Garry and Jane Blake

Sherwood Lodge Independent Healthcare

Inspection report

29-31 Severn Road
Weston Super Mare
BS23 1DW
Tel: 01934631294
www.sherwoodlodge.co.uk

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

Ratings

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

Summary of findings

Overall summary

At the previous inspection in May 2022, Sherwood Lodge was rated inadequate overall and placed in special measures. This comprehensive inspection was conducted to check that the improvements the service had detailed in their action plan to the commission had been undertaken. The inspection was unannounced and covered all key lines of enquiry.

Our rating of this service improved from inadequate to requires improvement and the special measures were lifted because:

- The environment had been improved since the previous inspection. The service had almost completed works on bedrooms, such as removing partition walls, and residents had been moved into single-sex bedroom corridors to ensure privacy and dignity.
- Staff were now completing comprehensive, and individualised assessments of people's needs and all residents had a completed and up to date personal emergency evacuation plan. Risk management plans were up to date and included appropriate details relating to people's risk. Staff knew about resident's known risks and how to act to prevent or reduce risks.
- All staff we spoke to understood how to recognise and report potential abuse and the service worked with other relevant agencies to protect residents from abuse. All staff had completed safeguarding training. The service was now submitting relevant notifications to external organisations, including the local authority and the Care Quality Commission, in a timely manner. This was an improvement from the previous inspection.
- Staff were reporting all incidents and managers investigated, identified learning and shared with the team. This was an improvement from the previous inspection.
- All staff were now completing care records that were up to date and easily accessible to all members of staff. Residents were encouraged to be involved in their care planning. Residents had regular access from a wider multidisciplinary team and this was now documented within care records. Residents and their loved ones were invited to take part in reviews. Verbal and written interactions with residents were respectful, supportive and person centred. This was an improvement since the last inspection.

However:

- Governance processes still required further improvement. Systems in place to assess, monitor and improve the quality and safety of the service were not always effective. There was a limited audit schedule, some audits were completed adhoc or hadn't been regularly repeated, such as the weekly management of medicines audit did not include a check of all medical sundries and first aid supplies and a closed culture audit did not include all necessary questions.
- Staff provided a limited range of care and treatment suitable for the residents in the service and care plans were not mental health recovery orientated and did not reflect personalised goals. Management had reviewed National Institute for Health Care and Excellence (NICE) guidance and identified which guidance was relevant to the service however this has not been addressed in a model of care for the service. The service provided activities, but they were not meaningful. Three out of the four relatives we spoke to said that the service wasn't "very lively" and "everyone just sits all day in the lounge".
- At the time of inspection, staff did not have access to policies which may have aided the running of the service and the manager was unable to provide assurances that staff had appropriate employment checks in place, such as valid disclosure and barring service certificates. This was because essential documentation and confidential staff files had been removed from the service to the provider's home address. However, we returned at a later date to review staff files and found employment checks in place

Summary of findings

- There were still several blanket restrictions in place but had no policy to ensure restrictions were proportionate, necessary, and least restrictive in line with the Mental Health Act Code of Practice. The blanket restrictions poster did not detail all restrictions in place and restrictions were not discussed as part of community meetings to ensure residents were aware of them. This included limited access to bedrooms, which some residents did not have their own keys for and could only access with staff support.
- Not all staff had received regular supervision or completed mandatory training.
- Some communal areas required further improvement and two bedrooms remained with a partition wall. There was still limited room and facilities to support therapeutic activities, for example a private area to meet with keyworker one to one. . Outside space had limited green space but had raised flower beds. Relatives we spoke with commented on the environment, stating it was run-down, grubby and required a freshen-up.

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	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Sherwood Lodge Independent Healthcare

Sherwood Lodge is an independent mental health hospital in Weston-Super-Mare that is dual registered as a nursing home, which provides community rehabilitative care and treatment of adults with mental health disorders, some of whom may be detained under the Mental Health Act 1983.

The service provides 24-hour residential care to both men and women and aims to provide a homely setting. The registration states the provider must only accommodate a maximum of 22 service users in receipt of the regulated activity of accommodation for persons requiring nursing or personal care, and those service users must be the only occupants of their rooms. At the time of the inspection there were 18 residents due to the majority of rooms now being single occupancy.

Sherwood Lodge has been registered with the Care Quality Commission since 1 October 2010 to carry out the following regulated activities:

- Assessment of medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury
- Accommodation for persons who require nursing or personal care.

There was a registered manager in post at the time of the inspection.

What people who use the service say

Most residents we spoke with said that the service was good, that they were content, and that the food was nice. Some residents told us they hated it at the service and wanted to leave.

