Acer

Quality Report

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services well-led?	

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

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

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

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

Overall summary

- The manager and head of care were visible on the ward, were accessible to staff and were proactive in providing support.
- The culture on the wards was open and encouraged staff to bring forward ideas for improving care.

Summary of findings

- Staff carried out a risk assessment of every patient before and on admission. Staff updated the assessments daily and reviewed them after an incident.
- Observation of the ward and patients was good.
- Staff were caring and treated patients with dignity.
- All staff had completed mandatory training and had access to further specialised training.
- Staff updated patient care plans regularly. Patient care plans showed staff engaged with patients.
- Staff understood the safeguarding process and took appropriate action when necessary.
- The manager completed a ligature risk assessment yearly which outlined plans and actions to reduce the ligature points. However, the ligature points had not been clearly identified.

Summary of findings

Contents

Acer

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

Summary of this inspection

Background to Acer

Acer registered with the CQC in May 2015 to undertake the following regulated activities:

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

The hospital is a locked rehabilitation service providing assessment, treatment and rehabilitation for up to 28 women with complex mental health needs, challenging behaviour and personality disorder. Acer comprises two separate buildings, Upper House and Lower House. Both wards have 14 beds for females with a primary diagnosis of personality disorder. There were 12 female patients on the day of our inspection of Upper House. Three patients were informal and 11 were detained under the Mental Health Act.

Acer had a registered manager and a nominated individual. The registered manager was on duty on the day of our inspection. We undertook a comprehensive inspection of this hospital in

May 2016. We rated Acer as Good at this inspection. We undertook a Mental Health Act review in November 2015, which identified no concerns. Lower House opened in March 2017 and has not yet been inspected or had a Mental Health Act review.

Acer was previously known as the Acer Clinic and the provider was previously known as Cambian Ansel Limited. In December 2016 Universal Health Services purchased Cambian Ansel Limited and the new name is now CAS Clifton Ltd. The names were changed in April 2017.

Our inspection team

Team leader: Nicholas Warren.

The team that inspected the service comprised two CQC inspectors.

Why we carried out this inspection

We carried out this unannounced inspection due to receiving information of concern and increased incident reporting to the CQC. We focused our inspection on the Upper House as the concerns mainly related to there. The concerns were raised around staff, their training and poor staff attitudes. Incidents of self-harm were high and managed incorrectly and ligature incidents were not followed up safely.

How we carried out this inspection

This inspection was unannounced. We have not rated the hospital. We looked at the three domains concerns had been raised in and asked:

- Is it safe?
- Is it effective?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients on the day by use of comment cards.

During the inspection visit, the inspection team:

- visited Upper House at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with one patient who was using the service
- spoke with the manager for the ward
- spoke with six other staff members; including nurses, social workers and activity coordinators

We also:

Summary of this inspection

- collected feedback from four patients using comment cards
- looked at five treatment records of patients
- carried out a specific check of the incident management
- specifically reviewed care notes of one patient in relation to information of concern received
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We received four comment cards from patients staying at Acer. The feedback on the cardswas positive about the care received and all said staff were kind and caring. One patient was interviewed and said staff were good and caring. The patient said they were involved with writing their care plans and had plenty of activities to be involved with.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Observation was good because of patient risk assessment and adequate staffing levels. The head of care was able to increase staffing numbers to manage increased risks.
- All staff were up to date with mandatory training.
- Staff had not used seclusion as part of nursing care and there was no seclusion room as it was policy of the provider not to use seclusion.
- Staff used de-escalation techniques before restraint. Staff had only used prone (face down) restraint once out of 67 times between 1 January 2017 and 19 July 2017. The other incidents recorded the patients were restrained on a chair or in sitting position.
- Staff understood the safeguarding process and reported incidents appropriately.
- Managers held monthly governance meetings where incidents were discussed and reviewed to see where these could be reduced.
- The manager completed a ligature risk assessment yearly which outlined plans and actions to reduce the ligature points.

However;

- The ligature points were not always clearly identified in the ligature risk assessment.

Are services effective?

- The five patient files we looked at were up to date and had clear admission notes, an assessment of needs and a physical health assessment.
- The care plans were personalised and looked at the treatment of the whole person, taking into account mental and social factors, rather than just the symptoms of an illness.
- Staff undertook a physical examination of patients on admission to the service and continued monitoring of patients' physical health and well-being. We saw evidence of further contact with the local GP.
- Staff from a range of mental health disciplines provided care and treatment to patients.
- An independent mental health advocate visited every week.

