addition of individual patient post boxes on the ward to support patients to manage their own correspondence. The care pathway for the service had also been revised to ensure the discharge focus for patients was clear from the point of admission and this work continued to be an ongoing focus for improvement.

In the last twelve months the service had discharged 19 patients from the rehabilitation wards; some of these patients had moved into independent living settings such as their own tenancy in the local community.

The facilities promote recovery, comfort, dignity and confidentiality

Long stay/rehabilitation mental health wards for working age adults

Good

Patients had access to facilities on all wards which included a communal lounge, an open laundry, and a skills kitchen. Due to the layout of the hospital, there was limited space for patients to undertake one to one activities and therapies, as only one therapy room was available for use by both wards. However the impact of this was reduced because patients accessed activities outside of the hospital. Clinic rooms did not have sufficient space to carry out examinations so patient bedrooms were used instead. There was insufficient space on the wards for patients to meet visitors or carers in private so the space in the reception area was used to facilitate these visits. The refurbishment plan for the hospital included increased communal spaces and therapy rooms. This work was due to be completed within the next 12 months.

Patient bedroom doors on either wards did not contain vision panels, this meant that staff had to enter the bedrooms to observe patients. Work had begun to change these doors on Oldfield ward with new doors that contained vision panels and this work was due to continue throughout the hospital as part of the refurbishment plan. However, whilst some windows contained privacy glass, we found that there was no privacy film on four bedroom windows across the hospital meaning that people could see into patient bedrooms from the outside of the hospital. The provider agreed to address this immediately after our inspection.

Patients were able to make a phone call in private because they had access to their own mobile telephones which they could use in their bedrooms. Patients who did not have mobile telephones in their bedrooms were able to use the ward telephone in private.

Patients had access to outside space which they could directly access via an unlocked door from Ingrow ward. Patients on Oldfield ward accessed the garden via a stair case because the ward was located on the first floor of the building. Staff provided additional supervision for patients using the staircase.

The communal lounges and skills kitchens were unlocked and accessible to patients throughout the day and night. Patients were able to use these areas to access hot and cold drinks and snacks.

Food was cooked and prepared on site for patients. Two patients we spoke with told us that they did not like the quality of the food and that they would like more choice. The hotel services manager responded immediately, stating they would make patient questionnaires to obtain more feedback from patients. They also told us they planned to make more regular changes to the menu. Patients were also able to cook and prepare their own meals in the skills kitchens on the wards. Each patient had differing skill levels and some made themselves only drinks and snacks whilst others shopped for, prepared and cooked their own meals with or without the support of staff. Some patients chose to eat take-out food and had this delivered to the wards.

Patients were able to personalise their own bedrooms, and each bedroom contained a set of lockable drawers so patients could store their possessions.

Patients had access to a variety of activities which ran during the week and at weekends. The hospital employed an occupational therapy lead, two occupational therapists, two occupational therapy assistants and three activity co-ordinators. On the wards patients and staff met together each morning to conduct a planning meeting. During this meeting patients voiced their choices about how they wished to spend their day. This included a variety of escorted and unescorted leave from the hospital and attendance at activities such as gardening, art work and craft groups. We spoke with patients who were proud of the work they had achieved. One patient had received a gardening award from the provider and another had displayed their artwork in the local town shopping centre. Photographs taken by patients in the photography sessions were displayed as artwork across the hospital. During weekends, occupational therapy and activity staff left activities and equipment for nurses and healthcare support workers to complete with patients. Each ward also had planned patient protective time which encouraged staff to leave the offices and spend time completing direct activities with patients such as card games, board games or completing care planning and one to one therapy or planning sessions. We also observed the hospital choir which included patients and staff practising for their upcoming Christmas fayre.

Meeting the needs of all people who use the service

Both wards were accessible to patients with mobility needs. Ingrow/Winfield ward was located on the ground

Long stay/rehabilitation mental health wards for working age adults

Good

floor and Oldfield/Steeton ward was accessible via a lift to the first floor. Both wards had accessible communal bathrooms with specialist bathing equipment and had access to equipment such as a hoist.

During the inspection we saw that both wards had detailed patient information boards regarding their rights and information about their medication, how to make a complaint and how to contact the Care Quality Commission. Staff told us that they could order information in easy read formats and other languages should they be required for a patient.

Staff had access to interpreters and we saw that one patient had an interpreter who visited the ward three times per week to translate for the patient to ensure they could voice their needs and wishes and to support with care planning.

Patient menus offered a choice of food, a vegetarian option was always offered, and because food was cooked on site staff were able to provide food for patients with specialist dietary needs.

Patients had access to appropriate spiritual support on an individual basis as discussed in their individual care plans. The hospital had one visitor's room which was also designated as the hospital's spiritual room. This room provided relevant religious material and a prayer mat.

Listening to and learning from concerns and complaints

Between 26 June 2017 and 29 March 2017 the hospital had received six complaints relating to rehabilitation wards. These were one complaint from a neighbour to the hospital, one direct patient complaint about a care decision, one about food, and one about missing clothing. Also, two complaints were received directly from patient advocates about care and treatment decisions which demonstrated that patients were engaged with advocacy services who were supportive in helping patients to raise concerns.

We reviewed all six of these complaints; all were resolved at a local level. The investigations were detailed and thorough. However the provider did not always meet their own target in responding to and concluding complaints within 25 working days. One complaint was lodged on 31 March 2017 and responded to in a final letter on 09 June 2017 and another was lodged on 22 March 2017 and a final letter sent on 9 June 2017. We did not see that staff had recorded how patients were kept updated when there was a delay in the response. We were concerned that in one complaint the patient's own voice was not clearly represented and the focus appeared to be on the staff perspective, and in another, the ward manager who completed the fact finding exercise was named as part of the patient's concern which meant that the review was not entirely independent.

Staff entered all complaints into a monthly complaints log along which they shared at regional clinical governance meetings. This information was also shared with staff at team meetings and in supervision sessions.

The hospital had a complaints lead and this information and their contact details were posted throughout the wards. Staff we spoke with were aware of complaints procedures and also knew that the service had an informal complaints log and complaints and compliments box on each ward to monitor patient views and ensure patients were able to voice their opinions about their care. Patients told us that they knew how to make complaints and the service provided a variety of ways for patients to do so.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

Vision and values

Elysium Healthcare had five values. Each value also included a supporting statement. The values and statements were:

- Empowerment: to encourage all to lead a meaningful life
- Integrity: because we are ethical, open, honest and transparent
- Innovation: so we drive forward the standards and outcomes of care
- Collaboration: because in partnership we can deliver transformational care
- Compassion: show respect, consideration and afford dignity to all

Long stay/rehabilitation mental health wards for working age adults

Good

Values were displayed on the staff intranet system and posted around the hospital. The majority of staff we spoke with were able to tell us about the organisation's values.

Staff knew who the senior managers were in the organisation and told us that they had visited the service. Staff said that their direct line managers were approachable, responsive and spent time on the wards with staff and patients. Staff told us that members of the multi-disciplinary team were visible and approachable and they spoke highly of the psychiatry team.

Good governance

The governance systems were effective and ensured patient safety. There was a clear framework in place which ensured managers could share essential information with staff and other organisations. The teams worked closely with other professionals such as commissioners and GPs.

A number of quality checking processes such as audits were in place and managers provided feedback on the outcomes to staff in team meetings.

