255 Lichfield Road

Quality Report

255 Lichfield Road
Walsall
WS33DT
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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

Overall summary

We rated 255 Lichfield Road as good because:

- All areas were clean and well maintained and furniture was in good condition and comfortable.
- Staff completed a risk assessment of every patient on admission and updated them regularly. All risk assessments included crisis plans.
- All of the care plans we reviewed were thorough, holistic and recovery focussed.
- Care plans were tailored specifically to the needs of the patient and included physical health and vocational goals
- Staff were using the Lester tool to assess the cardio-metabolic health of patients experiencing psychosis and schizophrenia.
- A psychologist recently joined the service and was developing a psychological intervention pathway for patients in line with the 2014 NICE guidance for the prevention and management of psychosis and schizophrenia in adults.
- During the inspection we observed care from staff that was respectful and promoted dignity and choice.
- A multi disciplinary approach to assessing the suitability of referrals to the service was taking place.
- There was a full range of facilities to support treatment and care.
- Patients told us that concerns were dealt with promptly and effectively by staff and that they received feedback following this process.
- Regular supervision had not been happening in the service. The new manager had identified this and developed a supervision strategy, with other senior staff to resolve this

However:

- The electronic records system had not been updated following the change in service provider. The manager had requested that the new providers' "care-notes" system be integrated within the service and training made available to staff.
- Effective communication with local services providing physical healthcare for patients was not consistently happening. Medical and nursing staff from the service had met with the local GP practice to improve this but it had not been fully resolved at the time of our inspection.
- Two staff raised concerns about poor exterior lighting in the self contained bungalow area, which made them feel vulnerable when working night shifts. This was fed back to the manager following our visit.

Summary of findings

Contents

Good

255 Lichfield Road

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to 255 Lichfield Road

Registered manager:

- At the time of our inspection, there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. They have the legal responsibility for meeting the requirements of the law; as does the provider. A new manager was in post and in the process of applying for registration.

Regulated activities:

- Accommodation for persons requiring nursing or personal care.
- Treatment of disease, disorder or injury.
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Diagnostic and Screening procedures.

Details about the service:

- 255 Lichfield Road has been owned by Partnerships in Care since spring 2015, prior to this it was owned by Care UK.
- 255 Lichfield Road is a modern, purpose-built rehabilitation service for men and women with mental health and psychological difficulties. It supports patients on their recovery journey with two main types of care - two four bed flats (one male/one female) for those requiring more intensive therapy and 20 individual apartments for people to live more independently but with full multi-disciplinary team (MDT) support.
- 255 Lichfield Road accepts referrals from medium and low secure forensic services, acute wards, out-of-area services, rehabilitation services and the community. To be eligible for referral to the service, patients must be:
- Men and women aged 18 years and over.
- Have a primary mental health diagnosis.
- Informal or detained under the Mental Health Act (1983).
- Severe complex and enduring mental health needs which might include treatment resistant conditions.
- May have challenging behaviour, substance misuse and learning disabilities.
- May be difficult to engage/motivate.
- May have a history of disengagement and non-adherence with traditional services.

Therapeutic Environment:

- Two four -bedded enhanced recovery and rehabilitation units for people who may be sectioned under the Mental Health Act (1983) who require a structured environment with intensive support to progress through their recovery pathway.
- 20 self-contained apartments that enable residents to live independently, whilst having the safety of a therapeutic structure if needed. Each apartment has its own front door, a lounge and kitchenette, bedroom and a bathroom. Residents had access to 24-hour support as required.
- Dedicated occupational therapy facility to promote independent living skills.
- Therapy and treatment areas, safe and private grounds and a family visiting room.
- A communal bistro was available for patients and provided hot and cold snacks and drinks for patients to purchase between 9am - 5pm.

Our inspection team

Team leader: Jonathan Petty. CQC inspector for Central/West England.

The team that inspected this service comprised two CQC inspectors, a specialist advisor nurse and an expert by experience. Experts by experience are people who have experience of using or caring for someone who uses health and/or social care services. The role involves helping us hear the voices of people who use services during inspections and Mental Health Act visits.

