St Andrew's Healthcare

St Andrew's Healthcare - Womens Service

Inspection report

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Date of inspection visit: 5-8, 20-21, 29 July 2021 and 3-5 August 2021
Date of publication: 10/11/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Inadequate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

This service was placed in special measures on 10 June 2020. Insufficient improvements have been made such that there remains a rating of inadequate for any core service, key question or overall. Therefore, we are taking action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Edward Baker
Chief Inspector of Hospitals

Our rating of this location stayed the same. We rated it as inadequate because:

Following our inspection we took urgent action because of immediate concerns we had about the safety of patients on the forensic, long stay rehabilitation and learning disability and autism wards. Conditions were placed on the provider's registration that included the following requirements; that the provider must not admit any new patients without permission from the CQC; that wards must be staffed with the required numbers of suitably skilled staff to meet patients' needs; that staff undertaking patient observations must do so in line with the provider's policy; that staff must receive required training for their role and that audits of incident reporting are completed. The provider is required to provide CQC with an update relating to these issues on a fortnightly basis.

- Staff on the forensic, long stay rehabilitation and learning disability and autism wards did not always treat patients with compassion and kindness. Staff did not always respect patients' privacy and dignity on the forensic and long stay rehabilitation wards. Staff at the learning disability and autism wards were unable to define a closed culture or describe how they ensured patients were protected from the risks associated with a closed culture developing.
- The service did not have enough nursing and support staff to keep patients safe at all core services. Patients regularly had their escorted leave, therapies or activities cancelled because of staff shortages.
- Staff did not manage risks to patients and themselves well. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others at all core services. Staff on long stay rehabilitation wards did not always know what incidents to report and how to report them, however staff in the other services we inspected did know what to report and how. Staff did not always follow the Mental Health Act code of practice in relation to seclusion, long term segregation, blanket restrictions and section 17 leave on the long stay rehabilitation and learning disability and autism wards. Staff were not always updating patient risk assessments and care plans at the psychiatric intensive care and long stay rehabilitation wards. Staff did not always ensure patients' physical healthcare needs were met at the psychiatric intensive care, forensic and long stay rehabilitation wards. Not all ward areas at the long stay rehabilitation service and learning disability and autism service were safe, clean and well maintained. Staff on the forensic wards did not always follow infection control procedures.
- Managers did not ensure all staff had the right skills, qualifications and experience to meet the needs of the patients in their care on the forensic wards and learning disability and autism wards. The provider had not fully responded to the needs of patients on the long stay rehabilitation and learning disability and autism wards.

Summary of findings

- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. Leaders at the long stay rehabilitation services did not have the skills, knowledge and experience to perform their roles. Concerns identified at previous inspections had not always been addressed.
- Staff did not always feel respected, supported and valued on the long stay rehabilitation and learning disability and autism wards. Managers did not always support staff with appraisals, supervision and opportunities to update and further develop their skills on the forensic and long stay rehabilitation wards.

However:

- Each patient had their own en suite bedroom, which they could personalise.
- Leadership development opportunities were available.
- Staff received and kept up to date with training on the Mental Health Act and the Mental Health Capacity Act.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	Our rating of this service stayed the same. We rated it as requires improvement because: • The service did not have enough nursing and support staff to keep patients safe. Staffing levels on the ward meant that staff were regularly completing patient enhanced observations for longer than five hours at a time. This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence. • Staff did not review the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Two patients who were prescribed high dosage anti-psychotics did not have a care plan in place to monitor the effects on their physical health. • Our findings from the other key questions demonstrated that performance and risk were not managed well. The provider's data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data. Managers had not addressed staff allocation to patient observations for long periods or reliance on multi disciplinary staff to cover breaks. However: • The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. • Staff completed and kept up to date with mandatory training. • Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation failed. • Staff made sure patients had access to physical health care, including specialists as required.

Summary of findings

- Patients and carers told us that staff were caring, respectful and polite. Staff kept family members informed and involved in patients' care.

We rated this service as requires improvement because it was not safe or well led.

Forensic inpatient or secure wards

Inadequate

Our rating of this service stayed the same. We rated it as inadequate because:

- Staff were not always able to protect patients' dignity. Staff were unable to meet a patient's needs on Bracken ward which resulted in them being unable to get to the toilet in time.
- The service did not have enough nursing and support staff to keep patients safe. On Willow ward we found recorded evidence of incidents where patient observations had been missed and night staff had to remain on shift due to a lack of day staff. We reviewed an incident on Bracken ward whereby a patient was able to tie a ligature due to the day area being left unobserved.
- Staff did not always follow infection control procedures. Four staff on Willow ward were observed to be wearing masks incorrectly. This was reported to managers as we were concerned that Personal Protective Equipment was not being used effectively.
- Staff did not always meet patients' dietary needs, and correctly assess patients who had specialist care needs for nutrition and hydration. We reviewed an incident on Willow ward that occurred in May 2021 where staff did not respond effectively when a patient refused food and then fluids. This resulted in the patient being admitted to the acute hospital for rehydration. The acute hospital raised this concern as a safeguarding for investigation.
- Managers did not ensure that staff had the right skills and experience to meet the needs of the patients. New and inexperienced staff were being sent to Bracken ward to provide cover due to staff shortages. We observed this on 8 July 2021 and observed that staff had insufficient time to give new covering staff a

Summary of findings

handover. Staff did not always appear to understand the individual needs of patients or support patients to understand and manage their care treatment or condition.

- On Bracken ward patients could not make hot drinks and snacks independently of staff. All drinks were kept in the office and patients had to ask staff to make them. If the ward was short staffed this could result in a delay to patients receiving a drink.
- Leaders had not addressed some of the concerns raised at previous inspections such as low staffing levels and patient observations.

However:

- Wards were clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.
- Care plans were personalised, holistic, and recovery orientated, and patients were routinely offered a copy of their care plan.
- Carers gave positive feedback about the staff.
- Each patient had their own en suite bedroom, which they could personalise. We saw examples of this during the inspection where patients had their own duvet covers, photographs, posters and music collections.
- Leadership development opportunities were available.

We rated this service as inadequate because it was not safe, effective, caring or well led.

Wards for people with learning disabilities or autism

Inadequate

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

- The service did not have enough nursing and support staff to keep patients safe and the wards were regularly short staffed. Senior leaders did not accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Patients regularly had their escorted

Summary of findings

leave, or activities cancelled, due to the ward being short staffed. Staff did not always provide a range of care and treatment suitable for the patients in the service.

- Staff did not always manage risks to patients and themselves well. Staff did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. Staff did not always act to prevent or reduce risks despite knowing any risks for each patient. Staff were not completing observation records in line with patients prescribed observation times or in line with provider policy.
- Staff did not always treat patients with compassion and kindness. They did not actively involve families and carers in care decisions.
- The service had not fully responded to the needs of patients with autism in the ward environment. Patients were not protected from closed cultures. Staff had not completed specialist training to meet the needs of patients. The design, layout, and furnishings of the ward did not always support patients' treatment. Wards had blanket restrictions in place. Not all patients could make hot drinks and snacks at any time.
- Senior managers did not always have a good understanding of the services they managed. Senior managers were not always visible in the service or approachable for patients and staff. Not all staff felt respected, supported and valued by senior managers. Not all staff felt they could raise any concerns without fear of retribution from senior managers. Senior managers are managers above ward manager level.
- Seclusion rooms did not meet all the guidance in the Mental Health Act Code of Practice. When a patient was placed in seclusion, staff did not always follow best practice guidelines.

Summary of findings

When a patient was placed in long term-segregation, staff did not always follow best practice guidelines in the Mental Health Act Code of Practice.

However:

- The ward environments were clean.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Ward leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Our rating of this location went down. We rated it as inadequate because:

- Staff did not always treat patients with compassion and kindness. They did not respect patients' privacy and dignity. Staff did not intervene to support patients when harming themselves or in distress. Staff did not ensure patients access to the toilet at all times.
- The service did not have enough nursing and support staff to keep patients safe and the wards were regularly short staffed. Patients and staff told us on escorted leave and activities were cancelled due to the service being short staffed. The service did not always have enough staff on each shift to carry out physical interventions safely.
- Staff did not always manage risks to patients and themselves well. They did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour and levels of

Summary of findings

restrictive interventions were high. Staff did not always know about risks to each patient, staff did not always act to prevent or reduce risks. Risk assessments were not updated after each incident. Staff did not always follow the Mental Health Act code of practice in relation to seclusion, long term segregation and blanket restrictions.

- Wards were not always safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff did not always complete and regularly update thorough risk assessments of all wards areas and remove or reduce any risks they identified. Patients and carers told us there has frequently been issues with toilets blocking, shower heads spraying and light bulbs in bedrooms needing replacing.
- The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service.
- Staff did not always assess the physical health of all patients on admission or support patients with their physical health. Staff failed to carry out recommended physical health observations following episodes of patients' head banging and administration of rapid tranquillisation medicine.
- Staff did not always inform and involve families and carers appropriately. Staff support, information and involvement for families or carers was inconsistent.
- The service did not meet the needs of all patients – including those with a protected characteristic. The service could not always support and make adjustments for disabled people. Staff had not made reasonable adjustments to ensure wheelchair bound patients could evacuate in an emergency.
- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed staff failures to follow the provider's procedures on risk

Summary of findings

management and incident management and reporting. Teams did not always have access to the information they needed to provide safe and effective care.

- Staff did not always feel respected, supported and valued. Staff told us they felt burnt out, stressed and unsupported. Managers did not always support staff who needed time off for ill health. Managers did not always support staff with appraisals, supervision and opportunities to update and further develop their skills.

However:

- Staff introduced patients to the ward and the services as part of their admission. Staff made sure patients understood their care and treatment. Patients could give feedback on the service and their treatment and staff supported them to do this.
- Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff always regularly reviewed the effects of medications on each patient's mental and physical health.
- Staff received and kept up to date with training on the Mental Health Act and the Mental Health Capacity Act.

We rated this service as inadequate because it was not safe, effective, caring, responsive or well led.

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Background to St Andrew's Healthcare - Womens Service

St Andrew's Healthcare Women's location has been registered with the CQC since 11 April 2011. The service has a registered manager and a controlled drugs accountable officer.

This location consists of four core services: acute wards for adults of working age and psychiatric intensive care units; long stay/rehabilitation mental health wards for working age adults; forensic/inpatient secure wards; wards for people with learning disabilities or autism.

St Andrew's Healthcare Women's location is registered to provide the following regulated activities:

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

This location has been inspected nine times. The most recent inspection in July 2020 was a focused inspection of one ward, Spencer South (now Upper Harlestone ward). We took enforcement action for breaches of the following regulation:

- Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We issued requirement notices for breaches of the following regulations:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care.
- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment.
- Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.

The last comprehensive inspection of this location was in March 2020. The location was rated as inadequate overall; inadequate for safe, requires improvement for effective, inadequate for caring, good for responsive and requires improvement for well led. We took enforcement action for breaches of the following regulations:

- Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and Respect.
- Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

We issued requirement notices for breaches of the following regulations:

- Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.
- Regulation 18 HSCA (RA) Regulations 2014 Staffing.

We found that the provider addressed some, but not all of the issues from the last inspection. The issues that remain are identified later in this report.

The following services and wards were visited on this inspection:

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

- Bayley ward, a psychiatric intensive care unit with 10 beds.

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Forensic inpatient/secure wards:

- Bracken ward, a medium secure ward with 10 beds.
- Willow ward, a blended low/medium secure ward with 10 beds.
- Maple ward, a blended low/medium secure ward with 10 beds.

Long stay / rehabilitation wards for working age adults:

- Upper Harlestone ward (previously Spencer South ward) with 12 beds.
- Ashby ward (previously Spring Hill House) with 16 beds.
- Naseby ward (previously Hereward Wake ward) with 15 beds.

Wards for people with learning disabilities or autism:

- Oak ward, a 10 bed medium secure service for women with learning disabilities and/or autistic spectrum conditions.
- Church ward, a 10 bed low secure service for women with learning disabilities and/or autistic spectrum conditions.
- Sycamore ward, a 4 bed medium secure enhanced support service for women with learning disabilities and/or autistic spectrum conditions.

What people who use the service say

We spoke with 28 patients.

At the psychiatric intensive care unit we spoke with two patients who told us that the ward was clean and safe. They told us that the ward was understaffed but that staff were caring, kind and respectful.

At the forensic inpatient/secure wards we spoke with seven patients. Six out of the seven patients said that there were never enough staff on the wards. Patients said the impact of this was that they often had their leave cancelled, even though they had been encouraged by the multi-disciplinary team to utilise their leave as much as possible. Three out of seven patients said that activities were often cancelled due to lack of staff and two patients told us that dialectical behavioural therapy (DBT) had recently been cancelled twice. Three patients told us that there was not enough to do on the wards due to activities being cancelled. This impacted on their wellbeing as they were bored and left with too much time to think.

One patient said that there were too many incidents of self-harm and three out of seven patients said that the wards felt unsafe. Two patients noticed that the alarms did not always work. Community meetings were held regularly and whilst patients attended, they said that they were repetitive and that nothing much got done. One patient raised concerns about low staffing levels, but nothing changed.

Two patients were unhappy about the food and said that there was a lack of variety and that pasta dishes were served too frequently. One said that they thought they were still on the winter menu when it should have been changed to the summer menu.

Generally, patients told us that staff were nice, but they often saw staff that they were unfamiliar with on the wards.

At the long stay / rehabilitation wards we spoke with nine patients who told us there are not enough staff on shift, activities and leave are cancelled, and it can feel dangerous.