Robust systems were in place to support staff in managing risks and we saw evidence of learning cascaded as a result of complaints and incidents. At the time of the inspection compliance rates for supervision, training and appraisal were above the services compliance targets.

The governance system ensured the transfer of information from ward to board level. The hospital's senior team participated in Elysium Healthcare's regional operational and clinical governance meeting. Information from regional governance meetings was passed to service level governance meetings, which in turn was collated and passed to ward managers to share with their teams. Information and concerns at ward level were then escalated back up through the clinical governance structure. We reviewed meeting minutes for June, July and August 2017 clinical governance meetings and ward level team meetings for the same time period. Minutes showed that the senior team and ward level teams had discussed the same issues and concerns such as mandatory training, staffing and supervision.

To further monitor quality and safety, in September 2017 the hospital launched a new 'ward to board' report which included a comprehensive assessment of the hospital's performance across a range of key performance indicators. The clinical governance lead told us that the report was newly introduced but had already allowed staff to gain a better understanding of how the hospital was performing. Key performance indicators where the hospital was performing well included:

- having up to date care plans on the electronic system
- having community meetings as planned
- shifts meeting planned requirements and/or shifts made safe where they did not meet planned requirements.

The report provided data for areas which required close monitoring without a set performance target. Examples included the number of incidents by type, involving the use of restraint, the number of restraints resulting in patient or staff injury, and key staffing indicators including turnover, vacancy and sickness rates.

There were some key performance indicators where the hospital was currently underperforming. These included:

- one to one sessions between patients and primary or associate nurses recorded on the electronic system
- number of patients without a forecast discharge date
- number of patients without a physical health care plan or a physical health care plan which was not in date

The senior leadership teams had action plans in place to address these concerns and hoped for an improvement in all areas when the next performance data was received.

The report also detailed the current and previous six months' compliance for supervision and for mandatory training.

The hospital had a local risk register in place. There were seven open identified risks at the time of inspection. Risks were graded according to severity using a red, amber, green tool that assessed the risk's probability and impact. The highest risks were those graded red that had the highest impact and probability. The service was aware of their own risks and challenges. All areas of concern and items on the risk register had action plans in place to improve quality and safety, for example there was a detailed action plan in place to address staff recruitment and retention, mandatory training, and the transfer of the service from the previous provider to Elysium Healthcare and the challenges this brought for the service.

There were no risks rated red on the risk register. Five of the seven risks were rated amber after controls. Four risks were risks to the entire hospital. One referred only to the wards

for older people with mental health problems. Amber risks were: (1) the ongoing integration of the hospital into the new provider; (2) the introduction of the new electronic patient record system; (3) the high turnover rate and increased use of agency staff; (4) the need for improvements to the physical environment of the hospital; and (5) the staff shortages on Oakworth Ward. Risk registers were discussed and updated in clinical governance meetings.

Leadership, morale and staff engagement

The organisation valued its staff and had a number of methods to reward staff such as local and organisational staff awards. Staff were offered opportunities for development and two healthcare support workers were being sponsored by the organisation to complete their nursing qualifications.

Staff had completed a culture of care barometer in June 2017, and the clinical governance lead had produced a clinical audit report and action plan on all areas of improvement such as staff behaviour, training and development, leadership and development, staff engagement and communication. Throughout the inspection staff told us that morale was either good or improving and that the addition of new ward managers had lifted staff morale and provided a new focus for the service.

The provider used different methods to engage with staff and to obtain their views and opinions. These were from staff culture surveys, increased benefits, and initiatives such a 'listening lunches' where staff were encouraged to meet informally with the hospital director. Staff told us that the operational director had visited the wards on Christmas day to thank staff for working on public holidays and that this made them feel valued.

Commitment to quality improvement and innovation

The service was not currently part of accreditation and peer review schemes. However the hospital director, supported by Elysium, had a clear vision and strategy for the service and plans in place to move this forward.

Good

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Good

Safe and clean environment

Oakworth ward was a nine bed male only service providing care for older people with organic mental health problems such as dementia. At the time of our inspection, all nine beds were in use.

We checked the whole of the environment to consider whether it was safe and clean.

The ward layout was an 'L shape. The staff office was located at the corner of the communal lounge which allowed staff a clear line of sight to observe patients using those areas. However staff could not easily see the ward corridor. In order to mitigate this risk a camera was in place with a mobile screen which staff carried with them to observe the corridor to reduce risk, of unwitnessed falls for example.

Staff also mitigated risk through the use of patient observations. One member of staff was allocated at each shift handover to observe patients throughout the day and night. Observation levels were determined by the level of risk presented. Staff would monitor a patient who had an increased risk of falls, assault to others or self-harm more closely. The multi-disciplinary team reviewed patient observation levels on a weekly basis and staff discussed them daily in handover meetings.

All areas of the ward contained ligature points (a ligature point is something which a patient intent on self-harm could use to tie something to in order to strangle themselves). The ward manager had undertaken a ligature risk assessment on 25 October 2017 which identified ligature risks in all areas of the ward. However the unlocked communal bathroom contained specialist bathing and moving and handling equipment which caused an increased risk to patients and this had not been included in the ward ligature risk assessment. This meant that staff were not aware of risks and risk was increased because patients accessed this unlocked room without supervision. The hospital director agreed to rectify this immediately after the inspection, and explained that the risk had been created by inappropriate storage of equipment rather than fixed items and therefore was easily rectified.

The ward provided accommodation to male patients only and therefore was compliant with guidance on same sex accommodation provided in the Mental Health Act Code of Practice, and Department of Health guidance in eliminating mixed sex accommodation.

The ward had a clinic room in which staff stored medication and equipment to support physical healthcare needs. We found that the clinic room was small and disorganised and staff struggled to find the appropriate equipment we requested to review. Some areas of the clinic room such as the walls were not clean because they had marks and splashes on them. The clinic room did not have an examination couch for staff to examine patients as there was insufficient space and so staff examined patients in their bedrooms.

The equipment stored in the clinic room such as blood pressure monitor and weighing scales was clean and well maintained. An emergency resuscitation bag with up to date required equipment was stored in the clinic room. A defibrillator and ligature knife were stored in the staff office.

Good

Wards for older people with mental health problems

The emergency resuscitation bags did not contain any of the emergency medications stated in the Elysium Healthcare policy, except for an epi-pen. The registered general nurse explained that a local risk assessment for the service identified that the wards would not hold emergency medications because staff did not use these medications regularly and the service was located within five minutes of the general hospital. Staff followed the local protocol detailed in the previous provider's policy which they were all familiar with that stated that staff would sustain life using immediate life support techniques whilst emergency paramedics arrived. However this did not fit with the provider's own national policy and we were concerned that this may cause confusion for staff.

The service's pharmacist carried out audits of the clinic room and medication every three months. We reviewed the last two audits from 25 July 2017 and 18 October 2017 and found that staff had addressed all issues highlighted.

The service did not have a seclusion area.

The ward was clean, except for parts of the clinic room, and furnishings were in good condition. Domestic staff were present on the ward throughout our visits.

Staff adhered to infection control principles including handwashing and we saw that hand wash was available to staff, patients and visitors throughout the hospital. Staff wore personal protective equipment when they carried out cleaning tasks and the handling of food. Staff carried out regular infection control audits to monitor the cleanliness of the environment.