Summary of this inspection

Are services well-led?

- The provider had systems in place to ensure staff mandatory training, supervision and appraisals were completed and up to date. The manager monitored these systems.
- The manager fed back incidents to the governance meetings and managers shared lessons learnt and feedback with the staff.
- The manager and head of care were visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and were proactive in providing support.
- The culture on the wards was open and encouraged staff to discuss ideas for improving care. This was seen in team meetings, supervision and reflective practise.
- Staff morale was good and staff were seen actively working with patients. The service had been proactive in capturing and responding to patients concerns and complaints. There were creative attempts to involve patients in all aspects of the service.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Staff had completed detention paperwork correctly; it was up to date and stored appropriately.
- In the five sets of patient notes we reviewed, Section 17 leave documentation was filled in, up to date, accurately completed and filed correctly. This meant patients detained under the Mental Health Act could take appropriate lawful leave.
- There were copies of consent to treatment forms accompanying the five medication charts we looked at. This ensured staff knew they could legally give medication when the patient may not agree or understand because of their illness.
- Staff had access to a Mental Health Act administrator based at the hospital who helped provide information if staff were unsure of anything related to the Mental Health Act.
- The Mental Health Act administrator made sure staff had completed all Mental Health Act paperwork correctly.
- Clinical staff undertook regular audits to ensure that the staff applied the Mental Health Act correctly. Managers and staff discussed the audits at the governance meeting and action plans had been monitored.
- Patients had access to the independent mental health advocate services. Staff said the advocate visited weekly and had a good rapport with the patients.
- All staff had received training in the Mental Health Act. The training records confirmed this.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were able to show their understanding of the basic principles of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Staff completed mental capacity assessments on a decision specific basis. In the five care plans and medical cards, we saw good examples of capacity assessments and staff had discussed best interest decisions where appropriate.
- The patient care records reviewed showed that staff had considered capacity.
- All staff had received training in the Mental Capacity Act. The training records confirmed this.
- There were no patients subject to the Deprivation of Liberty Safeguards between July 2016 and July 2017.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Well-led	

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

Safe and clean environment

- The ward layout was designed around the garden area and was on two floors. It was not possible to observe bedrooms from the main corridor and staff mitigated this by observation and risk assessment. Observations were increased based on patients level of risk. Staff records confirmed observations took place as per policy.
- The manager had carried out a yearly ligature risk assessment on 4 May 2017. This had identified the action taken to reduce ligature points but had not clearly identified what the actual ligature points were. A ligature risk assessment is a document that identifies places to which patients intent on self-harm might tie something to strangle themselves.
- The ward was single sex and therefore complied with same sex accommodation.
- The clinic room was clean and tidy and had the appropriate resuscitation equipment in place, which staff had checked daily. Drugs were stored correctly and were in date. Records confirmed staff checked and recorded fridge temperatures daily.
- There was no seclusion room and staff did not utilise this intervention.
- The corridors were clear and clutter free. The furniture and décor were in excellent condition. The ward smelt clean and fresh.
- Equipment was maintained and safety testing stickers were up-to-date on electrical appliances and equipment, which ensured they were safe to use.
- Cleaning rotas were up-to-date and complete .We observed the standards of cleanliness were good.
- Hand gel was available for staff to use in the ward areas as part of infection control principles and we observed staff using the gel.
- The manager and nursing staff carried out a full environmental risk assessment on a three monthly basis and completed a monthly audit that included areas such as care, medication, and environment. If there was an identified area of concern there were action plans put in place to reduce or remove them.
- Staff carried alarms to respond to emergencies and incidents. We activated the alarm during our inspection and response was good. However, two out of six staff went to the wrong area of the ward because the wall-mounted display in some areas directed some staff to the wrong room. The two staff quickly realised the mistake and the manager immediately reassured us that this would be resolved. There were nurse call buttons in the patient bedrooms.