Summary of this inspection

At the wards for people with learning disabilities or autism we spoke with 11 patients. Four patients told us the wards were short staffed. Two patients told us they had their escorted leave or activities cancelled due to the wards being short staffed, only one of these patients told us this was then rearranged.

One patient said there was not a lot to do on the ward.

Two patients told us they get feedback from incident investigations. Two patients told us they did not always get updates from their complaints.

Two patients told us they were not given a copy of their care plan and one patient said they would like a copy.

Three patients on Church ward told us night staff were rude. One patient on Church ward told us that she had sworn at staff and they had sworn back at her. One patient on Church ward told us that night staff ignore them.

One patient on Church ward told us that night staff sometimes come in chewing gum. Two patients on Church ward told us that night staff bring their mobile phones onto the ward and use them. Mobile phones and chewing gum are contraband items on the wards.

Two patients on Oak ward told us night staff denied them a drink during the night. One patient told us she had been denied a drink because night staff were asleep. One patient told us on Church ward and two patients on Oak ward told us that night staff fall asleep on night shifts whilst doing their enhanced observations.

We spoke with 27 carers.

At the psychiatric intensive care unit we spoke with three carers who all felt that they were kept up to date and received regular phone calls from ward staff.

At the forensic inpatient/secure wards we spoke with six carers. Three carers said that they had close communication with the hospital and that they had been asked to provide feedback about the service. Three carers (50%) felt that they were kept involved in their relative's care and treatment and that they were regularly provided with information and invited to meetings.

Four out of six carers spoke positively about the staff and only one carer was aware of cancelled leave.

At the long stay / rehabilitation wards we spoke with 14 carers. Carers told us that contact from staff was erratic, sometimes they would receive several calls a week and then not have contact for extended periods of time. A carer told us that "staff won't try and de-escalate; they do not explore the least restrictive option and go straight to restraint" and that the system feels punitive rather than encouraging and rewarding.

At the wards for people with learning disabilities or autism we spoke with four carers. One carer told us there had been times when patient section 17 leave hasn't been supported due to staff shortage or the patient had an incident and their leave was cancelled. One carer told us not all staff treat their relative with respect. Two carers told us they had not been invited to attend any of their relative's meetings. Three carers told us they never received any information about a carer's assessment.

Summary of this inspection

How we carried out this inspection

The inspection team visited services and wards between 6 July and 8 July 2021 on 20 and 21 July 2021 and completed further off-site inspection activity until 5 August 2021. During the inspection we:

- Visited the service and observed how staff cared for patients
- Toured the clinical environments
- Looked at the medicine management on the wards
- Spoke with 27 patients that were using the service
- Interviewed 55 staff and managers, including ward managers, clinical leads, doctors, nurses, healthcare assistants, psychologists, occupational therapists, technical instructors, social workers, dieticians, pharmacists, students and volunteers.
- Interviewed eight senior managers and the provider's quality improvement lead
- Spoke with 27 carers
- Observed two community meetings and two team meetings
- Observed three episodes of care
- Reviewed 47 patient care records
- Reviewed policies and procedures relevant to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

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

- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff review the effects of patients' medicines on their physical health. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure their data is accurate. (Regulation 17 (1) (2) (d))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))

Forensic inpatient/secure wards core service:

- The provider must ensure staff are able to respect patients' dignity at all times. (Regulation 10 (1))

Summary of this inspection

- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion and blanket restrictions. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff provide required physical health interventions in a timely manner. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure their data is accurate. (Regulation 17 (1) (2) (d))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))

Long stay / rehabilitation wards for working age adults core service:

- The provider must ensure staff treat patients with kindness, respect and dignity. (Regulation 10 (1))
- The provider must review the use of restrictive interventions on the wards and take action to reduce these. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff report and record all incidents appropriately. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff meet patient's physical healthcare needs. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure all staff are aware of and follow patient care and risk management plans. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff review and update individual risk assessments and care plans for all patients. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that the environment is well maintained, safe, clean and fit for purpose. (Regulation 12 (1) (2) (a) (b) (d))
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation and blanket restrictions. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure their data is accurate. (Regulation 17 (1) (2) (d))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))

Wards for people with learning disabilities or autism core service:

- The provider must ensure the service provides a range of care and treatment suitable for the patients in the service. (Regulation 9 (1) (a) (b) (c))
- The provider must ensure the wards respond to the needs of patients with autism in the ward environment. (Regulation 9 (1) (a) (b) (c))
- The provider must ensure staff treat patients with kindness, respect and dignity at all times, including use of appropriate language. (Regulation 10 (1))
- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that the environment is well maintained, safe and clean. (Regulation 12 (1) (2) (a) (b) (d))
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation, blanket restrictions and section 17 leave. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure long term segregation environments meet the Mental Health Act Code of Practice. (Regulation 12 (1) (2) (d))
- The provider must ensure all staff are aware of what constitutes a closed culture. (Regulation 13 (1) (2))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))

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- The provider must ensure their data is accurate. (Regulation 17 (1) (2) (d))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))
- The provider must ensure that staff receive the required specialist training to carry out their roles effectively. (Regulation 18 (2) (a))

Action the service SHOULD take to improve:

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

- The provider should ensure staff complete specialist care plans for all patients as required. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure they provide patients with a copy of their care plan. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure they provide outcomes to issues raised by staff (Regulation 17 (1) (2) (e) (f))

Long stay / rehabilitation wards for working age adults core service:

- The provider should ensure staff inform and involve families and carers appropriately. (Regulation 9 (1) (3) (f))
- The provider should ensure staff have access to regular team meetings. (Regulation 18 (2) (a))
- The provider should ensure staff receive regular supervision, appraisal and opportunities to learn. (Regulation 18 (2) (a))
- The provider should ensure staff are supported and able to access support functions when required. (Regulation 18 (2) (a))

Wards for people with learning disabilities or autism core service:

- The provider should ensure seclusion rooms have a fixed table for patients to use. (Regulation 12 (1) (2) (d))
- The provider should ensure when paperwork is updated electronically it is printed if these are the copies staff are relying on to support patients safely and effectively. (Regulation 17 (1) (2) (c))
- The provider should ensure staff review care plans when required. (Regulation 17 (1) (2) (c))
- The provider should ensure patient's Mental Health Act detention paperwork is clear. (Regulation 17 (1) (2) (c))
- The provider should ensure staff inform and involve families and carers appropriately. (Regulation 9 (1) (3) (f))
- The provider should ensure they regularly review the length of stay for patients to ensure they did not stay longer than needed. (Regulation 9 (1) (a) (b) (c))
- The provider should ensure senior managers have a good understanding of the services they manage and be visible in the service and approachable for patients and staff. (Regulation 17 (1) (2) (f))
- The provider should ensure that staff feel able to raise any concerns without fear of retribution from senior managers. (Regulation 17 (1) (2) (f))
- The provider should ensure they provide outcomes to issues raised in governance meetings. (Regulation 17 (1) (2) (e) (f))

Our findings

Overview of ratings

Our ratings for this location are:

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

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

Requires Improvement

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

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

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. The environmental risk assessment had been updated in February 2021.

Staff could observe patients in all parts of the wards.

The ward complied with guidance and there was no mixed sex accommodation as it only accommodates female patients.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Patient bedrooms and bathrooms were furnished with anti-ligature fittings and staff were aware of potential ligature anchor points in communal areas. The ward had ligature cutters available to staff in key areas of the ward to allow quick access in the event of a ligature incident.

Staff had easy access to alarms, and all carried personal alarms to call for assistance. Patients did not have call systems in bedrooms however there were staff based in the bedroom corridors if patients required assistance.

Maintenance, cleanliness and infection control

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

Staff made sure cleaning records were up-to-date and the premises were clean. The ward had housekeeping staff complete cleaning on most days however there had been some gaps where nursing staff had to complete the ward cleaning. All ward areas were visibly clean and no concerns were raised by patients about cleanliness.

Staff followed infection control policy, including handwashing. Staff wore masks at all times and additional personal protective equipment when required. Staff washed their hands on entry to the ward and throughout shifts and sanitising hand gel was available on the ward.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked clinic rooms weekly and kept records of findings, and the ward pharmacist audited controlled drugs.

Staff checked, maintained, and cleaned equipment. Staff recorded calibration and cleaning of equipment, and used clean stickers when this was completed.

Safe staffing

The service did not have enough nursing or support staff. However, staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. The service did not have enough staff on each shift to carry out any physical interventions safely.

Although vacancy rates were low with one qualified nurse vacancy and no healthcare assistant vacancies the service used a model to plan staffing of shifts that did not fully consider the number of observations required on the ward. The service used 'planned numbers' and 'optimum numbers' when planning shift staffing. Staff reported that it was rare for a shift to be staffed at optimum numbers and when a shift did have the optimum number of staff, nursing staff would be moved to another ward to meet their planned number of staff.

The planned staffing levels required staff to be allocated to observations of patients on enhanced observations for longer periods than prescribed. Staff shift rotas and observation records showed that between 25 May and 2 July 2021 staff had been allocated to patient observations for longer than five hours without a break on ten occasions. Between 25 May and 2 July 2021 staff had been allocated to patient observations for over eight hours without a break on two occasions. Multi disciplinary staff were regularly used to complete observations during nursing staff breaks.

This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence. Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety.

Staff reported that sometimes they did not feel safe on the ward due to the staffing levels.

The ward manager could adjust staffing levels according to the needs of the patients but only within the staffing model designated by the provider.

Managers limited their use of bank staff and requested staff familiar with the service. Bank staff were allocated by directorate so that they would be familiar with the needs of the patient group. Bank staff were given an induction onto the ward and attended handover meetings at the start of their shift to familiarise them with the patients.

The service had low turnover rates. The ward reported no staff turnover in the three months prior to inspection.

Levels of sickness were low with 7% staff sickness in the three months prior to inspection.

Patients had regular one to one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The ward manager and multi disciplinary staff were sometimes required to escort patients for activities or leave off the ward in order to maintain staffing levels on the ward.

Staff shared key information to keep patients safe when handing over their care to others. Staff attended a handover meeting at the start of morning and evening shifts where patients and ward activities were discussed.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The ward had a locum consultant psychiatrist and associate specialist doctor in post who covered across the men's and women's ward. The provider had out of hours cover available for evenings and weekends.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. Staff compliance with mandatory training sessions was 98%.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training sessions included Safeguarding Adults and Children, Immediate life Support, Least Restrictive Practice, and Infection Control.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers used an electronic dashboard system to monitor staff compliance with training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed five risk assessments and found that they were all thorough and had been updated regularly including after any incidents.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff completed a crisis plan for all patients on the ward following their risk assessment to help mitigate against risks.

Staff could observe patients in all areas of the ward.

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

Use of restrictive interventions

Levels of restrictive interventions were low. The ward reported 88 incidents involving restraint in the three months prior to inspection, with two of those involving prone restraint when the patient moved into a prone position before staff moved them into a supine position. The ward reported 16 instances of rapid tranquilisation and 16 instances of seclusion. The ward did not report any incidents of long term segregation.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff on the ward were piloting the use of wearing body cameras that would be switched on before a patient restraint and felt that this contributed to a reduction in incidents leading to restraint.

Staff understood the Mental Capacity Act definition of restraint and worked within it. All staff were up to date with training in the Mental Capacity Act.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff did not always keep clear records or follow best practice guidelines. We reviewed the seclusion paperwork of two patients (two episodes of seclusion for one patient and one episode for the second patient). We found the paperwork met some, but not all of the guidance in the Code of Practice. For example, in two records we were unable to find any evidence of the patient's family member being informed of the patient's seclusion. In another record, there was no evidence of an independent multidisciplinary team review taking place after the patient's eight hours of consecutive seclusion.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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

Staff kept up-to-date with their safeguarding training and 100% of staff completed either level 2 or level 3 safeguarding of adults and children.

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

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The ward social worker was the contact point for any safeguarding concerns and reviewed any incidents logged as a safeguarding. The social worker liaised with the hospital safeguarding lead and the local authority to explore any issues and whether the concern met the threshold for local authority investigation.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily.

The service used an electronic patient record system that was easy to access. Staff recorded patient observation notes on paper records and these were then uploaded onto the electronic system. Staff completing patient care plans had to print the forms off to complete with the patient and then type the notes up on the electronic system.

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

Records were stored securely.

Medicines management

Staff did not always review the effects of medicines on each patient's mental and physical health. However, the service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff did not record patient's legal status on their medicines chart.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff advised patients about their medicines during weekly reviews and also provided patients with medicine information leaflets.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff completed a weekly stock check of medicine and kept an up-to-date stock list. The hospital pharmacist checked expiration dates of stock and all medicines were in date.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The provider distributed 'patient safety action notices' to staff by email and in staff areas to make all staff aware.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff did not always review the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Two patients who were prescribed high dosage anti-psychotic medicines did not have a care plan in place for monitoring the effects on their physical health. This was raised with the provider at the time of inspection and rectified. However, patients had their physical health monitored twice per day and staff provided access to electrocardiogram and blood tests where patients consented.

Track record on safety

The service had a good track record on safety.

Staff reported 128 incidents between April and June 2021 with the majority of incidents involving physical aggression and violence, and self harm.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported serious incidents clearly and in line with provider policy.

The service had no never events on the ward. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. The provider had a policy for the debrief process including patient feedback forms.

Managers investigated incidents thoroughly.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. The ward held weekly team meetings where staff discussed incidents, learning and outcomes.