The health and safety manager had undertaken environmental and situational risk assessments on the ward alongside the ward manager on 15 November 2017. These were detailed and available to all staff. The hospital had a fire risk assessment completed on 23 November 2017. Fire extinguishers and equipment we checked were in date and an external provider had inspected the alarms and certificates were in place. Patient personal evacuation plans were stored in a 'disaster grab bag' on each ward. We saw that the hospital undertook regular fire evacuation practices.

Staff carried personal alarms to alert colleagues should they require assistance in an emergency. During the inspection we saw these alarms sound and staff responded to them quickly and appropriately. The service had a policy in place for the checking and monitoring of both alarm systems which included recording monthly maintenance checks. Patients had access to nurse alarm call systems in their bedrooms and on communal corridors.

Safe staffing

Prior to the inspection the hospital submitted data regarding their staffing levels. The whole hospital had 81 substantive staff in total including clinical, managerial, administrative and ancillary staff. This included five whole time equivalent qualified nurses and 11 whole time equivalent healthcare support workers on Oakworth ward. Between the 1 June 2017 and 31 August 2017 the ward had five outstanding vacancies for two qualified nurses and three healthcare assistants. By the time of the inspection the vacancy rate had reduced substantially to one vacancy for a healthcare support worker.

The wards had an average sickness rate between 1 September 2016 and 31 August of 3.8% which was slightly higher than the provider's own target of 3%.

The ward had experienced a high turnover of staff. Within the same time period there were twenty staff leavers from this ward. The reasons for leaving were varied from concerns about morale and staffing to retirement and leaving for other roles. The hospital director understood that the staff retention was a challenge and impacted on patient continuity of care and had implemented a staff retention policy. This included actions such as a culture of care survey and a review of staff exit interviews to analyse themes and trends and provide support to staff to improve retention.

The Care Quality Commission had received complaints from staff members In September 2017 who contacted us directly to raise concerns about low staffing numbers and concerns about staff morale. In direct response to this, the hospital had employed a new ward manager who had been in post for six weeks at the time of our inspection and staff spoke positively about them. The hospital director and clinical governance lead had also conducted staff discussions with staff working on the ward to support and encourage them to voice their concerns.

The hospital director used an in-house tool to estimate the numbers of staff required per shift on each ward. The wards were staffed with two shifts running from 7:30am to 8:00pm and 7:30pm to 8:00am. One qualified nurse and three healthcare support workers staffed the ward.

Good

Wards for older people with mental health problems

In addition to the above, a multi-disciplinary team supported the rehabilitation wards. This included sufficient medical input into the service from a lead consultant psychiatrist and a consultant psychiatrist, an occupational therapy and psychology team.

The service had a clear governance structure to manage staffing. Daily staffing numbers were reviewed by the clinical governance lead each morning, and staffing across the hospital was reviewed three times per week in the hospital's morning meeting.

We reviewed safer staffing reports from 30 June 2017 to 16 November 2017. We found that staffing met establishment levels on all shifts during this period other than on three occasions when the ward ran with one less staff member than planned. However a senior leadership team member had reviewed all reports and made comments of planned actions or reasons when staffing levels fell below establishment levels.

The service reported that there were 16 shifts on Oakworth ward between 1 June 2017 and 31 August 2017 that were not filled to establishment levels due to sickness or vacancies. This amounted to 9% of the total shifts available. However staff told us that during these staffing shortages other members of the multi-disciplinary team outside of staffing numbers could step into shifts to support the teams as needed.

The ward manager was able to request the support of temporary bank or agency staff as required in response to unplanned events such as sickness or changes in patients' risk.

The service used temporary bank and agency staff appropriately. Between 01 June 2017 and 31 August 2017, bank staff were used on 117 of 184 shifts (64%). Agency staff were also used on117 (84%) of shifts. The ward manager was aware that this usage was high but since the vacant posts were filled, the use of bank and agency was on a decreasing trajectory.

Ward managers told us that if additional staff were required, they utilised overtime from permanent staff or support from in house bank staff prior to requesting agency staff. Managers monitored the use of agency staff and safer staffing reports highlighted in amber when agency use rose above 25%. This was to ensure that the service never filled shifts entirely by agency staff. If agency staff were used, managers would spread the use across the wards to ensure it was equitable and provided consistency to patients.

Qualified nursing staff were available and visible to patients on the ward throughout our visit and were spending one to one time with patients. All staff we spoke with told us that they had enough time to complete one to one activities with patients.

The service did not record information regarding how often ward activities or patient leave was cancelled due to staffing shortages. All staff members other than one said that activities and leave were never cancelled due to staffing issues, and that the impact nurse shortages was also reduced because the occupational therapy teams were often working on the ward.

There was adequate medical cover day and night. Two full time consultants supported the ward during the day. At night there was an on call rota for this and other local hospitals in the group. The consultant psychiatrist told us that a doctor could reach the hospital in an emergency within 40 minutes.

Prior to the inspection we asked the service to provide us with evidence of staff training. Staff carried out mandatory training in moving and handling, suggestions, ideas and complaints, information governance, equality, diversity and human rights, fire safety, health and safety, safeguarding children level one, safeguarding adults Level 1, infection control level one and two, breakaway, conflict resolution and the management of violence and aggression, basic and immediate life support, Mental Capacity Act and Deprivation of Liberty Safeguards, Mental Health Act Code of Practice, food hygiene, and the safe administration of medication. Ninety-four percent of staff had completed face to face training in the moving and handling of patients and use of the hoist equipment on Oakworth ward.

Elysium Healthcare Ltd had a training compliance target of 95%. Over 91% of staff had achieved compliance with mandatory training other than in the management of violence and aggression which was 69%.

We asked the provider to explain why the compliance rate for staff management of violence and aggression training was below 69%. The hospital director told us that since the changeover of provider, the training has changed to require training in a new method. The manager was concerned

about the risks of training staff in different techniques. They had a structured plan to deliver training on each ward from January 2018 and no longer sent staff for refresher training on the old method to reduce the risk of confusion. In the interim hospital had developed a five person management of violence and aggression team who were up to date and complaint with all training and attend all incidents as the first responders to ensure consistency and mitigate any impact of those staff who had not received refresher training. All staff were trained in breakaway techniques.

Assessing and managing risk to patients and staff

We reviewed the risk assessments of five patients admitted to the ward. Staff used recognised risk assessments such as an in-house risk assessment matrix, the short term assessment of risk and treatability and the historical clinical risk management (20). This type of risk assessment is mainly used with patients with a forensic background and there are more suitable assessment tools for use with this patient group. Staff also completed a detailed risk care plan. All five patients had a current risk assessment which staff had completed within the last six months. Staff had updated all patient risk assessments every six months or sooner if an incident occurred.

Staff reviewed risk care plans for all patients monthly in the multi-disciplinary team meeting. The provider had an 'assessment and management of clinical risk' policy, which was written in June 2017. Staff had not entirely followed this policy, which stated that they should complete a short term assessment of risk and treatability assessment for each patient within seven days of admission (or at pre-admission). For patients admitted to the ward within the last twelve months staff had completed a risk assessment within one month of the patient's admission date. It was not possible to check these dates for other patients due to a change in the provider's electronic system. However staff had completed a historical clinical risk management (20) within the first 12 weeks of admission and reviewed all risk assessments at a minimum of six monthly which was in line with the provider's own policy.