Safe staffing

- The provider and managers assessed the number of nursing staff required in the hospital based on the clinical need of the patients, as well as bed occupancy. Staff told us there were sufficient staffing numbers to deliver care to a good standard. The rotas showed the right numbers and grades of staff were present on the day of inspection and between the dates 22 May 2017 to 19 July 2017.
- The provider employed six full time qualified nurses and a head of care nurse to work on Upper House and 32 support staff (to work across both wards) as well as 2 activity coordinators. There was one trained staff nurse vacancy on the day of our inspection.
- Duty rotas showed the hospital mostly met its planned staffing numbers. The duty sheets for 22 May 2017 to 19 July 2017 showed the Acer bank pool provided 55 (10%) staff out of 531 possible shifts. Further bank staff from another hospital with the same provider filled a further eight shifts (1.5%). Rotas indicated that the service did not cover 16 (3%) support worker shifts in the same period, however the manager and head of care had been available to cover shifts where necessary and we saw this had happened when the need had arisen.
- Day shifts on the upper house comprised one registered nurse and five support workers. Night shifts had one

registered nurse and four support workers. There was also a twilight shift from 6pm until midnight, and staff on these shifts were in addition to the ward numbers. A qualified head of care nurse and the hospital manager worked from 9am to 5pm Monday to Friday.

- Staff turnover was 19% from July 2016 to June 2017. The manager had meetings six to eight weekly with human resource staff to review these figures. The manager carried out exit interviews and analysed the findings. Staff had been leaving for a variety of reasons which included promotion, changing service. One staff member had failed their probationary period. Two staff that had left were in the process of coming back to work at Acer.
- The manager had also introduced some measures to identify areas that might help retain some staff. This included increased supervision for new starters as well as better explanations at interview of the type of work the role would involve.
- Between July 2016 and June 2017, the staff sickness rate was 7.5%. This had increased from 5.5%. The manager and the human resource team reviewed the sickness percentages every eight weeks and the increase had been noted on the most recent review in June 2017. This was mainly due to three staff going on long-term sick leave and not related to working at the hospital.
- Managers tried to use regular bank staff wherever possible to help promote continuity and consistency of care.
- The head of care was able to adjust staffing levels daily to take account of case mix.
- There was an experienced nurse present and available in communal areas of the ward at all times.
- Staff said there was enough time for patients to spend 1:1 time with their named nurse.
- Staff rarely cancelled escorted leave or ward activities because of low staffing levels. There was a full time activity coordinator and if they were away from work the activity coordinator from the other ward would cover. Ward staff would cover at weekends and when both activity coordinators were away from work.
- The duty rota's confirmed there were always enough staff to safely carry out physical interventions.
- The speciality doctor and the GP provided medical cover Monday to Friday during the day. The GP surgery provided out of hours medical cover. The provider used the local accident and emergency department for emergency medical care. An on call psychiatrist was available out of hours for emergencies.
- Staff were trained to safely meet the needs of patients. The provider delivered a wide range of face-to-face and e-learning mandatory training courses. For example, first aid, security, the Mental Health Act, and safeguarding. The provider's data on 19 July 2017 showed all staff had completed mandatory training.

Assessing and managing risk to patients and staff

- Staff did not use seclusion at Acer. The service did not have seclusion facilities. Staff understood what seclusion meant and had not used individual bedrooms to seclude patients.
- Staff did not use long term segregation at Acer.
- There had been 67 incidents of restraint of which one had been prone (face-down) restraint between 1 January and July 18 2017. Staff reported and recorded the other restraint incidents as sitting or standing restraint which meant only once in this period had a patient been put to the ground. We noted that self-harm and restraint incidents had reduced recently and this related to patients being transferred to other units. We monitored these incidents through our regulatory monitoring and noted the hospital had also used incident analysis to help reduce them.
- We looked at a sample of five patient care records. Staff carried out a risk assessment of every patient before and on admission. Staff updated the assessments daily and reviewed them after an incident. They did this using the Short-Term Assessment of Risk and Treatability (START) tool.
- There were no blanket restrictions in place and patients were individually risk assessed for items such as mobile phones. Blanket restrictions are rules or policies that restrict a patient's liberty and other rights.
- Informal patients could leave at will and there was a notice saying this at the entrance.
- There were policies and procedures for use of observation (including minimising risk from ligature points) and searching patients. We saw staff completing the forms that recorded the observation times and saw staff walking around the ward specifically designated to watch certain patients.