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

Requires Improvement

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

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient on admission.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The consultant psychiatrist and a nurse met with patients on admission and completed a thorough assessment of mental and physical health needs. We reviewed five patient records and saw that this had been completed for all patients.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery orientated. Staff told us that when care planning they printed the document from the system to complete with the patient and then entered it onto the electronic system. However, staff told us that they often did not have time to do this due to the staffing levels on the ward.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required. The provider employed physical health specialists including nurses, general practitioner, dentist and optician.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff used food and fluid charts to monitor patient's intake where required. There was a range of meal choices available for patients including healthy options.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

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

Requires Improvement

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used Health of the Nation Outcome Scores and Recovering Quality of Life Scales to assess patient outcomes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The provider had an annual audit plan. Audits over the past year included capacity assessments, Covid-19 care plans and rapid tranquilisation.

Managers used results from audits to make improvements.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of the patients on the ward. The ward team included a social worker, occupational therapist and occupational therapy technical instructor, a consultant psychiatrist and an associate specialist doctor, and nursing staff.

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

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

Managers supported staff through regular, constructive appraisals of their work and 88% of staff had an up to date annual appraisal.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Staff received regular management supervision and also attended group reflective practice sessions.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Managers held weekly team meetings and monthly clinical governance meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Healthcare assistants could also apply for a nursing qualification and join the provider preceptorship programme. Managers recognised poor performance, could identify the reasons and dealt with these. The ward did not have any staff on performance monitoring at the time of inspection, but the provider had a capability policy in place.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The ward held daily multidisciplinary meetings every morning and weekly ward round meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff held handover meetings at the start of day and night shifts to update staff starting shift on patients.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Staff worked closely with the local authority safeguarding team, commissioning groups and the local general hospital.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Compliance with Mental Health Act training was 100%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

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

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

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

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

Requires Improvement

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Compliance with Mental Capacity Act training was 100%.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

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

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

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

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

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

Good

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. We observed episodes of care on the ward and saw that staff were caring and respectful to patients. Patients we spoke with told us staff were respectful and kind.

Staff gave patients help, emotional support and advice when they needed it. Staff demonstrated a person centred approach to patients and tried to ensure patient activities were personalised.

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

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

Patients said staff treated them well and behaved kindly. We spoke with two patients and observed the weekly community meeting where patients could raise concerns. Patients did not raise any concerns about staff treatment of them.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff felt confident that they could raise any concerns with managers and that action would be taken as a result of their concerns.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff gave newly admitted patients a tour of the ward and met with them and the consultant to discuss their treatment. Staff provided a welcome booklet on admission and a pack of toiletries for patients to use. The ward had a supply of clothes for patients who had not arrived with additional clothing.

Staff involved patients and gave them access to their care planning and risk assessments. Staff completed risk assessments and care plans with patients but did not always fully record this or give patients a copy of their care plan. Patient voice was not evident within care plans. We reviewed five patient records and found that one care plan included patient views and had been offered to the patient.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff read patients their rights on admission and repeated this daily until patients could demonstrate they understood their rights. The hospital had access to translators and interpreters for patients who required them.

Staff involved patients in decisions about the service, when appropriate. Staff involved patients in decisions about ward activities and social events.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients completed a feedback form each week which the multi-disciplinary team discussed with the patient in weekly ward round reviews. Patients could also give feedback in the weekly ward community meeting. The provider held a monthly patient forum where patients could raise ideas or concerns.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. Patients could access an independent mental health advocate who visited the ward regularly.

Involvement of families and carers

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

Requires Improvement

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with three family members of patients who all felt that they were kept up to date and received regular phone calls from ward staff. Families were invited to attend weekly ward round meetings by video or phone call and spoke highly of how staff involved them in patient care.

Staff helped families to give feedback on the service. The provider was in the process of setting up a virtual carers forum for families to give feedback and had recently introduced a newsletter that encouraged carer feedback.

Staff gave carers information on how to find the carer's assessment. Families spoke positively about the support they received from social workers within the hospital and how they had been offered accommodation and financial support to visit their family member on the ward.

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

Good

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

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers made sure bed occupancy did not go above 85%. The average bed occupancy for the ward in the last year was 34% which was due to the ward operating as a long term segregation unit for one patient over a period of months. Since April 2021 the ward admitted patients back at a measured rate and the bed occupancy was 60% at the time of inspection. All patients admitted were nursed in isolation for a minimum of 48 hours to reduce the risk of Covid-19 transmission.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

The service had no/low out-of-area placements.

Managers and staff worked to make sure they did not discharge patients before they were ready.

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

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

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

Requires Improvement

Discharge and transfers of care

The service had no delayed discharges in the past year.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff began discharge planning at the point of admission.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions. Patients bedrooms had lockable cupboards and a safe to store valuable items.

Staff used a full range of rooms and equipment to support treatment and care. The ward included a television and games console room, lounge and dining area, art room and sufficient space for one to one and group meetings. There was a gym area and occupational therapy kitchen that patients could use dependent on risk and observation levels.

The service had quiet areas and a room where patients could meet with visitors in private. The ward had a designated meeting room for family and visitors and a quiet room.

Patients could make phone calls in private. Patients had access to their mobile phones subject to risk assessment or could use the ward cordless phone if necessary.

The service had an outside space that patients could access easily. The ward had two enclosed outside spaces, one of which was open to patient access all day. Patients could use electronic cigarettes that the ward provided in the outside space.

Patients could access cold drinks and snacks and staff offered hot drinks or provide them at patient request.

The service offered a variety of good quality food.

Patients' engagement with the wider community

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

Staff helped patients to stay in contact with families and carers. Patients could contact their family and friends by phone and video conferencing. The provider encouraged family visits by offering accommodation and financial support to visitors.

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

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

Requires Improvement

Meeting the needs of all people who use the service

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

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

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

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

Managers made sure staff and patients could get help from interpreters when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

The ward had received two patient complaints and two patient compliments in the past three months. We reviewed both complaints and were assured that they had been investigated and resolved. Patients, relatives and carers knew how to complain or raise concerns.

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

Staff understood the policy on complaints and knew how to handle them.

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

Managers investigated complaints and identified themes.

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

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

Managers shared feedback from complaints with staff and learning was used to improve the service.

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

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

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

Requires Improvement

Requires Improvement

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Local leaders at ward and directorate level had good knowledge and understanding of the service they managed and were visible on the ward for staff and patients.

Senior leaders above the directorate level were not usually visible on the ward although they had visited during the inspection. Senior leaders provided regular updates by email.

Vision and strategy

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

Staff could describe the provider values of Compassion, Accountability, Respect, Excellence and could evidence how they applied these values in their day to day work.

Culture

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

Staff reported that they felt supported and valued within the ward and directorate but that they often felt stressed and unsafe due to the staffing levels on the ward and the amount of time spent on enhanced observations. Staff felt able to raise concerns with their line managers but were frustrated that no action had been taken about staffing numbers by senior managers.

The provider offered development opportunities for staff including nursing qualification for healthcare assistants and three staff members were undertaking this at the time of inspection. Qualified nurses had the opportunity to develop into clinical nurse lead roles.

Governance

Our findings from the other key questions demonstrated that performance and risk were not managed well. Governance processes operated effectively at team level.

The provider had set planned numbers for staffing the ward that did not provide enough staff to cover patient enhanced observations safely. Staffing numbers were reviewed on a directorate level and when Bayley ward was staffed at optimum levels, staff were regularly reallocated to other wards to cover their unfilled shifts. Managers had not addressed staff allocation to patient observations for long periods or reliance on multi disciplinary staff to cover breaks.

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

Requires Improvement

The providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data.

The provider used effective governance dashboards for managers to have an overview of performance.

The provider held regular governance meetings with a clear framework of what was discussed and how this was fed back to staff.

Management of risk, issues and performance

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

The provider had a directorate level risk register in place. The risk register matched the concerns of staff on the ward but had not addressed the main concern about set staffing levels.

Ward staff had access to the information they needed to provide safe and effective care and used that information to good effect. However, the provider did not use technology effectively for staff to record care planning and observation records with patients. Staff used paper records to complete these which were then uploaded or typed onto the electronic system.

Information management

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

The provider used a dashboard system to collect data from the ward, and this was not burdensome on staff. The provider used key performance indicators to monitor the ward that included training, incidents and restraint.

Inadequate

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

Wards were not always safe, however, wards were clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff had easy access to alarms and patients had easy access to nurse call systems. However, alarms on Willow and Maple ward did not work consistently due to fluctuating Wi-Fi signals, and alarms were unreliable. We were concerned that this would affect staff and patient safety.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could not observe patients in all parts of the wards. Patients at greater risk were placed on enhanced observation to mitigate against this. However, enhanced observations were not always carried out effectively.

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

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We reviewed the ligature risk assessments on each ward and saw that these were complete and up to date.

Maintenance, cleanliness and infection control

Staff generally followed infection control policy, including handwashing. However, four staff on Willow ward were observed to be wearing masks incorrectly. This was reported to managers as we were concerned that Personal Protective Equipment was not being used effectively.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed the cleaning records on all three wards during the inspection and saw that cleaning and deep cleaning was regularly carried out. All cleaning items were locked away when not in use and not left unattended.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. It had a toilet and a clock.

Staff did not always keep clear records or follow best practice guidelines in the use of seclusion. We reviewed the minutes of a serious incident sign off meeting dated 16 July 2021, which related to an episode when a patient was placed in seclusion. The minutes from the meeting stated that there had been poor record keeping and that the seclusion review policy had not been followed.

We viewed the long-term segregation area on Maple ward. This area consisted of a bedroom, en suite area, lounge area. There was an observation area for staff. Access to fresh air was limited to a small secure courtyard. At the time of our visit there were no patients in long-term segregation. There was a blind spot in the bedroom area. Where the patient's bed was located, the patients' head area was obscured. This did not allow staff to see the patient's full body. However, staff told us if a patient was being nursed in long-term segregation, they would always be within eyesight or on arms' length observations.

Clinic room and equipment

Clinic rooms were clean, fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment. Cleaning records were seen, and clean stickers were in place.

Safe staffing

Nursing staff

The service did not have enough nursing and support staff who knew the patients to keep people safe from avoidable harm. On Willow ward we found recorded evidence of incidents where patient observations had been missed and night staff had to remain on shift due to a lack of day staff. We reviewed an incident on Bracken ward whereby a patient was able to tie a ligature due to the day area being left unobserved.

The service had reducing vacancy rates of four qualified nurses and four health care assistants across the three wards.

Managers were not able to access as many bank and agency staff as required due to the impact of the pandemic and requested staff familiar with the service. However, covering staff were not always familiar with secure forensic services.

Managers couldn't always ensure that all bank and agency staff had a full induction and understood the service before starting their shift.

The service reported a staff turnover rate of 3% between 1 April 2021-30 June 2021.

Managers supported staff who needed time off for ill health by maintaining regular contact with them.

Inadequate

Forensic inpatient or secure wards

Levels of sickness were lower on Maple and Bracken ward and higher on Willow ward with two qualified nurses and one health care assistant off sick at the time of inspection.

Managers did not accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. We reviewed 10 shift planners on Willow ward and found that in seven cases, no nurse was identified to respond to an emergency. The ward manager could not always adjust staffing levels according to the needs of the patients.

Patients and staff that we spoke with, said that sometimes escorted leave or activities were cancelled when the service was short staffed. Patients who wanted to attend the Recovery College often couldn't, due to a lack of escorting staff.

Managers had not ensured that staff who covered for ward shortages had a full induction and understood the service before starting their shift. On Bracken ward we observed that a newly employed staff member had never been on the ward and was unfamiliar with the nature of the service. Staff did not have sufficient time to provide an induction or handover.

Staffing levels were routinely low across all three wards and staff, patients and managers reported that low staffing was a frequent occurrence. The provider advised this was due to the impact of the pandemic. However, regulatory action has been taken against this core service for breaches relating to low staffing levels on three separate inspections between July 2018 and March 2020. On Bracken ward on 8 July the ward was one staff member short; on Maple ward we observed the ward manager had to sit in the lounge as there were no other staff free on the ward. We observed that staff were not always able to get their breaks.

Staff on Willow and Maple ward did not routinely respond to alarms when an emergency happened on another ward. We observed that staffing levels did not facilitate their ability to leave the ward to support staff in an emergency. This placed both patients and staff at risk.

The ward managers could not always adjust staffing levels according to the needs of patients. Whilst managers could request additional staff, these were not always provided so the shift continued with reduced staffing levels.

Patients did not always have a regular one to one session with their named nurse. Managers told us that other staff would provide a one-to-one session if the named nurse was not available.

The service had enough staff on each shift to carry out any physical interventions safely.

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

Handovers took place at the beginning of each shift

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The service had an on-call rota system for out of hours medical cover. Managers could call locums when they needed additional medical cover.

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

Inadequate

Forensic inpatient or secure wards

Mandatory training

Staff completed and kept up to date with their mandatory training. This was at 92% at the time of the inspection.

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

Ward managers monitored mandatory training via an easily accessible dashboard and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. However, they had not always achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed the risk assessments of 16 patients during the inspection.

Staff completed risk assessments for each patient on admission or very soon after, using a recognised tool. Patient risk assessments were reviewed regularly by the multi-disciplinary team and additionally after any incident.

Management of patient risk

Staff who were familiar with the wards knew about any risks to each patient. However, staff did not always act to prevent or reduce risks. Staff did not always carry out enhanced observations correctly. As a result, patients were left unsupervised for periods of time and came to harm. We found two examples of this on Willow ward resulting in patients requiring treatment at the acute hospital.