The ward did not have blanket restrictions in place, this is a rule which a provider puts into place for all patients regardless of their risk level or detention status. The provider reviewed blanket restrictions thoroughly and completed a blanket restriction audit.

At the time of the inspection there were no informal patients admitted to the ward. Seven patients had Deprivation of Liberty Safeguard applications in place and two patients were detained under the Mental Health Act. The ward had advice and signage for patients to ensure they were aware of their right to leave at will. However we saw that the entrance to the ward contained an air lock door. The provider had put this into place following an incident where a patient had left the ward without support. However we were concerned that this meant that other informal patients could not leave the ward informally and that this was a restrictive measure which did not meet the needs of the entire patient group.

The service had detailed policies and procedures in place for when restrictive interventions needed to take place such as the searching of patients and the use of breathalysing and drug testing equipment. These procedures had not been used on the ward.

Patients were allocated differing observation levels dependent on the risk they presented at the time. Qualified nurses were able to increase observation levels should they be concerned about the risk a person was presenting. Patients had a maximum of hourly observations on the ward as per the ward risk assessment to manage the environmental risks.

Staff told us that physical interventions were only used on the ward at a very low level and mainly to support those patients resistive to personal care. Staff used talking, distraction, and de-escalation techniques to reduce the need for physical interventions. Staff had a good awareness of the least restrictive principle and the hospital had a culture which promoted the use of none physical interventions.

Staff had not used seclusion or rapid tranquilisation in the last twelve months.

Between 1 March 2017 and 31 August 2017 staff had used restraint 30 times with three patients. Staff told us that these were low level restraints such as 'come along holds' and restraint was sometimes required to support patients who were resistive to personal care but only as a last resort. None of these restraints were carried out in the prone (chest down) position. None of the restraint incidents had involved the use of rapid tranquilisation (medication used to rapidly calm patients).

Good

Wards for older people with mental health problems

We reviewed two incidents of restraint which had taken place on the ward in November 2017. Both incidents noted aggression from patients towards staff or other patients. Staff recorded all incidents clearly with details of what de-escalation actions they had taken prior to the use of restraint. Staff recorded both restraint incidents as either 'friendly come along or low level forearm holds.

Between 31 October 2016 and 31 October 2017 the service had notified the Care Quality Commission of 33 safeguarding concerns at this location.

We reviewed the last six safeguarding referrals which the service had made to the local authority between 31 May 2017 and 15 November 2017 regarding patients on Oakworth ward. These referrals demonstrated that staff had correctly identified safeguarding concerns when incidents had occurred on the ward and had made appropriate referrals to the local authority safeguarding team and the Care Quality Commission.

The service had a thorough system in place for monitoring and reporting safeguarding. Where staff had made referrals to the local authority, the clinical governance lead kept a log of these until the local authority had made a final decision on any outcome from their investigation.

The service had an overall safeguarding lead and a designated safeguarding lead per ward. Patients and staff knew who they were and posters and details to contact them where located throughout the hospital. Staff knew about safeguarding procedures and could give examples of when to report and what to report.

During the inspection we checked the arrangements for managing medicines at the service. Medicines were stored securely according to the manufacturer's instructions in locked clinic rooms on both wards. The pharmacist visited the wards weekly and carried out a specific check of medication storage and the quality of medication cards. The pharmacist reported back to ward and senior managers on a number of areas such as; prescription errors, recording omissions, medications above recommended limits, and they also completed reviews when patients had refused medications. We reviewed the medications audits for April to June 2017 and found that staff had made improvements from then to the July to September 2017 audit which showed a significant reduction in errors. In addition, the pharmacist produced a detailed medicines management audit report every three months. This audit reported against standards including compliance with controlled drugs regulations and that weekly equipment and medication checks were taking place along with daily recordings of fridge temperatures.

We reviewed the medication records of all patients admitted to the ward. In all records checked we did not find any errors in the medication cards. Doctors had not prescribed any patients more than one anti-psychotic medication and no patients were prescribed medication over the recommended limit.

Detained patients had valid consent to treatment recorded and kept with their medications card. However, seven patients did not meet criteria for detention under the Mental Health Act and due to these patients lacking capacity to consent to their care and being subject to continuous supervision and control, staff had made applications for Deprivation of Liberty Safeguards for these seven patients. However the local authority had a waiting list for approvals meaning that these patients were in fact informal patients and marked as informal on their medication cards. This could potentially be confusing, particularly for temporary nurses administering medication.

Track record on safety

The service reported that they had not had any serious incidents take place in the last twelve months. No adverse events had taken place.

Reporting incidents and learning from when things go wrong

Staff used an electronic system to record and report incidents. The system was clear and logical and used by all designations of staff. Staff understood what they should report and how to use the system. The incident system joined up with the patient record system which meant that once staff had signed off an incident it recorded in the patient's daily records to highlight risks and concerns.

When incidents didn't meet the criteria for a serious incident, but evidenced potential learning points for staff, senior managers carried out investigations of these incidents in order to share and enhance learning opportunities to increase quality and safety. Managers had undertaken one investigation of such an incident between 6 April 2017 and 17 November 2017 where a patient left Oakworth ward without staff support and without

approved leave. The incident investigation was thorough and discussed findings, lesson learned for staff and immediate actions to be taken. We saw that direct action and changes were made to the ward following this incident, which included renewed observation levels for this patient.

Staff reported incidents onto the system and ward managers reviewed these initially. Senior managers reviewed these further, and signed them off at the hospital's morning meetings. Staff also discussed all incidents involving patients at their multi-disciplinary meetings to ensure that they updated care plans and risk assessments in response to changes in risks.

Staff were able to explain to us how they received feedback when incidents had taken place. They said that this took place in team meetings and supervision sessions and also in reflective practice sessions undertaken with the support of the psychology team. Staff were able to give clear examples about how things had changed following an incident. Where incidents with learning opportunities had taken place, all staff we spoke with were aware of what happened and the outcome, which evidenced that lessons were learned and information was shared across the hospital.

The Duty of Candour regulation explains the need for providers to act in an open and transparent way with people who uses services. It sets out specific requirements that providers must follow when things go wrong with care and treatment. The service had embedded a culture of openness and transparency and we saw in incident reports and staff recordings that senior staff had considered use of the regulation in response to incidents. Staff also noted in recordings that they provided feedback and had been open and honest with patients and their families when things had gone wrong.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed the care records of five patients. All patients had a comprehensive group of care plans which staff had completed with patients, within one month of their admission to the service.

The monitoring of patients physical health care needs was high on the agenda for the service. Staff used a national early warning scores system to record patient's physical health observations on a weekly basis and staff repeated this if a patient was unwell or had a long term condition which meant closer monitoring was required. However staff did not always record in patient records that they had checked these weekly.

Where patients had long term physical health conditions they had specific care plans to ensure staff could meet these needs. However, we reviewed the physical health recordings for four patients in daily paper files which were kept on the ward for staff to update. In these recordings staff had not always recorded whether they had completed weekly weights with patients. These gaps in the recordings of weights were from three weeks to six weeks in some cases. Staff told us that sometimes patients refused to be weighed or may be too unwell, and felt that this was not always recorded. Risk was reduced because all patients had hydration and nutrition plans in place which monitored their food and fluid intake in order for staff to highlight concerns. Any concerns were regularly reviewed by the nurse responsible for physical healthcare.

