

Manchester Mental Health and Social Care Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
TAE17	Anson Road	Anson ward	M14 5BY
TAE03	Park House	Acacia ward	M8 5RB

This report describes our judgement of the quality of care provided within this core service by Manchester Mental Health and Social Care Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Manchester Mental Health and Social Care Trust and these are brought together to inform our overall judgement of Manchester Mental Health and Social Care Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Requires improvement



Are services safe?

Good



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Good



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We have judged the service as requires improvement because:-

Acacia had dormitories, which contained four beds, and despite curtains partitioning the beds; the dormitories did not offer full privacy.

On Anson ward, the records and patient comments did not always demonstrate how the patient had been involved in their care and treatment.

Only half of the staff had completed their annual appraisals on Acacia ward.

There were some identified points that a patient could use to fix a ligature point. There was an environmental risk assessment in place that identified these and the staff had taken action to mitigate these areas of risks to protect patients.

Clear processes were in place to safeguard patients and staff knew about these. Incident recording and reporting had taken place. Teams discussed actions from incidents and patient alerts to ensure that staff learnt lessons.

Staff assessed, monitored, and managed risks to patients on a day-to-day basis. Staff assessed the needs of the patient and from this planned their care. Staff involved patients on Acacia ward in the development of their care plans. .

For both wards, we had positive feedback from patients in relation to the care and treatment they received from staff. Patients had the opportunity to be involved in all aspects of their care including regular reviews.

The wards had clear processes in place for managing referrals. Staff planned for patients discharge from admission. This meant that patients were discharged from hospital as soon as possible.

Patients knew how to complain and the staff responded to complaints and made changes as needed.

The formation of the rehabilitation group, the close working relationships between Acacia and Anson ward, and the service audit, demonstrated a commitment to quality improvement.

Compliance with mandatory training and line management supervision was good across both wards. However, the trust's systems did not enable the ward managers to monitor the nursing staff's compliance with the trust clinical supervision protocol.

The ward environments were clean and provided appropriate facilities to support patients recovery. The staff helped to ensure that the wards provided patients with privacy.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as good because:-

- There were some identified points that a patient could use to fix a ligature point. There was an environmental risk assessment in place that identified these and the staff had taken action to mitigate these areas of risks to protect patients.
- The wards were clean and in good decorative order. Staff completed cleaning and hygiene audits to ensure the upkeep of standards.
- Staff assessed, monitored, and managed risks to patients on a day-to-day basis.
- On Acacia ward, we found there were good systems in place for the management of medicines including appropriate storage, dispensing and recording of medication.
- Clear processes were in place to safeguard patients and staff knew about these.
- Incident recording and reporting was effective. Teams discussed actions from incidents and patient alerts to ensure that staff learnt lessons.
- The wards had sufficient nursing and support staff to meet patients' needs. However, staff rotas showed that sometimes Anson ward did not have a full complement of staff.

Good



Are services effective?

We rated effective as requires improvement because:-

- Staff on Anson ward had not prescribed or administered medication safely. Two patients' records out of the nine reviewed of patients detained under the MHA had medicine charts with a higher dose of medicine prescribed than agreed.
- There was inconsistent medical cover on Anson ward. This meant staff did not follow an evidence based rehabilitation care pathway. The multi-disciplinary team meetings did not always have a responsible clinician who could make medical decisions about patients detained under the MHA.
- The ward managers did not monitor staff clinical supervision to ensure it was compliant with the trust protocol.
- Staff assessed patients' needs and planned their care.
- Although Acacia ward offered a recovery group once a week, neither ward had a dedicated psychologist who could offer patients' therapies to help them recover from their mental illness

Requires improvement



Summary of findings

However:

- the ward was staffed by skilled and motivated staff, that generally had good access to training and support.
- Staff had been involved in clinical audits to improve the rehabilitation services.

Are services caring?

We rated caring as good because:-

- Motivated staff supported patients with care, dignity, and respect.
- Patients on Acacia ward were involved in and participated in decisions about their care and treatment.
- Patients had community meetings where they were consulted and involved in the changes to the services and were able to input their views.
- To improve services the trust sought and collated patient experiences.

However:

On Anson ward, the records and patient comments did not always reflect their involvement in their care and treatment.

Good



Are services responsive to people's needs?

We rated responsive as requires improvement because:-

- Acacia ward had dormitories, which contained four beds, and despite curtains partitioning the beds; the dormitories did not offer full privacy.
- The wards had clear processes in place for managing referrals.
- Patients knew how to complain and staff responded to these complaints by making changes as necessary.
- Staff planned for patients' discharge from admission. This meant that patients were discharged from hospital as soon as possible.
- Patients had the option of taking part in activities. Patients often made their own meals, drinks, and snacks and carried out their own shopping.

Requires improvement



Are services well-led?

We rated well-led as good because:-

- The ward managers had managed the wards well at ward level. Despite the uncertain future, staff provided care and treatment, which enabled patients' rehabilitation and recovery. Staff morale on both wards was good.