Staff did not always identify and respond to any changes in risks to, or posed by, patients. We reviewed an incident on Willow ward that occurred in July 2021 as a result of staff not following the patients care plan. The patient subsequently required emergency treatment at the acute hospital. We reviewed an incident on Willow ward that occurred in May 2021 where staff did not respond effectively when a patient refused food and then fluids. This resulted in the patient being admitted to the acute hospital for rehydration. The acute hospital raised this concern as a safeguarding for investigation.

Willow ward reported 35 incidents of patients self-harming whilst on enhanced observations from 1 April 2021 to 30 June 2021. Of the 35 incidents, 21 occurred when patients were on arm's length observations.

Staff could not observe patients in all areas of the wards. Staff did not always follow procedures to minimise risks where they could not easily observe patients.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patients were routinely searched on their return from leave.

Inadequate

Forensic inpatient or secure wards

Use of restrictive interventions

Levels of restrictive interventions were reducing.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques such as verbal de-escalation, distraction and Dialectical Behavioural Therapy. Staff restrained patients only when these failed and when it was necessary to keep the patient or others safe.

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

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. This included at least hourly monitoring of patients' physical health and vital signs until staff were assured that there were no concerns.

When a patient was placed in seclusion, staff did not always keep clear records or follow best practice guidelines. This was evidenced in an incident review which highlighted a lack of seclusion reviews and poor recording. Reviews on Willow ward were not always carried out or recorded in patient records for patients who were in seclusion.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

We saw evidence of blanket restrictions on Bracken ward. We reviewed the providers restrictive practice log which evidenced these restrictions were in place due to specific, individual patient risks on the ward at the time. However this meant patients could not make hot drinks and snacks independently of staff. All drinks were kept in the office and patients had to ask staff to make them. Patients could not access fresh air whenever they wanted, the courtyard was kept locked and patients had to ask staff to open it. This only took place when there was a staff member available to supervise. Patients could only vape three times each day and could not vape before bedtime.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. They were able to give clear examples of potential safeguarding issues and knew how to escalate this.

Staff kept up to date with their safeguarding training. The provider reported a compliance rate of 98% for level one and two safeguarding training and 93% for level three safeguarding training as of June 2021.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff described an improved relationship with the local authority safeguarding team and were in regular contact with them.

Staff followed clear procedures to keep children visiting the ward safe. The hospital social worker booked a suite on the ground floor to facilitate hospital visiting.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ward staff approached ward managers or the safeguarding lead if they needed to.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

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

Records were stored securely, either electronically or in the locked nurse's office.

Medicines management

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

We reviewed 17 prescription charts during the inspection.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Information was recorded on all prescription charts on patient allergies.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The pharmacist visited the wards bimonthly.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Track record on safety

The provider reported 721 incidents for this service between 1 April 2021-30 June 2021. Willow reported the most with 587, Maple reported the least with 20. The most common incident type was 'Self harm' accounting for 154 reported incidents.

Inadequate

Forensic inpatient or secure wards

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. They gave examples of incidents that happened and described how to record them on an electronic recording system.

Senior managers did not sign off incident reviews until actions plans were created to address recommendations. Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. We saw examples of this during the inspection.

Managers debriefed and supported staff after any serious incident. Managers contacted staff at home after their shift to check on their wellbeing and weekly reflective practice sessions focussed on specific incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. There was a monthly bulletin circulated to staff.

Staff met to discuss the feedback and look at improvements to patient care. These discussions took place at staff meetings.

There was evidence that changes had been made as a result of feedback. Managers gave the example of increased safety checks and improved documentation as a result of incidents.

Are Forensic inpatient or secure wards effective?

Requires Improvement

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

Assessment of needs and planning of care

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

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We saw evidence of this in patient records.

We reviewed 16 patient records during the inspection. Care plans were personalised, holistic, and recovery orientated, and patients were routinely offered a copy of their care plan.

Staff regularly reviewed and updated care plans when patients' needs changed.

Inadequate

Forensic inpatient or secure wards

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance including the National Institute of Health and Care Excellence. We saw in patients' prescription charts that medication health checks and medication levels were routinely checked.

Staff identified patients' physical health needs and recorded them in their care plans. Support workers facilitated healthy eating and cooking groups. Staff ensured that patients had access to physical health care, including specialists as required. One patient had sleep apnoea and the necessary equipment had been provided to monitor this.

Staff did not always meet patients' dietary needs, and correctly assess those needing specialist care for nutrition and hydration. We reviewed an incident from May 2021 where a patient on Willow ward was admitted to the acute hospital for treatment due to staff not responding to their needs.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included Health of the Nation Outcome Scales and Health of the Nation Outcome Scales secure.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used the results from audits to make improvements.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the wards. However, activities and therapies were routinely cancelled due to low staffing numbers and therapy staff having to provide cover on the wards. We saw evidence of activities being cancelled in community minutes on Willow ward.

Managers had not ensured that staff had the right skills and experience to meet the needs of the patients. New and inexperienced staff were being sent to Bracken ward to provide cover due to staff shortages. We observed this on 8 July 2021 and observed that staff had insufficient time to give new covering staff a handover.

Managers gave each new member of staff a full induction to the service before they started work. However, covering staff were not always familiar with working in secure forensic wards.

Managers supported staff through regular, constructive appraisals of their work. The provider reported a compliance rate of 100% for appraisals as of May 2021

We requested supervision data, which was not initially provided. However, we subsequently received data which reported a compliance rate in May 2021 of 75% for management supervision and 79% for clinical supervision.

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

Managers supported medical staff through regular, constructive clinical supervision of their work.

Team meetings took place regularly. Lessons learned were discussed at team meetings and reflective practice sessions but were not always embedded within teams or reflected in improved practice.

Managers identified any training needs their permanent staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure permanent staff received any specialist training for their role.

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

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early in the patient's admission to plan discharge.

Staff did not always provide clear information about patients to staff arriving part way through a shift to support the ward. However, staff made sure they shared clear information about patients and any changes in their care at shift handovers and within the weekly multi-disciplinary team meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Managers highlighted that they worked to improve relationships and communication with the local authority safeguarding team.

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

Staff fully understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

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

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

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

Staff couldn't always ensure that patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. This was due to routinely low staffing levels on the wards.

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

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

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Audits were routinely carried out by the Mental Health Act administrators.

Good practice in applying the Mental Capacity Act

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

Staff received and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. They could speak to qualified staff or contact the Mental Health Act Administrator on site for guidance.

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

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

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Inadequate

Forensic inpatient or secure wards

Are Forensic inpatient or secure wards caring?

Requires Improvement

Our rating of caring improved. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff had not always treated patients with compassion and kindness or respect patients' privacy and dignity.

A patient on Bracken ward was unable to get to the toilet in time due to a delay in staff assistance. Staff apologised to the patient about this incident.

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

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

Patients said that staff generally treated them well and behaved kindly.

Staff did not always appear to understand the individual needs of patients or support patients to understand and manage their care treatment or condition. This was evidenced when staff did not always provide enhanced observations as prescribed.

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

Staff followed policy to keep patient information confidential. Patient records were stored electronically or in lockable filing cabinets in the nurse's office.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. They were given orientation to the ward and to the systems and routines.

Staff involved patients and gave them access to their care planning and risk assessments. Patients were offered a copy of their care plan although many declined.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). This included daily provision of interpreters for two deaf patients on Maple ward.

Staff involved patients in decisions about the service, when appropriate.

Inadequate

Forensic inpatient or secure wards

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held weekly, and patients were invited to attend their multi-disciplinary team meetings.

Staff supported patients to make advanced decisions on their care.

Staff ensured that patients had easy access to independent advocates. We saw posters and leaflets and patients told us that the advocate regularly attended the ward.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with six carers during the inspection. All six gave positive feedback about the staff. Most said that they received good communication from the staff and that information was always forthcoming.

Staff helped families to give feedback on the service. There was an annual feedback questionnaire and carers were also invited to feedback at the carers' forum.

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

Are Forensic inpatient or secure wards responsive?

Good

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

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Bed management

Managers made sure bed occupancy did not go above 85%. The bed occupancy at the time of inspection was 73%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay was 634 days.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had two delayed discharges in the past year.

Managers monitored the number of delayed discharges.

The only reasons for delaying discharge from the service were clinical.

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality. However, not all patients could make hot drinks and snacks at any time.

Each patient had their own en suite bedroom, which they could personalise. We saw examples of this during the inspection where patients had their own duvet covers, photographs, posters and music collections.

Patients had a secure place to store personal possessions. We saw patients routinely accessing secure lockable lockers just off the wards.

The service had a full range of rooms and equipment to support treatment and care. This included a sensory room for patients who would benefit from its use, including those on the Autistic spectrum. Staff and patients could access the rooms.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. Some patients had mobile phones following an individual risk assessment.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients and staff that we spoke with told us about a local facility in which they could work in the kitchen, go to the coffee shop or make cakes.

Staff helped patients to stay in contact with families and carers. Most of the carers that we spoke with said that they had regular contact with the service and with their relative.

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

Meeting the needs of all people who use the service

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

The service supported and made adjustments for disabled people and those with communication needs or other specific needs. Staff ensured that two deaf patients had an individual interpreter throughout each day. A staff member who was deaf also had an interpreter working alongside them during each shift.

Wards supported disabled patients. All wards had disabled bedrooms and wide corridors for wheelchair access.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. This was displayed on each ward notice board.

The service had information leaflets available. Ward managers told us that these could be made available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters when needed. We saw evidence of this on Maple ward.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. This included, halal, kosher, vegan, vegetarian and gluten free.

Patients had access to spiritual, religious and cultural support. We saw that spiritual leaders visited the patients regularly and spoke with them during the inspection.

Listening to and learning from concerns and complaints

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

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

The service clearly displayed information about how to raise a concern in patient areas. A carer told us that they understood the complaints process and would feel confident to us it.

Staff understood the policy on complaints and knew how to handle them.

Managers shared feedback from complaints with staff through staff meetings, bulletins and supervision and learning was used to improve the service. We reviewed the lessons learned folder held on each ward.

Managers investigated complaints and identified themes.

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

Inadequate

Forensic inpatient or secure wards

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

Managers shared feedback from complaints with staff and learning was used to improve the service.

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

Are Forensic inpatient or secure wards well-led?

Inadequate

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Leadership development opportunities were available.

Vision and strategy

Staff knew and understood the provider's vision and values. However, staff did not always apply them in their teams.

The provider's vision was to Transform Lives Together. The values which underpin this vision and strategy were compassion; be supportive; understand and care for our patients, their families and all in our community. Accountability: take ownership; be proactive, be responsible, do what you say you will do. Respect: Act with integrity; be real, be open, be honest. Excellence: Innovate, learn and deliver; whatever you do, do it well. Staff knew and understood the provider's vision and values, but they were not always applied in the work of their teams.

Culture

The provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. Staff felt able to raise concerns without fear of retribution.

Staff often missed breaks and routinely worked on wards that were short staffed. However, they reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution. Staff were aware of the whistleblowing policy, where to find it and how to use it. However, staff did not always feel respected, supported and valued.

Governance

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

Some of the concerns raised at the previous inspection such as staffing, enhanced observations, dignity and respect to patients, patient's physical healthcare and blanket restrictions had not been fully addressed.

Inadequate

Forensic inpatient or secure wards

Staffing levels remained routinely low and the system in place for managing this was ineffective and placed patients and staff at risk. Senior leaders were aware of the staffing issues on all wards and had not acted upon this despite staff and ward managers having raised concerns and serious incidents occurring. Senior leaders acknowledged during the inspection that safe staffing levels had not been maintained.

The provider's data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

Senior leaders did not ensure that staff with sufficient skills, knowledge, and experience were provided for the women's forensic service. Staff were sent to provide cover when they had no experience of forensic wards and were newly in post.

Observations were not always carried out in line with patients care plans and risk and the provider did not have a robust system in place to ensure that this did not reoccur.

The provider did not investigate all incidents thoroughly and provide a clear action plan in order to learn from previous incidents and promote the embedding of change within the service.

Information management

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

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

Inadequate

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in nearly all areas of the wards. We found one blind spot in the bathroom on Church ward. We were told that this had been escalated to estates but no date was given as to when this would be resolved. Blind spots were mitigated by the installation of mirrors. We were told no patients use the shower in this bathroom where the blind spot was.

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

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

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff carried these on their belt and if activated pinpointed their location. Staff called for further assistance across the site using a radio.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. Dedicated domestic staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Seclusion room

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

Seclusion rooms did not meet all the guidance in the Mental Health Act Code of Practice. We viewed the seclusion rooms on all three wards. The blind to the seclusion room's window on Church ward was in the closed position. Staff were unable to open the blind at the time of our visit. The provider later told us the tool to operate the blind was kept in the nurses office.

When viewing the Oak ward seclusion room, we found that closed circuit television cameras were located in the bedroom and en suite areas in the seclusion suites. The viewing screens were located in the observation corridor outside. Staff told us the screens were switched on all the time therefore patients could always be seen. However, bathroom privacy would be individually risk assessed for each patient. Patients who had been in seclusion for a long time were able to personalise the area.

We viewed the seclusion room on Sycamore ward. We found that plaster was peeling off a wall in the bedroom area and there were stains on the wall and ceiling. Staff told us these stains were from blackcurrant juice.

We viewed the long term segregation area on Sycamore ward. This area consisted of a bedroom, en suite, lounge area and a small secure courtyard area for access to fresh air. There was an observation area where staff were provided with seating. The only storage the patient had was drawers located at the bottom of the bed.

Clinic room and equipment

Clinic rooms were fully equipped, with emergency drugs that staff checked regularly. Wards had access to resuscitation equipment.

Staff checked, maintained, and cleaned equipment.