Residents told us that staff were nice and kind, but some wished they would speak to them more often. One resident told us it was boring to live at the service.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the service. This comprehensive inspection was unannounced (the service did not know we were coming).

During the inspection visit, the inspection team:

- looked around the environment and clinic room
- spoke with the registered manager and owner of the service
- spoke with six members of staff including the deputy manager, a senior support worker, two support workers, and one domestic staff and the chef
- spoke to 12 residents
- spoke with four relatives
- looked at six care records
- completed a short observational framework for inspection (SOFI) and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that it takes a systemic approach to identify and challenge its practices that may amount to blanket restriction, with a view to ensuring that care and treatment is provided according to the principle of using the least restrictive option and maximising independence. (Regulation 13)
- The service must ensure that it completes the environmental works in relation to removing the partition walls and ensure bedrooms remain single occupancy (Regulation 15).
- The service must ensure that robust systems are in place to assess, monitor and improve the quality and safety of the service provided. (Regulation 17)
- The service must ensure that staff files and all other confidential documentation are stored securely at all times. (Regulation 17)
- The service must ensure that staff receive regular supervision and complete mandatory training (Regulation 18)

Action the service SHOULD take to improve:

- The service should ensure that residents are offered meaningful activity that promotes their health and mental wellbeing.
- The service should ensure that care plans met residents mental health needs and included individuals' goals for treatment.

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	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Is the service safe?

Requires Improvement

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

Safe and clean care environments

The environment had improved since the previous inspection. The majority of areas were safe, and well-furnished. However, at the time of the inspection two bedrooms had a partition wall remaining and some communal areas required redecorating. Three out of four relatives commented that communal areas were grubby and rundown. There was still limited room and facilities to support therapeutic activities and outside space had limited green space but had raised flower beds.

At the previous inspection the provider was told to remove the partition walls from all bedrooms as the inclusion of the wall made bedrooms very small, some only a single bed length, with limited space to move around next to the bed and furniture. Residents on one side of the partition did not have access to a window which meant they could not control light or ventilation independently. At this inspection, two bedrooms had a partition wall remaining. A schedule of works was in place which included the removal of these walls.

Staff now completed and regularly updated risk assessments of all service areas and removed or reduced any risks they identified. The service had completed an annual ligature audit and identified some potential ligature anchor points. Due to the nature of the client group, a comprehensive ligature risk assessment would not have been proportionate to complete.

The service complied with guidance and there was no mixed sex accommodation. All residents shortly after the inspection had moved into single-sex bedroom corridors. This meant the communal bathrooms and shower facilities were now single-sex use.

Residents had easy access to nurse call systems in their bedrooms.

Maintenance, cleanliness and infection control

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff made sure cleaning records were up-to-date and the premises were mostly clean. However, we observed coffee spilt on the dining room floor but staff did not immediately put out a wet floor sign and mop it up despite it being a high traffic area. We also saw that the bathroom on the male corridor had an unclean, wet floor.

Staff followed infection control policy, including handwashing.

Staff used a maintenance log to record and request repairs. There was a maintenance worker employed three days a week.

Clinic room and equipment

The clinic room was within a thoroughfare between staff offices and communal areas. Staff had access to basic equipment such as scales, blood pressure monitors and blood glucose monitors prescribed for residents who had diabetes. There was emergency portable oxygen. All equipment had been replaced within the past 12 months and therefore had not required servicing or calibrating.

Safe staffing

The service had enough staff, who knew the residents and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep residents safe.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

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

Managers supported staff who needed time off for ill health.

Managers calculated and reviewed the number and grade of nurses and support workers for each shift and could adjust staffing levels according to the needs of the residents.

Residents had regular one- to-one sessions with their named nurse. However, one resident commented that they wanted more time with staff.

Residents rarely had their escorted leave or activities cancelled, even when the service was short staffed.

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

Medical staff

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had access to one consultant psychiatrist who was the responsible clinician for patients detained under the Mental Health Act and worked at a local NHS trust. The consultant psychiatrist reviewed patients a couple of times per month and was available at all times to attend the service in an emergency or contact as necessary. All patients had access to a local GP, who attended the service monthly. The service reported that the relationship with the local GP had improved however we did not receive any feedback from the GP when requested.

Mandatory training

Not all staff had completed their mandatory training. For example, Some staff had not completed non-abusive psychology and physical intervention training. Two members of staff had only completed safeguarding training and no other mandatory training. Six members of staff were not included in the service's training matrix but had worked shifts during April 2023. These eight staff were either nurses or support workers.

The mandatory training programme was comprehensive and met the needs of residents and staff. The service had recently implemented a new e-learning programme.

