Southleigh Community Independent Hospital

Quality Report

Southleigh Community Independent Hospital
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Date of inspection visit: 14 May 2019
Date of publication: 09/07/2019

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

Ratings

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

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

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

Summary of findings

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

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

Overall summary

We rated Southleigh Community Independent Hospital as good because:

- The service was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Ligature risks had been assessed and fire safety arrangements were in place.
- Staff assessed and managed risks to patients and themselves. Staff followed best practice in anticipating, de-escalating and managing behaviour which challenged. As a result, they used restraint only after attempts at de-escalation had failed and this was very rare. Staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff provided care and treatment interventions suitable for the patient group, there was a good programme of rehabilitation in place. Staff ensured that patients had good access to physical healthcare.
- 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 team had effective working.
- Patients were partners in their care. All patients were involved in developing their care plans. Patients attended ward rounds and were supported to arrive at decisions. Patients' views were incorporated, even when they differed from the clinical teams. No decisions were made about any aspect of care or treatment without the involvement of the patient. All patients had a copy of their care plan and care programme approach documents.
- There was a strong, visible person-centred culture. Staff encouraged patients to take the lead on different activities as part of their progress. For example, one patient was lead on the art therapy group.
- Staff empowered patients to have a voice and realise their potential. Patients were involved in decisions about the service. There was a patient representative for the service. The patient representative regularly attended the clinical governance meeting and also got involved in interviewing potential new staff for the service. When rooms were redecorated, patients decided on the colour. Patients also decided parts of the activity programme and the menu.
- 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 helped patients with communication, advocacy and cultural and spiritual support. Advocates attended the service, and meetings, to support and represent patients.
- Staff actively encouraged families and carers to be involved. The social worker took the lead on this and was in regular contact with families and carers. Patients were supported to maintain positive relationships with them during their time at the service.
- The service treated concerns and complaints seriously, investigated them and invited patients and/or their carers to discuss their concerns with management.
- The service had a model of care and staff understood how to put this into practice. There was a pathway for rehabilitation which outlined timeframes and what the patient could expect from the service.

Summary of findings

- Governance systems were in place which supported the delivery of high-quality care. Regular meetings took place within the service to discuss overall performance and learning from recent safeguarding and other incidents. Regular audits were undertaken, and improvements made as a result.
- The team had access to the information they needed to provide safe and effective care and used that information to good effect.

However:

- Staff had limited understanding about how to support the needs of patients with protected characteristics, for example sexual orientation, and there was little information available to these patients to make them feel included and welcomed into the service.
- Whilst most patients had a length of stay of 1-2 years there were a small number of patients who had been admitted to the service for several years. The provider was actively working with commissioners to support them to move to more appropriate settings but it had proved a challenge to find another service that was willing to accept them.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Good

Southleigh Community Independent Hospital

Services we looked at
Long stay or rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Southleigh Community Independent Hospital

Southleigh Community Independent Hospital provides care, treatment and rehabilitation for people with mental health problems. The service offers community rehabilitation for up to 25 male and female patients with complex needs with an overall aim of moving most patients on to supported accommodation. The service consists of a ward and 5 semi-independent flats. The service receives referrals from NHS organisations inside and outside of London. There is a registered manager in place.

The service is registered by the CQC to provide assessment or medical treatment for persons detained under the Mental Health Act 1983, treatment of disease, disorder or injury and diagnostic and screening procedures.

At the previous inspection in August 2015, the provider did not always ensure staff followed best practice when administering medicines. When staff administered 'as required' (PRN) medication, they did not always record the reason. Also, they did not review medication when a patient continuously refused to take it. During this inspection we found that the necessary improvements had been made, although one patient's medication record was still not clear.

At the previous inspection in August 2015, the provider had not ensured that staff had undertaken training in safeguarding children. During this inspection we found that most staff had completed training in safeguarding children.

At the previous inspection in August 2015, staff were performing alcohol and drug testing for all patients. During this inspection we found that patients were only being screened according to risk.

At the previous inspection in August 2015, staff did not have a good working knowledge of the Mental Capacity Act and deprivation of liberty safeguards. During this inspection we found that staff had a good understanding.

At the previous inspection in August 2015, staff did not ensure patients were aware that they could access drinks day and night or go to bed at a time of their own choosing. During this inspection we found that patients knew they could access a snack or drink when they wanted one and that they did not have set times when they had to be in their bedrooms.

Our inspection team

The team that inspected the service comprised of a CQC inspector, a CQC inspection manager and one specialist advisor who was a nurse consultant with a background in long stay/rehabilitation services.

Why we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety.

Summary of this inspection

How we carried out this inspection

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

During the inspection visit, the inspection team:

- visited the clinic, looked at the quality of the environment and observed how staff were caring for clients
- spoke with three patients who were using the service
- spoke with the carer of two patients who were using the service
- observed staff interacting with patients including during a group activity
- spoke with the registered manager
- spoke with 11 other staff members across the multi-disciplinary team
- Looked at six care and treatment records of clients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service

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

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

What people who use the service say

We spoke with two patients who described staff as kind, caring and helpful. Both patients gave us positive feedback about the staff. Patients said that staff supported them whenever they needed and that they appreciated this. Patients told us that there were a lot of activities for them to take part in and that they were supported by staff with daily living tasks, for example, cleaning their room and taking care of their finances. Patients enjoyed their time at the service and, on the whole, liked the food, although they told us that it could be too spicy sometimes.

We were shown around the activities room where patients' artwork was displayed. We also observed patents taking part in making tie dye t-shirts. Staff took time throughout the day to sit and chat with patients. Patients and carers told us that staff always had enough time to spend with the patients. Carers also informed us that staff kept them up to date with how their relative was and that they were very happy with the arrangements. During our inspection we also observed staff encourage patients to tidy their rooms as well as support them on escorted visits.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because;

- The service was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Ligature risks had been assessed and fire safety arrangements were in place. Staff ensured that the service was compliant with requirements for mixed sex accommodation.
- Staff assessed and managed risks to patients and themselves. Staff followed best practice in anticipating, de-escalating and managing behaviour which challenged. As a result, they used restraint only after attempts at de-escalation had failed and this was very rare. Staff participated in the provider's restrictive interventions reduction programme.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The manager had recently increased staffing levels, which had temporarily increased the vacancy rate and impacted on the number of temporary staff used. The manager informed us that all vacant posts had been recruited to.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff had access to clinical information and it was easy for them to maintain high quality clinical records.
- Staff followed best practice when dispensing medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

We rated effective as **good** because:

- 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 were personalised and reflected the immediate assessed needs.