Clinic room temperatures were not always below the recommended 25 degrees for the safe storage of medicines. The clinic room on Oak ward regularly had a temperature of 25.4 to 34.3 degrees centigrade. This was above the recommended temperatures for the safe storage of medicines. Staff told us this had been the same since the ward moved to the new location earlier this year, and pharmacy staff were aware but no action had been taken.

Safe staffing

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

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. We reviewed seven daily shift planners on Church ward from 1 July 2021 to 7 July 2021 which stated that that one patient had their enhanced observations reduced from 1:1 continuous observations to 15 minute intermittent observations on four separate occasions. We were told by staff and the patient this was due to staff shortages. We reviewed one daily shift planner on Oak ward which

stated that on the night shift of 1 July 2021 one patient had their enhanced observations reduced from 2:1 continuous observations to 1:1 continuous observations for four hours. We were told this was because the ward was below safe staffing numbers and a discussion was held with the bleep holder who made the decision to do this. We were told by 13 out of 17 members of staff that staffing was an issue and the wards were regularly short staffed.

The vacancy rate for staff varied across wards. Oak ward reported a vacancy rate of 51% for qualified staff as of 06 July 2021. For the same time period Church ward reported a vacancy rate of 11% for qualified staff. Sycamore ward reported no qualified staff vacancies. Oak ward reported a vacancy rate of 9% for unqualified staff as of 6 July 2021. For the same time period Sycamore ward reported no unqualified staff vacancies. Church ward over-recruited for unqualified staff by 36%.

The service increased its use of agency staff. Between 1 April 2021 and 30 June 2021 qualified agency staff covered 2% of available shifts for staff across the three wards. For the same period unqualified agency staff covered 3% of available shifts across the three wards.

The service increased its use of bank staff. Between 1 April 2021 and 30 June 2021 qualified bank staff covered 8% of available shifts for staff across the three wards. For the same period unqualified bank staff covered 32% of available shifts across the three wards.

The service was not able to fill all required shifts. Between 1 April and 30 June 2021, 45 shifts (25%) were not filled across the 182 shifts. The provider told us this represents less than 0.3% of the total planned shifts.

Managers told us they tried to request staff familiar with the service.

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

The service had low turnover rates. Between 1 April 2021 and 30 June 2021 Oak ward and Sycamore ward reported a turnover of 1%. Church ward reported no turnover for the same time period.

Managers supported staff who needed time off for ill health. Levels of sickness were high and increased across the three wards. Between 1 April and 30 June 2021 the provider reported an average sickness rate of 18% on Sycamore ward, 9% on Church ward and 8% on Oak ward. We spoke to one staff member who told us five staff were injured and needed hospital treatment in the first month of Sycamore ward opening.

Divisional leaders did not accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Due to the wards being short staffed, ward managers were regularly included in the staffing numbers to increase the number of nurses required for that shift.

Staffing levels did not allow patients to have regular one to one sessions with their named nurse.

Patients regularly had their escorted leave, or activities cancelled, due to the ward being short staffed. Eight staff told us they had to cancel patient escorted leave or cancel activities due to the wards being short staffed. Two patients told us they had their escorted leave or activities cancelled due to the wards being short staffed, only one of these patients told us this was then rearranged. Four patients told us the wards were short staffed. One patient said there was not a lot to do on the ward.

The service did not always have enough staff on each shift to carry out any physical interventions safely.

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

Medical staff

The provider reported a whole-time equivalent vacancy rate of 20% for doctors. Of the patients we spoke with, one patient told us that doctors are busy, and they can go for weeks without seeing a doctor.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. Permanent staff had an overall compliance rate of 94% across the three wards. Non-permanent staff had a compliance rate of 90% for June 2021.

The mandatory training programme was comprehensive but did not meet the needs of patients and staff. Learning disability and autism training was not mandatory for these wards and only two non-permanent staff completed the introduction to autism training from April 2021 – July 2021. Staff had not completed training in relation to learning disabilities.

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

Assessing and managing risk to patients and staff

Staff did not always manage risks to patients and themselves well. Staff did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. However, staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly electronically, including after any incident.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others.

Staff did not always act to prevent or reduce risks despite knowing the risks for each patient. Staff were not completing observation records in line with patients prescribed observation times or in line with provider policy.

Managers allocated staff to complete enhanced observations continually on Church ward for patients who required it for between three and ten hours on 33 occasions between 1 and 7 July 2021. Managers allocated staff to complete enhanced observations continually on Oak ward for patients who required it for between three and ten hours on 18 occasions between 3 and 8 July 2021.

Staff were allocated to complete enhanced observations for the same patient for between three and ten hours at a time on Church ward, on 13 occasions between 1 and 7 July 2021. We found that staff were allocated to complete enhanced observations for the same patient for between three and five hours at a time on Oak ward, on two occasions on 3 July 2021.

Staff had not carried out patients' observations at the intervals prescribed. We reviewed observation records for one patient from 2 July to 6 July 2021. We found that the intervals in between this patient's observations exceeded their prescribed observation interval three times. We reviewed observation records for another patient on 6 July 2021. We found that the intervals in between this patient's observations exceeded their prescribed observation interval six times. We reviewed observation records for a patient on 8 July 2021. We found that the intervals in between this patient's observations exceeded their prescribed observation interval of five minutes once for a period of 15 minutes.

We reviewed five patient observation records. We found staff observed at regular intervals for 44% of the time (187 hours out of 425 hours).

This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety. We found issues with the use of enhanced observations on Oak and Church wards we visited.

We observed two staff retrospectively completing observation records twice on 6 July 2021. We were told by one member of staff that although observations are carried out at the prescribed time, observations are sometimes signed in one go due to staff shortages and a lack of time.

Wards had blanket restrictions in place. Patients on Oak ward had to ask staff for a drink and did not have access to facilities to make their own without staff support. We were told if they were kept in the communal area they may be thrown during an incident or have would have to be moved should an incident occur in that area. Both Oak ward and Church ward had set vape times where the patients were able to vape in the courtyard. Patients on Oak ward had to ask staff for toilet roll each time they wanted to use the toilets in the communal areas.

Use of restrictive interventions

Levels of restrictive interventions were high but reducing. Between 1 April 2021 and 30 June 2021, the provider reported 311 incidences of restraint. Oak ward had 148 incidences of restraint while Church ward had 41 incidences of restraint. The use of restraint had reduced by more than half on these wards since our previous inspection. Sycamore ward had 122 incidences of restraint despite only having one patient on the ward.

Levels of prone restraint were high on Sycamore ward. Between 1 April 2021 and 30 June 2021 the provider reported 13 incidences of prone restraint on Sycamore ward. Oak ward and Church ward reported no incidences of prone restraint for the same time period.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

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

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. Between 1 April 2021 and 30 June 2021 the provider reported 11 incidences of administering rapid tranquilisation. The highest was on Sycamore ward (seven) followed by Oak ward (three) and then Church ward (one).

We reviewed data provided that indicated the use of seclusion had decreased over the last 12 months. Between 1 April 2021 and 30 June 2021, the provider reported there had been 100 instances of seclusion. The highest was on Church ward (38) followed by Oak ward (34). Sycamore ward reported 28 instances of using seclusion relating to one patient.

When a patient was placed in seclusion, staff did not always follow best practice guidelines. We reviewed the records of a patient who was currently being nursed in seclusion since 20 October 2020. On the day of our visit the patient was being supported to reintegrate with the patients on the main ward and also had a 'shared lunch' with the multidisciplinary team. We were unclear why this patient was not being nursed in conditions of long-term segregation. The notes indicated periods where the patient did not meet the definition of seclusion as defined in Mental Health Act Code of Practice. Section 26.103 states that 'seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others'. The records showed the patient was accessing fresh air depending on risk and engaging with the multidisciplinary team. The patient started to reintegrate with the main ward population and we saw evidence of the patient attending a community meeting. The patient's care plan stated '…plan to reintegrate patient slowly into the main area of the ward, as Oak does not have a long term segregation area that is robust enough for the patient and her challenges are still high'. The patient's care plan did not clearly state what needed to happen for seclusion to end. Staff used the term long-term segregation and seclusion interchangeably in the patient's progress notes.

We reviewed the seclusion paperwork of one Sycamore ward patient. We found the paperwork met some, but not all of the guidance in the Mental Health Act Code of Practice. For example, we were unable to find evidence of a medical review taking place within one hour or without delay if the patient is not known or there is a significant change from their usual presentation. We were unable to find evidence of an independent multidisciplinary team review taking place after the patient's eight hours of consecutive seclusion.

In relation to two Church ward patients being cared for in long-term segregation, staff followed guidance in the Mental Health Act Code of Practice.

We found clear rationale for the use of long-term segregation for a Church ward patient in the extra-care suite on Fenwick ward. However, we noted that long-term segregation would end when a suitable bespoke community placement was identified. Therefore, this meant the patient would remain in long-term segregation indefinitely. We reviewed minutes of an external review that took place in February 2021 and recommended that long term segregation was no longer proportionate and a plan should be in place to reintegrate the patient back on the ward. The multi disciplinary team discussed this recommendation and decided not to follow it due to concerns about the patient's risk to others and the impact on their anxiety levels. There was evidence of commissioner involvement and agreement with this decision.

When a patient was placed in long term-segregation, staff did not always follow best practice guidelines in the Mental Health Act Code of Practice. We reviewed the long-term segregation paperwork of a Sycamore ward patient. We found the roles of staff involved in the decision for long-term segregation were not recorded. The criteria to allow the patient's long-term segregation to end, including the interventions, was present in the records, however, there was no evaluation of the efficiency of the interventions or whether they were completed. In the patient's observation record, over three days, there were gaps in the recording amounting to 32 hours. There was no record of the daily responsible clinician's

review on ten occasions. There were no records of the weekly multidisciplinary team's review on six occasions. In a review by an independent senior professional, consideration had been given to move the patient to another ward, however, internal and external services declined this. A further review by an independent senior professional referred to the patient's plan towards community discharge, however, there was no information about this. At the time of inspection there was only one patient on Sycamore ward and they were being nursed under long term segregation. After the inspection the provider advised long term segregation would end when another patient was admitted.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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

Staff mostly kept up-to-date with their safeguarding training. Permanent staff across all three wards had a compliance rate of 96.8% for safeguarding level one and two training. Permanent staff on Sycamore ward had a compliance rate of 60% for safeguarding level three training. Permanent staff on Church ward had a compliance rate of 90.9% for safeguarding level three training and permanent staff on Oak ward had a compliance rate of 100% for safeguarding level three training. Non-permanent staff had a compliance rate of 93.1% for safeguarding children, young people and adults (Level 1 and 2) training in June 2021 and a 100% compliance rate for safeguarding level 3 training.

Staff could give clear examples of how to protect patients from harassment and discrimination.

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

Staff followed clear procedures to keep children visiting the ward safe. Each ward had a dedicated family visitors' room within the building which could be booked in advance so managers can ensure staff are available to attend.

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

Staff did not make safeguarding referrals when patients were cared for in long term seclusion. We found no evidence of this.

Managers did not take part in serious case reviews and make changes based on the outcomes. We found no evidence of this.

Staff access to essential information

Staff had easy access to clinical information. Staff maintained electronic high quality clinical records. However, paper copies were not always up to date.

Patient notes were comprehensive, and all staff could access them easily.

The service used a combination of electronic and paper records across both wards. The paper records on Oak ward were not up-to-date. We were told staff rely on the paper records to support patients safely and effectively. However, we could see the electronic records were regularly updated across both wards.

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

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. All patient medication administration charts are stored on an online computer system. One staff member told us this system does go down at times which causes issues with administering medications.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Clinical Excellence guidance.

Track record on safety

The provider reported 487 incidents for this service between 1 April 2021-30 June 2021. Oak reported the most with 219, Church reported the least with 76. Sycamore ward (with one patient) reported 192. The most common incident type was 'Physical aggression and violence' accounting for 242 reported incidents followed by self harm accounting for 188.

Reporting incidents and learning from when things go wrong

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

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

Staff raised concerns and reported incidents and near misses in line with provider policy.

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

Inadequate

Wards for people with learning disabilities or autism

The service had no never events on any wards. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Two patients told us they get feedback from these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Are Wards for people with learning disabilities or autism effective?

Requires Improvement

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

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of patients who would benefit. Care plans reflected the assessed needs, were personalised, holistic and strengths based. However, staff did not always involve families and carers.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients did not have their physical health assessed in a timely way on admission. However, patients regularly had their physical health reviewed during their time on the ward and had an up-to-date hospital passport. Staff ensured that they identified patients' physical health needs and recorded them in their care plans during reviews and made sure patients had access to physical healthcare, including specialists.

Staff did not always regularly review and update care plans and positive behaviour support plans when patients' needs changed. We reviewed 12 patient records. One positive behavioural support plan stated it should have been reviewed in January 2021 but had not been reviewed at the time of our inspection. Staff had not updated one epilepsy care plan since February 2020. However, staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Patient care plans did not always contain the right patient name on Oak ward. We found the wrong patient name written in patients' personal emergency evacuation plans four times and written in patient care plans once. We found the mental health act paperwork for one patient filed in another patients' online records.

Inadequate

Wards for people with learning disabilities or autism

Staff on Oak ward did not always have access to the most up to date patient care plans. All of the paper versions of the care plans we viewed on Oak ward were not the most up to date care plans as viewed on the patients' electronic record. We were told by two staff on Oak ward that staff relied on the paper versions of patient care plans rather than the electronic patient record. However, care plans were personalised, holistic and strengths-based.

Positive behaviour support plans were present and supported by a comprehensive assessment.