Summary of this inspection

How we carried out this inspection

To fully understand 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?

During the inspection visit, the inspection team:

- Looked at the quality of the ward environment and observed how staff cared for patients.
- Spoke with eight patients using the service.
- Spoke to the carers of three people using the service.
- Spoke with the interim hospital director.
- Spoke with 12 other staff members; including doctors, nurses, an occupational therapist, a psychologist and a Mental Health Act administrator.
- Received feedback about the service from five care co-ordinators or commissioners.
- Attended and observed a hand over meeting and a ward round.
- Looked at six care and treatment records.
- Carried out a specific check of the medication management for all patients.
- Reviewed a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

All the patients we spoken to told us they felt safe at 255 Lichfield road. All patients said staff made them feel valued and were always available when needed.

Patients said the service helped them to become more independent and provided them with the opportunity to show that they are moving forward with their recovery and would be able to cope in the community.

Patients said they felt relaxed within the service and that staff were respectful of their needs. All patients told us that staff treated them with dignity and respect.

Stakeholders we spoke to told us that the service was very patient focussed and inclusive. Realistic objectives were set out and patients were given opportunities to contribute to and manage their own care.

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?

Good

We rated safe as good because:

- All areas were clean and well maintained and furniture was in good condition and comfortable. Environmental risk assessments were being undertaken on a regular basis. The service recently had a full ligature risk assessment on 15/09/2015. This included risks identified and the actions taken by the provider to mitigate them.
- We saw that the service had a fully equipped clinic room and that the fridge temperatures were being checked and recorded in line with guidance, records from November 2014 until the day of the inspection supported this.
- The bistro had a food hygiene rating of four out of five from the local food standards agency following inspection as part of their "scores on the door" initiative.
- The manager had used the service providers standardised tool to estimate the number and grade of registered mental health nurses and residential support workers on shifts. We looked at the staff rotas for the 3 months before our visit and all shifts were fully staffed.
- All staff and patients told us that there were enough staff on shift for patients to have regular 1:1 time with their named nurse.
- All staff and patients told us that escorted leave and planned activity times were occasionally changed due to pressures on the service but that they were never cancelled.
- All staff had access to personal alarms and nurse call systems. All staff had alarm fobs and were able to discuss how they were used. Within the communal living areas and two four bedroom flats every room had an alarm call for patients to use if they required assistance from staff.
- Every patient had a risk assessment on admission, which staff reviewed regularly. All risk assessments reviewed were up to date and thorough with historical and current risks identified.
- All risk assessments had crisis plans in place.
- Staff were able to describe the provider's safe and supportive observation policy and the process of risk assessment and care reviews to identify appropriate support from staff for patients.
- Patients and staff told us that searches were made randomly and there was not a blanket policy of routine searches. All

Summary of this inspection

policies and procedures we reviewed were completed and up to date, including the fire risk assessment, fire alarm testing, legionella prevention strategy and the employee insurance certificate.
- Records showed that incidents were being reported by staff and that staff received feedback from the investigations of external incidents via the monthly lessons learnt bulletin.
- Staff met on a regular basis to discuss incidents that had taken place and identify changes in practice as a result.

However:

- The average rate for staff compliance with all mandatory training was 79%. A key performance indicator (KPI) for the service rated this as below the level expected by the provider which was 95%, the new manager was aware of this at the time of our visit and was taking action to improve compliance levels.
- A sphygmomanometer, thermometer and weighing scales were present in the clinic room but without evidence of being checked or calibrated in line with manufacturer's recommendations. The weighing scales were not working and staff were made aware of this on the day of our visit. The manager had made arrangements for new physical health monitoring equipment to be provided following our inspection with a maintenance schedule from the equipment provider.
- Two staff raised concerns about insufficient exterior lighting in the self contained bungalow area and that this made them feel vulnerable when working night shifts. This was fed back to the manager following our visit.

Are services effective?