Assessing and managing risk to residents and staff

Staff assessed and managed risks to residents and themselves well. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. However, they did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate residents' recovery.

Assessment of resident risk

Staff completed risk assessments for each resident on arrival, and reviewed this regularly, including after any incident. A care plan had been created for each resident's area of risk.

Management of resident risk

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

Staff identified and responded to any changes in risks to, or posed by, residents.

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

Use of restrictive interventions

Staff only used physical restraint as a last resort and used de-escalation techniques when necessary to keep the resident or others safe.

Safeguarding

Staff understood how to protect residents 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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Staff kept up-to-date with their safeguarding training. All staff had completed either level 2 or level 3 safeguarding training depending on their role.

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

We saw evidence that safeguarding referrals had been made to the local authority and that incident reports and handover forms highlighted potential safeguarding concerns. Management and staff recognised adults at risk of or suffering harm and worked with other agencies to protect them. This was an improvement since the last inspection.

Staff access to essential information

Staff had easy access to clinical information. Records were all paper based.

Resident notes were comprehensive and all staff could access them easily. Each resident had their own folder in the staff office, which was colour-coded to correspond to their key nurse.

Staff made sure records were up-to-date and complete.

Records were stored in the staff office however they were not stored securely. The office was not routinely closed or locked and records were stored on a shelf rather than a lockable filing cabinet. There was also archived records in envelopes on the floor that weren't securely stored.

Medicines management

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

Nurses monitored the effects of medications on resident's mental and physical health and discussed this with the consultant psychiatrist and GP as necessary. Staff monitored the physical health and side effects for residents prescribed specific medicines such as lithium and clozapine. Residents were supported to attend the necessary phlebotomy appointments at the local hospital. Staff completed medicines records accurately and kept them up to date.

The deputy manager had completed a weekly management of medicines check. However, it did not include all aspects of medicines management. For example, the check did not include reviewing all medical sundries and first-aid supplies. We found that seven out of 14 boxes of test strips for blood glucose monitoring went out of date in July 2022. We found three out of nine packets of lancets had expired in 2022. There were urine strips that went out of date in 2020 and two packets of steri-strips that expired in October 2022 and November 2021. These items were stored in drawers under the medication cabinet and were not being checked by staff but were in use.

We found no medication out of date.

Staff were not responsible for prescribing resident's medication.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Reporting incidents and learning from when things go wrong

The service managed resident safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave residents honest information and suitable support. This has improved since the last inspection.

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

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

Managers debriefed and supported staff after incidents.

Managers investigated incidents and audited incidents monthly to identify any learning and actions.

Staff received feedback from investigation of incidents. Staff met to discuss the feedback and look at improvements to resident care.

There was evidence that changes had been made as a result of feedback. For example, following incidents where residents had unexplained bruising, a body map form had been introduced to ensure all markings and injuries were recorded at the time of incidents.

Is the service effective?

Requires Improvement

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all residents on admission. They developed individual care plans which focussed on physical health, risk, and medication needs which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected residents' assessed physical health needs and identified risks but didn't reflect personalised goals and were not recovery-oriented.

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

Residents had their physical health assessed soon after admission and regularly reviewed during their time on the service.

We reviewed six resident care records. Staff completed care plans for each resident that met their physical health needs. Care plans related to mental health and wellbeing for focussed on risk, medication and meeting with health professionals. Care plans didn't reflect personalised goals and were not recovery-orientated.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Best practice in treatment and care

Staff provided a limited range of treatment and care for residents. This included support for self-care, medication, and some activities. Management had identified which best practice guidance was relevant to the service, but this had not been addressed in a model of care. There was little evidence of meaningful activities taking place.

Staff provided a limited range of care and treatment suitable for the residents in the service. This included support with self-care, medication and some activities. Three out of four relatives told us that the service wasn't "very lively" and "everyone just sits all day in the lounge". We completed a Short Observational Framework for Inspection and during that time we observed the majority of residents sat in the main lounge with a neutral or withdrawn expression. The television was on but no one was engaged in watching it. The volume was loud. One resident asked staff to change the channel but they were unable to as the remote control was missing.

Staff identified residents' physical health needs and recorded them in their care plans. Staff made sure residents had access to physical health care, including specialists such as tissue viability and district nursing. Staff met residents' dietary needs, and assessed those needing specialist care for nutrition and hydration.

All residents had care co-ordinators from the placing NHS trust and adult social care who kept separate clinical and risk documentation. Care co-ordinators reviewed the patients as required. The registered manager told us that there was good working relationships between the care co-ordinators and the team at Sherwood Lodge.

