Elysium Healthcare (St Mary's) Limited

St Mary's 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	Requires Improvement
Are services safe?	Inadequate
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

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

- We rated the safe domain as inadequate. Staff did not always provide safe care. Staff did not always carry out restrictive interventions safely and in line with best practice, policy and guidance. Patients were not always safeguarded from harm.
- The ward environments were mostly safe and clean. The wards had enough doctors but did not always have enough nurses and support staff. Staff did not always assess and manage risk well.
- The service was not always well led, and the governance processes did not always ensure that patients were kept safe in the hospital.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for people with acquired brain injury	Requires Improvement 	See the summary above for details. Wards for people with learning disabilities or autism is a small proportion of hospital activity. The main service was services for people with acquired brain injury. Where arrangements were the same, we have reported findings in the services for people with acquired brain injury section.

Summary of findings

Contents

Summary of this inspection

Background to St Mary's Hospital

St Mary's Hospital provides inpatient care for men aged 18 years and older. The service was in the process of reconfiguring the wards, but at the time of our inspection it had 67 beds over five wards. These wards are:

- Cavendish ward – 17-bed ward for men with an acquired brain injury. This includes four self-contained flats.
- Leo ward – 12-bed assessment, treatment and rehabilitation ward for autistic men.
- Hopkins ward (part of Leo ward) – four bed assessment and treatment ward for autistic men.
- Adams ward – 12-bed medium secure ward for men with an acquired brain injury including up to four beds for deaf patients.
- Dalston ward – 18-bed low secure ward for men with an acquired brain injury.
- Eve ward – four-bed acute mental health ward, used by a local NHS acute trust.

We carried out this inspection because we had received information of concern that may affect the care and safety of patients. During this unannounced inspection we focussed on Cavendish ward and Leo ward and looked at parts of the safe and well led key questions.

This is the sixth time we have inspected St Mary's Hospital since it was registered by the Elysium Healthcare group in August 2018. We previously carried out a comprehensive inspection in June/July 2021, and a focused inspection in October 2021 because of concerns about the service. The service received an overall rating of requires improvement following both these inspections.

Following these inspections, the provider is still working through an ongoing action plan with dates for completion set after the date of this current inspection. As such, the regulatory breaches and rating from the previous inspections still stand for effective (requires improvement), caring (good), responsive (good) and well led (requires improvement).

The previous rating of safe was requires improvement. During this current inspection we have issued a warning notice in the safe domain, regarding the safeguarding of patients. We can issue a warning notice where the quality of the care falls below what is legally required. The issuing of a warning notice normally limits the rating of that key question to inadequate.

The service is registered to provide the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983; and
- treatment of disease, disorder or injury.

The service has a registered manager.

What people who use the service say

The feedback we had from patients was mixed. Most were broadly positive about the service, but some had specific complaints about their own care. Patients said that most but not all staff were helpful, supportive and polite. Some patients had complaints about individual staff, which had been reported and dealt with. Most patients told us they felt listened to and could raise concerns. Some patients felt their concerns were responded to, but others did not. Patients were aware of the multidisciplinary team and of the advocacy services. Patients liked the activities, but some wanted to do more and thought they could be a bit boring. Patients told us they enjoyed activities and trips outside the unit.

Summary of this inspection

How we carried out this inspection

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

During the inspection visit the inspection team:

- visited Cavendish ward and Leo ward, looked at the ward environment and observed how staff were caring for patients
- spoke with nine patients or relatives of patients
- spoke with the registered manager
- spoke with 13 other staff
- reviewed eight care records of patients and other care related documents
- spoke with an advocate
- attended two meetings
- looked at CCTV footage
- looked at a range of policies, procedures and other documents relating to the running of the whole service.