Some patients admitted to the ward had specific care plans in place for complex medication regimes such as convert medication protocols. Where these were in place staff had liaised with the multi-disciplinary team, conducted best interest meetings and capacity assessments and liaised with pharmacists.

Some patients had 'do not attempt cardio pulmonary resuscitation' notices in place. However these were photocopies kept on site rather than original copies. The clinical governance lead said that originals were kept with the patient's GP and on an electronic system accessible by the ambulance service. We did not think that this followed guidance written by the Yorkshire and Humber Ambulance service which stated that 'in the event of the form being a photocopy, the signature should always be the original, legible and written in black ink.". None of the do not attempt cardio pulmonary resuscitation' notices we observed had original signatures recorded on the photocopy. We reviewed national guidance (2016) written

jointly by the British Medical Association, resuscitation council (UK) and the Royal College of Nursing which states that "In general we recommend that CPR decision forms should not be copied, to avoid the possibility that inappropriate clinical decisions or actions result from a copy of a form that relates to a decision that has been cancelled."

Staff updated patient care plans at least monthly in multi-disciplinary team meetings. Care plans were holistic and discussed the entirety of a patient's needs such as; finances, leave, rehabilitation, discharge, physical health and mental health insight. Care plans were personalised and discussed the patient's history, likes and dislikes and any decisions they had made about their care and advanced decisions for treatment. We saw evidence that staff carried these out collaboratively with patients where possible, however many patients were unable to contribute. Care plans contained little detail regarding patient involvement with family and friends including family and friend's opinion on how the patient may wish to be cared for should they be able to offer this information.

Best practice in treatment and care

The service embedded national guidance in staff practices and patient treatment. They ensured that patient care plans referred to guidance from the National Institute of Health and Care Excellence and the Mental Health Act and Mental Capacity Act Codes of Practice. In addition to this, all working policies and procedures referenced the relevant guidance, such as National Institute of Health and Care Excellence 'supporting people with dementia and their carers (CG42) and dementia quality standards (QS1 and QS30). Staff we spoke with were aware that each ward had a reference folder which contained copies of all relevant guidance. Staff told us the organisation communicated changes in policies and national guidance via staff meetings, email and newsletters. The occupational therapy teams worked closely with the staff team and used methods of care to improve the lives of older people with dementia such as the use of life story work, reminiscence therapies, and keeping the patient group active and engaged.

Patients had limited access to psychological therapies due to a vacant post for a lead psychologist which the service had struggled to recruit to. However in order to reduce the impact of this for patients, a locum psychologist had been employed by the service. They worked one day per week and offered advice and support in weekly multi-disciplinary team meetings on individual patient care. They were also completing a service review to make plans for a renewed focus for the psychology team once the new post holder was employed.

The service employed two assistant psychologists; they delivered some direct therapies to patients using a cognitive behavioural therapy approach. They also supported staff by assisting them to complete historical clinical risk management (20) risk assessments, formulating risk and behaviour management plans and running group supervision and reflective practice sessions with staff.

Access to physical healthcare was high on the agenda for the service. A physical health strategy was in place to follow the service initiative to integrate better physical health care for patients. This strategy included a health promotion element such as 'mission fit,' and delivery elements including physical health champions on each ward and a hospital wide health and wellbeing group. The service employed a registered general nurse in a leadership role to manage and support this strategy and to enhance the skills of the staff group to support patients with long term conditions. The registered general nurse attended all patient multi-disciplinary team meetings to highlight risks and offer support and enhance specific care plans for patients with complex or long term physical health conditions. They also visited each ward daily to review physical health needs and support staff to meet patient needs. They maintained a liaison with patient's GP's which has enhanced and developed these relationships.

The service had a large occupational therapy department which was led by a senior occupational therapist. They managed two occupational therapist, two occupational therapy assistants and three activity co-ordinators. The activity co-ordinator posts were recently added to ensure occupational therapists could spend more time being therapy rather than activity based. The occupational therapy department's role on the ward was less about rehabilitation for patients and more about the use of therapies such as sensory integration to enhance patient's quality of life and support staff to help patients remain active and engaged. They team used the 'pool activity level' tool on the ward to gather and record information to improve the opportunities of patients with a cognitive impairment. The occupational therapy time had also

introduced individual sensory activity boxes for each patient. These boxes contained activities that patients enjoyed and also some reminiscence items such as photographs. These boxes enabled all staff to engage in activities with patients and also provided distraction should patients become agitated or distressed.

Some patients had additional needs in relation to nutrition and hydration. This ranged from some patients who required staff support with feeding, to others who required softened diets and fluids which were thickened. Staff were aware of individual patient needs and we observed them working with patients at mealtimes in a kind, caring and patient manner. However, the ward did not have a designated dining area and only had one table with three chairs. This meant that patients could not eat together and that eating and drinking took place in patient's individual bedrooms or whilst they sat in chairs in the living room, potentially making mealtimes less sociable and therapeutic. However, staff told us that the patient group preferred to eat in this way. However, the patients we spoke with were not able to express this and we felt that the lack of dining area limited social opportunities for patients.

Staff used a variety of rating scales to assess and record severity and outcomes for patients. These included the malnutrition universal screening tool, the health of the nation outcome scale, model of human occupation outcome scale and national early warning score system.

Staff participated in a range of audits to monitor the quality and safety of the service. These included infection control audits, ligature and environmental audits, Mental Health Act and Mental Capacity Act audits, a culture of care barometer, medication audits and equipment audits, information governance audits, a high dose antipsychotic audit and patient and carer surveys. The hospital had a clinical improvement schedule in place which listed the variety of audits taking place and dates for completion.

Skilled staff to deliver care

The service had experienced and qualified staff. Managers ensured they supported professional development for example the provider had seconded two healthcare support workers to complete their mental health nursing qualification. In addition to mandatory training the provider had trained staff in a variety of additional skills. These included; phlebotomy, electro-cardio grams, leadership and management, sensory integration and dementia mapping.

The service followed robust human resources policy and procedure. We reviewed three staff files for Oakworth ward along with the staff files for the consultant psychiatrists. Staff files contained all recruitment checks in line with the Elysium Healthcare recruitment policy with the exception of evidence of tuberculosis immunisation. This was specified in the recruitment policy as part of employment checks for nursing and healthcare workers in line with Department of Health guidance. Staff files contained all relevant information such as evidence of disclosure and barring service checks, reference checks and right to work checks.

All staff received an appropriate local and corporate induction programme. Bank and permanent staff received the same induction. All new permanent staff also had a week where they were not included in planned staffing levels for orientation, shadowing and mandatory training when they started. Staff also received a ward specific welcome pack. All new staff were managed by an experienced staff member until their induction was signed off. The hospital also had an induction process for agency staff including the completion of an agency induction checklist upon commencement of their shift.

Staff received regular supervision and appraisal. Between 1 September 2016 and 31 August 2017 only 50% staff had received clinical supervision. However, at the time of our inspection all staff were receiving clinical supervision and compliance exceeded the provider's supervision target of 95%. Staff also received managerial supervision, as well as reflective practice sessions with the support of psychology staff. The reflective practice sessions we reviewed demonstrated staff sharing ideas and learning, and peer support, around care planning and providing treatment and care for patients with more complex needs.