Best practice in treatment and care

The provider described the service as supporting patients with a learning disability and/or autism in a way that was person centred and addressing holistic needs, however staff did not always provide a range of treatment and care for patients based on national guidance and best practice for this service. Staffing shortages meant that access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation was at times, limited. Staff supported patients with their physical health and encouraged them to live healthier lives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff did not always provide a range of care and treatment suitable for the patients in the service. There was a comprehensive therapy timetable available which staff were unable to carry out on Oak ward due to multidisciplinary staff being counted in numbers on the ward as the ward was so short staffed. We were told by eight out of 17 members of staff across both wards, that multidisciplinary staff were regularly required to work within the ward numbers, and this had been requested by the senior management team. This meant that patients missed out on having regular therapies. Three members of staff told us it was now an expectation of the senior management team to work within the ward numbers but they were also being challenged by the senior management team to continue providing therapies at the same time, which was not always possible. Staff told us they felt there was not enough importance put on therapies by the senior management team. The multidisciplinary team on Church ward were not counted in staffing numbers as often and so patients received more therapies on this ward. We reviewed 14 community meeting minutes for Church ward and Sycamore ward. It had been documented in eight of the community meeting minutes that patients said that they missed out on all or some of their therapy sessions due to short staffing.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg National Institute for Health and Care Excellence).

Staff understood patients positive behavioural support plans and provided the identified care and support.

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

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients.

Managers took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

Managers did not always ensure staff had the range of skills needed to provide high quality care, or offer opportunities to staff to update and further develop their skills. However, the ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers supported staff with appraisals. Managers provided an induction programme for new staff.

The service had access to a full range of therapy staff. However, managers did not make sure all staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including non-permanent and agency staff. Managers did not make sure staff received any specialist training for their role. We were told that non-permanent staff were split into divisions across the hospital and the learning disability and autism division covered Oak and Church wards. We were told that non-permanent staff in the learning disability and autism division did not require learning disability or autism training. This meant that staff could be working with patients without the knowledge or skills to support patients with their required needs.

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

Managers supported most staff through regular, constructive appraisals of their work. As of 24 May 2021, the overall appraisal rate for staff within this service was 80%. The ward with the lowest appraisal rate was Oak ward with an appraisal rate of 70%. Church ward had an appraisal rate of 80% and Sycamore ward had an appraisal rate of 90%.

We requested supervision data, which was not initially provided. However, we subsequently received data which reported a compliance rate in May 2021 of 83% for management supervision and 67% for clinical supervision.

Managers did not make sure staff attended regular team meetings. We were told as the wards were short staffed, team meetings did not happen as regularly as they should. We did not see any evidence of recent team meetings on Oak ward.

Managers did not always give staff the time and opportunity to develop their skills and knowledge. Three staff told us that training regularly had to be cancelled due to staffing shortages on the wards.

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

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Inadequate

Wards for people with learning disabilities or autism

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Permanent staff across all three wards had a compliance rate of 92.7% for Mental Health Act, Mental Capacity Act and Deprivation of Liberty training. Non-permanent staff had a compliance rate of 84.7% for Mental Health Act, Mental Capacity Act and Deprivation of Liberty training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

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

Staff could not always facilitate patients taking section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Eight staff told us if the wards were short staffed, staff were unable to facilitate patient escorted leave. One carer told us there had been times when patient section 17 leave hasn't been supported due to staff shortage or the patient had an incident and their leave was cancelled.

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

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

Patient's Mental Health Act detention paperwork was not always clear. We looked at the Mental Health Act detention paperwork of one patient. On the patient's "Section 20 – renewal of authority for detention" (Form H5) that profession of the person being consulted had been omitted (part one of the form). In part two of the same form, the profession was entered as "SSN". Whilst we were aware this meant "senior staff nurse", other readers may not be aware of this. We discussed this with the provider's mental health law team leader. However, the detention paperwork was complete and appeared to be in order.

Good practice in applying the Mental Capacity Act

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

Inadequate

Wards for people with learning disabilities or autism

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Permanent staff across all three wards had a compliance rate of 92.7% for Mental Health Act, Mental Capacity Act and Deprivation of Liberty training. Non-permanent staff had a compliance rate of 84.7% for Mental Health Act, Mental Capacity Act and Deprivation of Liberty training.

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

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

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

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

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

Are Wards for people with learning disabilities or autism caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

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

Not all patients said night staff treated them well and behaved kindly. Three patients on Church ward told us night staff were rude. One patient on Church ward told us that she had sworn at staff and they had sworn back at her. One patient on Church ward told us that night staff ignore them. One patient on Church ward told us that night staff sometimes come in chewing gum. Two patients on Church ward told us that night staff bring their mobile phones onto the ward and use them. One staff member told us she had seen night staff on Oak ward use their mobile phone on the ward. Mobile phones and chewing gum are contraband items on the wards. One patient told us on Church ward and two patients on Oak ward told us that night staff fall asleep on night shifts whilst doing their enhanced observations. We raised these concerns with senior managers who told us they would look into them and provide more detail and what had been done the following day but this was not provided.

Staff did not always consider patients' dignity when in seclusion. If patients were secluded for a prolonged period on Oak or Sycamore wards, they were expected to use the mattress, floor or their laps to eat. We were concerned that this potentially could compromise patients' dignity.

One carer told us not all staff treat their relative with respect.

Day staff were discreet and respectful when caring for patients. We observed day staff treating patients with respect, kindness and dignity. We spoke with one patient (with two staff present). The patient told us the staff were good and she saw her doctor every day. The patient was complimentary about the independent mental health advocate and told us she was supported on the telephone and more recently face to face contact restarted. Staff supported her to get fresh air and keep in touch with her family.

Staff were not always responsive to patient needs. One staff member told us that a patient had to wait for personal care as they were busy with another patient and the ward was short staffed. Two patients on Oak ward told us night staff denied them a drink during the night. One patient told us she had been denied a drink because night staff were asleep.

Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition.

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

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

Staff followed policy to keep patient information confidential.

Involvement in care

Staff tried to involve patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff sat with patients to get their input into their care plan, however the design and layout of care plans did not reflect the needs of people with a learning disability and/or autism. Two patients told us they did not have a copy of their care plan and one patient specifically said they would like a copy.

Not all staff had access to the appropriate communication resources to enable effective communication and to support patients to understand their care. We witnessed staff trying their best, but therapy staff had sole access to the resources required.

Staff involved patients in decisions about the service, when appropriate. Staff sought patient views during a relocation of the service to design the environments of the new wards.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff introduced patients to the ward and the services as part of their admission.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Inadequate

Wards for people with learning disabilities or autism

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

Staff did not always support, inform or involve families or carers. Two carers told us they had not been invited to attend any of their relative's meetings.

Staff helped families to give feedback on the service and followed the principles of Ask, Listen, Do in relation to feedback, concerns and complaints.

Staff did not always give carers information on how to find the carer's assessment. Three carers told us they had never received any information about a carer's assessment.

Are Wards for people with learning disabilities or autism responsive?

Requires Improvement

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

Access and discharge

Staff planned and managed discharge well. Staff liaised well with services that would provide aftercare. Discharge was rarely delayed for other than a clinical reason. However, some patients had excessive lengths of stay.

Bed management

We reviewed bed occupancy rates from June 2020 to June 2021. The bed occupancy rate for Church ward was 105%. The bed occupancy rate for Oak ward was 91%. The bed occupancy rate for Sycamore ward was 25%.

We reviewed patient's average length of stay from June 2020 to June 2021. Patient's average length of stay on Oak ward was 1667 days. Patient's average length of stay on Church ward was 1134 days. Sycamore ward opened in April 2021, therefore no patients had been discharged.

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had low numbers of delayed discharges in the past year. Oak ward had four delayed discharges. Church ward had one delayed discharge. No patients had been discharged from Sycamore ward.

The only reasons for delaying discharge from the service were clinical.

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

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The service had not fully responded to the needs of patients with autism in the ward environment. The design, layout, and furnishings of the ward did not always support patients' treatment. Not all patients could make hot drinks and snacks at any time. However, each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were some quiet areas for privacy. The food was of good quality.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and had access to a room where patients could meet with visitors in private.

The service had not fully responded to the needs of patients with autism in the ward environment. Patients on Oak ward did not have access to a sensory room. There was a room allocated to this and the sensory equipment was on site, but we were told due to COVID-19 the work required for the room to be used had been delayed. Patients on Church ward had access to a sensory room and we spoke to patients who told us they had been involved in painting the room, but the room was not yet fully furnished. However, patients on both wards did have access to sensory equipment they could use.

One staff member told us the ward was noisy.

Patients could make phone calls in private.

Patients could not freely access the outside space on Oak ward. The door was kept locked unless a patient asked to access this area. Four staff on Oak ward told us that patient access to fresh air was dependent on staff availability. Patients told us they were able to access outside areas when they wanted. Church ward had an outside space that patients could access easily.

Patients still could not make their own hot or cold drinks and snacks and were dependent on staff to make these for them on Oak ward. Patients on Church ward could make their own and had access to hot and cold drinks and snacks.

The service offered a variety of good quality food.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients told us about their education and work commitments.

Staff helped patients to stay in contact with families and carers.

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

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff devised communication plans for patients with communication needs. Staff used social stories and easy read versions of information to support patients.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service could access information leaflets in multiple languages and formats to meet patients' communication needs.

Managers made sure staff and patients could get help from interpreters when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

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

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

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints.

We were unable to find evidence that complaints were formally analysed to identify themes, trends and identify lessons learned. Complaints were recorded separately in individual patient files so there was no oversight of complaint trends.

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

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

Inadequate

Wards for people with learning disabilities or autism

Managers shared feedback from complaints with staff but two patients told us they did not always get updates from their complaints.

Are Wards for people with learning disabilities or autism well-led?

Inadequate

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

Leadership

Senior managers did not always have a good understanding of the services they managed. Senior managers were not always visible in the service or approachable for patients and staff. However, ward leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Not all staff and patients knew who the senior managers were. Senior managers are managers above ward manager level. We were told senior managers rarely go onto the wards unless Care Quality Commission staff are inspecting them. Five staff told us senior managers do not listen to them when they tell them the wards are short staffed and when this is reported to senior managers they get questioned as to the accuracy of this information. However, staff told us ward managers were very visible and they could approach them with any concerns.

Ward managers had the right skills and abilities to run a service. They understood the service they managed.

Vision and strategy

Staff knew and understood the provider's vision and values. However, staff did not always apply them in their teams.

Staff knew and understood the providers vision and values and the hospital's leadership team had communicated these to staff, but staff did not always apply them to their work.

Culture

Not all staff felt respected, supported and valued by senior managers. Not all staff felt they could raise any concerns without fear of retribution from senior managers. Senior managers are managers above ward manager level. The service did not always provide opportunities for development and career progression. However, staff felt respected, supported and valued by the ward managers. staff felt they could raise any concerns without fear of retribution from the ward managers.

Seven staff across both Oak and Church wards did not know what a closed culture was. Care Quality Commission inspectors explained the meaning of this to staff despite senior managers saying they worked with staff on this. Two staff told us that they felt there was a closed culture across the learning disability division once they understood it's meaning.

Not all staff felt respected, supported and valued by senior managers. However, staff told us they felt respected, supported and valued by ward managers.

Staff did not feel able to raise concerns without fear of retribution from senior managers.

Staff knew how to use the whistle-blowing process if they needed to.

We saw numerous certificates in the office on both wards that staff success was celebrated in line with the provider's vision and values and staff received certificates monthly. Patient success was also celebrated in weekly community meetings and we saw patients receive certificates for their weekly achievements.

Governance

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

Although senior managers ensured there were structures, processes and systems of accountability for the performance of the service, senior managers did not appear to support staff even when these systems showed consistently staffing was an issue across the wards. We viewed monthly governance minutes from April 2021 to June 2021 which stated there were staffing issues across all wards. The same concerns were discussed each month with no outcome or solution.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

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

The providers data was not always accurate. For example, we requested the provider send us the data to reflect how many patients used long-term segregation between 01 April 2021 and 30 June 2021. The provider reported one use of long-term segregation on Oak ward. The provider reported no use of long-term segregation on Church ward or Sycamore ward. Despite this, at the time of our inspection we saw two patients in long term segregation on Church ward who had been in long-term segregation for several months. Executive leaders told us they were not able to capture accurate staffing data.

Management of risk, issues and performance

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

Senior managers did not effectively manage ward performance despite using systems to identify, understand, monitor, and reduce or eliminate risks. We saw evidence in governance meeting minutes of these risks being escalated but we saw no evidence of an outcome to these.

Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Information management

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

Staff had access to the equipment and information technology needed to do their work.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

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

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

Wards were not always safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff did not always complete and regularly update thorough risk assessments of all wards areas and remove or reduce any risks they identified.

The Ashby ward environmental risk assessment was last updated in December 2020 and had not been updated to reflect restrictions currently in place around locking the toilet and garden doors. The assessment did not mention concerns around the stairwell next to the lift which was open and required blocking in for the safety of the patient acuity mix on the ward. However, staff routinely updated Naseby and Upper Harlestone environmental risk assessments.

Staff could observe patients in all parts of the wards.

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

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

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

Maintenance, cleanliness and infection control

Ward areas were not always clean, well maintained, well-furnished and fit for purpose. Patients and carers told us there has frequently been issues with toilets blocking, shower heads spraying and light bulbs in bedrooms needing replacing. One patient told us that there had been a shower blocked in their room for up to three months, which constantly flooded the bedroom, but no one could come out to repair it due to COVID-19.