Summary of this inspection

- Staff provided some care and treatment interventions suitable for the patient group, there was a good programme of rehabilitation in place. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives when patients were willing to engage.
- Staff used recognised rating scales to assess and record severity and outcomes.
- The staff team had a range of skills needed to provide high quality care. This included medical, occupational therapy and psychology input. The manager and clinical lead supported staff with appraisals, an external facilitator conducted reflective practice sessions. The manager provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients were cared for appropriately. The team had effective working relationships with staff from services that provided aftercare and engaged with them when patients were preparing for discharge.
- Staff supported patients to make decisions about their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.
- The manager supported patients to share their views about the service.

Are services caring?

Outstanding ☆

We rated caring as **outstanding** because:

- 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.
- Members of the multidisciplinary team had their offices in patient areas. Patients were welcome to approach staff in their offices, unless a sign indicated they were busy.
- Staff communicated with patients sensitively, and in a kind and respectful manner. Staff spoke about patients as individuals. Patients and carers described staff in very positive terms.
- Staff supported patients to be empowered, for example by encouraging and supporting them to live independently and take on responsibilities which promoted their own rehabilitation. For example, one patient was a keen artist and attended art classes in the community as well a leading an art class for other patients in the service.

Summary of this inspection

- Patients were partners in their care. All patients were involved in developing their care plans. Patients attended ward rounds and were supported to arrive at decisions. Patients' views were incorporated in care plans, even when they differed from those of the clinical team. No decisions were made about any aspect of care or treatment without the involvement of the patient. All patients had a copy of their care plan and care programme approach documents.
- Staff empowered patients to have a voice and realise their potential. Patients were involved in decisions about the service. Patients were able to attend the patient forum and suggest ideas and changes which were put into practice. This included areas such as the decoration of the hospital, activity programme and food. There was a patient representative for the service. The patient representative regularly attended the hospital clinical governance meeting and helped interview potential new staff for the service.
- Staff ensured that patients had easy access to independent mental health advocates.
- Staff involved families and carers and invited them to attend patient review meetings. They recognised many relatives lived long distances from the hospital and supported patients to maintain contact using a range of means of communication such as conference calls. Staff held an annual barbecue which families and carers could attend.

Are services responsive?

Good

We rated responsive as **good** because:

- Discharge planning arrangements were well defined within patient care plans and started approximately six months following a patient's admission. Patients had clearly defined recovery goals.
- Staff were exceptional at enabling people to be independent as they progressed towards discharge. Staff encouraged patients to undertake activities of daily living before progressing to an independent flat within service before their eventual discharge.
- The design, layout, and furnishings supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Staff helped patients with communication, advocacy and cultural and spiritual support. Advocates attended the service and other meetings to support and represent patients.

Summary of this inspection

- The service treated concerns and complaints seriously, investigated them and invited patients and/or their carers to discuss their concerns with management.
- Patients were satisfied with the quality of food or the choices available to them. Although some patients commented that food could be too spicy at times.

However:

- Whilst most patients had a length of stay of 1-2 years there were a small number of patients who had been admitted to the service for several years. The provider was actively working with commissioners to support them to move to more appropriate settings, although it had proved a challenge to find another service who was willing to accept them.
- Staff had limited understanding about how to support the needs of patients with protected characteristics, for example sexual orientation, and there was little information available to these patients to make them feel included and welcomed into the service.

Are services well-led?

Good

We rated well-led as good because:

- The service had a community rehabilitation model of care and staff understood how to put this into practice. Patients experienced a full range of interventions to support the development and maintenance of independent living skills, rehabilitation and recovery.
- Governance systems were in place which supported the delivery of high-quality care. Regular meetings took place within the service to discuss overall performance and learning from recent safeguarding and other incidents. Regular audits were undertaken, and improvements made as a result.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt able to raise concerns without fear of retribution.
- The team had access to the information they needed to provide safe and effective care and used that information to good effect.

Detailed findings from this inspection

Mental Health Act responsibilities

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

As of 30 April 2019, 66% of staff had completed mandatory training in mental health law. Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Patients' capacity to consent to treatment was assessed at regular intervals. When patients did not have the capacity, the appropriate treatment forms were completed and attached to their medicine administration charts.

Patients were informed of their rights under the MHA on admission to the hospital, and at regular intervals. There were monthly audits to ensure MHA documentation was complete and procedures were working appropriately. An independent mental health advocate (IMHA) visited the hospital each week.

Staff had easy access to administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice. The Mental Health Act administrator worked part-time and was based at the service. Staff could access support and advice from the Mental Health Act office during their working hours and from the consultant or manager out of hours.

Mental Capacity Act and Deprivation of Liberty Safeguards

Seventy-six percent of staff had completed training in the Mental Capacity Act (MCA). Staff said they had received training in the Mental Capacity Act (MCA) and understood how the MCA related their professional practice.

The majority of staff in the service could not describe the five principles or the capacity test. However, all staff supported patients to make day-to-day decisions regarding their care. The consultant, social worker and clinical nurse manager had a good understanding of the MCA.

Capacity assessments were thorough and respected the patients' previous preferences and history. Decisions were made in the patients' best interests.

There were no deprivation of liberty safeguards (DoLs) applications in the previous six months. None of the patients were subject to DoLs.

The provider had policies for the MCA and DoLs. These were available for staff electronically and in a policy folder.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Good	Good	☆ Outstanding	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

Safety of the ward layout

Staff carried out hourly checks of the environment. Staff recorded and reported on any areas that required attention, for example spillages or broken items of equipment.

The service had some blind spots. There were no convex mirrors installed to mitigate the risks, however, patients who were admitted to the unit were risk assessed as low risk in terms of self-harm or suicidal ideation.

There were ligature risks in the main building and in the individual flats but these were managed safely. The service had completed a ligature risk assessment. Staff were aware of the ligature points and followed plans to reduce the risk of them being used. The risk was also mitigated by regular and ongoing risk assessment of patients.

The service complied with guidance on eliminating mixed-sex accommodation. All patients had their own bedrooms. There were three separate floors within the main building and five individual flats. Within the main building males and females had bedrooms on different floors. A key was required to access each floor. Patients only had keys to access their own floor. Each floor had shared bathroom and toilet facilities. Patients in the flats had their own space including a private bathroom and toilet.

Staff had easy access to alarms and patients had easy access to nurse call systems. The service had wall based panic alarms throughout the service. Staff could also access personal alarms when they assessed they were needed.

A fire risk assessment was carried in 2017 with a follow-up in 2018. The risk assessment was supported by an action plans, and each of the actions was recorded as completed. The service undertook weekly fire alarm tests and fire drills took place every six months. A record was maintained of the evacuation, although staff did not record how long it had taken.

Fire extinguishers were available although correct signage was not always displayed. Extinguishers on the female floor and flats were stored with the correct signage above them. The extinguishers on the male floors, were stored in the office on floor 1 due to risk incidents, signage was not displayed outside the office door. All staff knew where the extinguishers were kept and had a key to access these rooms.