All staff on Oakworth ward had received an annual appraisal.

Managers informed us that there was no poor staff performance requiring additional management in the last twelve months. However the hospital director had worked within the human resource procedures to manage and support staff through periods of sickness and absence.

Good

Wards for older people with mental health problems

Multi-disciplinary and inter-agency team work

There was a range of professional disciplines available at the service which made up the multidisciplinary team. This included psychiatry, psychology, nursing and occupational therapy.

We observed a multi-disciplinary meeting during the inspection. All professionals involved in patient care attended the meeting. Staff also invited the patient, their carer or relative, and any professionals from outside of the service to the meeting. The consultant psychiatrist chaired the meeting. A second consultant who was a specialist in old age psychiatry and worked at the service for one day per month attended the meeting to review patients' needs offered specialist advice and support. Staff discussed a range of issues for each patient, including physical healthcare, best interest decisions and mental capacity, medication, dignity and end of life care planning. We saw that the meeting gave all professionals the opportunity to give a view on the patient and their progress and evidenced meaningful team working. Staff spoke about the patients respectfully at all times. The patient did not wish to attend the meeting so nursing staff agreed to give feedback where necessary.

The service had effective working relationships with professionals outside of the service. The hospital director sent weekly update reports on all patients to their relevant commissioner and had regular discussions with them regarding the discharge plans for patients. The team also worked closely with the local GP. Staff had made referrals to other professionals to support patients with ongoing physical health problems which required specialist support. The occupational therapy team had organised external agencies to provide music therapy and pets therapy sessions on the ward for the patients.

There was a handover meeting twice daily at the start of each shift, including the nurse in charge of both shifts and the healthcare support workers beginning the new shift. We observed two handover meetings during the inspection and found them to be of good quality. The staff member in charge of the current shift discussed each patient in turn including their behaviour, sleep patterns, continence, and eating habits and any change in risk and the need for enhanced physical health monitoring. In addition to this, the senior leadership team met three times per week at a morning meeting to discuss incidents, risks and staffing.

Adherence to the MHA and the MHA Code of Practice

At the time of the inspection 94% of staff had received training in the Mental Health Act. This training was mandatory for staff.

The service had an onsite Mental Health Act administrator. Staff knew who this member of staff was and told us that they were accessible and offered advice to staff. They had recently delivered some updated training to the staff teams to enhance knowledge and improve practice.

The Mental Health Act Administrator organised and scrutinised paperwork on admission. monitored tribunals and renewals and provided reminders to psychiatrists when action was required They also completed regular audits to ensure the Mental Health Act documentation was being completed appropriately and the Act was being applied as required.

Staff had a good working knowledge of the Act and the application of its principles in their practice, for example the principle of least restriction.

We reviewed the provider's 'working with the Mental Health Act' policy (April 2017). The policy was detailed and thorough and referenced relevant legislation including the Mental Health Act Code of Practice (2015).

We reviewed the Mental Health paperwork of two patients during the inspection. Paperwork was stored electronically and in good order. All patients had valid consent to treatment forms stored with medication cards. All patient records contained a copy of their detention papers and relevant approved mental health practitioner report other than in two records. Staff explained to both detained patients of their rights under the Act at the appropriate time. Staff displayed patients' rights information around the units, and informal patient notices were visible around the hospital. We saw that for patients lacking capacity, staff had requested a second opinion doctor at the appropriate time. All patients had a capacity assessment undertaken in relation to their capacity to consent to treatment and this was stored with patient medication cards.

Patients were allocated section 17 leave by the responsible clinician in weekly multi-disciplinary team meetings. Staff documented leave appropriately. Only one of the two patients had a current leave care plan.

Good

Wards for older people with mental health problems

All patients admitted to the service who lacked capacity to consent where referred to an independent mental health advocacy service.

Our Mental Health Act Reviewer last visited the ward in May 2017. At this visit, the reviewer raised concerns about; access to consent to treatment for one patient, a lack of availability of activities on the day of their visit, patient forums and community meetings not taking place, and patients not being read their rights on a regular basis. We found that the majority of these concerns had been addressed at the time of the inspection; however patient forums or community meetings were not yet taking place.

Good practice in applying the MCA

At the time of the inspection 93% of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This training was mandatory for staff.

We reviewed the provider's policy for the Mental Capacity Act and Deprivation of Liberty Safeguards (August 2017). The policy was thorough and contained all relevant guidance including updates from the 2014 supreme court judgement in relation to Deprivation of Liberty Safeguards.

Staff had a good understanding of the Act and its principles and were able to explain these to us during the inspection. Staff were aware that they should assume capacity. They had undertaken specific two-stage capacity assessments and best interests meetings in relation to specific decisions which were highly complex such ongoing complex physical healthcare needs, finances or end of life care pathways where there was an indication that the patient lacked capacity to make that decision. These assessments gave a clear rationale and senior members of staff had undertaken them. Where staff had completed best interests meetings all relevant parties were involved including the patient, their family or advocate and any external professionals involved. We saw that staff had recorded the thoughts and feelings of the patient in these meetings when important decisions were being made.

At the time of inspection, the service had made seven applications under the Deprivation of Liberty Safeguards. The service understood the interface between the two pieces of legislation. These seven patients did not meet criteria for detention under the Mental Health Act; however due to these patients lacking capacity to consent to their care and being subject to continuous supervision and control, staff had made applications for Deprivation of Liberty Safeguards for these patients..

However six of these patients continued to await approval from the relevant supervisory body. Some of these had been outstanding since March 2016. The local authority had a waiting list for approvals meaning that these patients were in fact informal patients and marked as informal on their medication cards. This was a complex situation which was outside of the control of the service and they continued to chase the local authority teams for approval of these applications.

All patients had access to the support of an independent mental capacity advocate, who visited the wards on a weekly basis. Staff automatically referred patients who lacked capacity for the support of an advocate.

The Mental Health Act administrator organised and scrutinised paperwork relating to the Mental Capacity Act and Deprivation of Liberty Safeguards, and renewals and provided reminders to staff when action was required. They also undertook audits to ensure documentation was being completed appropriately.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

We completed short observational framework for inspection observations during the inspection, which included observing patient and staff interactions at various points of the day such as at lunchtime and during a music therapy group. All of the interactions we observed between patients and staff were kind, compassionate and exceptionally caring.

Staff knew patient's individual needs to a very high standard and we saw staff discussing where patients preferred to sit, what they liked to drink and what their favourite snacks and treats were. We saw staff support patients to make choices and where choices were unclear, staff were patient and calm and allowed patients time to communicate their needs. In the handover meeting we

Good

Wards for older people with mental health problems

listened to staff talking about how patients were communicating their needs in order for the staff team to be able to respond quickly and reduce distress, i.e. they discussed how one patient sang loudly when they became incontinent and needed support.

Not all patients we spoke with were able to tell us how staff treated them. However one patient described them as 'nice'.

The involvement of people in the care they receive

The service had a robust admission process supported by an admission checklist for staff to complete with each new patient. Each patient worked with one member of staff on arrival who orientated them to the ward. Patients were provided with a detailed admission booklet for the service but this was not specific for patients and carers using Oakworth ward.