Good



Summary of findings

- On Acacia ward staffing establishments were reviewed by the ward manager and increased should the need arise. Staff had completed mandatory training but many staff had not completed their annual appraisals.
- On Acacia ward staff reported incidents promptly and there was evidence of staff learning from the investigation of incidents.
- The ward had a register of any potential risks to the service and audits took place to ensure the maintenance of standards.
- On Anson ward both the ward manager and matron had implemented changes and improvements to the ward. Staff sickness rates and turnover had reduced. Staff had completed mandatory training but the manager did not monitor staff clinical supervision to ensure it was compliant with the trust protocol..
- Anson ward had a local risk register that identified the risks to the service. The ward manager had submitted a business case to improve medicines management and the environment in November 2014.
- However, improvements were limited by the lack of a permanent full time consultant psychiatrist who could give medical leadership and by the lack of regular audits by the trust pharmacy. Both of these issues were outside of the ward managers and matrons' authority
- The formation of the rehabilitation group, the close working relationships between Acacia and Anson ward, and the service audits demonstrated a commitment to quality improvement.

Summary of findings

Background to the service

Manchester Mental Health and Social Care Trust had two registered locations that provided long stay and rehabilitation services. There was one service at Park House in the north of Manchester and a second at Anson Road in the south of the city.

Acacia ward on the Park House site was a locked 20-bed recovery focused rehabilitation service, for men aged between the ages of 18 and 65, with complex and enduring mental health needs.

The service at Anson Road was an open 17-bed recovery and rehabilitation service, for men aged between the

ages of 18 and 65. The patients had complex and enduring mental health needs and where the patient is close to being capable of living independently in the community.

The CQC inspected Anson ward in June 2013 and Park House in 2014 and found both compliant. There were no current enforcement or compliance actions being taken by CQC in relation to either of the rehabilitation wards visited at the time of this inspection.

Our inspection team

Our inspection team was led by:

Chair: Steve Shrubbs, Chief Executive Officer, West London Mental Health NHS Trust.

Team Leader: Brian Burke, Care Quality Commission.

Head of Inspection: Nicholas Smith, Care Quality Commission.

The inspection team included CQC inspectors and a variety of specialists; a consultant psychiatrist, a psychologist, a pharmacist, a mental health and learning disability nurses and a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Prior to the inspection we reviewed a range of information we held about long/stay rehabilitation

mental health wards for working age adults and asked other organisations to share what they knew. We also held public listening events and focus groups for patients who used the service.

During the inspection, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, and therapists.

We carried out the following announced visits:-

- Anson ward on the 24 and 25 March 2015,
- Acacia ward on the 25 March 2015,

During the inspection we:

Summary of findings

- Spoke with 11 patients individually and 25 patients as part of two community groups which we attended.
- Interviewed fifteen members of staff were interviewed these included, consultant psychiatrists, modern matron, nurses, occupational therapists, ward and service managers,
- Attended and observed two community meetings, two handovers and a MDT team meeting,
- Reviewed twelve sets of patient records were reviewed.
- Checked the management of medication.
- Reviewed the Mental Health Act documentation.

What people who use the provider's services say

During the visits to the ward areas we spoke with 11 individual patients and 25 patients whilst attending two community groups. They all told us that staff were kind, caring and treated them with respect. We observed good interactions between staff and patients throughout the service. Patients appeared relaxed and comfortable in the presence of staff.

Patients gave positive feedback about staff. Comments made were “interested in my well-being”, “supportive”, “very good” and “nice and polite” and “staff go all the way to help and engage with patients”.

However, some patients on Anson ward told us they had not seen a copy of their care plans.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

- The trust must ensure that medication records and the agreed medication limits of patients detained under the MHA are correct at Anson ward. Also, that patients are informed about the purpose or side effects of their medications.
- The trust must ensure all qualified nursing staff have appropriate clinical supervision.
- The trust must provide a plan of how bed bays can be replaced with single rooms. The plan should include the interim measures that will be put in place to ensure the privacy and dignity of the patients using shared accommodation is improved.
- The trust should make sure that patients at Anson ward have a consistent approach to their medical treatment.
- The trust should make sure that patients are involved with the development of their care plans on Anson ward.
- The trust should ensure that staff at Anson ward are able to find all the patient information.
- The trust should ensure that patients have access to psychological therapies, to help them recover from their mental health problems and regain the skills and confidence to enable them to live successfully in the community.
- The trust should ensure that a local rehabilitation care pathway for patients with complex mental health needs is agreed and implemented at Anson ward.
- The trust should ensure that patients who are risk assessed and safe to do so, have access to the internet on the wards.
- The trust should ensure that staff have access to MHA and MCA training.

Manchester Mental Health and Social Care Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Anson ward	Anson Road
Acacia ward	Park House

Mental Health Act responsibilities

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

The Mental Health Act reviewer looked at the rights of detained patients under the Mental Health Act on both wards. They found that Mental Health Act documentation was present and available for inspection and in order on both wards.