There were no seclusion rooms at the service.

Maintenance, cleanliness and infection control

The service was clean, had good furnishings and was well-maintained. The environment was visibly clean and clutter-free. The service had dedicated domestic staff responsible for cleaning. Staff and patients said that the level of cleanliness was good.

Maintenance repairs were carried out within a reasonable timeframe. The manager informed us that the provider was

very responsive and that repairs were carried out promptly and in accordance with the urgency of the request. There was also a planned maintenance programme in place for ongoing work such as redecoration.

Staff adhered to infection control principles, including handwashing and wearing appropriate personal protective equipment, such as disposable gloves.

Clinic room and equipment

The clinic room was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff kept an emergency grab bag containing lifesaving equipment in the clinic room. Staff undertook checks to ensure all items within the bag were kept in accordance with policy. Ligature cutters were stored safety in the clinic room.

Staff ensured medical equipment stored in the clinic rooms was maintained in line with manufacturers' instructions. Equipment was labelled with the date it was last checked and calibrated.

Staff cleaned equipment after use and weekly in line with a cleaning schedule. Staff kept records of cleaning checks. Staff used a yellow plastic bin to dispose of needles and sharps, we noted it had been overfilled, making it unsafe. We informed the nurse in the clinic room who addressed this promptly.

Safe staffing

Nursing staff

Managers had calculated the number and grade of registered nurses and non-registered nurses required on each shift. The manager had been in post for approximately nine months. During this time, they had reviewed staffing levels and increased the number of non-registered nurses who worked during day shifts from two to four. The manager had also created a clinical lead nurse role and a senior non-registered nurse post.

The number of registered nurses and non-registered nurses on most shifts matched the core staffing level the provider had assessed to be required. The recent increase in the establishment had created additional vacancies which temporarily meant that a high number of bank and agency nurses were deployed to provide cover.

The manager and staff reported that there were sufficient staff deployed on each shift to keep patients safe. Additional staff could be brought in if required, such as when a patient required close observations.

Recruitment to fill vacant posts was ongoing. There had been a spike in vacancies due to the increase in establishment, all positions had recently been filled and staff were undergoing the necessary checks prior to commencing employment.

The manager and staff felt supported by senior management, in their approach to ensuring the service was staffed safely.

Between the period 1 October 2018 to 31 December 2018, there were no registered nurse vacancies and eight non-registered nurse vacancies which was 45% of the establishment. The service had seen an increase in non-registered nursing vacancies as a direct result of the increase in establishment. The manager had worked hard to ensure all vacancies were filled.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. When agency staff were used they were staff who came to the wards regularly and were familiar with patients and ward routines. There had been a high reliance on agency staff due to the vacancy rate as well as ensuring enhanced levels of observations were covered. The manager assured us that agency staff had not been used for several weeks since most of the vacancies had been filled. Registered nursing staff were over established which allowed flexibility in the workforce until the non-registered nursing staff were in post. On average 2% of shifts per week could not be filled.

When bank and agency nursing staff were used, those staff received an induction to familiarise them with the ward. The bank or agency nurse completed a checklist to demonstrate they had been inducted to the unit.

There was always a permanent member of staff on shift, and we observed sufficient cover with nurses present in the communal areas of the wards.

Patients escorted leave, one to one sessions with named nurses and ward activities were rarely cancelled because there were too few staff. We were informed that, on occasion, patients leave may be delayed for a few hours. To minimise this, staff encouraged all patients to attend the daily planning meeting to ensure leave was agreed and

discussed at the beginning of each day. Patients said they could have one to one time with their named nurses most of the time and could speak to any member of staff when needed.

The sickness rate for the service was low at 1.8%.

Medical staff

There was one consultant psychiatrist who attended the service four days a week. They were also on-call in the evenings and at weekends and happy to be contacted by staff. They could attend the unit quickly in an emergency. Cover for the consultant was in place when they were not available.

Mandatory training

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

Overall, staff in this service had undertaken 87% of the various elements of training that the service had set as mandatory. There was one mandatory training session which was below 75%, mental health act law at 66%. We were informed by the manager that additional staff had been booked onto a training session in June 2019.

Staff said they were up to date with mandatory training or booked on to the next available session for particular topics

Assessing and managing risk to patients and staff

Assessment of patient risk

During the inspection, we reviewed the risk assessments of four patients.

Staff had completed a risk assessment for every patient on admission and updated it regularly. Staff formally reviewed risk assessments at care planning meetings and ward rounds and updated them every, one to three months, plus after any incident involving the patient.

The consultant psychiatrist had developed a risk assessment tool based on the short-term assessment of risk and treatability (START) model and introduced these risk assessments in December 2018. Staff prepared a risk management plan for each patient. Each risk management plan set out the risks that were specific to the patient and gave details of how staff should respond to these risks. Risk assessments were individualised and considered the patient's mental well-being, for example, their risk of harm to themselves or others.

Staff identified risks which may result in a setback to a patient's progress, and documented how the patient would be supported to minimise any potential impact.

Management of patient risk

Staff identified and responded to changing risks to, or posed by, patients. Staff discussed any changes in patients' behaviour at daily handover meetings and reviewed risks for each patient at multidisciplinary meetings. We observed a handover during our inspection and found it to be thorough and effective.

Staff told us that detained patients who went absent without leave (AWOL) usually returned or made contact and came back on their own accord. Only patients with higher levels of risk were being reported to the police. In the previous 12 months one patient had gone AWOL for approximately four months. All other patients who went AWOL had returned to the service within a short period of time.

Each patient had a behavioural management plan. Staff used the plan to record changes in their behaviour, based on their interactions with them, and any incidents which occurred. Staff recorded changes in a patient's behaviour and adapted their care plan to ensure that their wellbeing was appropriately managed.

Staff checked patients' vital signs each week, although they did not routinely record them on a recognised tool such as the National Early Warning Score (NEWS) chart (NEWS is a tool developed by the Royal College of Physicians, which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes). Staff told us that they only used a NEWS chart if a patient became physically unwell, then they would use this to monitor any deterioration in their physical health.

Staff followed policies and procedures for the use of observation and for searching patients or their bedrooms. Staff completed observation records for each patient on admission to the unit and on an individual risk basis thereafter, in accordance with provider's guidance.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff applied blanket restrictions on patients' freedom only when justified. At the previous inspection in August 2015 we found that staff were performing alcohol and drug testing on all patients and that patients did not have access to drinks and snacks when they wanted them. We also found that patients believed they had to be in their bedroom at set times of the day. During this inspection we found that improvements had been made and that blanket restrictions were not applied unnecessarily. Drug and alcohol testing was only performed on patients according to risk. Patients had access to drinks and snacks 24 hours per day and could order takeaways if they wished to do so. Patients knew they did not need to be in their bedroom at set periods.