Staff were not completing regular audits of the care they provided. The registered manager had a leave of absence for six months prior to the inspection and audits had stopped during this time.

Skilled staff to deliver care

The service team included or had access to a range of specialists required to meet the needs of residents. Managers did not always make sure they had staff with the range of skills needed to provide quality care. Staff did not always receive regular supervision. Managers provided an induction programme for new staff.

The service had access to a range of specialists to meet the needs of the residents.

Managers did not always ensure staff had the right skills to meet the needs of the residents in their care, including bank staff. For example, only 28% of staff had completed mental health awareness training and 56% had completed diabetes training. Support staff had not completed the care certificate, which is a nationally recognised sets of standards for health care support workers to demonstrate skills, knowledge, values and behaviours associated with their role.

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

Managers did not always support staff through regular, constructive supervision of their work. The deputy manager had not had formal supervision since August 2022, two members of staff had only had formal supervision once in the past 12 months, and two members of staff had only had formal supervision once in the past five months.

Managers supported staff through regular, constructive appraisals of their work.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit residents, this included nurses, support workers, and a consultant psychiatrist as well as external professionals from the local mental health NHS trust. They supported each other to make sure residents had no gaps in their care. They had effective working relationships with staff from services providing care following a resident's discharge.

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

Staff had effective working relationships with the visiting responsible clinician and care coordinators. Care coordinators and the responsible clinician attended the service to complete reviews throughout the year and attended annual care programme approach meetings.

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

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

Staff did not receive training on the Mental Health Act and the Mental Health Act Code of Practice.

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

Residents had access to information about independent mental health advocacy and residents who lacked capacity were automatically referred to the service.

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

Staff made sure individuals could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

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

Good practice in applying the Mental Capacity Act

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The majority of staff had received and kept up-to-date with training in the Mental Capacity Act.

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

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

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

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

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

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

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were mostly respectful, and responsive when caring for residents. For example, by offering cups of tea, checking if they were ok and offering to bring jumpers out if they were cold. However, one resident told us that staff pulled their duvet off them in the morning.

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

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

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

Residents said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each resident.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes to residents. The provider had a Speak Up Guardian and dignity champion, in order to make it easier to raise concerns.

Staff followed policy to keep residents information confidential.

Involvement in care

Staff offered care plans to residents. Staff actively sought patient's feedback on the quality of care provided more generally.

Involvement of residents

Staff introduced residents to the service and the services as part of their admission.

Staff involved residents and gave them access to their care planning and risk assessments.

Staff made sure residents understood their care and treatment.

The service held monthly house meetings, which residents and staff attended. Staff kept minutes of the meetings and provided feedback to residents following these.

Residents could give feedback on the service and their treatment and staff supported them to do this. Staff made sure residents could access advocacy services.

Involvement of families and carers

Staff informed families and carers appropriately.

Staff supported and informed families or carers as appropriate. Carers we spoke with felt the service informed them as often as needed.

Is the service responsive?

Requires Improvement

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

Access and discharge

Residents at the service had multiple and complex specialist care and treatment needs and it was not always expected that individuals would be discharged from the service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The model of care was under review at the time of inspection. This was because the service had agreed to remove the regulated activity of assessment and treatment for persons detained under the Mental Health Act 1983. If the regulated activity was removed the service would solely run as a nursing home rather than mental health hospital and the service would no longer be able to accept people detained under the Mental Health Act.

Facilities that promote comfort, dignity and privacy

The majority of the design, layout, and furnishings of the service supported residents' treatment, privacy and dignity. Each resident had their own bedroom and access to single-sex communal bathrooms. There was a female-only lounge. The food was of good quality and residents could make hot drinks and snacks at any time. When clinically appropriate, staff supported residents to self-cater.

There were several blanket restrictions in place; however there was no policy or in place to ensure that the service was adhering to the Mental Health Act Code of Practice. We were concerned that the restrictions may not always be proportionate, necessary or the least restrictive option. For example, most residents who were smokers were not allowed their own bedroom key and could only access their bedroom during the day if they asked staff to unlock the door. The rationale was to prevent risk to lives by residents smoking indoors and accidentally causing a fire; however all cigarettes and lighters were also restricted and locked away. Residents had to ask staff to give them cigarettes and lighters, and then were prompted to go outside to the smoking area. Only one resident had been risk assessed to have their own bedroom key. Some residents told us they were not allowed to go into their bedrooms during the day; however staff told us they had to ask and they would let them in. We raised this at the time of inspection and asked that residents be informed they could go into their bedrooms during the day.