Long stay/rehabilitation mental health wards for working age adults

- Staff did not routinely search patients or carry out any pat down searches unless this was included in a patient's care plan because of a known risk.
- Staff were trained in Management of Actual or Potential Aggression and data showed that five out of 74 staff (6%) had not undertaken this training. These five staff were trained in management of violence and aggression which was the previous training provided and had dates to undertake the new training.
- Staff used restraint only after de-escalation had failed. We saw good examples of staff de-escalating situations when a patient became agitated.
- There had been one use of rapid tranquilisation between 1 January 2017 and 18 July 2017.
- The notes were not available because the patient had been transferred. We were assured the provider had followed the National Institute of Health and Care Excellence guidelines: Violence and aggression: short-term management in mental health, health and community settings in the prescribing and management of the medication given.
- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Staff gave examples of when they had identified and dealt with safeguarding enquiries. This showed they had a good awareness of safeguarding issues, how to report them, and who to, including concerns about patients being abused, financially or otherwise, outside the ward environment.
- There was a visitor's room outside the ward area used for children visiting the ward. All visits were risk assessed and had a member of staff present either in the room or at the door.
- There was good management of the storage and dispensing of the medication on the ward and we saw that medical staff carried out medicine reconciliation on admission.

Track record on safety

- There had been no serious incidents within the year from June 2016 to June 2017.
- Following internal incidents, the management had reviewed access to ligature knives and now there were designated staff that carried them on each shift.

Reporting incidents and learning from when things go wrong

- Staff we interviewed knew what incidents or concerns to report. They were very clear on how to recognise and report forms of patient abuse. Staff we spoke with gave examples of the types of incidents they would report and the process for reporting incidents, for example reporting verbal aggression and arguments between patients.
- Staff reported and recorded 815 incidents between 1 Jan 2017 and July 18 2017 with 673 being related to self-harm with one patient mainly. We looked at this patients care records between 25 April 2017 and 21 May 2017 and saw all ligature incidents had been recorded and reported appropriately and the correct action taken in regard to health checks where the patient allowed.
- There had been 20 statutory notifications between 1 January 2017 and 17 July 2017, of which 10 had been safeguarding enquiries. The hospital had appropriately reported all of these to the local authority and to us. Action plans submitted to us showed staff took appropriate action to ensure the safety of patients. We tracked eight concern forms and found that staff reported concerns to the manager and, where appropriate, the head of care (safeguarding lead) reported them to the local authority's safeguarding team. . However, on one concern we found no notes to indicate what other actions staff had taken. We asked the manager and we were told that the concern had been investigated and the patient did not feel they were being exploited and did not wish for this to be taken further. Staff had assessed the patient as being competent in making this decision and this concern had been noted in the care notes.
- Senior staff held monthly governance meetings where they reviewed incidents. The manager fed back investigations from incidents through staff meetings and emails. The psychiatric consultant held reflective practice meetings for local staff to discuss internal incidents.
- As a result of lessons learnt, first aid had now become mandatory training. There were also various lessons learnt from internal incidents and these included checks for ligature knife sharpness and further training on use of a ligature knife.
- The nurse in charge or the head of care debriefed and offered support to staff after a serious incident. The debriefs were recorded and action plans included along with lessons learnt, interventions used, precipitating factors as well as positive outcomes.

Long stay/rehabilitation mental health wards for working age adults

Duty of Candour

- We spoke with four members of staff during the inspection who were aware of their need to be open and honest. All four staff could give examples of times when they needed to explain to patients when things had gone wrong. Providers of healthcare services have a duty to be open, honest and transparent with patients and their families when things go wrong with care and treatment. This duty involves providing support. The provider had a policy in place to inform staff about their responsibilities.

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

(for example, treatment is effective)

Assessment of needs and planning of care

- We looked at a sample of five paper patient care records and staff had completed clear admission notes and an assessment of needs within 72 hours following admission. We found them to be comprehensive from admission to discharge. We also looked specifically at one patient's daily care notes following concerning information received. We did not find any areas of concern.
- Staff undertook a physical examination of patients on admission to the service. There was on going monitoring of patients' physical health and well-being and we saw evidence of further contact with the local GP including well woman clinics.
- Care records contained up to date, personalised, holistic (the treatment of the whole person, taking into account mental and social factors, rather than just the symptoms of an illness) recovery-oriented care plans.
- Staff kept care plans and medical notes in locked cupboards within locked rooms. Some information was now stored on secure, password protected computers.
- The service was in the process of changing from paper to electronic records.