Good

We rated effective as good because:

- Seventy two hour care plans were in place for patients that had recently been admitted to the service and there was a one week target for a recovery plan to be developed following admission. This was evident in all care records reviewed during our inspection.
- All of the care plans we reviewed were thorough, holistic and recovery focussed.
- All care plans included a discharge plan with clear aims.
- During our inspection staff said that they experienced difficulties using the electronic records system in place. Effective plans were in place to mitigate risk from this.

Summary of this inspection

- Patients were registered with the local GP practice and had access to physical healthcare needs. Patients had been given the option to attend an alternative practice and had the choice of a male or female GP.
- There was evidence that patients were using a physical health checklist developed in response to the 2014/15 national Commissioning for Quality and Innovation(CQUIN) to improve physical health outcomes for people affected by mental illness.
- Care plans had detailed evidence of physical health needs being considered, this included supporting patients to attend their dentists and planned reduction of smoking.
- Staff were using the Lester tool to assess the cardio-metabolic health of patients experiencing psychosis and schizophrenia.
- A psychologist had recently joined the service and was developing a psychological intervention pathway for patients. This was in line with the 2014 NICE guidance for the prevention and management of psychosis and schizophrenia in adults.
- A range of disciplines fed into the care planning process and we saw evidence of a multi-disciplinary approach to the review of new referrals to the service to ensure their needs would be met.
- All staff had received an appraisal in the 12 months prior to our inspection, 75% of staff had received clinical supervision.
- The manager had identified training opportunities for staff including working with personality disorders training, 33% of staff had attended this and further sessions were planned.
- The new manager set up a range of training opportunities, including deprivation of liberty safeguards (DoLs) and Mental Capacity Act training (MCA). Staff compliance with this training was at 80%. A plan was in place for all staff to receive this training and future dates for this were being arranged.
- Most staff had received Mental Health Act (MHA) training at the time of our visit. A plan was in place for all staff to receive this training and future dates for this were being arranged.
- All Patients detained under the Mental Health Act had received their rights under section 132 read to them on admission to the service and every six months thereafter. All patients had a consent to treatment form completed within their notes and this was evident in all care records reviewed.
- All section 17 leave forms had evidence of patient and staff reviews of leave that that had been utilised and had the expiry date clearly documented.
- Most staff had received training in DOLs and the MCA. The manager had put two further dates in place to ensure all staff could receive this training.

Summary of this inspection

- Where there were concerns that patients may not have capacity to consent to treatment, a second opinion appointed doctor had been consulted and attended the service to discuss the patient's care and treatment.

However:

- Staff were using the electronic notes system in place from the previous service provider. The manager had requested this be changed but no date had been set for this.
- The service did not have effective communication links with the local GP surgery and reported that the surgery was reluctant to share information about patients care with them. The service manager had attempted to resolve this locally but it remained an issue at the time of our inspection, this could impact on the continuity of patient care.

Are services caring?

Good

We rated caring as good because:

- Throughout the inspection we observed care from staff that was respectful and promoted dignity and choice.
- All patients that we spoke to said that staff were supportive and approachable.
- Staff and patients could describe the admission process and steps taken to inform and orientate a new patient to the environment.
- Patients played an active part in the care planning and their views, goals and wishes were expressed within care records.
- Posters and leaflets were available throughout the service explaining the role of advocacy for patients.
- Carer involvement was promoted throughout the service including attendance at care reviews and planning meetings.
- Carers we spoke to said they were happy with the care provided and felt the service communicated effectively with them and included them where possible in the care planning process.
- A weekly "tea and talk" meeting gave patients the chance to give feedback, plan activities, and develop the service philosophy with staff.

Are services responsive?

Good

We rated responsive as good because:

- Average bed occupancy for the previous six months was 65%. The service had been under occupied since opening in 2013.

Summary of this inspection

Following the change in provider and the appointment of the new manager referrals to the service had increased and 5 patients had been admitted in the two months prior to the inspection taking place.