There was good compliance with the requirements of the MHA on Acacia ward. However there were some issues identified on Anson ward which needed addressing.

We looked at six medication charts for the five patients subject to an agreed certificate to prescribe and administer medication and we could not find evidence that the responsible clinician had discussed with the patient the

purpose, or side effects of treatments. We found discrepancies in two patients' records between the medication being administered and medication listed on the T2 (certificate of consent to treatment) and T3 (certificate of second opinion forms). This meant two patients' medicine charts had a higher dose of medicine prescribed than agreed.

In addition, one of the authorised medications was outside of the British National Formula (BNF) limits. Moreover, the responsible clinician had not recorded on one T2 certificate either the name of the drug or the BNF code for that drug. Instead, the responsible clinician had recorded broad classes of drugs such as "anti-psychotic". This practice does not comply with the MHA Code of Practice.

Detailed findings

Two patients were ready for discharge, but the trust had not ensured procedures took place under the MHA to facilitate that discharge. The records demonstrated that patients had their rights explained under the MHA. However, the trust did not routinely use a rights checklist to ensure that patients had knowledge of all the rights they were entitled to know.

On Anson ward two patients said they had not had access to an independent mental health advocate to help them appeal against their detention. Other patients on both wards told us staff had offered access an advocacy service. On both wards, patients had accessed tribunals and had access to legal advice.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our visit, there were no patients subject to a deprivation of liberty safeguards (DoLS) on either of the wards.

Overall, we found that staff had a good understanding in relation to issues regarding capacity and consent. MCA training was part of mandatory training and all staff were expected to update this every two years. Although, we found only 9 out of 13 staff on Anson ward and 5 out of 14 on Acacia ward had completed MCA and DoLS training. The ward managers reported that the figures were low because training was difficult to access.

On Acacia ward, we saw evidence that ward staff had considered patient's capacity to consent, where specific decisions had to be made. However, on Anson ward, we could not find evidence that the doctor had discussed the reasons for treatment, the side effects of medications, nor assessed the patients capacity to consent to treatment in five patients' record out of the 11 we reviewed.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We rated safe as good because:-

- There were some identified points that a patient could use to fix a ligature point. There was an environmental risk assessment in place that identified these and the staff had taken action to mitigate these areas of risks to protect patients.
- The wards were clean and in good decorative order. Staff completed cleaning and hygiene audits to ensure the upkeep of standards.
- Staff assessed, monitored, and managed risks to patients on a day-to-day basis.
- On Acacia ward, we found there were good systems in place for the management of medicines including appropriate storage, dispensing and recording of medication.
- Clear processes were in place to safeguard patients and staff knew about these.
- Incident recording and reporting was effective. Teams discussed actions from incidents and patient alerts to ensure that staff learnt lessons.
- The wards had sufficient nursing and support staff to meet patients' needs. However, staff rotas showed that sometimes Anson ward did not have a full complement of staff.

identified that when a patient was identified as a risk of self-harm, individual risk assessments and closer observations would be put in place and the ward staff had taken actions to respond to the risks.

Staff told us if a patient continued to pose a risk to themselves or others, which staff could not be safely managed on the ward, they would transfer the patient to a more appropriate environment to meet their needs and ensure their safety.

The risks associated with ligature points and the banisters were in the environmental risk assessment and included in the ward risk register. The ward manager reviewed the risk of ligatures regularly. The tour of the ward identified one further risk that was not included on the risk register. The team manager immediately amended the risk assessment to include this.

The ward manager had submitted a business case with recommendations to improve the environment to senior managers in November 2014.

On Acacia ward risks to patients were managed locally, by using increased levels of observation.

The buildings were clean throughout and staff followed good practices for the control and prevention of infection. Patients told us that standards of cleanliness were usually good. The patient led assessment of the care and environment scores for the period of January to June 2014 found Anson and Acacia wards above 97% for cleanliness and above 96% for maintenance. However on Acacia ward patient said the toilets were often blocked causing an unpleasant odour.

The clinical room was clean, tidy and equipped with appropriate resuscitation equipment and emergency drugs. However, the clinic room door at Anson ward did not have a warning sign to alert people to an oxygen cylinder in the room.

Staff carried personal attack alarms to ensure their and patient safety. However, on both wards we found that many alarms had been lost. Both managers stated that they were awaiting delivery of new alarms.

Our findings

Safe and clean ward environment

Acacia and Anson wards were single sex male rehabilitation wards.

We found that Anson ward had places where patients could use as ligature points. We found these in areas where the patient could be unobserved. The stair banisters were at above waist height and had spindles. This meant it was possible for patients to fall over or use them as ligature points.

