Coveberry Limited

Uplands Independent Hospital

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Uplands Independent Hospital provides long stay and rehabilitation mental health services to people aged over 18.

On 28 and 29 June 2022 the Care Quality Commission undertook an unannounced focussed inspection at Uplands Independent Hospital, to look at whether required improvements identified at our last inspection (11/12 January 2022), had been made. Following that inspection, we served the provider with a Warning Notice because we found that significant improvement was needed to ensure patients received safe care. The Warning Notice required the provider to make immediate improvements to meet the legal requirements set out in the Health and Social Care Act.

In order to meet those requirements, we told the provider that it must ensure that, robust risk assessments were completed, medicine systems were managed safely, care plans were person centred and clearly identified patient's needs, appropriate and timely physical health care for all patients was taking place, the environment and equipment were safe and clean, there were enough suitably qualified and competent staff, and that robust governance arrangements were in place to assess, monitor and improve the safety and quality of the service provided.

In addition to the improvements identified in the Warning Notice, we also told the provider it must ensure that, a recovery focused rehabilitation model was developed to support patients in their pathway to discharge, patients on high dose antipsychotic therapy (HDAT) had their physical health monitored appropriately, patients were treated with compassion and respect, staff completed mandatory training and received regular supervision, Mental Health Act 1983 T2 and T3 forms were up to date, and Mental Health Act 1983 S132 rights were explained to patients regularly and a process was in place to monitor this.

The provider submitted an action plan to demonstrate how they were going to meet the required improvements set out in the Warning Notice along with the other improvements required. We rated the service inadequate in all key questions and overall, and placed into special measures.

During this inspection, we found that not all the required improvements identified in the Warning Notice had been met. However, we identified that a number of positive steps had been taken since our last inspection and it was evident that the hospital was on a transitional phase, trying to implement improvements and to review their philosophy and working practices. Following the inspection, we asked the provider to provide us with assurance that they would continue to make immediate and ongoing improvements. The provider responded positively and gave us assurance that it would continue to make the required improvements within a clear timeframe. This included the move towards implementing a recovery focussed model of care. We therefore made the decision not to take any further enforcement action at this time. However, we will continue to closely monitor the hospital and will not hesitate to act if improvements aren't made in a timely manner.

The previous rating of 'inadequate' given following our inspection in January 2022 remains in place.

During the inspection we found:

- The ward environments and equipment were cleaner and the overall state of the building had improved since our last inspection.
- Risk assessments were mostly in place and reviewed, however, they sometimes lacked detail on how staff were managing risks.

Summary of findings

- At the previous inspection we found that staff did not always safely manage medicines. During this inspection, we found that whilst improvements had been made, some areas of concern remained.
- The service did not comply with same sex guidance. There was no female lounge in the complex care unit despite female patients living there. Staff were not aware of all the risks and relevant risk assessments had not been carried out.
- The provider had taken action to improve the number of suitably qualified staff. However, new staff were recently recruited, so more time was needed for them to have a meaningful impact on the quality of the services offered.
- The quality of care plans had improved since our last inspection, however, this was work in progress and further improvement needed. For example, care plans included more information about patients' physical health monitoring, but there was little evidence to demonstrate patient progress.
- The service did not work to a recognised model of mental health rehabilitation.
- Some people were living at the service for significant periods, however, some patients had moved on since our last visit.
- We identified improvement around the governance arrangements in place. For example, new audits and meetings had been introduced. However, processes were not fully embedded and management oversight needed to be strengthen.

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	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Uplands Independent Hospital

Uplands Independent Hospital provides long stay rehabilitative care and treatment to people aged over 18 who may be informal or detained under the Mental Health Act 1983. It offers assessment, treatment and continuing care for up to 24 patients. The service takes referrals from acute and low secure inpatient wards.

The hospital has two wards. The Complex Care Unit (CCU) provides care and support for patients with complex care needs, and the High Dependency Unit (HDU) is focused on supporting patients with high dependency needs. At the time of the inspection, there were ten patients in CCU and five in HDU.