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

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action the 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 service must ensure that it protects patients from abuse and improper treatment, and that it has systems and processes that are established and operated effectively to safeguard patients (regulation 13(1)(2)). We issued a warning notice to the provider telling them to improve by 30 November 2022.
- The service must ensure that monitoring of patients' safety is carried out as required and recorded correctly. This includes body maps, epilepsy charts, post-rapid tranquilisation monitoring and enhanced or one-to-one observations (regulation 12(1)(2)(a)(b)(c)).
- The service must ensure that restrictive interventions, including physical interventions, follow recognised guidance and individual care plans (regulation 13).

Action the service SHOULD take to improve:

- The service should ensure that staff receive robust training and support in working with patients with an acquired brain injury or autism, which enables them to provide appropriate support to patients in accordance with their care and positive behavioural support plans (regulation 18).
- The service should ensure that there is strong and visible leadership at all levels and continue to work to stabilise the leadership team (regulation 17).
- The service should ensure that enhanced observation levels are carried out in accordance with the service's policies and individual patient's plan of care and are documented correctly (regulation 12).

Summary of this inspection

- The service should ensure that patient records, including positive behavioural support plans and risk assessments, are up to date and of sufficient quality and detail to meet the needs of patients (regulation 12).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	Inadequate	Not inspected	Not inspected	Not inspected	Inspected but not rated	Requires Improvement
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inspected but not rated	Requires Improvement

Requires Improvement

Services for people with acquired brain injury

Safe	Inadequate
Well-led	Inspected but not rated

Are Services for people with acquired brain injury safe?

Inadequate

Our rating of safe went down. We rated it as inadequate. We issued a warning notice about safeguarding procedures and therefore the rating we gave has been limited to inadequate.

Safe and clean care environments

All wards were safe, mostly clean and maintained, but there were signs of wear and tear.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff carried out an environmental ligature point audit and risk assessment each month. This identified the level of risk and if any action was required to remove this, or to mitigate against it, for example if the risks were in communal or supervised areas.

Staff had easy access to alarms and patients had easy access to nurse call systems. A silent alarm system had been introduced on Leo ward, to minimise the distress to autistic patients from loud and persistent noise. This was part of a programme of measures being implemented to improve the environment and make it more suitable to people with sensory needs. An ongoing programme of refurbishment was in progress.

Maintenance, cleanliness and infection control

Ward areas were mostly clean, maintained, and well furnished. Some areas of the wards were worn and tired.

Staff mostly followed infection control policy, including handwashing. Staff carried out regular audits, which had been increased during the COVID-19 pandemic. Staff meetings included reminders to staff of the importance of following guidance. Managers and staff implemented a corporate response following changes to national guidance in response to the pandemic.

Safe staffing

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

Nursing staff

At our inspection in June/July 2022, we told the service that they needed to improve their staffing levels as they relied heavily on agency staff. At the following inspection in October 2021, we found that the service still did not have enough

nursing and support staff, but that overall staffing levels had improved, and the service was developing an action plan to address the staffing issues. At this inspection we found that the service still had staffing challenges and was continuing to implement the action plan to address this. The requirement notice remains in place, as for this focused inspection we only reviewed staffing levels on two wards, and not across the whole site.

The service had core staffing levels of 40 registered mental health nurses, of which 20% (eight posts) were vacant. There were five nurses in the process of being employed. The service had core staffing levels of 130 support workers, of which 19% (twenty-five posts) were vacant. The core staffing levels do not reflect the additional staff required to carry out enhanced observations with patients, or the use of bank and agency staff. Cavendish and Leo wards both had several patients who needed to be with one or more staff at all times. Managers had contingency plans if staffing levels went below the minimum. This involved reviewing and potentially reducing the observation levels of some patients, so that they remained safe, but activities may be limited.

Managers routinely used high levels of bank and agency staff. They tried to request staff who were familiar with the service, and with individual patients. Managers had block-booked individual staff to promote consistency.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. New bank staff had a similar induction to permanent staff. New agency staff had an induction to the service, and to the needs and care plans for specific patients. The service provided specific training to staff on how to support specific patients with complex care and communication needs.