However, most patients were in recovery and staff had assessed all patients as not at risk of self harm. Staff

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Safe staffing

The medical cover at Anson ward was inconsistent. This was because when we inspected, the planned medical cover of two half-time consultants and a junior doctor for two days a week was not in place. One half-time consultant was on annual leave until retirement at the end of March and a rota of temporary consultants covered their post. The other half-time consultant was an academic and did not provide medical cover at Anson. The junior doctor had not trained as a responsible clinician and 11 patients were detained under the MHA and required the regular input from a responsible clinician who could authorise leave and discharge from hospital.

We found this had affected two patients who were ready for discharge and had accommodation in the community available. Before leaving, the responsible clinician had not started the process for assessment for a community treatment order to enable their discharge from the ward. In addition, despite the trust having a rota of consultant/responsible clinicians available, staff had not rectified this situation.

We discussed this with the clinical lead for community services. They also acknowledged that the ward had lacked medical leadership. They informed us that from 1 April 2015, a locum part time consultant was to commence for three months during the recruitment process.

Medical cover at Acacia was sufficient and consisted of one full-time consultant and two full-time junior doctors for the 20 patients.

Anson and Acacia wards had arrangements in place to deal with medical emergencies. For physical conditions the trust had set the staffing establishments of nursing and support assistants (levels and skill mix). These were constantly reviewed to keep patients safe and meet their needs. On both wards, there were two qualified nurses on duty during the day and two health care assistants.

Staff vacancy rates and sickness levels were within or below expected limits when compared with other services. Anson ward sickness was 5% and vacancies below 1%. On Acacia ward, sickness was 5.9% and the ward had one vacancy.

There was limited use of temporary staff. Both ward managers reported they only used temporary staff that were familiar with the patients and the ward routines.

Between 1 October and 31 December 2014, Anson ward had used agency or bank staff to cover 90 shifts and Acacia to cover 120 shifts. The number of shifts they had been unable to fill was five.

Overall, patients we spoke with told us they had the opportunity to spend one to one time with their named nurse or a member of their allocated staff for that day. Staff rarely cancelled patient leave or activities. However, Acacia ward reported staff had recently had to help on other wards at Park House hospital. In addition, a review of the rotas for Anson ward for February 2014, showed there were six occasions when the number of staff was one qualified and two support workers.

We found evidence that ward staff accessed statutory and mandatory training. Ward managers monitored this. Compliance rates across both wards were good. For example, all staff on Anson ward had completed fire and health and safety, clinical risk and recovery training. On Acacia ward 21 out of 24 had completed health and safety, and infection control training, and all had completed clinical risk and recovery training. In partnership with the public health development service and dual diagnosis service, bespoke staff training for rehabilitation had commenced.

Assessing and managing risk to patients and staff

On Acacia ward, we found there were good systems in place for the management of medicines including appropriate dispensing and recording of medication.

The minimum and maximum temperatures of the medicine refrigerator were not recorded; only the current temperature when the fridge was checked each day. This meant medication may not have been kept at the correct temperature.

Each patient had a risk assessment completed on admission. We saw that staff had effectively assessed and managed any risks to individuals on admission and following any incidents. These risk areas included clinical, health and risks of harm to self and or others. Staff completed comprehensive risk assessments and associated intervention plans for the areas of risk.

The trust had an observation and engagement policy that ensured staff monitored patients who needed additional

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supervision. We checked the records on the ward and found that staff had completed records appropriately when a patient had been identified as requiring increase levels of observation.

Patients did not raise any issues about restrictions. When patients had been an identified risk of drug and alcohol misuse staff carried out searches and tested individuals for using drugs on their return from leave.

As part of their recovery and rehabilitation, patients detained under the MHA had section 17 leave from the ward to visit the local community. Staff escorted patients where they had assessed there to be potential risks. However, on Anson ward we found that for four out of nine patients the leave was not goal orientated and for two patients it had remained the same for 11 months. This meant it was not clear that medical staff had regularly reviewed patients leave so that they could identify improvements or risks.

Between 1 October to 31 December 2014, Anson ward did not use restraint. Staff reported using restraint to the floor twice at Acacia ward. Over 88% of staff had completed conflict resolution training, and discussed using de-escalation techniques to support patients.

Over 95% of staff had completed safeguarding vulnerable adults training. Staff had an understanding of the safeguarding procedures and told us they were confident about making referrals.

Forty-two of the 48 staff had completed basic life support training.

Track record on safety

The trusts quarterly incident report showed that from 1 October to 31 December 2014, Anson ward had 29 incidents and Acacia had 35 incidents. These consisted of medication errors, patients absconding, falls, and use of illegal substances.

Reporting incidents and learning from when things go wrong

The wards had an electronic incident reporting system. Incident recording and reporting was effective and embedded across all services. Ward managers with matrons reviewed all the incidents. The trust clinical governance team reviewed and collated the incidents to identify any trust wide patterns. This ensured all levels of management maintained an oversight.

Staff had a good understanding of recent incidents that had taken place in their services. Close working relations between the staff on both Acacia and Anson wards ensured that learning from incidents that could affect either service was shared. We found that the staff meeting agenda included safeguarding, and learning from incidents.