Some residents were subjected to restrictions, but it was not clear if these were proportionate, necessary or the least restrictive option. For example, we spoke to one resident who was waiting to be given their money by staff. They told us they could only have their money at a certain time that day but there appeared no rationale for the time and the resident was distressed they had over an hour to wait before being given it. We observed another resident only being allowed two cans of fizzy drink a day at set times.

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

There was a limited range of rooms and equipment for staff to use to support treatment and care. The clinic room was within a thoroughfare between staff offices and communal areas, and did not allow for privacy when residents were administered their medication or checking their blood glucose levels. There were no private rooms for residents to have one to one sessions with their key nurse and staff and residents had to use a lounge.

The service was registered to provide the regulated activity 'accommodation for persons requiring nursing or personal care'. However, there was limited space to provide nursing procedures or interventions due to small bedrooms and a small clinic area that was not accessible to patients.

There was limited appropriate space within the building for residents to have private conversations.

The service had an outside space with limited green areas that was mostly designed as a smoking shelter.

Residents could make their own hot drinks and snacks and were not dependent on staff. However, hot drinks were not allowed during mealtimes.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service offered a variety of good quality food.

Residents' engagement with the wider community

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

Staff supported residents on trips in the local area, including the beach and town centre.

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

Staff organised events and activities to celebrate events such as resident's birthdays, the queen's jubilee and the king's coronation.

Meeting the needs of all people who use the service

Staff helped residents with communication, advocacy and cultural and spiritual support.

The service was not suitable for individuals with significant mobility issues however those with mobility needs were placed in downstairs bedrooms.

Staff had access to interpreters and arranged for religious support if needed.

Staff made sure residents could access information on treatment, local services, their rights and how to complain. Information on treatment, local services, their rights and the complaints process was displayed on notice boards, but it was not clear how residents accessed or understood this information.

The service had access to information leaflets available in languages spoken by the residents and local community.

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

Residents had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

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

The service clearly displayed information about how to raise a concern in resident areas. The service had implemented 'You said, We did' boards to demonstrate how feedback had been listened to and actioned.

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

Managers investigated complaints and identified themes.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

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

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, a relative had informally complained that they didn't receive regular updates on their loved one. Staff now send a regular email update to relatives who chose this option.

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

Is the service well-led?

Requires Improvement

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

Leadership

Leaders had the skills, knowledge and experience to perform their role. They had an understanding of the services they managed and were visible in the service and approachable for residents and staff. The registered manager had a significant leave of absence prior to the inspection. The deputy manager had stepped-up to provide a leadership role, supported by an experienced member of staff and the owner of the service. Staff, residents and relatives spoke highly of the deputy manager.

Vision and strategy

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

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear. The deputy manager had been appointed the Freedom to Speak Up Guardian for the service. However, we were concerned that a closed culture could develop.

We reviewed the service in line with CQC's closed culture guidance and were concerned there were risk factors for a closed culture to develop. These issues are potentially indicative of a closed culture and could put individuals at risk of harm.

The service had completed a closed cultures audit as part of their action plan however it didn't identify all potential indicators of risk. For example, an inherent risk factor of a closed culture is the workforce comprising of many members of staff who are either related or friends. The audit completed by the service did not include this, despite several members of staff being related. A warning sign of a closed culture is the use of restrictions. The service's audit highlighted this as a risk but actions had not been put in place to address this and a policy had not implemented despite this being raised at the previous inspection.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Governance

Our findings from the other key questions demonstrated that governance processes didn't always operate effectively. Systems and processes to assess, monitor and make improvements where needed were not robust.

For example, the audits and checks that monitored medicines management did not identify the out of stock supplies and medical sundries, the closed culture audit had not been fit for purpose and the blanket restrictions audit had not identified all restrictions. For example, restricted access to bedrooms during the day if a smoker, handing in all smoking materials to be locked away by staff, no hot drinks allowed during meal times.

Clinical governance meetings were held monthly.

Management of risk, issues and performance

Gaps in supervision and training had not been identified by management as a risk.

Engagement

Managers engaged other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. The owner of the service met regularly with the local safeguarding team, commissioners and Care Quality Commission to review their action plan and safeguarding procedures.

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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not take a systemic approach to identify and challenge its practices that may amount to blanket restriction, with a view to ensuring that care and treatment is provided according to the principle of using the least restrictive option and maximising independence

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The service had not ensured that all rooms with a partition had been addressed by building works to make the rooms single occupancy

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have robust systems are in place to assess, monitor and improve the quality and safety of the service provided. The service did not ensure that staff files and all other confidential documentation are stored securely at all times.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Accommodation for persons who require nursing or personal care

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The service did not ensure that staff receive regular supervision and complete mandatory training