The service had continuing staff turnover. In each of the months of May, June and July 2022 there had been five or six staff leaving the service, and between two and five new starters.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Staffing was discussed in the daily multidisciplinary team meeting. Staffing issues including recruitment, engagement and absence was discussed in the monthly operational governance meeting. There was an ongoing local and corporate recruitment programme.

The service had enough staff on each shift to carry out any physical interventions safely. Over 88% of required staff were up to date with management of violence and aggression training. Agency staff were required to complete the same standard and type of physical intervention training as permanent and bank staff.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There were no vacancies for medical staff. Doctors were part of the Elysium-wide on-call rota that provided medical cover in the evenings and at weekends.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Over 90% of 207 permanent staff and nearly 88% of 111 bank staff were up to date with their mandatory training.

The mandatory training programme was comprehensive and broadly met the needs of patients and staff. Most of the training was completed online, but some training was face to face including management of violence and aggression.

Most training had been completed by over 85% of staff. The only areas that were below this were food safety level 2 training, that was completed by nearly 55% of the nine staff who were required to do it, and safeguarding adults and children level 2 which had been completed by 75% of the 8 staff who were required to do it. Managers monitored mandatory training and the online system also alerted staff when they needed to update their training.

The corporate mandatory training programme did not include all training that may be essential for staff who worked at St Marys Hospital. The provider had not fully prescribed the specialist mandatory training required for each role and how regularly this should occur. It was not robustly monitoring uptake rates to ensure all staff had appropriate training for their responsibilities.

Most of the wards were for patients who had an acquired brain injury, and Leo ward was predominantly for autistic people. Specialist training had been provided and included training on acquired brain injury, autism, dysphagia (difficulty swallowing), positive behavioural support and Huntington's disease. Training sessions were also provided to staff on the needs of individual patients, and how to support them. Records showed that this training had taken place, and had been completed by some permanent, bank and agency staff. However, it was not clear whether the training was sufficient to meet the needs of patients, and what proportion of current staff had completed this.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves. The level of detail in risk assessments was variable and not always up to date. Staff did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. However, we did observe some positive practice by staff. Staff responses to challenging behaviour varied. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Risk assessments did not always include the most recent risk information about the patient. The level of detail in the risk assessments was variable. They were reviewed, but not always changed as a result of this even when it appeared that a patient's needs or level of risk had. Risk information was documented elsewhere in the care record, such as in the discussions at multi-disciplinary meetings, meaning that staff may use or relay information form the risk assessment that was not fully complete. Staff used a recognised tool to assess the risk of each patient on admission.

Management of patient risk

Staff identified and responded to any changes in risks to, or posed by, patients. Patients had care plans and positive behavioural support plans that reflected their needs and how to minimise the risks presented. However, the level of detail in the care plans and positive behavioural support plans was variable. Some plans, particularly on Leo ward were very detailed and clearly identified each patient's needs and how to work with them; others were more basic and did not reflect the complexity of individual patients. On both Cavendish and Leo wards all patients had a communication passport and two-page profile. This provided a summary of key information for staff, including new and temporary staff, about each of the patients.

Staff did not always monitor patient risk as required or record this correctly. If a patient had bruising or an injury, this was recorded but body maps were not always completed or did not contain the necessary level of detail. For example, staff were not fully recording the approximate size and colour of any bruising, scratch or injury. Patients who received rapid tranquilisation (medicines administered to rapidly sedate them), did not always have the necessary physical health checks completed afterwards. Monitoring forms showed that one set of observations was taken immediately/ shortly after the medicines were administered, but no further monitoring was carried out as stated in NICE guidelines. Epilepsy charts were not always completed when required for at least two patients, so there was no clear record of the

frequency or severity of their seizures. Patients were still receiving treatment for their epilepsy, including medication and action by staff immediately after seizures occurred. However, for one patient there had been repeated requests for epilepsy charts for over a month, which were not responded to, which led to a delay in referral for specialist assessment/treatment.