- We saw evidence that a multi disciplinary approach to assessing the suitability of referrals to the service was taking place.
- Discharge planning was evident in all care records reviewed, 33% of patients had been discharged from the service in the year prior to our inspection.
- The service had low waiting times, with the four most recent referrals waiting only five days to be assessed.
- There was a full range of facilities to support treatment and care.
- The communal area was used as focal point for patients and staff to carry out activities together.
- A self contained bungalow had been converted into a therapy bungalow. Patients could access this with support from staff and the occupational therapist to carry out daily living skills assessments and practice.
- Patients had privacy if they wished to use the unit phone and staff supported patients with this.
- There was access to well maintained outdoor spaces equipped with benches.
- Patients told us they had access to hot and cold drinks and snacks day or night.
- Patients were encouraged to personalise their living spaces, patients were able to decorate the self contained bungalows and one patient we met with had been supported by staff to keep a bearded dragon as a pet.
- Patients were able to lock their bungalows and had their own keys. Staff had a master key for emergency access but did not use this unless required.
- The service was accessible for disabled people including adapted bathrooms and designated parking.
- Staff and patients told us that they had access to activities at weekends.
- Throughout the service there were posters and information leaflets advertising activities that the unit was holding and providing information on advocacy services and helplines.
- There was a poster in the communal area advertising interpreter services for patients and carers where English was not their first language, this service had been used a week prior to our inspection to facilitate family involvement in a patient's care review.

Summary of this inspection

However:

- We did not see information leaflets in a range of languages and made staff aware of this during our visit.

Are services well-led?

Good

We rated well-led as good because:

- The provider's values were on display in multiple locations across the service. Staff explained what these values were and how they used them to influence their care.
- Minutes from the weekly "tea and talk" meetings showed that staff and patients had been encouraged to reflect and develop the service philosophy collaboratively.
- Staff were aware of who the senior managers were in the organisation and the senior management team had visited the service recently.
- All staff had received an appraisal in the previous 12 months following the appointment of the new service manager and 75% of staff had received clinical supervision. All staff that had not received recent supervision had dates allocated for this by the manager.
- A supervision passport scheme for clinical staff was being implemented and rolled out across the staff team.
- The clinical lead nurse had developed a monthly staff supervision forum.
- Shifts were always covered by sufficient staff of the right grade and experience.
- Patients we spoke to told us that when they had raised concerns with staff they had been dealt with promptly and effectively. Patients told us that staff were open and transparent with them and that if things did go wrong they were given an explanation as to why this had occurred.
- The unit manager was well supported by administrative staff and felt that they had sufficient authority to do their job.
- At the time of our inspection there were no grievance procedures being pursued within the team and there were no allegations of bullying or harassment.
- Staff were aware of the providers whistleblowing policy and process and felt able to raise concerns using this.
- All staff said they felt well supported by the new service manager and had opportunities for development and leadership.
- A full time psychology post had recently been recruited to. This enabled the service to develop psychological intervention pathway for patients.

Summary of this inspection

- The psychologist had set up a weekly staff reflection meeting and this was being promoted to increase staff engagement in reflective practice.
- The clinical lead nurse had set up a monthly supervision group for staff.

However:

- All staff had not received mandatory training. The manager had recognised this and arranged further dates to enable all staff to attend training.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Adherence to the MHA and the MHA code of practice:

- At the time of our inspection 14 patients were detained subject to the Mental Health Act 1983/2007.
- Most staff had received MHA training at the time of our visit, this included updates to the mental health act code of practice. Plans had been put in place for future training dates to ensure all staff had received MHA training.
- All patients had a consent to treatment form completed within their notes and all records reviewed showed that patients had their rights explained to them on admission and regularly following this.
- MHA administration support was available on site and audits took place to ensure that the MHA was being applied properly.
- Access to Section 17 leave was reviewed by both patients and staff, and the expiry date was clearly documented on the form.
- The service had completed an internal audit of MHA documentation in April 2015. The audit checked that T2 and T3 forms were present and correct, ensuring medication was being administrated in line with MHA law. The audit also detailed that copies of consent to treatment forms were in medication files, and that the original remained in mental health act administration paperwork.
- Where there were concerns that patients may not have capacity to consent to treatment a second opinion appointed doctor (SOAD) had been consulted and attended the service to discuss the patients care and treatment.
- Patients had access to independent mental health advocacy services (IMHA's). There were leaflets and posters throughout the service promoting the local IMHA service. Staff in the ward round discussed the use of this service with patients and offered to assist with accessing it.