We saw that Acacia ward had learnt lessons and introduced new protocols from a serious incident where a patient had obtained illegal substances, which resulted in harm.

Staff said they had learned from external events, such as serious case reviews but they were not able to provide examples of this learning. We saw that the ward held regular shift handovers to ensure that oncoming staff were made aware of any incidents which had taken place on the ward, who had been involved and the outcome of the incident.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We rated effective as requires improvement because:-

- Staff on Anson ward had not prescribed or administered medication safely. Two patients' records out of the nine reviewed of patients detained under the MHA had medicine charts with a higher dose of medicine prescribed than agreed.
- There was inconsistent medical cover on Anson ward. This meant staff did not follow an evidence based rehabilitation care pathway. The multi-disciplinary team meetings did not always have a responsible clinician who could make medical decisions about patients detained under the MHA.
- The ward managers did not monitor staff clinical supervision to ensure it was compliant with the trust protocol.
- Staff assessed patients' needs and planned their care.
- Although Acacia ward offered a recovery group once a week, neither ward had a dedicated psychologist who could offer patients' therapies to help them recover from their mental illness

However:

- the ward was staffed by skilled and motivated staff, that generally had good access to training and support.
- Staff had been involved in clinical audits to improve the rehabilitation services

clinicians. Anson used the Manchester care assessment schedule (MANCAS) screening tool for mental health needs. The ward manager told us they were planning to adopt the same assessments as Acacia.

Staff on Anson ward told us they were not using specific rehabilitation or recovery-orientated care plans. On Anson ward, we looked at six care records. These plans included how to meet the physical health and discharge needs of the individual. However, we found one patient who had a history of alcohol misuse, this risk had not been identified in the care records.

On Acacia ward, we looked at six care records. Each patient had a comprehensive assessment. Staff had delivered patients care to meet their identified care needs.

On both wards, the care records showed that staff undertook physical examinations on admission and there was on going monitoring of any physical health problems.

Best practice in treatment and care

On Acacia ward the referral, pre-assessment, and monthly protocols demonstrated staff followed the National Institute for Health and Care Excellence guidance (NICE). However, on Anson ward the trainee psychiatrist and the occupational therapist said that staff did not routinely follow NICE guidance.

Neither ward had a clinical psychologist allocated to them. On Acacia ward, the occupational therapist offered a recovery group once a week. Eight patients attended the group, which helped them to plan and work towards discharge. All patients had developed a 'My Recovery Story'.

We found that the wards had good access to physical healthcare; including access to specialists when needed. The wards used a mixture of local GP services, and specialists at local hospitals. To assist patients on Acacia ward have a healthier lifestyle, staff offered assistance with healthy eating and weight loss.

In some patient records, we saw staff had used recognised rating scales to assess and record the severity of the patient's illness and the effectiveness of the care and treatment. For example, health of the nation outcome scale.

To improve the service, nursing staff on Acacia ward had taken part in an internal service evaluation of patients and staff perspectives of recovery, dual diagnosis, and physical health co-ordinator roles within the in-patient

Our findings

Assessment of needs and planning of care

The wards used an electronic system to store patient records. This meant that if staff transferred a patient from one ward to another within the trust, staff receiving the patient had immediate access to their care records. However, on Anson ward we found three staff was unable to find information in patient files.

To obtain an accurate assessment on Acacia, staff completed three mental health assessments on patients on their first three days following admission by different

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

rehabilitation setting. Also, the consultant psychiatrist carried out a service evaluation study between 11 August 2011 and 31 January 2014. This aimed to assess the efficacy of admission to rehabilitation unit. The study found that admission to Acacia ward reduced the need for readmission following discharge.

Skilled staff to deliver care

Staff we met on both wards were generally skilled and motivated

Both ward managers provided evidence to show compliance with monthly line management supervision. Staff told us they had monthly line management supervision and yearly appraisals and felt supported in their roles. The trust policy requires registered nurses to have clinical supervision a minimum of monthly. Ward managers were unable to provide details about the levels of compliance. Both ward managers said they thought it was about 50%. Clinical supervision enables staff to reflect on their clinical practice and look for ways to improve. Also, only 48% of staff had completed their annual appraisals on Acacia ward.

The consultant psychiatrist on Acacia ward was on the General Medical Council (GMC) specialist register as rehabilitation specialist.

Multi-disciplinary and inter-agency team work

A multi-disciplinary team meeting (MDT) is a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the patient's needs and the condition or disorder being treated.

Acacia followed a multi-disciplinary collaborative approach to care and treatment. Nursing staff, occupational therapists, a consultant psychiatrist, and specialist doctors, attended the weekly meetings. For those patients detained under the MHA 1983, staff supported the involvement of the local care managers in the care programme approach process (CPA). This ensured planning for patients' recovery back into the local community.

On Acacia and Anson wards, patients were invited to attend multi-disciplinary team meeting that were held twice a week and a CPA meeting that were held three monthly.