Uplands Independent Hospital is registered to provide the following regulated activities:

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

The hospital was last inspected in January 2022 following a number of concerns brought to our attention by staff and from information that we had gathered during our routine monitoring of the hospital. Following that inspection, we rated the hospital inadequate overall and in all key questions. As a result of our serious concerns the CQC's Chief Inspector of Hospitals placed this service in special measures. We inspect services placed in special measures within six months of the previous inspection and if insufficient improvements have been made we will take further action in line with our enforcement powers.

At the time of our most recent inspection a new interim hospital director was in place, but they had not applied to become the registered manager.

What people who use the service say

We had mixed reports from people who used the service. Some patients told us that staff could be nasty and punitive, and that they spent most of their time watching TV or listening to radio.

Other patients told us that they liked the staff and would tell them if they had any problems. They also said that they had the opportunity to have visitors; one patient told us that they were supported to maintain relationships with their family.

How we carried out this inspection

The team that inspected the hospital comprised a CQC director of operations, two inspectors, one specialist advisor and a member of CQCs medicines optimisation team.

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

During the inspection, we visited both units at the hospital and looked at the quality of the ward environment and observed an activity.

Summary of this inspection

We spoke with the interim hospital director, team leaders, a volunteer, two visitors, a psychiatrist and other staff members, including members of the multidisciplinary team, registered nurses and support workers. We also spoke with three patients who used the service.

We looked at six care and treatment records of patients and at the management of medicines at the hospital. We reviewed a range of documents relating to the running of the service.

We also observed a multidisciplinary team meeting and a staff handover.

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

Action the service MUST take to improve:

- The provider must ensure robust individual patient risk assessments are always completed and that risks are managed effectively to keep all patients safe. Regulation 12
- The provider must ensure that the physical health of patients is assessed, monitored and managed effectively in accordance with patients' needs. Regulation 12
- The provider must ensure medicines are managed safely and effectively, and the impact of medicines on people's mental and physical health is appropriately monitored and reviewed. Regulation 12
- The provider must ensure that there are sufficient numbers of appropriate skilled and qualified staff deployed on all units at all times to meet the patients' needs. Regulation 18
- The provider must ensure a recovery focused rehabilitation model is implemented to support patients in their pathway to discharge or to an appropriate onward placement. Regulation 9
- The provider must ensure that staff continue to improve the quality of the care plans in order for them to be person centred, holistic and recovery-oriented. Regulation 9
- The provider must ensure that they provide a range of activities and interventions suitable to the needs of patients cared for in a mental health rehabilitation service and in line with national best practice guidance. Regulation 9
- The provider must ensure that robust governance processes are put in place to assess, monitor and improve the quality of care delivered at the hospital. Leaders must ensure clear oversight of the services provided. Regulation 17

Our findings

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	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Safe	Inspected but not rated
Effective	Inspected but not rated
Caring	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

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

Inspected but not rated

Safe and clean care environments

Wards were clean, well maintained and fit for purpose.

Safety of the ward layout

Staff completed risk assessments of all wards areas. We saw that the provider had carried out various environmental assessments, such as for legionella, fire, and general environmental risk assessments. However, staff had not always recorded whether actions had been allocated to a responsible person and whether these actions had been completed. During the inspection, we found that the provider had received an enforcement notice following an inspection from the fire service. However, managers informed us that they had asked for this inspection to ensure that all necessary actions related to fire safety had been appropriately identified, and they were taking action to make the required improvements.

Uplands Independent Hospital was set within an old listed manor house and as a result there were some blind spots and narrow corridors. However, mirrors were positioned in places where staff were not able to easily observe patients and CCTV was also used in communal space.