Mental Capacity Act and Deprivation of Liberty Safeguards

Good practice in applying the Mental Capacity Act 2005 (MCA).

- At the time of our inspection 80% of staff had received training in Deprivation of Liberty Safeguards (DoLS) and the MCA. The manager had put two further dates in place to ensure all staff could receive this training.
- There had been one DoLS application made in the last six months. The manager had sought advice from the local council DoLS lead and a best interest assessment for the patient was being planned.
- Staff were able to discuss the five key characteristics of the MCA and the principles of DoLS. The manager had recognised training needs amongst staff and put in place plans to mitigate this.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment:

- All staff had access to personal alarms and were able to explain how these were used and the process for staff response if an alarm was raised. Communal areas and patients' bedrooms had nurse call systems in place for support if patients required assistance.
- The service had a clinic room with equipment for physical health checks available. However, there was no evidence of equipment being checked or calibrated in line with manufacturers recommendations. The weighing scales were not working and staff were made aware of this on the day of our visit. Replacement physical health monitoring equipment had been obtained by the service manager following our inspection and service schedules had been agreed with the supplier. Records from November 2014 to October 2015 showed fridge temperatures were being checked and recorded
- Accessible resuscitation equipment was available for all staff to use and was stored within the clinic room for the unit. Equipment available included a manual resuscitator, a defibrillator and emergency oxygen. The equipment available was checked on a weekly basis and records of this were kept within the clinic room.
- Seclusion of patients did not take place in this service and there were no seclusion room facilities.
- All areas were clean and well maintained and furniture was in good condition and comfortable. The service had a cleaner in place that worked weekdays from 10am-6pm. At weekends patients and staff ensured that the communal areas remained tidy and clean. Cleaning schedules were reviewed from March 2015 until the day of the inspection and were complete and up to date.
- Two staff were concerned there was insufficient exterior lighting in the self contained bungalow area. This made them feel vulnerable when working night shifts. This was This was fed back to the manager following our visit.
- We viewed the temperature checklists for the fridges and freezer in the Bistro for the previous four months, all checks were completed and dated accurately. Storage of food checks for the previous four months were also reviewed as part of the inspection and found to be up to date, complete and accurate.
- Environmental risk assessments were undertaken on a yearly basis. The service had carried out a full ligature risk assessment of all areas on 15/09/2015. Ligature risks had been identified in the disabled access bathroom via hand rails, assist bars, bath lift, taps, door, closers and handles, hand wash fittings, and hand towel fittings. This had been risk assessed and this bathroom was only used with support from the occupational therapist or other staff and was kept locked at all other times. Ligature cutters were available in the nursing office for emergency use and all staff we spoke to were aware of this.
- Ligature risk assessments of the bungalows were carried out on a weekly basis. A pathway was in place for patients to live in the supported flats when they were new to the service and for them to step down to independent bungalows following a period of risk assessment and continued stability in their mental

health needs. Decisions to reduce the support required for patients was discussed in ward round, required the agreement of the Multi-disciplinary team and was documented within care records. An updated risk assessment was completed following any change in accommodation and support.

- We reviewed nine policies and audits relating to the service. These included the fire risk assessment, fire alarm testing, legionella prevention strategy and the employee insurance certificate. All were completed and in date.
- The bistro had a "scores on the door" food hygiene rating of four out of five from the local authority.