Staff made sure cleaning records were up to date.

Staff followed infection control policy, including handwashing.

Seclusion room

The seclusion room was on Naseby ward, with direct access from Ashby ward and was shared across the service, it allowed clear observation and two-way communication. It had a toilet in the connected extra care suite and there was a clock.

Clinic room and equipment

Clinic rooms were not fully equipped with accessible resuscitation equipment and emergency drugs. The resuscitation equipment and emergency drugs from Ashby was shared between wards and we were concerned staff would not always have easy access.

Staff checked, maintained, and cleaned equipment.

Safe staffing

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

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. We reviewed staffing levels across Ashby ward for the previous 28 days prior to our site visit on 6 July 2021., During the day shifts only six out of the 28 days were staffed at optimum levels. We interviewed 13 multi-disciplinary team staff and they told us they were allocated to frontline shift work due to staff shortages as often as one full day a week.

We spoke with 33 staff of all grades and levels beneath management across Ashby, Naseby and Upper Harlestone wards who told us that staffing levels are constantly short. Staff described working over their hours to complete work, not having time to eat lunch and staying after their shift ended as there were no qualified staff on the next shift. Three nurses from Ashby and Upper Harlestone wards told us it is difficult to plan the day as there is not always enough restraint trained staff on shift. Staff on Upper Harlestone told us that there is always less staff on the ward at the end of the day due to staff being moved to support other wards. We observed at one point on Upper Harlestone ward that there was only one qualified staff on shift with no team leader or ward manager. Staff advised there should be three qualified staff on shift.

Patients on Ashby ward told us “they did not feel safe due to staffing levels, staff did not get a break and they are pushed to the limit”. Patients told us that there is not enough staff to manage incidents as they occur. They told us that staff are often injured. One patient told us there was a lack of staff to monitor the ward which meant she was afforded the opportunity to cause herself harm. We observed two staff members being injured on Ashby ward, one needed to go to accident and emergency.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The vacancy rate for staff varied across wards. The provider reported a qualified vacancy rate of 16% as of July 2021. Thornton reported the highest rate at 15% and Naseby the lowest at 0%. The provider reported a vacancy rate of 11% for unqualified staff. Thornton reported the highest at 35% and Upper Harlestone reported the lowest vacancy rate with a fill rate of 104%.

The service reduced its use of agency staff. The provider reported agency staff were used to cover 1% of all shifts between 1 April 2021-30 June 2021.

The service increased its use of bank staff. The provider reported bank staff were used to cover 19% of all shifts between 1 April 2021-30 June 2021.

Managers told us they tried to request staff familiar with the service.

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

The service had low turnover rates. The provider reported a turnover rate of below 1% between 1 April 2021-30 June 2021. When staff moved it was often to a different area within the provider. Staff told us they have been forced to move wards.

Levels of sickness were average. The provider reported a sickness rate of 8% of between 1 April 2021-30 June 2021. This was highest on Upper Harlestone and Ashby ward with 9% and lowest on Thornton ward with 5%.

Managers did not always support staff who needed time off for ill health. Staff told us that on returning to work after an incident on the previous shift they were not asked how there were and no return to work interview was done, other staff told us they had not been supported after returning from long term sick, one staff member had to cancel appointments with occupational health on two occasions due to staff shortages on the ward.

Managers could not accurately demonstrate how many staff were on shift. Nurses and healthcare assistants could be moved to a different ward throughout a shift, and they were reliant on the bank team managers updating the system in a timely manner to reflect this.

The ward manager could adjust staffing levels according to the needs of the patients, but they were not always able to access the additional staff they required.

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

Patients and staff told us on escorted leave and activities were cancelled due to the service being short staffed. We spoke with eight patients and 15 carers and five told us that activities and leave were cancelled. On Ashby ward two patients and two staff told us there was no activity at weekends.

The service did not always have enough staff on each shift to carry out physical interventions safely. Qualified nurses told us when they look at planning the day, they did not always have enough restraint trained staff on shift. Three nurses from Ashby and Upper Harlestone wards told us although they try not to put staff on back to back observations this sometimes happens due to staff shortages.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Mandatory training

Not all staff completed and kept up to date with their mandatory training. The provider reported a mandatory training rate of 96% for the Women's long stay rehabilitation service as of 5 July 2021. The provider reported compliance of 75% or below for the following courses and wards- Safeguarding level 3: Ashby- 70% and Thornton- 71%. Immediate life support/identifying a deteriorating patient- Thornton- 71%. Effective record keeping: Ashby- 64% and Thornton- 75%.

Bank and agency staff were not always restraint trained. Two staff told us they did not always have time on shift to complete their mandatory training.

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

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

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. They did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion prior to de-escalation.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool. Risk assessments available to review on inspection had not been updated after each incident. Healthcare assistants did not consider risk assessments to have anything to do with them. However, following the inspection the provider supplied risk summaries for seven patients.

Management of patient risk

Staff did not always know about risks to each patient, staff did not always act to prevent or reduce risks. We reviewed 12 records and risk assessments were updated routinely but were not updated after each incident. Staff could not find the most up to date information when they needed it. Staff could not identify and respond to changes in risks to, or posed by, patients. We reviewed an incident where it stated on handover that a patient should be put in secure clothing overnight, staff did not do this and as a result there was a serious incident.

Ashby ward reported 142 incidents of patients self-harming whilst on enhanced observations from 1 April 2021 to 30 June 2021. Of the 142 incidents, 115 incidents occurred when patients were on arm's length observations. Upper Harlestone ward reported 135 incidents of patients self-harming whilst on enhanced observations from 1 April 2021 to 30 June 2021. Of the 135 incidents, 106 incidents occurred when patients were on arm's length observations. An incident occurred during the inspection whereby staff did not observe a patient as prescribed resulting in the patient self harming and requiring emergency medical treatment.

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Use of restrictive interventions

Levels of restrictive interventions were high on all wards and staff applied blanket restrictions around vaping times, laundry rotas and toilets access. On Ashby and Upper Harlestone ward there was not free access to the courtyard. On Ashby ward patients were not able to freely access hot and cold drinks. The provider supplied evidence from 1 July 2021 that showed restrictive interventions were reviewed in daily huddles.

The provider reported 1,016 restraints between 1 April 2021-30 June 2021. Naseby reported the most with 496. Thornton reported the fewest with one. Of the 1,016 restraints 25 were prone restraints, 11 of these were on Naseby ward.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff had not made every attempt to avoid using restraint by using de-escalation techniques. Patients and carers told us that staff did not always use de-escalation prior to use of restraint, one carer told us the staff "are hands on and did not try and de-escalate and they did not explore least restrictive option, prior to going straight to restraint".

Staff did not always follow National Institute of Clinical Excellence guidance when using rapid tranquillisation. The provider reported 239 uses of rapid tranquillisation between 1 April 2021-30 June 2021; 91 on Naseby, 90 on Ashby and 58 on Upper Harlestone. Staff did not always monitor patients' physical health following the administration of rapid tranquillisation.

The use of seclusion was reducing. The provider reported 25 seclusion incidents between 1 April 2021-30 June 2021. Ashby ward reported the most with 22 and Naseby reported three.

Staff did not always keep clear records or follow best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in seclusion. We reviewed records for two episodes of seclusion for a patient on Ashby ward who was secluded in Naseby ward's seclusion room. We found the paperwork met some, but not all the guidance in the Mental Health Act Code of Practice. Staff had not documented what the patient had taken into the seclusion room. We were unable to find evidence of an independent multidisciplinary team review taking place after the patient's eight hours of consecutive seclusion. In the care plan relating to one episode of seclusion, there was no plan as to how the patient's needs were to be met, how de-escalation attempts would continue and how risks would be managed. Staff recorded "encourage patient to come up with a plan".

The provider reported one incident of long-term segregation between 1 April 2021-30 June 2021, this was on Ashby ward.

Staff did not always keep clear records or follow best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. We reviewed the long-term segregation paperwork of an Ashby ward patient who was in long-term segregation on Naseby ward. We found the paperwork met some, but not all of the guidance in the Code of Practice. For example, over a period of seven weeks, there was no evidence of the patient's situation being formally reviewed by an approved clinician in any 24-hour period on five days. In the same period, we were unable to find evidence of two reviews taking place on a weekly basis by the full multidisciplinary team. There was no evidence of a periodic review by a senior professional who was not involved in the patient's case.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff completed training on how to recognise and report abuse.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The provider reported the following rates for level three safeguarding training; Ashby ward 70%, Naseby ward 87% and Upper Harlestone 78%. However, staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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

Safeguarding referrals were made by the social workers on each ward, staff knew who to inform if they had concerns. Staff told us on occasions safeguarding reports can be late due to social workers and social worker assistance being brought into ward staffing numbers to support the ward.

Managers did not take part in serious case reviews and make changes based on the outcomes. We found no evidence of this.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were available, and all staff could access them easily.

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

Records were stored securely.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines. Staff told us as there is only one nurse after 17.00, they are required to call a qualified nurse from another ward if drugs needs dispensing. Medics told us on occasions they have been called to support with dispensing drugs due to nurse shortages.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were not in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Ashby ward reported high use of rapid tranquillisation, on average, 25 incidents a month. Staff did not review the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance. We reviewed care records of three patients on Ashby ward following the administration of rapid tranquillisation. Staff had not recorded physical observations following the use of rapid tranquillisation.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Track record on safety

The provider reported 1,343 incidents for this service between 1 April 2021-30 June 2021. Naseby reported the most with 570, Thornton reported the least with 31. The most common incident type was 'Self harm' accounting for 632 reported incidents.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service.

Staff told us they knew what incidents to report and how to report them. Staff told us they have access to the provider's reporting system, and they know how to report incidents. However, staff did not always report serious incidents in line with provider policy. We reviewed the incident report for an incident witnessed by the inspection team and staff had not accurately reported the incident.

We observed local and divisional huddles where incidents were discussed and reviewed incident reports. We found discrepancies in how they were reported. Staff told us that serious incidents are downplayed by managers. Staff told us incidents are not always reported straight away, and that incidents are not being documented thoroughly.

Managers did not always debrief and support staff after any serious incident, Staff told us that they did not always receive feedback from incidents. Staff had not always been supported by managers. Staff told us that debriefing after incidents was not happening currently due to staffing shortages. Staff told us they did not always receive feedback from investigation of incidents.

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

Inadequate

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

Staff did not always assess the physical health of all patients on admission. However, they assessed the mental health of patients and developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed mental health needs but care plans were not always personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Staff did not complete physical health assessments on all patients on admission or soon after. Staff reviewed most patients' physical health during their time on the ward. We reviewed 14 sets of care records; staff had updated patient's physical health records in 13 records. Staff had not updated one record for over two months.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. However, staff did not regularly review and update care plans when patients' needs changed. Staff had not updated one patient's care plan for over three months. Staff had not updated a care plan for nutrition for three months for a patient requiring nasogastric feeds. Out of the 14 care plans reviewed, seven were not always personalised, holistic and recovery orientated.

Best practice in treatment and care

The provider described the service as specialist rehabilitation, however staff did not always provide a range of treatment and care for patients based on national guidance and best practice for a rehabilitation service. This did not always include support for self-care and the development of everyday living skills and meaningful occupation. Staff did not always support patients with their physical health and living healthier lives. However, staff provided psychological therapies and used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Ashby, Naseby and Upper Harlestone wards provided a dialectical behavioural therapy service for patients with a diagnosed emotionally unstable personality disorder. Thornton ward offered slow stream rehabilitation for women.

Staff did not always provide a range of care and treatment suitable for the patients in the service.

Staff did not always deliver care in line with best practice and national guidance (from relevant bodies e.g. National Institute for Health and Care Excellence).

Staff did not always identify patients' physical health needs and recorded them in their care plans. Staff did not always make sure patients had access to physical health care, including specialists as required. We reviewed care records for 14 patients. On Upper Harlestone staff did not complete physical observations as required. Staff on Ashby ward did not record neurological observations for patients following episodes of head banging on 46 occasions in June 2021. We reviewed care records of three patients on Ashby ward following the administration of rapid tranquillisation. Staff had not recorded physical observations post administration. Patients could be exposed to the risk of harm if they did not receive the necessary monitoring.

Staff did not always meet patients' dietary needs and assess those needing specialist care for nutrition and hydration. We reviewed care records on Naseby ward where a patient on a nasogastric tube and another patient who had shown deterioration in her blood results had not seen a dietician for over two months. On Upper Harlestone staff missed one nasogastric tube feed for a patient over the last two months.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. However, On Upper Harlestone, since moving in July 2020, staff have not provided suitable storage in patients' bedrooms for self-medicating patients and they are still required to request their medication via the clinic room.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Teams used Health of the Nation Outcome scales, physical health assessments and recognised occupational therapy assessment tools. On Upper Harlestone ward staff used 'Management of Really Sick Patients with Anorexia Nervosa' (MARZIPAN) to monitor and assess patients.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff took part in clinical audits, benchmarking and quality improvement initiatives, the dietician from Upper Harlestone ward was part of the East Midlands eating disorder network, and routinely attended external training and shared the information with the team.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. However, managers did not always support staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward.

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

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

Managers did not always support staff through regular, constructive appraisals of their work. Staff told us that there is no routine feedback mechanism between ward managers and bank staff managers, so unless they identify an issue with the bank staff member it is not fed back. Managers did not always support non-medical staff through regular, constructive clinical supervision of their work. Bank staff told us that they did not have routine supervision or appraisals, after their initial three months review.

We requested supervision data, which was not initially provided. However, we subsequently received data which reported a compliance rate in May 2021 of 98% for management supervision and 75% for clinical supervision.