The front door to the unit was kept locked. Most patients were under section and were either prescribed escorted or unescorted leave. There were three informal patients on the unit, these patients knew they could leave the building when they wanted to and they could ask a member of staff to unlock the door. All patients had been risk assessed as able to use their own mobile phone.

Patients were able to smoke in the communal garden. The manager informed us that this was under review but feedback from the patients indicated that they did not want this policy to change. Patients were encouraged to purchase nicotine replacement therapies.

All patients at the service had a personal emergency evacuation plan (PEEP) to follow in the event of a fire or other emergency. A PEEP is an escape plan for patients who may not be able to reach an ultimate place of safety without assistance within a suitable time period. Patient PEEPs were used to identify any risks which may prevent a patient from reaching the safety point unaided with details of action required to ensure they were appropriately supported.

Informal patients could leave the service at will and they knew that. At the time of inspection most patients were admitted under a section of the Mental Health Act. There were three informal patients. Staff reminded patients that they could leave at will and there were also signs placed near the door as a reminder.

Use of restrictive interventions

There were no reported incidents of seclusion or long-term segregation.

There were two reported incidents of restraint in the 12 months prior to the inspection. We were informed by the ward manager that restraint rarely occurred. The provider had recently changed the reporting system from a paper-based system to an electronic reporting tool. Records showed that the more recent electronic record contained all the required level of detail in accordance with NICE guidelines and the provider policy. One paper-based record did not record which member of staff held which part of the patient's body.

Staff used restraint only after de-escalation had failed and used the correct techniques. Staff had been trained in physical interventions as part of their mandatory training. This meant that staff had the required skills to de-escalate patients who became aggressive to minimise the use of restrictive interventions. Staff knew to avoid restraining people in the prone position where possible.

There were no reported incidents which required the use of rapid tranquilisation.

Safeguarding

Staff had received training in safeguarding adults and children, knew how to recognise a safeguarding concern and refer to the local safeguarding team. At the previous inspection in August 2015 we found the provider had not ensured that staff had undertaken training in safeguarding children. During this inspection we found that most staff had completed training in safeguarding children.

Over 78% of staff were trained in safeguarding adults and children.

The service's social worker took the lead on safeguarding for the service and provided support to staff in relation to safeguarding concerns. The social worker reported that there had been difficulty getting feedback from the local authority team regarding on-going investigations and outcomes. They had met with the local authority team to try to improve communication and working relationships. This had so far proved successful.

Staff could give examples of safeguarding alerts they had made. This service made three safeguarding referrals between 1 January 2019 and 30 April 2019. Staff completed records of safeguarding referrals and submitted them to the local authority safeguarding team. Staff put protection plans in place to keep patients safe.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff followed safe procedures for children who visited patients. Children were not permitted on the unit, instead arrangements were made for patients to visit their children during leave from the service, in accordance with any safeguarding arrangements, if required. Where necessary the service involved the patient's social worker in any engagement which took place.

Staff access to essential information

Staff used a paper based system to document patient records. Electronic records were held of handovers, multidisciplinary meetings, incidents and complaints. The service planned to move to an electronic patient record system at some stage in the future. Staff told us that the system was very slow, this meant that staff spent unnecessary amounts of time recording information for example when using the incident reporting system. Staff had reservations about switching to an electronic patient record system because the provider's IT infrastructure may not be capable of supporting it.

Medicines management

Staff followed good practice in medicines management. Staff ordered, stored, dispensed and disposed of medicines safely. Staff placed orders for medication and ensure stock levels were regularly checked and rotated to avoid medication going out of date. Unused or out of date medication was disposed of safely in accordance with the provider's policy.

Staff reviewed the effects of medicines on patients' physical health regularly and in line with the National Institute Health and Care Excellence (NICE) guidance, especially when the patient was prescribed a high dose of antipsychotic medication. Staff monitored the side effects of medicines using a measurement scale. There was a protocol in place which outlined additional observations and health monitoring for patients who were receiving antipsychotic medication above the limits set out in the British National Formulary (BNF).

Staff checked controlled drugs and fridge temperatures daily. Records showed that fridge temperatures were within permissible limits.

We reviewed the medicine administration records for six patients. At the previous inspection in August 2015 we found that the provider did not always ensure that when 'as required' (PRN) medication was administered, the reason for administration was always documented and that where a patient continuously refused medication this was reviewed. During this inspection we found that the necessary improvements had been made. Most of the records were completed appropriately. Staff signed when they administered medicines or recorded why not, although we noted that staff had not signed the administration records for one of the patients on each occasion when medication should have been administered. Staff had not recorded whether the patient had refused their medication or whether a dose had been missed. Staff noted allergies and potential adverse reactions on the patients' records. The prescriber gave staff clear directions about when staff should administer 'as required' medicines.

Audits of medicines administration records were completed each month, although during our inspection, we found that the audits had not identified the gaps in records for one patient.

Track record on safety

The service reported one serious incident during the 12 months prior to inspection.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents they should report. Staff said that they knew what, when and how to complete an incident report.

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. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.

Staff met to discuss feedback from incidents. The new manager had introduced a weekly incident analysis meeting. This was a forum for recent incidents to be discussed and for learning to take place. The meeting was open to all staff to attend. Incidents were also discussed at daily handover, team meetings, and a newsletter was produced by the provider each month to share learning from incidents across the sites.

Long stay or rehabilitation mental health wards for working age adults

Good

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed six patient care and treatment records during our inspection. Most records demonstrated good practice in terms of assessment, treatment and risk management.

The consultant psychiatrist and/or registered manager assessed potential new patients when they were referred to the service. The service accepted patients who were ready for rehabilitation and did not take patients who were acutely unwell. Most admissions to the service were planned transfers from other mental health wards or forensic services.

The clinical psychologist had been involved in drafting positive behaviour support plans to help staff plan their support of patients with behaviour that was challenging or harmful.

The occupational therapist assessed all new patients on admission or shortly after.

Staff assessed patients' physical health needs in a timely manner after admission and documented the frequency of follow-up checks required.

Staff developed care plans that met patients' individual needs. The care plans we reviewed were individualised and mostly comprehensive and recovery focussed.

Staff updated care plans when necessary. Staff regularly reviewed patient care plans and involved the patient and their family or carer in this process. Patients' views were recorded in the patient records.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. There was evidence of psychological intervention for those assessed as suitable, and input from occupational therapists. This included access to psychological therapies, support for self-care and the development of everyday living skills, and to meaningful occupation.