On Anson ward whilst they were awaiting the commencement of a locum consultant from April 1 2015, the junior doctor attended the meetings. However, staff

were unable to explain how patients would continue to have the participation of a consultant psychiatrist/responsible clinician who could approve changes to detained patients leave or treatment. In addition, the occupational therapist told us they were rarely involved in the meetings.

Staff held daily handover meetings to discuss the previous 24 hours on the unit. Within the meetings they reviewed patients' potential risks in order to identify changes and agree management plans.

Adherence to the MHA and the MHA Code of Practice

On Anson ward, we reviewed patient records detained under the MHA. We found there were some discrepancies in the records that demonstrated the staff had not always followed the MHA code of practice. For example:-

- We looked at six medication charts for the five patients subject to an agreed certificate to prescribe and administer medication and we could not find evidence that the responsible clinician had discussed with the patient, the purpose or side effects of treatments
- We found discrepancies in two patients' records between the medication being administered and medication listed on the T2 (certificate of consent to treatment) and T3 (certificate of second opinion forms). This meant two patients' medicine charts had a higher dose of medicine prescribed than agreed. In addition, one of the authorised medications was outside of the British National Formulary (BNF) limits.
- One T2 certificate, the responsible clinician had not recorded either the name of the drug or the BNF code for that drug. Instead, the responsible clinician had recorded broad classes of drugs such as "anti-psychotic". This practice does not comply with the Code of Practice MHA 1983.
- Two patients were ready for discharge but the trust had not ensured procedures took place under the MHA to facilitate that discharge.
- Two patients said they had not had access to an independent mental health advocate to help they appeal against their detention.
- The records demonstrated that patients were explained their rights under the MHA. However, the trust did not routinely use a rights checklist to ensure that patients had knowledge of all the rights they were entitled to know.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

On Acacia, we reviewed two patient records for patients detained under the MHA. We found the paperwork was correct, up to date and stored appropriately. Most patients on both wards told us staff had offered access an advocacy service. On both wards, patients had accessed tribunals and managers' and had access to legal advice.

Good practice in applying the MCA

At the time of our visit, there were no patients subject to a deprivation of liberty safeguards (DoLS) on either of the wards.

Overall, we found that staff had a good understanding in relation to issues regarding capacity and consent. MCA training was part of mandatory training and staff was

expected to update this every two years. Although, we found only 9 out of 13 staff on Anson ward and ward 5 out of 14 on Acacia ward had completed MCA and DoLS training. The ward managers reported that the figures were low because training was difficult to access.

On Acacia ward, we saw evidence that staff had considered patients capacity to consent, where specific decisions had to be made. However, on Anson ward, we could not find evidence that the doctor had discussed the reasons for treatment, the side effects of medications, nor assessed the patients' capacity to consent to treatment to their own treatment in five patient's record.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

We rated caring as good because:-

- Motivated staff supported patients with care, dignity, and respect.
- Patients on Acacia ward were involved in and participated in decisions about their care and treatment.
- Patients had community meetings where they were consulted and involved in the changes to the services and were able to input their views.
- To improve services the trust sought and collated patient experiences.

However:

On Anson ward, the records and patient comments did not always reflect their involvement in their care and treatment.

The involvement of people in the care they receive

Patients had the opportunity to visit the wards before admission to help them decide if it was the right place for them and where possible staff visited patients before admission.

We found patients on Acacia ward, were involved in and participated in decisions about their care and treatment.

However, on Anson this was not the case. The patient records did not demonstrate active involvement of the individuals in their care. Staff were not able to explain how patients were involved in their care. There was some evidence of family involvement at MDT meetings.

On Acacia ward patients said they were involved in the planning of their care and treatment. However on Anson ward four out of six patients could not recall whether they had seen their care plans.

Both wards held community meetings where patients had the opportunity to raise issues about the ward. Patients on Anson ward had been involved in staff recruitment.

The trust asked patients about their experience when they were admitted to the ward and when they left the ward. For inpatient services from 1 July to 30 September 2014, 95% of inpatients stated that staff listened to them and explained, 87% stated staff discussed goals and outcomes, and 88% stated they were involved in decision making.

In addition to the questionnaires, each ward held regular patient feedback meetings with the patient advice and liaison service team. Anson ward had also produced a series of patient stories, highlighting how services have responded to their care and treatment needs, which had been shared with the trust board.

Patients on both wards had access to advocacy services.

Our findings

Kindness, dignity, respect and support

Throughout the inspection we observed staff being respectful and caring towards the patients they were supporting. Patients appeared relaxed and comfortable in the presence of staff. Staff we spoke with were respectful and caring in manner. They had a good understanding of the differing needs of patients and sought to meet those needs.

All patients said that staff treated them with kindness, with dignity and respect. Patients gave positive feedback about staff. Comments made were “interested in my well-being”, “supportive”, “very good” and “nice and polite” and staff go all the way to help and engage with patients”.