There were potential ligature anchor points, such as low hanging ceiling lights, wall lights and handles in the HDU and CCU lounges and multipurpose room. Daily ligature checks were carried out and ligature risk assessments were in place, however, the rationale for taking, or not taking, action to mitigate risks was not always clear. For example, low ceiling lights in the HDU lounge was rated low priority for action, but there was no rationale for this decision.

Staff had access to alarms and patients had access to nurse call systems. However, some of these were missing from some bedrooms in the HDU. Senior staff assured us that these would be replaced before the bedrooms were used again.

The service did not fully comply with same sex accommodation guidance. Bedrooms were en-suite and female patients did not have to pass male bedrooms to use toilets and washing facilities, but there was no female only lounge in CCU despite female patients being cared for there. Staff were not all aware of assessments that mitigated risks of mixed accommodation. For example, we observed an incident where a male patient exhibited inappropriate behaviours in communal space, in the presence of a female patient. However, when we alerted staff, some seemed unaware of the

risks despite that information included in the patient's care plan identified that such behaviours have been seen previously. We informed the provider of our concerns and asked them to provide us with assurances of what steps they were intending to take to comply with guidance and to mitigate risks. The provider took immediate actions to address our concerns. A separate female lounge was created and risk assessments were reviewed.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and fit for purpose. Since our last inspection, the provider had improved the overall state of the building and it was now clean following the provider engaging cleaning contractors. We also saw staff cleaning in all areas of the building during the inspection. Equipment service records were completed and showed that equipment servicing was up to date. A maintenance book was used by staff to report repairs and requests for remedial action were actioned.

Cleaning schedules were in place and they specified the tasks needed to be completed. However, the records sometimes lacked detail on the frequency of the tasks to be carried out. Records were not completed consistently which made it difficult to determine the housekeeping that had occurred. While housekeeping staff documented when patients refused them access to their bedrooms to clean, they did not record this consistently. The provider has engaged external contractors to carry out checks of electrical installations, portable equipment, gas safety and emergency lighting systems. Managers informed us that all recommendations were being actioned within the specified timeframes.

Staff were completing monthly infection control audits. The records for January to April 2022 showed that, overall, all assessed standards were met. Where shortfalls were identified action plans were developed on how to fully meet the standards. However, completion dates, or information about who was responsible for the actions, was not always included. There were posters on the use of Personal Protective Equipment and hand sanitizers were located in various places within the property.

Food hygiene was rated as 'five', meaning very good, by the Food Standards Agency. Fresh fruit was available to patients in the lounges and refreshment making facilities were also available.

Safe staffing

The service was taking action to ensure there were enough nursing and medical staff, who knew the patients and to ensure they received basic training to keep people safe from avoidable harm.

Staffing levels had improved since our last inspection, agency staff were used to maintain staffing ratios. The provider had taken action to improve the number of suitably qualified staff. There were still vacancies, especially for registered nurses but the provider informed us that they had a recruitment plan in place, which included recruiting nurses from overseas.

Managers could adjust staffing levels according to the needs of the patients and they informed us that they were devising a revised staffing model. The hospital was using agency staff who knew the service to cover vacancies, however, some staff told us that there were times when agency staff had to be supervised to ensure they covered the expectations of their roles. Some staff told us that they had to dedicate time away from their normal duties to support patients, because there was a lack of understanding of patients' needs and more staff were needed.

The provider had an induction checklist for new starters and managers were in the process of developing a formalised induction programme that they would undertake before commencing their first shift. The agency staff we spoke with said an induction checklist was completed when they started working at the hospital.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Mandatory training

Managers monitored mandatory training and alerted staff when they needed to update their training. The number of staff completing mandatory training had significantly improved since our last inspection. The hospital had a target of 90% completion rate and at the time of the inspection 83% of staff had completed their mandatory training. Mandatory training included training courses such as safeguarding vulnerable adults, data protection, emergency first aid, infection control and equality and diversity.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well.