The service was able to provide psychological interventions in line with NICE guidance. The clinical psychologist offered a range of interventions including cognitive behavioural therapy and eye movement desensitisation and reprocessing (a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories). The service employed a psychotherapist to provide mentalisation-based therapy to some patients on Saturdays. The clinical psychologist and occupational therapist had plans to run a group for patients on sex and relationships.

The consultant psychiatrist prescribed patient medicines in line with national guidance.

Some patients were able to manage and administer their own medicines. The service had several flats where patients could live independently but with staff support close by. Some patients living in the flats prepared their meals in their own kitchen. Other patients developed their cooking and meal preparation skills individually with occupational therapy staff.

The occupational therapy team ran three group activities a day from Monday to Friday. Activities were planned with patients at the end of the previous week. The team also worked individually with patients on developing their skills and confidence. For example, they provided support with computer skills and enabled patients to attend college courses and prepare for voluntary or paid employment. Some patients attended a local jazz club and others had attended pet therapy in a local primary school. Activities were also provided on the premises, especially for those patients with limited leave opportunities. A music group came into the service to run groups. There was a box of activities for nursing staff to use to facilitate groups at weekends.

Staff understood the interests and strengths of patients well and worked with them to develop and build on existing skills, accessing opportunities in the community when they could. For example, staff were supporting a patient with excellent artistic skills to take up voluntary work in an art-based setting. One patient had improved their confidence to the extent that they were now

facilitating a group for other patients on a Saturday morning. There were five paid work opportunities within the service including working as a gardening assistant, participating in staff interview panels and cleaning and tidying the service. Patients who undertook these roles received supervision from the occupational therapist every six weeks.

The social worker had run sessions for patients on managing their finances. They also helped patients develop financial care plans as a way of budgeting more effectively.

Primary nurses met with their patients individually on a regular basis to discuss their progress and review their care plans.

Staff ensured that patients had good access to physical healthcare. A chiropodist came into the service to support patients with foot care. All patients were registered with one of two local GPs. The GP would visit the service to see those who could not come to the surgery. Patients with long-term health conditions were referred to other secondary healthcare services when required. Some patients had long-term health conditions, for example, diabetes. The manager for the service was in the process of looking into developing health passports with patients. It was anticipated that the passports could be used to explain the patients' physical health problems in plain English and in pictorial form to make it easier for patients to have meaningful conversations with health professionals and others about their health.

Staff supported patients to attend appointments at other hospitals in relation to their physical health. Where necessary a member of staff accompanied patients to appointments. There was good evidence on patient files of communication between the medical and nursing staff at the unit and the hospital staff responsible for meeting the patients' physical health needs.

Staff supported patients to live healthier lives and offered support to patients who wanted to stop smoking. Patients were encouraged to eat healthily, and the occupational therapist supported patients to go to a local gym for exercise. However, the premises were not smoke-free. Patients could smoke in the garden.

The service used health of the nation outcome scales (HoNOS) to measure patient outcomes but recognised the limitations of these measures. The clinical psychologist and psychiatrist described using bespoke behavioural measures of outcomes for patients rather than specific outcome tools. The occupational therapist administered the model of human occupation screening tool every six months to measure patients' progress.

Staff undertook local audits were undertaken on the completion of care plans, risk assessments, privacy and dignity, capacity and consent. We found that care plan audits were not supported with a clear action plan when areas for improvement were identified, however, identified weaknesses were highlighted and improvements had been made each month. We also noted that an audit of physical healthcare assessment or follow up had not taken place, which meant that the manager could not be assured that the physical health needs of patients were being met.

Skilled staff to deliver care

The service had access to the full range of specialists required to meet the needs of patients. The team included skilled staff from a range of disciplines including qualified nursing staff on every shift, a consultant who worked four days per week, an occupational therapy team, a full-time clinical psychologist and full-time social worker.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Most registered nursing staff had worked at the service for a long time, all registered staff from the multidisciplinary team had worked across different mental health settings and had a good understanding of patients' needs. The service also had their own local induction checklist to support new staff in their role.

Managers and leads provided staff with supervision. Staff said they received regular supervision and an annual appraisal. Staff took part in reflective practice meetings with an external facilitator. Allied health professionals received clinical supervision from a member of their own profession. The clinical psychologist linked with a psychologist in another of the provider's hospitals for peer supervision. Records showed that staff supervision had not taken place regularly in 2018, the new manager had ensured that significant improvements had been made and staff had received supervision approximately every two to three months. Supervision records demonstrated comprehensive discussions had taken place between the supervisor and supervisee. Supervision sessions covered both managerial and clinical supervision.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers and supervisors provided staff with appraisal of their work performance. At 4 February 2019, 80% of non-clinical staff had received an appraisal. Detailed appraisal records were held on each staff file we reviewed.

Managers ensured that staff had access to regular team meetings. Team meetings were held every month, there was also a governance meeting for senior staff and nurses' meetings. More recently meetings had been established for non-registered nursing staff to meet; one meeting had taken place to date. These meetings gave staff the opportunity to discuss any general issues relevant to the unit and the chance to exchange ideas.

Managers identified the individual learning needs of staff and provided them with opportunities to develop their skills and knowledge, although more could be done. Staff were able to attend training and conferences for professional development in addition to mandatory training. The manager had also worked closely with another service to arrange delivery of training for staff on substance misuse.

Managers dealt with poor staff performance promptly and effectively. Managers took appropriate action and followed the provider's disciplinary policy as required.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. The service held weekly multi-professional meetings that staff from all disciplines attended. All staff were very positive about the multidisciplinary team and said they worked together as equals in planning patient care and treatment. They said they were able to present different points of view and felt listened to by colleagues.

The service had effective handovers between changes in nursing shift and we observed this taking place. The lead nurse from the out-going shift led the handover and briefed all incoming staff about each patient on the ward, and any incidents which had occurred. Staff provided handovers to other services when patients were transferred.

The service had effective working relationships with teams outside the organisation. The service was in at least monthly contact with patients' care coordinators and involved them in case presentations, as well care programme approach meetings.

Staff also communicated regularly with the clinical commissioning groups who had funded each patient's care, social services, patients' GPs and other organisations that provided support to the patients.

The social worker had developed links between the service and the police. A police officer attended the service regularly and offered individual meetings to patients to discuss any safety concerns they had.

The service had good links with a local drug and alcohol service. The clinical psychologist in the service had met with their counterpart at the drug and alcohol service to discuss an online portal that patients with substance misuse problems could access. Staff signposted patients to other providers such as the local mental health voluntary organisations and telephone support lines when needed.