Staff could observe patients in all areas of the ward and followed procedures to minimise risks where they could not easily observe patients. CCTV covered communal areas. This was used retrospectively, including regular random reviews of CCTV as part of the safeguarding of patients.

We looked at CCTV during the inspection, reviewing random times on Cavendish and Leo ward as well as tracking incidents. Staff were not always managing risks in line with best practice, care plans and policies. For example, we saw a patient not getting their required observation levels in line with his corresponding multidisciplinary team risk assessment, as staff were talking with each other or carried out other duties such as laundry. Another example was that staff did not always interact in a therapeutic manner during observations. We saw patients eating lunch in a communal area whilst staff sat on their own table and carried out a conversation amongst themselves. These incidents were discussed with a senior manager during the inspection.

Patients on each of the wards had a range of needs and risks and were at different stages of their recovery. Bedrooms and areas of the wards had been tailored and adapted to meet the needs of specific patients. Managers had identified that the mix of patients was not always beneficial and were in the process of reconfiguring Cavendish and Leo wards and reviewing the pathway.

The speech and language therapist assessed all patients and developed and oversaw care plans for patients who had dysphagia (difficulty swallowing). They also provided assessments and care plans for patients with communication and sensory needs, including autistic patients on Leo ward. The speech and language therapist provided training for staff in dysphagia risk assessment and management.

Use of restrictive interventions

Staff did not always follow best practice when using restrictive interventions. We reviewed CCTV footage of a notifiable safeguarding incident. Staff were seen on several occasions not following best practice and using unauthorised breakaway techniques, which put patients and staff at risk of harm.

Patients had individual positive behavioural support plans that described how staff should respond to their needs and support them. The quality of these varied, as some were very detailed and clear, with others more basic. Patients had complex needs and most staff worked well with them, and patiently supported them even when they were potentially aggressive. However, there were some occasions when staff had not responded to these situations correctly. Staff did not always make every attempt to avoid using restraint by using de-escalation techniques and restraining patients only when these failed and when necessary to keep the patient or others safe. We observed numerous staff on CCTV not de-escalating a patient's agitation in line with their care or positive behaviour supports plans. For example, by putting hands on a patient to move and re-direct them, when this was contrary to their care plan if there was no immediate risk to themselves or others.

Elysium employed its own tutors to teach physical interventions, and these were all part of a nationally recognised training body. Over 88% of 134 permanent staff had completed management of violence and aggression training. Agency staff were required to complete the same programme as part of their contract. The tutors trained staff and

worked with them onsite. Physical interventions were tailored to individual patient needs when required. Tutors also carried out a training needs analysis review, which identified any areas of difficulty, or where more training was required. Tutors would also review CCTV following incidents, to see if best practice was being followed, or if there were any areas for improvement.

Cavendish ward had relatively low levels of physical interventions. For the period from February to June 2022 this varied from one to eight per month, apart from April which was notably higher with 18 physical interventions related to a specific patient. The interventions were used with between one and five patients each month.

Leo ward had higher levels of physical interventions. For the period from February to April 2022 this varied from 182 to 192 interventions per month and had increased to 250 in May and 361 in June. This covered a range of interventions, with the highest levels being "friendly come along – stage 2" (between 67 to 89 interventions per month) and "team/ emergency intervention – upper limb wrap" (between 46 and 77 per month).

Physical interventions were used with most patients on the ward, but there were higher levels used with some specific patients. Following a significant increase in escalation of incidents for one person, staff took appropriate action to safeguard other people. We tracked one patient's day on Leo ward and identified that they were restrained in different rooms at different times of the day. This service recorded this as one prolonged restraint, with each step of the physical interventions recorded under this on the service's incident reporting system. It was not clear if this was recorded as one or multiple restraints.