We identified some improvement since our last inspection, but risk assessments were still not always robust. In some cases it was not clear how risk was rated and risk management plans were not always updated following incidents, or when risk assessments were reviewed. For example, it was not clear what the risk management plans were for a patient who was found in possession of illicit drugs.

Staff did not always know about all the risks for each patient and how to respond to prevent or reduce risks. For example, information included in some care plans suggested that patients were at risk of falls but relevant risk assessments had not been carried out. However, the provider told us that these had been carried out, but believed the documents had been intentionally removed from the care plans and destroyed. An investigation was under way regarding this.

The provider had introduced new ways to rate and manage risks since our last inspection. For example, a dynamic daily risk assessment tool had been introduced to determine the level of risk for each patient and to respond accordingly. The tool included a set of questions relevant to known risks that staff had to answer each day to determine the level of risk for each patient. For example, we saw that the level of risk for a patient who was not accepting support for their physical health had increased. The tool was stored electronically on a spreadsheet, but each day's assessments for the patients were also kept on a whiteboard in offices for staff to have easy access.

Improvement had been made to physical health monitoring since our last inspection. We saw that patients had been offered appointments with relevant clinicians and the service had appropriate monitoring charts in place where needed, such as food and fluid charts.

Staff followed procedures to minimise risks when patients needed to be observed. We saw that observation charts had been appropriately completed.

Use of restrictive interventions

Levels of restrictive interventions were reducing. During our last inspection, there were some blanket restrictions in place including staff keeping all patients smoking/vaping materials and limiting smoking times. During this inspection, staff told us that patients were able to smoke more regularly if they wanted to do so. There were set smoking breaks and posters were on display specifying the breaks times. Staff told us that regular smoking breaks were more effective, and patients no longer had to approach them for their cigarettes or wait outside the office for staff to support them

Staff attended training on how to manage situations where patients placed themselves and others at risk of harm. Restraint was used as a last resort and staff used distraction and de-escalation techniques to manage these situations.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

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. We saw that safeguarding incidents were reported on the hospital's electronic incident system and safeguarding referrals were made to the relevant authority when appropriate.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Managers were able to describe in detail their safeguarding processes. Senior staff members had recently been appointed as safeguarding leads for the hospital.

Medicines management

The service did not always use systems and processes to safely manage medicines. Staff did not regularly review the effects of medications on each patient's mental and physical health.

During the previous inspection, staff did not follow systems and processes when safely prescribing, administering, recording and storing medicines. At this inspection, whilst improvements had been made, some areas of concern remained. The issues around medicines administration not being recorded had been resolved.

Medicines were stored securely and within their recommended temperature ranges. During this inspection we saw that staff were attending training in the use of an electronic medicines management system that the provider was intending of introducing.

High dose antipsychotic treatments (HDAT) documentation was in place. Staff reviewed patients medicines regularly. Since the previous inspection, Mental Health Act documentation had been updated.

However, staff did not always manage all medicines and prescribing documents in line with the provider's policy. Expiry dates for in-use medicines did not reflect the manufactures directions. For example, in one clinic room we found medicines that needed to be discarded one month after opening, but the expiry date was revised to three months after opening.

One medicine administration area was not suitable for the administration of medicines as there were safety risks to patients and staff, and the area did not ensure privacy and dignity. The room was a converted toilet, the door was unstable and it was not fit for purpose. These issues had also been raised following our previous inspection, but the provider had not taken action yet.

Staff did not review the effects of each patient's medicines on their physical health according to the National Institute for Health and Care Excellence (NICE) guidance. Although HDAT monitoring had been introduced, some patients refused to have physical health and medicines checks for long term conditions. This meant we were not assured that the impact of medicines of people's physical health was appropriately monitored and reviewed.

Staff assessed whether it was safe for patients to administer their own medicines. However, where this was not safe, patients were not encouraged, or supported to take part in other medicines tasks that might have been suitable to promote their independence. For example, patients were not encouraged to appropriately ask for their medicines.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.