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

As of 30 April 2019, 66% of staff had completed mandatory training in mental health law. Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. The Mental Health Act administrator worked part-time and was based at the service. Staff could access support and advice from the Mental Health Act office during their working hours and from the consultant or manager out of hours.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. Policies were regularly reviewed to ensure they took into account the latest guidance, and any local changes

Patients had easy access to information about independent mental health advocacy. The service provided all detained patients with written information about their rights under the Mental Health Act. This information included the contact details of the advocacy service. The service also displayed contact details of advocacy services on a notice board in a communal area. The advocate visited the service each week and attended the patients' community meetings. The advocate could be contacted by patients by telephone on request.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff understood the Mental Health Act and how this affected patients under their care. Staff explained to patients their rights under the Mental Health Act in a way that they could understand.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. The doctor granted patients leave as part of their therapeutic intervention. Clinicians had clearly recorded the start and end date of patients leave and an overnight address where this was applicable. Staff undertook risk assessments prior to patients taking their leave to ensure they did not present a risk at that time.

Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. Staff at the Mental Health Act office stored original documents in a locked cabinet.

Staff undertook regular audits of the Mental Health Act to ensure relevant paperwork was present on the patients' files.

Good practice in applying the Mental Capacity Act

Seventy-six percent of staff had completed training in the Mental Capacity Act (MCA). At the previous inspection in August 2015 we found that staff did not have a good working knowledge of the Mental Capacity Act and deprivation of liberty safeguards. During this inspection we found that staff had a good understanding. Staff said they had received training in the Mental Capacity Act (MCA) and understood how the MCA related their professional practice.

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies. The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Staff understood the Mental Capacity Act, in particular the five statutory principles. There were no patients at the service under deprivation of liberty safeguards at the time of inspection.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent. The treating clinician's assessments of patients' capacity to consent to treatment was recorded on all but one of the patient records we reviewed. These assessments were revisited regularly in ward review meetings.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. For example, following a safeguarding incident a best interests decision had been made for a patient with regards to management of their finances.

The provider had policies for the MCA and DoLs. These were available for staff electronically and in a policy folder.

Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

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

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients were exceptional. They showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Staff demonstrated a caring, respectful and compassionate attitude towards patients when interacting with them. They showed that they understood the needs of patients. Staff were person-centred in their approach to care. Staff prioritised patients' needs above other tasks. Patients told us that staff were caring and helpful.

Staff communicated positively with patients and their carers. Staff went the extra mile to build relationships with patients and those close to them. Staff were caring, respectful and supportive and took the time to ensure families felt included in the patients care, if this was in accordance with the patients' wishes. The carer we spoke with told us that the service were excellent at communicating.

Staff said they always put patients first and maintained a positive and hopeful attitude when working with patients

with long term mental health problems. Staff showed a deep interest in patients and were alert to signs of progress, however small, and celebrated these. Staff took time throughout the day to sit and chat with patients. Patients and carers told us that staff always had enough time to spend with the patients.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that is kind and promotes people as individuals. Staff encouraged patients to take the lead on different activities as part of their progress. For example, one patient was lead on the art therapy group. We were shown around the activities room where patients' artwork was displayed. We also observed patents taking part in making tie dye t-shirts.

Staff were exceptional at enabling people to be independent as they progressed towards discharge. During the inspection we observed staff supporting and encouraging patients to tidy their rooms. Staff encouraged patients to undertake other daily tasks and personal care before progressing to an independent flat within the boundaries of the service before discharge.

Staff were patient in their approach, persistent and worked with patients over long periods of time to effect change. Staff were highly committed to each patient and put in the necessary time and effort on an individualised basis to ensure positive outcomes were reached. For example, a staff member described how it had taken six months working closely with a patient to get them to visit their GP in the local community.

Staff helped patients celebrate their birthday. Patients had collectively opted to receive £10 as a gift from the service rather than a present.

Members of the MDT had their offices in patient areas. Patients were welcome to approach staff in their offices, unless a sign indicated they were busy.

Staff supported patients to understand and manage their care, treatment or condition. Staff and patients told us how some patients had progressed since being at the service through the support and care of the staff and the activities that were taking place.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. Staff had supported one patient who had a keen interest in art to lead on the art therapy group at the service and were supporting this patient to seek voluntary work at an art gallery. Other patients were being supported to attend college. Staff also supported patients to live as independently as possible. Patients assessed as suitable were able to live in one of the five flats located on site. If patients were unable to cope, they could move back into the main unit.

Staff knew patients well. They were familiar with their histories and recognised changes in mood and behaviour. They worked patiently with people to build trust and improve engagement. Patients said staff treated them well and behaved appropriately towards them.

Patients reported that staff always knocked and waited before entering their room and respected their privacy and dignity.

Staff maintained the confidentiality of information about patients. Handovers, multidisciplinary meetings and ward rounds all took place in a designated room to ensure discussions about patients could not be overheard.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the service. Patients received a recovery folder on admission that included information about the service, including information about activities at the service and patient rights. Staff also took the time to speak with patients who were new about the activities available and what their treatment would involve.

Staff involved patients in care planning and risk assessment. All patients were involved in the development of their care plans and risk assessments. Patients wrote their views directly onto the care plan and they had been provided with a copy. Patients attended ward rounds and were supported to arrive at decisions. No decisions were made about any aspect of care or treatment without the involvement of the patient. Patients' requests at ward round were considered seriously. All patients had a copy of their care plan and care programme approach (CPA) documents.

Staff were very positive about patient recovery and supported patients to make progress as an individual. Staff

Long stay or rehabilitation mental health wards for working age adults

Good

communicated with patients so that they understood their care and treatment. Staff held regular individual sessions with patients. Staff also involved patients in their Care Programme Approach (CPA) meetings.

The team held planning meetings with patients every day to discuss what was happening during the day and to find out what patients would like to do and participate in. This helped staff to plan how they would deliver care and support and ensure escorted leave could be facilitated for those who needed to be accompanied.

Staff and patients together had decorated rooms within the service. Patients' artwork was on display throughout the premises.

Staff involved patients, when appropriate, in decisions about the service. Patients met regularly with staff in community meetings. Minutes of the meeting were taken. Staff followed up issues raised by patients and fed back on progress at the next meeting. For example, patients reported how much they had enjoyed the live music session arranged by the manager and that they would like to see these musicians again. Patients had recently raised the issue of the food being too salty and spicy and staff agreed to share this feedback with the chef.

There was a patient representative for the service. The patient representative regularly attended the clinical governance meeting and also got involved in interviewing potential new staff for the service.

Patients were asked to provide feedback about the service. Patients were asked to provide feedback at the community meetings, this part of the meeting was led by the patient representative. The advocate had recently undertaken a questionnaire with patients. The provider also undertook regular patient surveys. The October 2018 survey identified five action points, four of which had been completed. The fifth concerned the manner and approach of some staff. There had been a number of staff changes since this survey was undertaken. We observed positive improvements had been made and this was followed up with patients at each community meeting. There had been no recent comments or complaints. The service were awaiting an update from the next survey, the results were due at the time of inspection.