Staff did not always follow NICE guidance when using rapid tranquilisation. The level of monitoring required after rapid tranquilisation was not routinely carried out and documented. Monitoring is required after rapid tranquilisation because of the increased risk of impact on breathing, blood pressure and severe side-effects. The number of uses of rapid tranquilisation varied between months – in the period from February to June 2022 it had been used between none and four times on Leo ward and between none and three times on Cavendish ward.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. Cavendish ward had three patients in long term segregation with at least two members of staff in the separate flats. Leo ward had one patient in long term segregation.

Cavendish ward had six patients on enhanced observations, including the patients in the separate flats. Leo ward had eight patients on enhanced observations for at least part of the day, with some reduced at night. Some patients had higher staffing levels to support them with activities, or to support their physical healthcare needs.

Staff did not always follow best practice in the use of seclusion. Following a recent incident identified through the provider's own random review of CCTV footage, staff had been seen to prevent a person from leaving their bedroom for a sustained period even though this person had not been deemed to require such restrictions, called 'de-facto detention'. We observed numerous staff involved in the de-facto detention across a number of hours. They used the chair and door to push the patient back into his room. Managers had taken action following these incidents.

Staff participated in the provider's restrictive interventions reduction programme. The service had a policy on the Use of Force Act, and managers had carried out an initial assessment against the standards and was mostly compliant. Elysium Healthcare complied with restraint reduction network training standards.

The service had systems for monitoring the use of restrictive interventions, but they had not always been effective to safeguard patients.

Clinical governance meetings had identified a possible trend for restraint to be used sooner than required, rather than de-escalation. Staff recorded the use of physical interventions in the electronic incident recording system. This was very detailed and included a step-by-step description of the different types of holds or restraint used. For individual incidents this described how a situation had developed, including attempts to de-escalate. This was useful for identifying what had been successful, what could be improved, and if further advice was required or changes to the patient's positive behavioural support plan. The reducing restrictive practice data for physical interventions listed the types of interventions by type. An incident may involve one short intervention, or it may include a group of interventions which could last for several hours.

Restrictive interventions were discussed in the morning senior multidisciplinary team meeting, to identify any further actions required. This included any patients in seclusion or long-term segregation, any use of physical restraint, and enhanced observations. The service had a dashboard of information that included detailed information about the use of restrictive interventions. This was reviewed in governance meetings and was presented on a rolling three-months so that changes or themes could be seen.

Staff participated in the provider's restrictive interventions reduction programme. The service had a policy on the Use of Force Act, and managers had carried out an initial assessment against the standards and was mostly compliant. Elysium Healthcare complied with restraint reduction network training standards.

Safeguarding

Staff did not always understand how to protect patients from abuse and were not always reporting abuse in a timely way when they saw it. The service had systems to recognise and follow up on abuse, and worked with other agencies to do so, however these were not always effective. Staff had training on how to recognise and report abuse, but these were not always followed.

We have issued the provider with a warning notice as we found that patients were not always protected from abuse and improper treatment. When potential safeguarding incidents occurred, these were not always identified or reported. Several potential safeguarding incidents had occurred where staff were participants or observers. These incidents had not been immediately reported by the staff involved or those who observed the events. The incidents were only reported some time afterwards, or when seen on CCTV footage. Managers had taken some action following the identification of most concerns in relation to patient care. However, we saw one example just prior to the inspection where managers had identified probable concerns following random CCTV footage but had not acted robustly.

All Elysium's services were expected to review a small sample of CCTV footage each month. Following the missed potential safeguarding incidents, managers were reviewing more CCTV footage for a wider range of incidents, and random events, and had identified further incidents. Where physical interventions had occurred, the therapeutic management of violence and aggression trainer was also reviewing the footage. We reviewed a sample of CCTV footage including incidents that had been reported to us. It was not clear that appropriate physical intervention techniques were always used.