Safe staffing:

- At the time of our inspection there were four whole time equivalent (WTE) and two part time registered mental health nurses in post with two qualified nurse vacancies which were in the process of being recruited to. Fifteen WTE residential support workers (RSW's) were in post and there were four RSW vacancies.
- The manager used the service providers standardised tool to estimate the number and grade of nurses and residential support workers (RSW's) on shifts. During the daytime shifts the ratio of staff to patients was 1:3. This staffing level was comprised of two registered mental health nurses (RMN's) and four RSW's. In addition to this there was an Occupational Therapist (OT), a clinical lead nurse, a psychologist, an OT assistant and the unit manager. At night the ratio of staff to patients was 1:5; two RMN's and one RSW.
- There had been 699 of an available 1,512 shifts filled by bank staff in the six months prior to our inspection. The manager recognised that this number was high and had also identified that the staffing establishment for the unit when fully occupied had previously been followed, although the service was operating with 50% of beds used. The manager had changed staffing levels to reflect this and reduce over staffing at the time of our inspection.
- Staff sickness rate in the previous 6 month period was 10% and staff turnover was low at 2%. The manager reported that prior to this staff turnover had been high due to frequent changes in the services management structure and low staff morale, 15 staff had left whilst the previous service manager had been absent long term and this had included 6 qualified nurses. Most vacancies were now filled and recruitment was in process for those vacancies that remained.
- Rota''s for the previous three months showed that all shifts had been fully staffed. Bank and agency staff that were used had previous experience of working in this service where possible. A policy for the provision of bank and agency staff was in place and was reviewed annually, next review due in July 2016. All bank staff were required to attend the partnerships in care induction and management of violence and aggression training prior to commencing work. A risk assessment was required for all bank or agency staff if they had not worked in the service previously or if four weeks had elapsed since their last shift at the location, this included a review of the location of emergency resuscitation equipment, incident reporting and the providers supportive observation policy.
- An RSW worked daily from 9am-5pm to increase opportunities for vocational and leisure activities for patients. Staff and patients told us that this ensured that planned activities and staff availability for escorted section 17 leave was maintained during busy times.
- There were enough staff on shift for patients to have regular 1:1 time with their named nurse. One patient told us that on the occasion their named nurse had been absent due to sickness 1:1 time had been facilitated by another staff member that they had a good relationship with and this had worked well.
- Patients and staff said that escorted leave and planned activity times were occasionally changed due to pressures on the service but that they were never cancelled.
- A range of training opportunities had been put in place by the new manager in post. This included deprivation of liberty safeguards (DoLs) and mental capacity act training (MCA), 80% of staff had received training in DoLs and MCA and the manager was able to show us that two further dates had been put in place to ensure all staff could receive training.
- The average rate for staff compliance with mandatory training was 79%. A key performance indicator (KPI) for the service rated this as below the 95% level expected by the provider. The new manager was aware of this at the time of our visit and was in the process of making future training dates available for staff.

- Medical support for the service was available via the responsible clinician who had been available from 9am to 5pm two days a week, this had been increased to include a further day from 9am-2pm in response to increased admissions to the service. Out of hours on call provision and emergency response provision for the service was also provided by the responsible clinician with support from a senior colleague. All patients we spoke to said that access to the responsible clinician was available when required.

Assessing and managing risks to patients and staff:

- Staff undertook a risk assessment of every patient on admission and this was updated regularly following any changes in the patients wellbeing, risk incidents, MDT meetings and patient reviews at ward round. All care records reviewed had a recent and in date risk assessment contained with them. Risk assessments had been updated following incidents and levels of support including the observation of patients had been changed to reflect increased or decreased risk levels. This ensured that patient safety was maintained using least restrictive options and that care provided could be responsive to patient need.
- The manager had recently introduced training for risk assessment using START (short term assessment of risk and treatability), 69% of qualified nursing staff had attended this. The Sainsbury's risk assessment was in use by the service at the time of our inspection and the psychologist used the historical clinical risk management-20 (HCR-20) tool for risk assessment and formulation, this was incorporated into the care planning and review process.
- All six of the risk assessments reviewed were up to date and thorough with historical and current risks identified. There was evidence of individualised management plans and protective factors to assist patients in remaining well. All risk assessments contained early warning signs to identify when a patients mental health began to deteriorate and how to support them effectively.
- Staff could describe the providers safe and supportive observation policy. They offered clear rationales for why a change in observation levels would be used proportionately to support the changing needs of the patients. Observation levels could be increased by nursing staff on shift in response to changing needs. A decrease in observation levels could only be made by the responsible clinician following discussion with the MDT.
- Routine searches of patients did not take place. Patient searches were carried out following individual risk assessment and discussion within care reviews and the MDT meeting. A contraband list was in place and included alcohol, drugs, legal highs, and weapons. All other high risk items (e.g. kitchen knives, glass bottles, animals, lighter etc.) were individually risk assessed and this was evidenced in care records. If there was a suspicion that patients were bringing illicit items onto the premises they would be asked to allow staff to search their belongings.
- Restraint and rapid tranquilisation were not used in this service. Staff had previously been NAPPI (non abusive physical and psychological interventions) trained. The new manager was in the process of introducing prevention and management of aggression and violence (PMAV) training. The manager had recognised that as the service increased in size due to new referrals, staff needed to have increased training and skills to work effectively with patients and had put training dates in place available to all staff.
- At the time of our inspection all medication was ordered via the local GP practices and was completed on a monthly basis. Reconciliation of medication took place by the nursing staff and was carried out weekly to allow for the ordering of extra medication as required. Daily clinic checklists were completed including a medication audit book and this was completed by nursing staff also.
- Medication management was individually assessed for all patients and agreed in discussion with patients at weekly MDT reviews and ward rounds. Stages of medication management ranged from patients attending the clinic room and having staff supervision to them keeping a weeks supply of medication in a safe in their room and self administering. A review of individual medicine management took place following changes in the patients wellbeing and evidence of this was available in care records.
- The staff stated that informal patients could leave at will, and there were notices to this effect on the exit doors to the unit which were locked. The nursing office was adjacent to the front door as was the communal

Long stay/rehabilitation mental health wards for working age adults

Good

bistro area. There was a visible staff presence in both these areas during the time we spent at the service and staff ensured that patients wishing to leave were not delayed in doing so.

Track record on safety:

- There had been no serious incidents in the 12 months prior to our visit.

Reporting incidents and learning from when things go wrong:

- Records showed that incidents were being reported. Staff were able to describe what should be reported, to whom and the processes in place for doing so.
- We were able to review incident forms that had been completed and what outcomes had taken place as a result. Patients told us that when they had raised concerns with staff they had been dealt with promptly and effectively.
- Staff received feedback from the investigations of external incidents via the monthly lessons learnt bulletin. This was available via the intranet and was emailed to staff.
- Staff met regularly to discuss incidents and identify lessons learned. Staff had access to psychology services for support with the debriefing process following incidents and told us that this had been helpful when used.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care:

- Patients that were referred into the service had a 72 hour care plan put in place following admission to ensure staff could manage their care needs effectively. Of the six care records reviewed, all had evidence of this process being completed.
- All care plans we reviewed were holistic and recovery focussed. Care plans were tailored specifically to the needs of the patient and included physical health and vocational goals. One care plan had a reduction in smoking identified as a goal by the patient, and another had an increase in leave to visit a relatives work place and gain work experience.
- All care plans incorporated a discharge plan with clear aims. We saw that care plans reflected individual dietary preferences and individual emergency evacuation plans.
- sStaff sometimes experienced difficulties accessing the electronic records system in place (Caresys), and had been unable to the weekend prior to our visit. Plans had been developed to mitigate risks, including the use of paper progress notes, paper copies of risk assessments, and care plans stored in patient's files. Staff updated all electronic records including risk assessments and care plans with any changes made following any periods when electronic records were unavailable.
- The service was using the previous providers electronic records system which was not the system used by partnerships in care (PIC). The manager had notified their senior management team of this and requested that the PIC "care-notes" system be integrated within the service and training made available to staff. A date had not been agreed by the provider for this electronic care record keeping system implementation at the time of our visit.

Best practice in treatment and care:

- Patients were registered with the local GP practice and had access to physical healthcare monitoring through attending appointments at the practice. Patients were given the option to attend an alternative practice so they had the choice of a male or female GP.
- There was evidence that some patients were using a physical health check booklet developed for people using mental health services by RETHINK. This had been developed in response to the 2014/15 national Commissioning for Quality and Innovation (CQUIN) to improve physical health outcomes for people affected by mental illness.
- Staff from all disciplines used profession specific rating scales and outcome measures to assess and record patient progress and the effectiveness of the interventions offered. The model of human occupation (MOHO) was used by occupational therapy staff and a

screening tool was used (MOHOST) to provide evidence on patient progress for MDT reviews in line with national guidance from the college of occupational therapists (COT).