Since our last inspection, the provider had introduced an electronic system to record incidents. We saw evidence that incidents were recorded and in some cases they informed risk assessments and care planning, however, this was inconsistent. We saw examples of actions taken by managers following receiving reports from the safeguarding authorities.

The provider had introduced ways to disseminate lessons learnt to staff. Reflective practice sessions had been introduced and lessons learnt were specifically discussed during supervisions.

The provider had an incident log in place which included a section about immediate actions taken. In some cases, actions taken by staff and recorded on this log seemed did not always correlate with care plans.

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

Inspected but not rated

Assessment of needs and planning of care

Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected patients' assessed needs, however, they were not always recovery-oriented.

During the previous inspection, we found that staff did not always develop comprehensive care plans for patients that met their mental and physical health needs. Staff did not always regularly review and update care plans when patients' needs changed. During this inspection, we looked at six care plans across the hospital and we identified improvement.

Care plans were mostly personalised but we found that actions to meet individual needs were not always followed up. This was work in progress and some areas of care planning required further improvement. The provider had created a spreadsheet based on the arrangements for discharges. While there were improvements since the last inspection for example, five patients were on a pathway for discharge but "no plans" were documented for three patients and there was no entry made for two patients.

The provider had taken steps to assess the most suitable rehabilitation recovery model for the patient group. Governance meeting notes showed that one of the actions, was for managers to share the preferred therapeutic model with staff for consideration. However, the model was not yet embedded or evident in planning of care to support patients to learn or regain lost skills

Care plans were mostly personalised but we found that actions to meet individual needs were not always followed up.

Some staff told us that they carried out mental and physical health assessments which then informed the care plans. They also told us that patients were more involved in care planning and that care plans were being appropriately reviewed. However, they acknowledged that there was still more work to do.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Care records were kept securely. Staff had access to the care records and made daily notes about patients.

Best practice in treatment and care

Staff did not always effectively support patients with their physical health. Staff did not always use recognised rating scales to assess and record severity and outcomes.

Physical health monitoring had improved since our last inspection. Staff identified patients' physical health needs and recorded them in their care plans. We saw that managers had scheduled a meeting with GPs during our visit to improve access to healthcare for patients. We found evidence that patients had been offered physical health appointments and follow ups with relevant clinicians, however, patients often refused to attend and the actions to encouraged patient's participation was not clear in the records.

The provider used recognised assessment tools to identify signs and symptoms of deteriorating ill health, such as national early warning score (NEWS2), pressure injury risk assessment tool (Waterlow) and falls risk assessment tool (FRAT). However, these were not always used for all the patients with such needs.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. The service had in place appropriate monitoring charts where needed, such as food and fluid charts. We saw that these charts were appropriately completed for a patient with dietary needs. Staff were aware of the relevant care plan and knew how to appropriately support this patient.

Positive Behaviour Support (PBS) plans were in place when appropriate. The therapy team provided therapies and had access to assessment tools, such as the Model of Human Occupation framework (MOHO).

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 provided an induction programme for new staff, however, they did not always support staff with appraisals and supervision.

The hospital had access to a range of specialists to help meet the needs of the patients. The service had recently recruited a consultant psychiatrist, an occupational therapist, a psychologist and a number of registered nurses and support workers. However, they had only recently been recruited, so more time was needed for them to have a meaningful impact on the quality of the services offered.

Since our last inspection, the service had introduced new training for staff, such as training to deal with behaviours of concern and violence. All staff, including agency staff, had the opportunity to attend.

A formal process of annual appraisals was not yet taking place. Managers told us that appraisals had not been done yet because they had recognised the need for staff to have some supervisions prior to doing appraisals. They explained that some staff never experienced one to one supervision and they wanted these to be seen by staff as a supportive tool. At the time of the inspection 79% of staff had received supervision. Most of the staff we spoke with told us that they felt supported by their managers.