Are services responsive to people's needs?

Requires improvement 

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

We rated responsive as requires improvement because:-

- Acacia ward had dormitories, which contained four beds, and despite curtains partitioning the beds; the dormitories did not offer full privacy.
- The wards had clear processes in place for managing referrals.
- Patients knew how to complain and staff responded to these complaints by making changes as necessary.
- Staff planned for patients' discharge from admission. This meant that patients were discharged from hospital as soon as possible.
- Patients had the option of taking part in activities. Patients often made their own meals, drinks, and snacks and carried out their own shopping.

Our findings

Access, discharge and bed management

The service has a centralised rehabilitation panel. This panel reviews all referrals into the service. The panel consisted of ward managers and consultant psychiatrists from Anson, and Acacia wards and staff from community services. This group of staff planned each patient admission. Each new patient was given the opportunity to visit the wards and talk to staff before admission. We found detailed assessments of each patients needs had been completed prior to admission.

Each patient had a discharge plan in place and an allocated community care coordinator to support them to work towards discharge. A recent audit on Acacia ward identified 76% of patients stated that, they had received specific input from the recovery coordinator.

The patient care records demonstrated that the discharge plans discussed at multidisciplinary meetings. Staff were aware of patients recovery, and if there were any obstacles to being discharged. Although staff reported patients discharge from hospital was rarely delayed, on Anson ward we identified the lack of a responsible clinician had delayed the discharge of two patients.

The ward optimises recovery, comfort and dignity

Acacia had dormitories, which contained four beds, and despite curtains partitioning the beds; the dormitories did not offer privacy. Each dormitory had adjoining bathroom, and patients told us this often caused the dormitories to have unpleasant odours. All patients had secure storage space to store their belonging.

Both wards had a full range of rooms and equipment to support the rehabilitation and recovery of patients.

Quiet areas were available on the ward, where patients met with visitors.

Anson ward had single person bedrooms and communal bathrooms. Some patients chose to personalise their rooms.

Community involvement was encouraged, patients had their own mobile phones and regular access to the local community. However, neither ward had access to the internet.

Both wards had a full time dedicated occupational therapist. A list of planned activities was on the ward noticeboards, and patients agreed any changes to activities in the daily community meetings. During the inspection we saw patients attending the sessions planned for that day. Patients often made their own meals, drinks, and snacks and carried out their own shopping.

Both wards had activity timetables, which were health related, such as shopping and cooking shared meals. Patients from both wards had been involved in music therapy and had released a CD of their music.

On Acacia ward the staff had produced a map which showed where activities outside of the hospital took place. However, we found patients were not engaged in activities outside of the ward, such as volunteering, education, or local community groups. Which when discharged would help them towards reintegrate into the community.

Meeting the needs of all people who use the service

Both wards had a range of noticeboards with information available for patients, carers, and family members. Information was available on advocacy services and PALS (patient advice and liaison services).

Are services responsive to people's needs?

Requires improvement 

By responsive, we mean that services are organised so that they meet people's needs.

The wards were compliant with the Disability Discrimination Act 1995. There were adapted accessible bedrooms on the ground floor.

Interpretation services were available for people for who English was not their first language.

Staff catered for patients with specific dietary needs. On Anson ward patients chose and made their own meals. On Acacia ward patients were involved in planning group meals.

Patients were able to attend local religious services if they wished. At Acacia ward there was also a multi faith room to all to use.

Listening to and learning from concerns and complaints

We found the staff listened to the concerns and complaints of patients and their families. Patients could access the complaints process in an accessible format. They were also signposted to the patient advice and liaison service for support if needed.

Noticeboards displayed information about the patient advice and liaison Service, which supported patients to raise concerns. Advocacy services were available to support patients.

All the patients we spoke with told us that they were aware of how to make a complaint or raise a concern. Staff we spoke with were aware of how to support patients if they needed to raise a concern.

We attended two community meetings. At these meetings patients raised concerns about the ward environment. Staff said that most patients concerns were resolved locally at ward level. If unresolved they would be escalated to the modern matron and would be investigated by a member of staff independent to the ward. We found evidence that staff responded to complaints. Staff shared any feedback or recommendations made following a complaint during team meetings.

Anson ward had four complaints in the last 12 months; three were informal concerns and resolved at ward level. Acacia ward had only had one complaint in the past 12 months.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We rated well-led as good because:-

- The ward managers had managed the wards well at ward level. Despite the uncertain future, staff provided care and treatment, which enabled patients' rehabilitation and recovery. Staff morale on both wards was good.
- On Acacia ward staffing establishments were reviewed by the ward manager and increased should the need arise. Staff had completed mandatory training but many staff had not completed their annual appraisals.
- On Acacia ward staff reported incidents promptly and there was evidence of staff learning from the investigation of incidents.
- The ward had a register of any potential risks to the service and audits took place to ensure the maintenance of standards.
- On Anson ward both the ward manager and matron had implemented changes and improvements to the ward. Staff sickness rates and turnover had reduced. Staff had completed mandatory training but the manager did not monitor staff clinical supervision to ensure it was compliant with the trust protocol..
- Anson ward had a local risk register that identified the risks to the service. The ward manager had submitted a business case to improve medicines management and the environment in November 2014.
- However, improvements were limited by the lack of a permanent full time consultant psychiatrist who could give medical leadership and by the lack of regular audits by the trust pharmacy. Both of these issues were outside of the ward managers and matrons' authority
- The formation of the rehabilitation group, the close working relationships between Acacia and Anson ward, and the service audits demonstrated a commitment to quality improvement.