Staff worked collaboratively in multi-disciplinary team meetings with patient's families and the involvement of the advocate who visited the ward regularly to try to ensure that patients, relatives and carers were involved in the care and treatment. Staff also supported patients to achieve things which were important to them such as assisting one patient and their family to attend their daughter's wedding .However patient care plans did not always provide evidence of the patient's involvement with their family or friends and this collaborative approach to planning care and treatment.

Advocacy support was embedded in the service. The advocate visited the wards twice weekly and patients we spoke with knew who they were and how to contact them.

Staff had completed a patient satisfaction survey with patients in the hospital in February 2017. This did not include Oakworth ward. The hospital didn't feel this survey was relevant for the ward; however we felt that some patients may have been able to input into this survey.

We spoke with four carers of patients admitted to the service. Carers said that they felt their relative was safe and well cared for by staff that were friendly and caring. However they all reported a high use of temporary staff on the ward and were concerned about how this impacted on the care of their relative. Carers told us that they would like more updates and involvement from the service regarding the care and progress of their relative. One carer told us that they had been a refused a copy of their relative's care plan and another told us that they felt information about the transfer to another provider was not well communicated. However carers told us that they had received a 'your voice' questionnaire in July 2017 to offer quarterly feedback which they felt was a positive step.

Patients were not involved with the running of the service. The ward manager explained that patient community meetings were not currently in place but they had planned the initial meeting for 21 December 2017.

Are wards for older people with mental health problems responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

At the time of the inspection there were nine patients admitted to the ward. Between 1 March 2017 and 31 August 2017 average bed occupancy on the ward was 89%. This had increased to 100% by the time of our inspection. There were no available beds on the ward and the service ran a waiting list.

We saw that patients sometimes had periods of overnight leave as a transition to a new care setting. The service did not use these beds for newly admitted patients until staff had fully discharged that patient.

In order to ensure continuity of care, should a patient's condition deteriorate staff increased their observation levels and enhanced staffing levels.. This reduced the need for patients to transfer to other more intensive service provisions unless the risk presented became more unmanageable.

All patient discharges involved long term planning; usually to an alternative care setting. This meant that staff never discharged patients at an inappropriate time of the day or night.

The service reported that between 1 September 2016 and 31 August 2017 the average length of stay was 1276 days. This figure had reduced to 214 days for the current patient group. However, these figures for the average length of stay were skewed by the longer patient stays. Some patients

had shorter lengths of stay before being transferred to alternative accommodation, for example one patient remained with the service for five weeks whereas others remained with the service for longer periods of time due to a need for them to continue to receive specialist hospital dementia care.

The hospital director was aware of the long length of stay for patients and discussed that the model of care offered to patients was specialist dementia care, and where appropriate and in the best interest of the patient, this may be to the end of patient's life.

All patients had a discharge plan in place with measurable and achievable goals; some patients had planned dates for discharge. The occupational therapy team continued to work with and assess all patients to enhance their skills for independence outside of a hospital setting using a variety of assessment tools in order to facilitate discharge where appropriate.

In the last twelve months the service had not discharged any patients.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had access to facilities on the ward which included a communal lounge, an open laundry, sensory room and a skills kitchen. Due to the layout of the hospital, there was limited space for patients to undertake one to one activities and therapies, as only one therapy room was available for use by all wards. This impacted on the patient group because many patients were unable to access the community for activities due to their medical conditions. Clinic rooms did not have sufficient space to carry out examinations so patient bedrooms were used instead. There was insufficient space on the wards for patients to meet visitors or carers in private so the space in the reception area was used to facilitate these visits. The refurbishment plan for the hospital included increased communal spaces and therapy rooms. This work was due to be completed within the next 12 months.

Patient bedroom doors on the ward did not contain vision panels, this meant that staff had to enter the bedrooms to observe patients. Work had begun to change these doors on the rehabilitation ward with new doors that contained vision panels and this work was due to continue throughout the hospital as part of the refurbishment plan. However, whilst some windows contained privacy glass, we found that there was no privacy film on four bedroom windows across the hospital. This meant that we were able to see into patient bedrooms on the ground and first floor of the hospital. The provider agreed to address this immediately after our inspection.

Patients were able to make a phone call in private because they had access to their own mobile telephones which they could use in their bedrooms if they were able too. Patients who did not have telephones in their bedrooms were able to use the ward telephone in private with the support of staff.

Patients had access to outside space which they could directly access via an unlocked door from Oakworth ward. The Oakworth ward garden contained a shed and staff had turned this into an old-fashioned sweet shop which patients enjoyed using in warmer weather.

The communal lounge and kitchen was unlocked and accessible to patients throughout the day and night. Patients were able to use these areas to access hot and cold drinks and snacks.

Food was cooked and prepared on site for patients. Patients on Oakworth ward did not all have abilities to cook and prepare food. We observed staff supporting patients at meal times and saw that food which was liquidised or softened was well presented to encourage patients to eat their meals. There was a variety of drinks and snacks available which staff regularly offered to patients in order to support them to maintain their weight.

Patients were able to personalise their own bedrooms, and each bedroom contained a set of lockable drawers where patients could safely store their possessions. All patient bedrooms contained a memorabilia box on the bedroom door to give patients an identity to staff and to support patients to recognise their own space.

Patients had access to a variety of activities which ran during the week and at weekends. The hospital employed an occupational therapy lead, two occupational therapists, two occupational therapy assistants and three activity co-ordinators. Activities included a variety of escorted leave from the hospital and attendance at activities such as gardening, and music groups. Staff worked hard to ensure patient care was individualised. We saw highly responsive care for one patient who had been a plumber and continued to make attempts to use tools on the ward. The staff had created a board of locks, pipes switches for the

Good

Wards for older people with mental health problems

patient and had also bought them a tool set which they could use with lower risk. We observed staff spending one to one time with patients, signing, chatting and playing games such as cards and dominos during our visit. Another patient was spending time with staff in the sensory room and was happily singing. Where patients needed to spend time resting or sleeping, staff encouraged and supported them to come into communal areas and join activities at differing points throughout the day. We also observed the hospital choir which included patients and staff practising for their upcoming Christmas fayre.

Meeting the needs of all people who use the service

The ward was accessible to patients with mobility needs because it was located on the ground floor of the hospital. The ward had accessible communal bathrooms with specialist bathing equipment and access to equipment such as a hoist. Staff told us that this bath was sometimes used as a therapeutic tool with patients.

The ward had detailed patient information boards regarding patient rights and information such as about their medication, how to make a complaint and how to contact the Care Quality Commission. Staff told us that they could order this information in easy read formats or other languages should they be required for a patient.

Patient menus offered a choice of food, a vegetarian option was always offered, and because food was cooked on site staff were able to provide food for patients with specialist dietary needs. We observed staff providing patients with softened or liquidised and thickened food to meet specialist needs.

Patients had access to appropriate spiritual support on an individual basis as discussed in their individual care plans. The hospital had one visitor's room which was also designated as the hospital's spiritual room. This room provided relevant religious material and a prayer mat.

Listening to and learning from concerns and complaints

Between 26 June 2016 and 29 March 2017 the hospital had not received any complaints in relation to the ward. However one carer told us that they had made a complaint to the provider in regards to a lack of communication about the changeover of provider. The carer told us that they did not think they received a satisfactory response to their complaint at provider, rather than at a hospital level.

The hospital had a complaints lead and this information and their contact details were posted throughout the wards. Staff we spoke with were aware of complaints procedures and also knew that the service had an informal complaints log and complaints and compliments box on each ward to monitor patient views and ensure patients were able to voice their opinions about their care.