Staff received training on how to recognise and report abuse, appropriate for their role. Safeguarding training was provided in three levels as part of the mandatory training programme. The most basic safeguarding training, usually for non-clinical staff, had been completed by over 89% of 37 staff. The next level had been completed by 75% of eight staff. Most staff who worked directly with patients were required to complete the third level of training, and over 85% of 158 permanent staff had done so. Agency staff were contractually required to have safeguarding training before they could work in the service. Staff were not reporting in line with the service's policies and procedures.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The social work department led on safeguarding in the service. They provided additional training and support to staff, and liaised with the local authority safeguarding teams. Safeguarding incidents were recorded on the electronic incident reporting system. The social work department also kept a log of potential safeguarding concerns, so they could track events even if they were closed by the local authority. All reported incidents were discussed in the daily multidisciplinary team meeting. These identified any concerns, and if an incident needed to be reported to the local authority. The social work department would usually make the referral to the local authority.

Staff access to essential information

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

Permanent and bank staff had access to an electronic records system, that included detailed information about each patient. Not all agency staff had access to the electronic records system. Many patients had large amounts of detailed information about their history, ongoing needs, and how to support and care for them. As it was not always practical for staff to read and absorb this information, and for agency staff, all patients had a paper communication passport and a two-page profile. These provided a summary of key information about the patient. Patients on enhanced observations had key information about them with the observation recording forms. Some patients had key information about them and their care on display in their rooms.

Records were stored securely. The electronic record system was password protected, and paper records were stored in the staff office.

Reporting incidents and learning from when things go wrong

Staff did not always recognise incidents and report them appropriately. Staff did not always feel supported after incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not always know what incidents to report and how to report them. There had been some potential safeguarding incidents that had not been reported by staff or had been identified and reported later – either by staff or following reviews of CCTV footage.

The provider had an electronic incident reporting system. All permanent staff had access to this system and used it to report incidents. Bank and agency staff recorded incidents in a book, and this information was then put into the electronic system. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers did not always debrief and support staff after any serious incident. Staff had mixed views about the support they received following incidents. There were policies in place for staff to have debriefing sessions following incidents, but it was not clear if these always happened.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Information about incidents in other organisations was discussed in the daily senior multidisciplinary team meetings, and in the clinical governance meetings.

Requires Improvement

Services for people with acquired brain injury

There was evidence that changes had been made as a result of feedback. For example, following incidents involving patients with dysphagia, care plans and ward-based training had been implemented.

Are Services for people with acquired brain injury well-led?

Inspected but not rated

Leadership

Leaders were not always visible. Staff did not always feel supported by their managers. Some managers had had a good understanding of the services they managed. There had been ongoing changes and some gaps in the leadership team since our last inspection. Staff gave mixed feedback about how supported staff felt by their managers. Most staff felt supported by their local managers. Staff had divided opinions about more senior managers , some felt they were approachable and visible, but others said there was limited communication with them.

Cavendish ward had had several changes in ward manager, including absence, and had an interim manager who had been in post since December 2021. Staff and managers agreed that the absence of leadership on the ward had left staff feeling unsupported.

Managers agreed that staff were probably not that aware of who constituted the senior management team, which included the wider multidisciplinary team. Managers acknowledged that staff absences and restrictions due to the COVID-19 pandemic, had led to them spending less time visiting the wards.

The management structure in the hospital had been reviewed and was in the process of changing. Managers acknowledged that this would be another change in leadership within the organisation and would create gaps in the short term. However, they felt that the creation of new roles would be of benefit in the future.

Culture

Staff did not always feel respected, supported and valued. Staff did not always feel able to raise any concerns without fear. There was some evidence of staff not reporting poor practice and abuse.

The service used a closed culture audit tool last completed in February 2022. The external tool found some areas that put it at risk of a closed culture. The self-assessment identified a number of areas where factors indicated a high risk of closed cultures. This included staffing levels, patients being in the service for a long time, and disagreements about the care provided and care plans not always being followed.