Staff ensured that patients could access an independent advocate. A patient advocate visited the service every week, and contact details of the advocacy services were displayed on the notice board of each unit. They also provided individual support to patients at ward rounds and CPA meetings.

Patients were involved in decisions about the service. Most changes to the service were discussed with patients at community meetings. Patients decided on parts of the activity programme as well as the food menu. Patients had also recently requested that the garden was open later than 10pm. The manager informed us that the garden was now open until midnight.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Staff kept in contact with family members and carers with patients' consent and encouraged them to be active in supporting the patient. The social worker took the lead on work with families and carers. Some families were very involved in patient care and attended ward rounds and CPA meetings. Most carers lived in the London area and the service kept in regular telephone or email contact where appropriate. The service held an annual barbeque which all families and carers were invited to attend.

Staff enabled families and carers to give feedback on the service they received. Staff invited families and carers to attend meetings to review patients' individual progress and support the patient. Families could provide feedback to staff directly at these meetings. Patient records showed communications with families including invitations to attend review meetings, if the patient consented. All carers received a pack containing information about the service and carers' rights. A survey of carers' views, carried out the previous year, showed that carers were 99% positive about the service and the care received by their relative.

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

Good

Access and discharge

Long stay or rehabilitation mental health wards for working age adults

Good

Bed management

The service reported an average bed occupancy of 76% between the period 1 July 2018 to 31 December 2018.

Beds were available when needed. The service accepted patients from all catchments, although most patients were from within the south London area.

There was a waiting list of patients for admission. Staff from the service visited patients to assess whether they were suitable for a rehabilitation service prior to admission. The waiting list was low. Delays in accessing a bed were often due to delays in commissioners agreeing funding for patients. There were four people on the waiting list. Regular meetings were held with the commissioners to discuss new referrals, and positive moves out.

There was always a bed available when patients returned from leave.

The average length of stay for the service was 990 days between the period 1 February 2018 to 31 January 2019. The service aimed for a length of stay of between 12 months and two years. The average length of stay was skewed by a small number of patients who had lived at the service for many years. We were informed by the service that they were working in partnership with NHS England, and local commissioners, to reduce the length of stay for those patients who had been with the service for more than two years. Most patients were admitted from acute inpatient wards, with a small number admitted from forensic wards.

When patients were moved or discharged, this happened at an appropriate time of day. Discharges out into the community, including to supported living, and transfers to other inpatient wards, always followed a graduated approach. The patient would usually be prescribed leave to initially spend several hours at their new home or placement followed by an overnight stay, then a weekend stay, until the patient and staff felt confident that the patient was ready to be discharged from the service.

Discharge and transfers of care

Between 1 July 2018 and 31 December 2018 there were four discharges from this service.

Patients' discharge planning was documented in their care plans around six months after they were admitted. This provided staff with the opportunity to ensure patients progressed on a discharge pathway which was right for them. Staff supported patients to set goals so that they could make progress towards discharge.

Patient discharge arrangements were discussed at ward round and the MDT meetings. Discussions focussed on how the patient could be supported with their discharge; this included personal goals, as well as housing arrangements, funding for any potential move to another service and any obstacles there may be.

The manager held regular meetings with relevant commissioners to discuss the patients they provided funding for. Meetings included discussions around discharge and transfer and whether anything additional was required to facilitate the discharge.

Discharge was delayed for a range of reasons. The service aimed for a length of stay of 12 to 24 months although there were patients who had been at the service for many years. The manager informed us that it was more realistic for new admissions to be discharged within that time frame. The manager also reported that it was sometimes difficult to find placements for patients who had a forensic history, and the service was dependent on the Ministry of Justice completing the required paperwork which could lead to a delay in discharge.

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Patients could personalise bedrooms and we saw that some patients displayed photos and personal belongings.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. These included an occupational therapy kitchen and an activity room.

There were quiet areas on each ward and a room off the unit where patients could meet visitors. There was one very small visiting room. It was too small for lengthy visits and restricted the number of visitors a patient could see. The manager informed us that consideration was being given to rearranging some of the rooms to provide an adequate space for visitors.

Patients were able to make telephone calls in private. There was a phone for patient use in the main corridor of the hospital. There was no hood, and privacy during phone calls could not be maintained. However, all patients

currently at the service had been risk assessed as suitable to use their own personal mobile. Patients could also access a cordless phone which they could take into a separate room if they did not have their own mobile and wished to have a private conversation.

Patients had access to outside space. There was a spacious garden area at the rear of the main building. Patients were able to access the garden area until midnight.

Different food options were available for patients which met dietary and cultural needs of patients. Most patients reported that the food was fresh and of good quality, although some patients said it could be a little spicy. There was a choice of meals which patients selected each day. Patients could make special requests if they did not like the options available.

Patients could make hot drinks and snacks throughout the day and night.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. One patient was being supported to undertake volunteer work at an art museum. Others were encouraged and supported to attend college, including IT courses. Up to six patients who were well enough had the opportunity to have small jobs at the service, which they were paid for.

Staff supported patients to participate in activities outside of the unit. The service was trying to focus on more community-based activities and took patients on regular outings to community venues and places of interest. Occupational therapy assistants and non-registered nursing staff took patients outside of the unit on walks, and to attend local amenities and go to the shops.

Meeting the needs of all people who use the service

The service was accessible to patients with disabilities. Bedrooms were suitable to accommodate patients with some degree of physical disability and there was a lift to each floor.

The service used interpreters for patients' whose first language was not English. Staff invited interpreters to care reviews and medical appointments to ensure patients could understand and be actively involved in decisions about their care.

Patients had a choice of food to meet their dietary requirements or religious needs. The occupational therapy team provided one to one cooking sessions with patients. Staff described how they had supported a patient from overseas to prepare culturally appropriate meals.

Staff ensured that patients had access to appropriate spiritual support. Staff supported people to attend places of worship and spiritual significance if the patient wished. One patient liked to attend church occasionally and we were informed that staff supported them to do this when possible. Although we noted that the patient had made a complaint that they had not been supported to go to church on Easter Sunday due to a lack of staffing.

Staff were supportive of patients who were LGBT+, although struggled to describe how the service demonstrated it was inclusive in its approach to patients and carers, regardless of their sexual orientation or other protected characteristics.

Listening to and learning from concerns and complaints

During the previous 12 months, the service received two complaints. One complaint had been filed because the manager had encouraged and supported a patient to make a complaint. One of the complaints was upheld.

Patients knew how to complain or raise concerns. Information on how to make a complaint was available on the noticeboard and regularly discussed at community meetings. The manager held sessions with patients where they could make suggestions about how the service was run, discuss any concerns, complaints or give feedback about their care.