Best practice in treatment and care

- The doctor had prescribed antipsychotic medication in the three cards we looked at. Prescribing followed National Institute of Health and Care Excellence guidelines: Psychosis and schizophrenia in adults: prevention and management. We also saw written information recording the discussions held with patients regarding their medication.
- Patients had access to psychological therapies as recommended by the National Institute of Health and Care guidelines on Improving Access to Psychological Therapies. A psychologist and an assistant psychologist, along with staff, offered various interventions including dialectical behaviour therapy, cognitive analytical therapy, cognitive behaviour therapy, schema therapy and mindfulness. These therapies aimed to develop self-awareness and alternative, functional coping strategies.
- All patients had access to the local general hospital if needed for further physical investigations and staff helped patients research physical health on the internet to support them in their decisions to access health problems appropriately.
- All patients had positive behaviour support plans in place. Positive behaviour support plans outline strategies to use if a patient is escalating towards risk behaviours.
- Staff used Health of the Nation Outcome Scales to assess progress towards care plan outcomes. Staff carried out this assessment once a month. These scales measure the health and social functioning of people with severe mental illness and are a way of seeing any improvement to treatment.
- Clinical staff actively participated in audit such as clinic audit, care records audit and medicine chart audit. The action plans were then monitored at clinical governance meeting locally and regionally and this supported maintaining good practice.

Skilled staff to deliver care

- The provider had a full range of staff disciplines working on the ward. This included nurses, support workers, consultant psychiatrist, an occupational therapist, activity coordinators, a social worker, and a psychologist.
- Staff at the service were appropriately qualified and were experienced in working with patients with complex needs in a rehabilitation unit. Newer staff worked with the more experienced staff.
- Staff told us they received a four-day induction when they started to work at the service. The provider also

offered further training to meet the needs of this patient group. This included specialist training provided by the consultant and the psychologist on managing boundaries with people with personality disorder as well as suicide and risk management.
- Support staff had training on induction and as part of their mandatory training to cover the standards of the Care Certificate. The Care Certificate ensures that support workers have the same introductory skills, knowledge, and behaviours to provide compassionate, safe, high quality care and support.
- Senior nurses provided preceptorship for newly qualified nurses for six months to support them in their new role.
- In the supervision records we looked at we saw staff received one to one supervision every six to eight weeks. The managers in the service kept records to ensure supervision took place regularly. Supervisors used standard templates to record supervision. All staff had received an annual appraisal. Supervision was mainly managerial. Managerial supervision mainly provides an opportunity for staff to review their performance. Supervision records showed that some nurses had taken additional supervision.
- The psychiatrist or psychologist were able to offer clinical supervision through reflective practice sessions. These were held monthly and more regularly if either the staff or managers identified further support was needed. Clinical supervision mainly provides an opportunity for staff to reflect on and review their practice regarding individual patients.
- Staff performance was measured through key performance indicators used in supervision.
- The ward manager said they addressed poor staff performance promptly and followed hospital policy and used the advice of human resources.

Multi-disciplinary and inter-agency team work

- A consultant, specialist doctor, occupational therapist, psychiatrist, nurses, social worker and support workers and other disciplines were involved in the assessment, planning and delivery of people's care and treatment.
- There were two shifts per day. Each shift had a handover meeting, prior to the handover meeting; the nurse in charge for the ward completed a 24-hour nursing report. This report contained information such as risk status and behaviour of patient.
- Staff used daily record sheets that included the risk status of the patient, plans for the day and any issues from previous shifts. These were updated at the morning meeting.
- There were effective working relationships with other teams. Staff invited community mental team members to ward rounds and review meetings. However, due to distance, some community mental health staff did not frequently attend multidisciplinary team meetings. The social worker often helped liaise with these teams on those occasions.
- The multi-disciplinary team had made good working relationships with other agencies such as care coordinators, accommodation providers and local authority safeguarding teams. The social worker in particular had put in a great deal of effort to create positive relationships with other agencies.