Managers and staff had mixed views about whether there was a 'closed culture' on any of the wards. This was particularly relevant to Cavendish ward which had had several changes of manager, and no manager at all for a period of time. CCTV showed poor practice and potential abuse and restrictive practices had been observed but not always reported by staff. Some staff told us they thought there had been or still was a closed culture, as staff had been a close-knit group with limited support. However, they thought most staff were still caring towards patients, and skilled at working with them and meeting their needs. Other staff believed that staff sometimes did what they thought was in the best interests of the patient, without following a formal process for this; and that some staff did not always understand the needs of the patient group and why they might behave how they did.

Managers had increased reviews of CCTV, which had identified some incidents that had not been reported. These had subsequently been reported as incidents and investigated and responded to.

Requires Improvement

Services for people with acquired brain injury

We observed care generally and using a recognised monitoring tool. We saw some positive interactions between staff and patients, and some neutral ones, but no negative interactions. Some of the relationships between staff and patients were positive, very person centred, and reflected a friendly but respectful relationship. We saw CCTV footage of positive and neutral interactions, but there were also some negative interactions. These included incidents the provider was aware of, and some occasions where staff were not interacting with patient for extended periods, or not carrying out enhanced observations as required.

Managers had brought in a service development and wellbeing lead to work with staff in the service, with a particular focus on supporting staff on Cavendish ward.

Staff received supervision and appraisal. Eighty-five percent of 160 staff had received supervision in the last quarter, and 94% of these had had an appraisal.

Governance

Our findings from the other key questions demonstrated that governance processes were in place, but not always operated effectively to ensure that performance and risk were managed well, and patients were safe from abuse.

The service had an ongoing action plan, from regulatory breaches following previous inspections, which included improving the robustness of its governance processes. The completion dates for these actions was after this current inspection. The service continued to be under greater scrutiny from the host commissioner process with colleagues from the integrated care boards meeting regularly to discuss the improvement journey that St Mary's Hospital was on.

The service followed the corporate Elysium governance process, which was changed in early 2022. Operational governance and clinical governance meetings were held separately each month, and fed into the regional and national governance system, and ultimately up to the board. Each meeting had a standard agenda and was attended by the multidisciplinary team. It included the expected areas such as staffing, incidents and complaints, and service developments. An action log was completed, which was followed through at following meetings. However, some actions went on for extended periods of time. For example, following several incidents with patients with dysphagia (difficulty swallowing), the need for all staff to have training was identified in February 2021. However, low completion rates were recorded for a further year until it was noted to be completed in March 2022. Similarly, the need for staff to complete competency assessments to carry out enhanced observations was identified in July 2021, but not removed until May 2022.

Managers had initiated a reducing restrictive practice group in September 2021. This met bi-monthly and reviewed restrictions within the service, at both ward and unit level, and where relevant for individual patients. However, this had not picked up that one patient was subject to de-facto seclusion by staff.

The service was in the process of developing the model of care on Cavendish and Leo wards, with the aim of making the pathway clearer for patients and addressing some of the problems created by having patients with very differing needs. The service had identified some of the difficulties with having staffing problems and changes in managers and was taking steps to address these. This included reintroducing reflective practice sessions and the introduction of a service development and wellbeing lead. The service had made some changes to its senior leadership team and support around compliance and governance and was also making further planned changes to further improve its oversight and governance.

Requires Improvement

Services for people with acquired brain injury

The morning senior multidisciplinary team meeting reviewed all the significant incidents and events in the service each week day morning, in order to identified where changes were required, or if incidents could be signed off by the team. However, this had not picked up, for example, that body maps were not completed correctly.

Staff were mostly up to date with their mandatory training. However, the provider had not fully prescribed the specialist mandatory training required for each role and how regularly this should occur. It was not robustly monitoring uptake rates to ensure all staff have appropriate training for their responsibilities.