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, however, handovers between staff needed to be strengthened. Staff had effective working relationships with external teams and organisations.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We saw that such meetings were happening regularly. Staff were liaising with external teams and organisations, such as commissioners for discharges.

We attended a multidisciplinary meeting held during the inspection. We observed that most of the staff who attended this meeting were either new to the service or agency staff, but key issues were discussed for each patient, such as, personal safety and discharge pathways.

We also observed a staff handover meeting. Some agency staff were not aware of the unit they were meant to be working at, and it appeared that they were prepared to support both units if needed. However, the handover meeting they attended was specific to one unit only. A handover document was in place for each patient with sections for morning, evening and night, however, some sections had not been completed prior to the handover, or had limited notes on them. Some information was verbally handed over to the staff who were starting their shift. This meant that staff commencing their shift were not always up to date with all patients' needs and potential risks.

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

Inspected but not rated

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. However, they did not always understand the individual needs of patients and did not always support patients to understand and manage their care, treatment or condition.

We observed some caring interactions between staff and patients. Staff supported patients when they needed it. Some staff told us that there was a focus on building rapport with patients to provide their preferred activities. They also told us that they were building trust relationships and listening to patients, to assure them that their comments, queries and suggestions mattered to staff.

We had mixed reports from patients regarding staff support. Some patients told us that they liked the staff and would tell them if they had any problems. Some others told us that staff were not always nice to them.

During the inspection we observed that not all staff interacted meaningfully with patients and there were times when staff were talking to each other in lounges and did not interact with the patients. This was something that managers had also identified as an area that they felt needed to improve.

We saw that activity timetables were placed on notice boards but these included mainly leisure activities. Staff told us that they were trying to devise activities in a person centred and rehabilitating manner.

Although activities were organised, they were not meaningful or support life skills training such as work or education or meaningful activities. For example,

A coffee afternoon was organised by the psychologist and activities coordinator. The aim of the activities was for patients to come together for a chat. There were three patients having coffee, but we saw little interaction between staff

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

and patients. We saw a member of staff on their mobile phone. During the activity patients were asked for their preferred music however, this was not used as a conversation instead it was used for background music. The acting hospital director agreed activities were not totally meaningful but anticipated an improvement with the introduction of a recovery model.

Involvement in care

Staff did not always involve patients and their families in care planning and risk assessment. The service ensured that patients had access to independent advocates.

We only saw evidence of patient involvement in two out of the six care plans we reviewed. A patient told us that they were aware of their care plan and had been involved in some relevant reviews.

Staff made sure patients could access advocacy services. We found that a new contract with an organisation that provides advocacy services to patients had commenced in May 2022.

We saw that community meetings with patients were taking place, but it was not clear whether these were held regularly.

Some staff told us that families were involved as much as possible. They said that social gatherings had been organised and they regularly contacted families to inform and involve them following consent from patients. Family involvement was only recorded in one of the six care plans we reviewed.

We saw that a meeting with family members had taken place in April 2022, but it was unclear whether such meetings were held regularly.

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

Inspected but not rated

Access, discharge and transfers of care

Sometimes patients had to stay in hospital when they were well enough to leave, or would have benefited from moving to a different type of service that could meet their needs effectively.

During our previous inspection, we found that many patients at the hospital had been there for long periods of time and had their discharge delayed. During this inspection, we found that managers monitored the number of patients whose discharge was delayed. Whilst some patients were still at the hospital for long periods of time, three patients had moved on since our last visit.

The discharge planning information included in the patients care plans showed that, whilst improvement was made since our last inspection, there were agreed actions related to discharges that had not been initiated. For example, a new placement had been found for a patient, but no visits to their new home had been arranged yet.

Staff were working with commissioners to identify appropriate placements for patients outside the hospital. Some staff told us that they were involved in discharge planning and met regularly with commissioners when patients were ready for discharge. Patient discharges were delayed due to the lack of suitable alternative placements.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Patients' engagement with the wider community

Staff supported patients mainly with social activities outside the service.