Our findings

Vision and values

Some staff knew who senior managers in the organisation were. Senior staff had visited some of the wards. Staff told us they felt management was visible and supportive. Information provided by the trust showed in the previous two months, that the wards had been visited by chief executive, medical director and director of strategy, transformation and performance.

Staff we spoke with were not aware of the organisation's development strategy. Most staff said they did not know what the future of the trust was.

Good governance

Acacia ward had an established ward manager. We observed that staff had clearly defined roles on the wards. Staff understood the management structure and staff saw the structure as supportive and transparent. This enabled the staff to raise concerns on the ward. All staff reported that they liked working on the ward. Staffing establishments were reviewed by the ward manager and increased should the need arise. Staff had completed mandatory training.

Although, some nursing staff had not had regular clinical supervision or annual appraisal, staff said that they were supported. Staff reported incidents promptly and there was evidence of staff learning from the investigation of incidents. The ward had a register of any potential risks to the service and audits took place to ensure the maintenance of standards.

The trust appointed Anson ward manager and matron in late 2014. Both had implemented changes and improvements to the ward. They were planning to follow the systems used on Acacia ward. They had also commenced the rehabilitation development group. This group consider best practice across all of the rehabilitation services. Staff sickness rates had reduced from 9% to 4% and staff turnover from 11% to below 1%. Staff had completed mandatory training and had line management supervision. They had a local risk register that identified the risks to the service. The ward manager had submitted a business case to improve medicines management and the environment in November 2014.

However, improvements were limited by the lack of a permanent full time consultant psychiatrist who could give

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

medical leadership and by the lack of regular audits by the trust pharmacy. Both which were outside of the ward managers and matron's authority. A senior manager acknowledged that Anson ward had an 'identity' issue regarding its role within the trust structure. This was because community services managed the unit instead of inpatient services. Overall, the lack of consistent medical cover had resulted in a lack of a local rehabilitation pathway for patients with complex mental health needs and insufficient involvement by patients in their care and treatment. The lack of regular audit by the trust pharmacy had resulted in some medication inaccuracies in the prescribing and administration of medication for detained patients for patients detained under the MHA. In addition, the managers did not monitor staff clinical supervision to ensure it was compliant with the trust protocol.

Leadership, morale and staff engagement

On both wards staff reported that morale was good.

Anson ward had reduced staff sickness rates from 9% to 4% and Acacia ward had only one member of staff sick, staff turnover was 3.8%.

Staff reported support from their line managers and we saw that staff had regular team meetings. Staff we spoke with demonstrated they were aware of how to raise concerns and most told us they would do this through their line managers. Staff understood the whistleblowing process.

Commitment to quality improvement and innovation

The consultant psychiatrist and nursing staff on Acacia ward had carried out audits of the service to drive improvements.

Staff on both wards for infection control, hand hygiene, MHA documentation, and care documentation carried out audits. Both wards had a local risk register that senior managers reviewed.

The staff had the first meeting of rehabilitation development group on the 11 February 2015, which planned to formulate outcome measures and develop the recovery pathway. In addition, it planned to enable the wards to work towards Royal College of Psychiatrists' accreditation for inpatient mental health services.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>We found that [the registered person had not protected people against the risk of unsafe management of medication.</p> <p>This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>How the Regulation was not being met:</p> <p>The MHA medication records were incorrect on Anson ward regarding their agreed medication limits on the T2 and T3 when checked against the medication prescribed to patients. There was no evidence that the responsible clinician had informed patients about the purpose or side effects of the medication.</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>We found the provider did not have clinical supervision arrangements in place in order to ensure that qualified staff were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard.</p> <p>This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>How the Regulation was not being met:</p>

Requirement notices

Ward managers did not monitor staff clinical supervision to ensure it was compliant with the trust protocol.

We found that 50% of staff had completed their annual appraisals on Acacia ward.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

We found that the premises used by the service provider were not suitable for the purpose for which they were being used.

This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the Regulation was not being met:

In several clinical areas the beds provided were in bays. The beds in these areas were only separated by curtains.

There was no clear guidance in the ward information about how the dormitories operate.

The curtains in these areas were not drawn around the bed spaces at all times.

There was no guidance for those patients sharing a dormitory to ensure people are respectful of each others privacy and dignity.