Staff knew how to handle complaints. The service had a complaints policy and staff knew how to access this. Informal complaints were dealt with as they arose. If patients wanted to make a formal complaint staff supported them to do this.

When patients complained or raised concerns, they received feedback. When a formal complaint was made which required investigation, patients received communication from the manager acknowledging their complaint. A written response was sent to the complainant. Complainants were also invited to meet with the manager to discuss their concerns.

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Good

Staff received feedback on the outcome of investigation of complaints and acted on the findings. We were told that complaints were discussed at handover meetings and the team meetings.

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

Good

Leadership

Leaders had the experience to manage the units safely. The manager had been in post for nine months and came to the service with previous managerial experience in a mental health setting.

Leaders had an understanding of the services they managed. The manager was aware of the strengths and weaknesses within the service and had taken action in their relatively short time in post, for example by increasing the staffing establishment. The manager understood what the local risks were and what quality assurance measures were in place. They knew all the patients and had a good understanding of each patient's individual day to day needs. The manager recognised that a coordinated approach was needed to ensure a high-quality service was provided to support patients to become well and learn to live independently.

Leadership development opportunities were available, the manager informed us that they may take advantage of these once settled in to the role. There were limited development opportunities for staff below manager level, due to the small size of the organisation. However, since the manager had been in post, two new positions, senior support worker and clinical nurse lead, had been created.

Vision and strategy

Managers and staff knew and understood the provider's vision and values and how they were applied in the work of their team. The values and mission statement for the service were created with input from both patients and staff. The provider's vision was, "To improve and enhance the mental and physical health and wellbeing of everyone we serve through delivery of services that match the best in the world. We exist to help people to reach their potential, personal best and live well in their communities. We aim to be the provider of choice for individuals with mental health needs at the rehabilitation stage of their journey. We aim to provide a healing, warm, friendly and pleasant environment which will feel like a therapeutic space for all." The manager confirmed the vision for the service was underpinned by the clearly defined values of growth, recovery, ownership, warmth, time and healing. This was achieved through putting patients first, holistically meeting the needs and empowering patients and commitment to progressing them through their recovery journey.

The manager was able to explain how they worked to deliver high quality care within the budget available and how they supported staff to do this. The manager was responsible for working within budget and ensuring that staff who worked for the service provided high quality care to patients.

Culture

Staff felt very proud to be working in the service. They praised the service for the emotional support they had received following the tragic death of a colleague at work three years before.

Staff felt respected, supported and valued. Staff had not reported any cases of staff bullying or harassment and told us that they felt supported by their colleagues. The team worked well together and there was a positive staff culture.

Staff felt well supported by the manager and the rest of the multidisciplinary team. They felt able to speak up if they had any concerns and were confident they would be listened to.

Staff appraisals included conversations about career development, although internal opportunities were limited due to the size of the company.

Staff reported that the provider promoted equality and diversity in its day to day work and when opportunities for career progression arose. Staff members came from diverse backgrounds.

The sickness rate for the service was low at 1.8%.

Staff were aware that they could access support for their own physical and emotional health needs through the

service's occupational health service. The manager informed us that they referred employees to the service in accordance with provider policy and staff could also make self-referrals.

Governance

Governance arrangements were in place that supported the delivery of the service. We noted there was no documented rehabilitation strategy in place, however, there was a clearly defined care pathway for patients which outlined five separate stages and approximate timescales to reach discharge. This was supported by a good programme of rehabilitation activities for patients.

The service had identified risks and monitored the quality and safety of the service provided. Regular meetings were held where essential information was discussed. However, we noted that three of the mandatory training courses were below 75% attendance, these were basic life support, intermediate life support and mental health act law.

Staff participated in local audits. Examples of audits included care plan audits, medication audits and infection control audits. The audits supported managers to identify areas requiring improvement, although we noted that the medication audit had not identified gaps in administration records for one patient. Staff did not develop action plans following audits, however, we noted improvements were made each month.

Staff understood the arrangements for working as a team and linking with external organisations. For example, staff worked hard to engage with the patients' care co-ordinators and social workers and their funding CCG.

Staff told us they took part in regular quality governance meetings where they were able to look at new ways of doing things and consider innovations. Governance meetings also covered standing agenda items, such as incidents and safeguardings.

Management of risk, issues and performance

The manager maintained a risk register. Staff had access to the risk register and could escalate concerns to the manager. The manager assessed risks for their likelihood and impact and added risks to the register if they met agreed criteria. The risks identified on the risk register matched concerns discussed with staff during the inspection.

The provider had plans for emergencies; this included contingency arrangements for adverse events. The manager knew how to access the plan and would refer to it in the event of an emergency. The continuity plan included basic instructions for staff to follow in the event of a major incident, or disruption to the service due to loss of utilities or inadequate staff cover.

Information management

The service used systems to collect data that were not over-burdensome for frontline staff. The manager required to collate and submit data to a central team, for example human resources. The manager used data to have oversight of the service.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked. However, staff described the computer systems at the service as quite poor and very slow, causing delays. However, senior managers told us that an upgrade, in terms of internet speed, was about to be introduced and the quality of computer equipment would be reviewed following this.

The consultant psychiatrist was keen to introduce digital innovations in recording and move the service away from paper-based records. They had designed a number of electronic information recording systems to enable the service to make better use of data. For example, information on patient HoNOS scores could now be entered electronically and enabled progress to be tracked more easily. They had taken a similar approach to monitoring patients receiving high doses of antipsychotic medicines. Staff were about to roll out an electronic nursing handover tool and the consultant was developing an app-based approach to recording patient care.

Information governance training (data protection and EU general data protection regulation) was included in the mandatory training modules. The training informed staff how to maintain confidentiality. Staff compliance with this training was 80%.

The manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. For example, the manager could access data on the number and type of incidents which had occurred during a given period. The manager also kept a record on the

number staff who had attended mandatory training and the rate of staff sickness. Performance information about patients' length of stay and discharge rate was also available.

Staff made notifications to external bodies as needed. For example, one serious incident had been reported to the police and clinical commissioner. The service made safeguarding referrals to the local authority safeguarding team when they were concerned about the possible abuse of patients.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. Staff kept patients up-to-date by displaying information on notice boards, and discussion of any relevant matters during their one to ones with their named nurse. Staff received regular bulletins and newsletters that kept them informed of developments and incidents.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patient community meeting minutes confirmed this. Positive feedback on the service was received as part of the carers' survey.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. The consultant psychiatrist was keen to introduce digital innovations in recording and move the service away from paper-based records and had introduced some electronic monitoring tools to aid patient care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure that they continue to with commissioners and NHS England to support patients who have been at the hospital for several years to move on to more appropriate services.

The provider should ensure that staff have the necessary skills to develop an understanding of how to support patients with protected characteristics.