Managers did not make sure staff attended regular team meetings. Staff told us due to being short staffed meetings did not always take place, and they were not always free to attend. Managers gave information to those who could not attend. Managers told us they gave staff the option of attending team meetings virtually.

Managers identified any training needs for permanent staff, however, staff told us they do not always have the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance in permanent staff and could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines did not always work together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients. However, staff did not always make sure they shared clear information about patients and any changes in their care, including during handover meetings.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Permanent staff across all wards had a compliance rate of 93% for Mental Health Act training.

Patients did not always have easy access to information about independent mental health advocacy. Staff told us that St Andrews Healthcare had a recent change of advocacy providers and staff on Ashby ward were unclear how to access the new service, staff told us there had been lack of advocacy support over the COVID period.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

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

Staff did not always make sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Patients, carers and staff told us that section 17 leave was cancelled due to staff shortages.

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

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

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Permanent staff across all wards had a compliance rate of 93% for Mental Capacity Act and Deprivation of Liberty training.

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

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

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

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

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were not always compassionate and kind when caring for patients. We observed on Ashby ward a patient in distress due to noise coming from another patient in the extra care suite. Staff turned up the music channel, but no one attempted to support the distressed patient.

We observed a patient in distress whilst in seclusion on Ashby ward, the patient was banging their head on the wall. The staff member observing the patient made no attempt to intervene or support the patient with their distress. We noted this continued when we re-visited the seclusion area later in the day. We raised this to the provider as an immediate concern.

We reviewed seclusion records for a patient on Ashby ward and staff documented on one occasion that, "… continues head banging hard on the seclusion door", however, there was no evidence as to how staff intervened in this situation.

A patient on Ashby ward stated, "staff can be dictators, and treat us like children, other staff cannot cope, and they are a nightmare". She stated what she says to the staff falls on "deaf ears". Another patient from Ashby ward told us that some night staff tried to de-escalate situations, but most immediately turned to rapid tranquillisation. One carer told us the system felt punitive rather than encouraging and rewarding. One carer told us her daughter had been refused her visit after an incident. This upset her as she was not aware her mum would be visiting.

Staff did not always respect patients' privacy and dignity. Patients and carers from Ashby ward told us the toilets were often blocked, one patient told us she asked three times to go to the toilet but was told she would have to wait until she could go up to her room. Another carer told us a patient waited 45 minutes to gain access to a toilet after she requested to go. Patients told us they felt they were a burden when they requested to go to the toilet. Another patient told us she frequently waited up to 15 minutes to gain access to a toilet after she has requested to go.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff on Naseby and Upper Harlestone wards supported patients to understand and manage their own care treatment or condition. Patients told us there are some "good" and "fantastic staff", but they get "pushed to the limit."

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment, staff did not always actively seek patient feedback on the quality of care provided. They did not always ensure that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff made sure patients understood their care and treatment.

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were chaired by patients and patients set the agenda. We reviewed community meeting notes where patients raised concerns and they had been appropriately actioned. However, in six meetings between May and June 2021 patients reported the same maintenance concerns and food issues. Although staff escalated these issues there were delays in addressing them.

Managers did not always make sure patients could access advocacy services. The provider recently changed their advocacy provider and staff on Ashby ward were unclear how to access the new service, staff told us there had been lack of advocacy support over the COVID period either in person or virtually.

Involvement of families and carers

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

Staff support, information and involvement for families or carers was inconsistent. Carers told us that contact from staff was erratic, sometimes they would receive several calls a week and then not have contact for extended periods of time. Staff told us families are not involved in patient care.

Staff did not help families to give feedback on the service.

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

Inadequate

Our rating of responsive went down. We rated it as inadequate.

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Data provided for Ashby ward showed bed occupancy at 89%. Upper Harlestone was 69% and Naseby was 63%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay for Ashby ward was 832 days, Naseby ward 860 days and Upper Harlestone 437 days.

Managers and staff worked to make sure they did not discharge patients before they were ready.

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

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had a low number of delayed discharges in the past year. There was one delayed discharge for Ashby ward.

Managers monitored the number of delayed discharges.

The only reasons for delaying discharge from the service were clinical.

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

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality, patients could not always make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private, although the public phones in each ward were not available at the time of our visit due to phone leads being a risk to patients.

The service had an outside space, on Ashby and Upper Harlestone ward this was locked, on Naseby ward there was open access.

Patients could access hot drinks on Naseby and Upper Harlestone but had to request access on Ashby ward. Fruit was available on Ashby for patients without staff access, however, on Upper Harlestone snacks were monitored and there were specific times they could access them.

The service offered a variety of good quality food. However, we reviewed community meeting notes which highlighted requests for pure juice at breakfast which was raised at several meetings prior to it being actioned.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients although during the COVID period this diminished.

Staff helped patients to stay in contact with families and carers.

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

Meeting the needs of all people who use the service

The service did not meet the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could not always support and make adjustments for disabled people.

The service inclusion criteria states, "The unit is able to meet the needs of women with moderate or transient physical disability and concurrent physical health problems (e.g. epilepsy, diabetes). Certain physical limitations may preclude the acceptance of a patient unable to use stairs". The service accepted patients to Ashby and Upper Harlestone ward who used a wheelchair. Staff had not made reasonable adjustments to ensure the patients could evacuate in an emergency. We reviewed one patient's emergency evacuation plan which stated that an emergency rescue and evacuation aid mat would be used to bring her down the stairs. At the time of our inspection the service did not have the required evacuation aid mat. They did however have an evacuchair available which was locked in a cupboard at the top of the stairs. Staff stored the keys downstairs in an office at the other end of the ward. Staff had not received Evacuchair training and were unaware of the key location. Managers could not assure us that staff trained to use the evacuchair worked on every shift. Staff on Upper Harlestone ward described the evacuation plan for wheelchair users was to take the patient through the upstairs corridors to Ashby ward. This required passing through many locked doors. We were not assured that in the event of an emergency staff would have the right knowledge and equipment to support patients to safety.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Listening to and learning from concerns and complaints

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

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

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

We have requested information from the provider around compliments and complaints, but we have not received this.

Managers did not always share feedback from complaints so staff could learn and to improve the service. Staff told us they have not received feedback from complaints.

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

Inadequate

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

Leadership

Leaders did not always have the knowledge and experience to perform their roles. They did not always have a good understanding of the services they managed. However, they were visible in the service and approachable for patients and staff.

We interviewed ward managers, their experience in their roles varied based on their length of time in the roles. Some were unable to answer all of our questions due to inexperience. Managers who had been in post longer had an understanding of their role and the service they managed. Clinical nurse leaders had not always had the right training to access management reports, in the absence of their ward manager.

Vision and strategy

Staff knew and understood the provider's vision and values but did not always apply them to the work of their team.

Staff knew the providers four care values, Compassion, Accountability, Respect, Excellence but did not always apply them to their work and within the team. Staff were not always respectful, kind and compassionate when caring for patients.

Managers did not always show respect compassion or accountability or excellence with staff. Managers did not always support staff who needed time off for ill health.

Culture

Staff did not always feel respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff told us they did not feel respected or valued, three staff told us that they were made to move wards with no explanation, and when they requested further information, from local management and by formally writing to Human Resources, they did not get a response.

Staff gave a variety of other feedback including: they come to work when physically unwell, they cannot sleep due to work anxiety and they feel panicky coming to work. Staff told us they feel stressed, not supported and feel guilty leaving their shift.

Staff told us they felt burnt out. They told us staff shortages was having a negative effect on their mental health and two staff told us that there is a high level of staff burnout. One staff member told us they sometimes work a 13-hour shift without a break or time to get their lunch out of the fridge. Staff told us they frequently work beyond the end of their shift feeling they cannot leave, and one member of staff told us they came in on their day off to catch up with their work.

A patient told us staff did not get a break and they are pushed to the limit, and they have seen staff break down in front of them.

Managers we spoke to had been part of the provider's nurse training programme and had been given opportunities to develop their career within the organisation.

Governance

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

The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed breaches identified at previous inspections or staff failures to follow the provider's procedures on risk management and incident management and reporting. We observed that staff did not record incidents accurately. Staff told us that due to staffing levels they often reported incidents after the shift when they had time, so it was not live information.

Managers did not routinely feedback incident investigation outcomes to staff and reflection sessions were not always held to learn from these at a local level. Staff told us reflective learning sessions were often cancelled due to short staffing, and that if they do go ahead, staff often are unable to attend.

Staff told us that work around safeguarding referrals can be delayed due to multidisciplinary staff being pulled into the ward staff numbers.

The providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care and could not always use that information to good effect.

Staff did not always have access to information, they did not have the opportunity to read essential patient information or emergency evacuation plans. Multiple folders containing information meant staff did not have the capacity, due to staffing levels, to read all required information. Managers and staff on Ashby ward had not reviewed emergency evacuation plans so were unaware of the emergency escalation plan for the patient who mobilised using a wheelchair.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patient risk assessments available to view on inspection were not continuously updated after each incident. We were concerned vital information about patient risk was not up to date and accurate.

Information management

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

Management had a comprehensive audit programme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment On the psychiatric intensive care unit staff were regularly completing patient enhanced observations for longer than five hours at a time. Staff did not review the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Two patients who were prescribed high dosage anti-psychotics did not have a care plan in place to monitor the effects on their physical health. When a patient was placed in seclusion, staff did not always keep clear records or follow best practice guidelines. On the forensic wards staff did not always follow infection control procedures. Four staff on Willow ward were observed to be wearing masks incorrectly. This was reported to managers as we were concerned that Personal Protective Equipment was not being used effectively. The long stay rehabilitation wards were not always safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff did not always complete and regularly update thorough risk assessments of all wards areas and remove or reduce any risks they identified. Patients and carers told us there has frequently been issues with toilets blocking, shower heads spraying and light bulbs in bedrooms needing replacing. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. On the wards for people with learning disabilities or autism seclusion rooms did not meet all the guidance in the Mental Health Act Code of Practice.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Across all core services the providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data. The leadership, governance and culture did not always support the delivery of high quality, person centred-care. Leaders at the long stay rehabilitation services did not have the skills, knowledge and experience to perform their roles. Concerns identified at previous inspections had not always been addressed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing On the psychiatric intensive care unit the service did not have enough nursing and support staff to keep patients safe.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care On the wards for people with learning disabilities or autism staff did not always provide a range of care and treatment suitable for the patients in the service. The service had not fully responded to the needs of patients with autism in the ward environment. The design, layout, and furnishings of the ward did not always support patients' treatment.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Across the forensic wards staff missed opportunities to prevent or minimise harm. On Willow ward we found recorded evidence of incidents where patient observations had been missed and night staff had to remain on shift due to a lack of day staff. We reviewed an incident on Bracken ward whereby a patient was able to tie a ligature due to the day area being left unobserved. Staff did not always meet patients' dietary needs, and correctly assess patients who had specialist care needs for nutrition and hydration. We reviewed an incident on Willow ward that occurred in May 2021 where staff did not respond effectively when a patient refused diet and then fluids. This resulted in the patient being admitted to the acute hospital for rehydration. The acute hospital raised this concern as a safeguarding for investigation. On Bracken ward patients could not make hot drinks and snacks independently of staff. All drinks were kept in the office and patients had to ask staff to make them. If the ward was short staffed this could result in a delay to patients receiving a drink. On the long term rehabilitation wards staff did not always manage risks to patients and themselves well. They did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour and levels of restrictive interventions were high. Staff did not always know about risks to each patient, staff did not always act to prevent or reduce risks. Staff did not always follow the Mental Health Act code of practice in relation to seclusion, long term segregation and blanket restrictions. The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the

This section is primarily information for the provider

Enforcement actions

wider service. Staff did not always assess the physical health of all patients on admission or support patients with their physical health. Staff failed to carry out recommended physical health observations following episodes of patients' head banging and administration of rapid tranquillisation medicine. Staff had not made reasonable adjustments to ensure wheelchair bound patients could evacuate in an emergency.

On the wards for people with learning disabilities or autism staff did not always manage risks to patients and themselves well. Staff did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. Staff did not always act to prevent or reduce risks despite knowing any risks for each patient. Staff were not completing observation records in line with patients prescribed observation times or in line with provider policy. Wards had blanket restrictions in place. Not all patients could make hot drinks and snacks at any time. When a patient was placed in seclusion or long term-segregation, staff did not always follow best practice guidelines in the Mental Health Act Code of Practice.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Across the forensic wards, long term rehabilitation wards and wards for people with learning disabilities or autism there were not enough nursing and support staff to keep patients safe. Patients regularly had their escorted leave, therapies or activities cancelled because of staff shortages. On the wards for people with learning disabilities or autism staff had not completed specialist training to meet the needs of patients.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment On the wards for people with learning disabilities or autism patients were not protected from closed cultures.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Across the forensic, long stay rehabilitation and wards for people with learning disabilities or autism we identified closed circuit television in seclusion bathrooms were routinely on, regardless of whether the patient presented a risk necessitating this. On the forensic wards staff did not always treat patients with compassion and kindness or respect patients' dignity. A patient on Bracken ward was unable to get to the toilet in time due to a delay in staff assistance. Maple ward shared a seclusion corridor with a male ward. On the long stay rehabilitation wards staff did not always treat patients with compassion and kindness. They did not respect patients' privacy and dignity. Staff did not intervene to support patients when harming themselves or in distress. Staff did not ensure patients access to the toilet at all times. On the wards for people with learning disabilities and autism staff did not always treat patients with compassion and kindness. A female patient was allocated a male only team to observe her whilst in long term segregation.