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

- The Mental Health Act administrator made sure staff had completed all Mental Health Act paperwork correctly.
- Staff had access to a Mental Health Act administrator based at the hospital who helped provide information if staff were unsure of anything related to the Mental Health Act.
- Staff had completed detention paperwork correctly; it was up to date and stored appropriately.
- Section 17 leave documentation was correctly filled in, up to date and filed correctly. This meant patients could take appropriate lawful leave.
- There were copies of consent to treatment forms accompanying the medication charts. This ensured staff knew they could legally give medication when the patient may not agree or understand because of their illness.
- Patients had their Mental Health Act rights read to them on admission and on a regular basis. Staff recorded this in the patient notes.
- Clinical staff undertook regular audits to ensure that the staff applied the Mental Health Act correctly. The audit was discussed at the governance meeting and action taken if any errors noted.
- Patients had access to the independent mental health advocate services. Staff said the advocate visited weekly and had a good rapport with the patients. There were posters on the walls describing the advocacy service and ways to contact them.

Long stay/rehabilitation mental health wards for working age adults

- All staff had received training and had a working knowledge of the Mental Health Act and the revised code of practice and it's principles.

Good practice in applying the MCA

- Staff we spoke with were able to show their understanding of the basic principles of the Mental Capacity Act.
- Staff completed mental capacity assessments on a decision specific basis. In the care plans and medical cards, we saw good examples of capacity assessments.
- All staff had received training in the Mental Capacity Act and guidance was available through policy and senior staff.
- There were no patients subject to the Deprivation of Liberty Safeguards between July 2016 and July 2017. The patient care records showed that staff had considered capacity and had discussed best interest decisions where appropriate.

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

Vision and values

- Acer shares the vision of CAS Clifton to be the highest quality provider of specialist behavioural health services to adults. Staff shared the organisations values of care, openness, commitment and honesty in the interviews and conversations we had with them. Staff were proud of their service and the work they did. We saw and heard this in the work and interviews we undertook on our visit.
- The values were reflected in the objectives discussed in team meetings and supervision.
- Staff knew who the most senior managers in the organisation were. The manager and staff told that us the chief executive had visited the unit to meet them.

Good governance

- The provider had systems in place that the manager monitored to ensure staff mandatory training, supervision and appraisals were completed and up to date. The manager kept computerised records. We reviewed these and found that they were accurate and up to date.
- Staff received supervision within the 6 to 8 weeks as stipulated in the policy. The manager oversaw the supervision given throughout the hospital.
- Staff told us they spent most of their working time in delivering direct care to patients rather than on administrative tasks.
- The hospital used many key performance indicators to measure team performance. These included sickness and absence, complaints and restraints, training, supervision and medication appraisals. Managers reviewed these at the monthly governance meetings.
- Four patients in the comment cards had said staff were always available for them. We observed staff actively engaging with patients throughout our inspection. Care records demonstrated staff spending meaningful time with patients on a daily basis rather than spending time on administrative tasks.
- Staff were participating in clinical audit.
- The manager and the head of care worked closely together and both had the authority to make changes quickly and efficiently to meet patient need.

Leadership, morale and staff engagement

- There was evidence of clear leadership. The manager and head of care were visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. The culture on the wards was open and encouraged staff to bring forward ideas for improving care.
- Sickness rates were above the NHS national average of 4.5% but the manager had been trying to address this. There were three people on long-term sickness. The manager contacted them monthly to ensure they were receiving the correct support.
- There had been no bullying or harassment cases between July 2016 and July 2017.
- Staff said they knew who to contact if they had any concerns including any whistleblowing.
- Staff said they felt the manager would take appropriate action if they expressed concerns and felt there would be no victimisation towards them.
- The ward staff were enthusiastic and engaged with developments on the ward. They said their morale was high and they liked working at Acer.
- The manager felt supported by their immediate line manager.

Long stay/rehabilitation mental health wards for working age adults

- Staff were open and transparent with each other and with patients. Staff were able to confidently describe the importance of transparency and honesty and their duty of candour.
- Staff said the morale had started to improve now that the hospital take over was clearer.
- Staff meetings were held weekly and ideas, thoughts and views were listened to and acted upon. Staff said they felt listened to.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that the wall-mounted alarms are functioning properly so that staff can attend emergencies promptly.
- The provider should ensure the ligature risk assessment forms identify the ligature risks clearly.