Oakworth ward had received two compliments from carers of patients using the service where they thanked staff for being kind and compassionate in the care they had offered to patients and their families.

Are wards for older people with mental health problems well-led?

Good

Vision and values

Elysium Healthcare had five values. Each value also included a supporting statement. The values and statements were:

- Empowerment: to encourage all to lead a meaningful life
- Integrity: because we are ethical, open, honest and transparent
- Innovation: so we drive forward the standards and outcomes of care
- Collaboration: because in partnership we can deliver transformational care
- Compassion: show respect, consideration and afford dignity to all

Values were displayed on the staff intranet system and posted around the hospital. The majority of staff we spoke with were able to tell us about the organisation's values.

Staff knew who the senior managers were in the organisation and told us that they had visited the service. Staff said that their direct line managers were approachable, responsive and spent time on the wards with staff and patients. Staff told us that members of the multi-disciplinary team were visible and approachable and they spoke highly of the psychiatry team.

Good governance

Good

Wards for older people with mental health problems

The governance systems were effective and ensured patient safety. There was a clear framework in place which ensured managers could share essential information with staff and other organisations. The teams worked closely with other professionals such as commissioners and GPs.

A number of quality checking processes such as audits were in place and managers provided feedback on the outcomes to staff in team meetings.

Robust systems were in place to support staff in managing risks and we saw evidence of learning cascaded as a result of complaints and incidents. At the time of the inspection compliance rates for supervision, training and appraisal were above the services compliance targets.

The governance system ensured the transfer of information from ward to board level. The hospital's senior team participated in Elysium Healthcare's regional operational and clinical governance meeting. Information from regional governance meetings was passed to service level governance meetings, which in turn was collated and passed to ward managers to share with their teams. Information and concerns at ward level were then escalated back up through the clinical governance structure. We reviewed meeting minutes for June, July and August 2017 clinical governance meetings and ward level team meetings for the same time period. Minutes showed that the senior team and ward level teams had discussed the same issues and concerns such as mandatory training, staffing and supervision.

To further monitor quality and safety, in September 2017 the hospital launched a new 'ward to board' report which included a comprehensive assessment of the hospital's performance across a range of key performance indicators. The clinical governance lead told us that the report was newly introduced but had already allowed staff to gain a better understanding of how the hospital was performing. Key performance indicators where the hospital was performing well included:

- having up to date care plans on the electronic system
- having community meetings as planned
- shifts meeting planned requirements and/or shifts made safe where they did not meet planned requirements.

The report provided data for areas which required close monitoring without a set performance target. Examples included the number of incidents by type, involving the use of restraint, the number of restraints resulting in patient or staff injury, and key staffing indicators including turnover, vacancy and sickness rates.

There were some key performance indicators where the hospital was currently underperforming included:

- one to one sessions between patients and primary or associate nurses recorded on the electronic system
- number of patients without a forecast discharge date
- number of patients without a physical health care plan or a physical health care plan which was not in date

The senior leadership teams had action plans in place to address these concerns and hoped for an improvement in all areas when the next performance data was received.

The hospital had a local risk register in place. There were seven open identified risks at the time of inspection. Risks were graded according to severity using a red, amber, green tool that assessed the risk's probability and impact. The highest risks were those graded red that had the highest impact and probability. The service was aware of their own risks and challenges. All areas of concern and items on the risk register had action plans in place to improve quality and safety, for example there was a detailed action plan in place to address staff recruitment and retention, mandatory training, and the transfer of the service from the previous provider to Elysium Healthcare and the challenges this brought for the service.

There were no risks rated red on the risk register. Five of the seven risks were rated amber after controls. Four risks were risks to the entire hospital. One referred only to the wards for older people with mental health problems. Amber risks were: (1) the ongoing integration of the hospital into the new provider; (2) the introduction of the new electronic patient record system; (3) the high turnover rate and increased use of agency staff; (4) the need for improvements to the physical environment of the hospital; and (5) the staff shortages on Oakworth Ward. Risk registers were discussed and updated in clinical governance meetings.

Leadership, morale and staff engagement

The organisation valued its staff and had a number of methods to reward staff such as local and organisational

staff awards. Staff were offered opportunities for development and two healthcare support workers were being sponsored by the organisation to complete their nursing qualifications.

Staff had completed a culture of care barometer in June 2017, and the clinical governance lead had produced a clinical audit report and action plan on all areas of improvement such as; staff behaviour, training and development, leadership and development, staff engagement and communication. Throughout the inspection staff told us that morale was either good or improving and that the addition of new ward managers had lifted staff morale and provided a new focus for the service.

The provider used different methods to engage with staff and to obtain their views and opinions. These were from staff culture surveys, increased benefits, and initiatives such a 'listening lunches' where staff were encouraged to meet informally with the hospital director. Staff told us that the operational director had visited the wards on Christmas day 2016 to thank staff for working on public holidays and that this made them feel valued.

We saw that the management team had responded quickly to reports of low staff morale on Oakworth ward in August and September 2017 to ensure this was not having an impact on patient care. They met with staff to discuss the concerns, and employed a new ward manager who was working on re-building the team at the time of our visit. Staff told us there had been a significant improvement in morale.

Commitment to quality improvement and innovation

The service was not currently part of accreditation and peer review schemes. However the hospital director, supported by Elysium, had a clear vision and strategy for the service and plans in place to move this forward.

Outstanding practice and areas for improvement

Outstanding practice

On Oakworth ward we saw that staff had gone the extra mile to provide dignified and comforting care to patients with complex needs. For example staff had supported one patient in their end of life care needs and wishes, and had supported another patient to attend their daughter's wedding. Staff had also used innovative ideas on the ward to provide specialist individualised care to patients such as creating an 'old fashioned' sweet shop for patients and supporting one patient to continue his passion for his work in plumbing while staying on the ward to reduce his distress.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that plans for renovation continue to ensure patients have access to facilities that promote recovery, comfort, dignity and confidentiality.
- The provider should ensure that the storage of emergency drugs on site is clear to staff by providing a policy and protocol for use which fits with the provider's own national policy.
- The provider should ensure that all bedroom windows have obscured glass to provide dignity and privacy for patients.
- The provider should ensure that the air locked door on Oakworth ward ensures informal patients are able to leave at will, and that this is the least restrictive option.
- The provider should ensure that all ligature risks are included in their ligature risk assessments.
- The provider should ensure that the training plan for the management of violence and aggression continues to ensure all staff are trained.
- The provider should ensure that staff recordings are always adequate and follow the provider's own policy such as in leave plans and the recording of patient's physical observations.
- The provider should ensure that all complaints are investigated independently and fairly and include the views of the patient.
- The provider should ensure that all areas of the wards including the clinics are clean
- The provider should ensure that patients are able to receive psychological support from qualified staff to support therapy and assessment.
- The provider should consider the models of care used for risk assessment to ensure this meets the needs of both patient groups.
- The provider should ensure that patients on Oakworth ward have the opportunity to contribute to the running of the service and provide feedback about their care.
- The provider should ensure that staff record the involvement of carers for all patients.
- The provider should ensure that their admission information includes Oakworth ward.
- The provider should ensure that guidance in relation to do not attempt cardio-pulmonary resuscitation forms is followed correctly.