During this inspection, we found that community activities were more regular. Outings were being organised, such as shopping trips. However, there were no work or education related activities.

Staff helped patients to stay in contact with families and carers. We saw that visitors were welcomed. They told us that staff had facilitated a visit with their friend. A patient told us they were able to maintain relationships with their family.

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

Inspected but not rated

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.

The provider had taken action to strengthen the management arrangements since our last inspection. An interim hospital director was in place. There was also a permanent clinical quality lead and a clinical nurse manager. The provider was supporting the local management team by allocating senior staff, such as an improvement lead, to support them. The interim hospital director had commenced employment with the service only a few weeks prior to the inspection, but they had a good understanding of the needs of the service. A service improvement plan had been devised and included actions to address issues, who was responsible for ensuring action was taken, and progress to date.

Leaders told us that the service was in a considerable period of change and recognised that further improvement was still needed. Their focus to date had been on ensuring the building was clean and well maintained, ensuring good quality leadership was in place, making staff feel valued and holding them to account. Leaders told us that once the preferred rehabilitation recovery model was implemented, the aim of the service would be to appropriately support patients to move into the community.

Culture

Most of the staff felt respected, supported and valued.

The staff we spoke with recognised that the service needed to improve and acknowledged that the new leadership was taking steps to that direction. Most of the staff we spoke with said that they felt supported by managers.

Staff told us that the team was more cohesive and they felt valued. However, some staff were still reluctant to change. Some staff were concerned that the service may close because of the inadequate rating.

Leaders were concerned that the documentation that was being put in place to improve the service, was being sabotaged. The provider had written to staff about this and an investigation was under way.

Governance

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

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

We saw that some improvements had been made to the oversight and governance processes, but these still needed embedding.

Leaders were taking action to strengthen their oversight of the service. The governance meetings had been recently updated and information was feeding into the providers board meetings. The local leadership team was working closely and regularly discussed issues. We saw that the service had recently recruited admin staff to undertake tasks such as preparing notes for multidisciplinary meetings and making sure that paperwork was up to date.

During this inspection, we found that various meetings, such as staff and quality governance meetings had been introduced. There were also team leaders meetings, but it was not clear whether these meetings were taking place regularly. Staff team meetings were held every two weeks. We saw that areas of discussion included improving documentation, cleaning, incidents reporting and training. We also saw that the service had recently introduced staff meetings for night staff.

Various audits had been introduced, such as care plans and Mental Health Act audits. There were also daily checklists completed by team leaders and a managers' walk round checklist. However, these processes were not yet fully embedded. There were no arrangements in place to ensure that audits were taking place when they should. For example, the care plan audit for June 2022 had not been completed, because the person responsible was on leave. Some audits did not include completion dates for actions, or who was responsible for these actions.

The clinical governance risk registers had been reviewed, but risk ratings were not being updated. For example, a risk had been described as 'improving' but the risk rating remained the same.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider did not ensure a recovery focused rehabilitation model was implemented to support patients in their pathway to discharge or to an appropriate onward placement. • The provider did not ensure that care plans were always person centred, holistic and recovery-oriented. • The provider did not provide a range of activities and interventions suitable to the needs of patients cared for in a mental health rehabilitation service and in line with national best practice guidance.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider did not ensure that robust individual patient risk assessments were always completed and that risks were managed effectively to keep all patients safe. • The provider did not ensure that the physical health of patients was assessed, monitored and managed effectively in accordance with patients' needs. • The provider did not ensure medicines were managed safely and effectively, and the impact of medicines on people's mental and physical health was appropriately monitored and reviewed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not ensure that robust governance processes were put in place to assess, monitor and improve the quality of care delivered at the hospital. Leaders did not ensure clear oversight of the services provided.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider did not ensure that there were sufficient numbers of appropriate skilled and qualified staff deployed on all units at all times to meet the patients' needs.

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.