- The mental health recovery star which is a ten point multi faceted outcome measure was also used on admission and at six months to assess patient outcomes and the effectiveness of interventions offered. Patients were able to express their views on progress achieved and to identify goals for future care planning.
- Care plans had detailed evidence of physical health needs being considered, this included supporting patients to attend their dentists and planned reduction of smoking.
- Staff used the Lester positive cardio-metabolic health resource to assess and provide interventions to protect the cardiovascular and metabolic health of patients receiving anti-psychotic medication. This was in line with recommendations relating to the monitoring of physical health in the national institute for health and care excellence (NICE) guidance cg178 and cg155, and was also supported by the NICE quality standard for psychosis and schizophrenia in adults,qs180.
- A psychologist had recently joined the service and was developing a psychological interventions pathway for patients in accordance with the 2014 NICE guidance for the prevention and management of psychosis and schizophrenia in adults.

Skilled staff to deliver care:

- All staff had received an appraisal in the two months following the appointment of the new service manager.
- Most staff had received recent clinical supervision at the time of our inspection. Regular supervision had not previously been happening on a monthly basis in line with the providers supervision policy. The new manager had identified this and developed a supervision strategy with other senior staff.
- A range of disciplines including nursing, psychology and occupational therapy staff fed into the care planning process. We saw evidence of a multi-disciplinary approach to the review of new referrals to the service to ensure their needs would be met.
- Training opportunities had been identified by the manager including working with personality disorders training, 33% of staff had attended this and further sessions were planned.

Multi-disciplinary and inter agency team work:

- There were regular and effective team meetings and we observed this taking place. Two shift handovers took place each day between staff working day and night time shifts. A multi-disciplinary team (MDT) meeting took place daily for staff that worked core hours (9am-5pm), this included the service manager, psychologist, occupational therapist and clinical lead nurse. Medical input to these meetings was provided by the responsible clinician. Any change to patients support needs was discussed at the MDT and included a review of their progress for the previous 24 hours. Incidents that occurred were reviewed and a risk formulation and care plan for how to manage patients with increased support needs was developed by all staff in attendance.
- Care co-ordinators in the community told us that the service involved them in decisions made about patients care and, communicated effectively informing them of any meetings being held at the providers location. On the day of the inspection we met with a care co-ordinator and a patient's family member who were visiting as part of a MHA tribunal process and received positive feedback about the quality of care provided.
- Staff received support from local authority social services at weekends if they had queries regarding DoLs.
- The manager said that the service had previously experienced difficulties with the local GP practice sharing information from patient's routine blood tests and physical health checks. The responsible clinician for the service had met with the local GP to discuss and review procedures for information sharing and links had been made with the practice manager at the local GP surgery. Staff fed back that they now received the results of patients physical health checks via telephone and although there were still difficulties in obtaining written copies of physical health checks from the general practice, the relationship between the services was improving.

Long stay/rehabilitation mental health wards for working age adults

Good

Adherence to the MHA and the MHA code of practice:

- At the time of our inspection 14 patients were detained subject to the Mental Health Act (MHA).
- At the time of our inspection 80% of staff had received MHA training and dates had been arranged for all staff to undertake this.
- All patients had a consent to treatment form completed within their notes and all records reviewed showed that patients had their rights under section 132 of the mental health act explained to them on admission and regularly following this.
- All section 17 leave forms had evidence of patient and staff reviews of leave that had been taken, and had the leave expiry date clearly documented.
- We reviewed an audit of MHA paperwork that had taken place earlier in the year. All medication was given under a lawful authority. Consent to treatment was obtained from patients in line with MHA requirements and was documented on T2 forms accompanying prescription charts. T3 forms had been completed for patients who lacked the capacity to consent to continued treatment under the MHA and were kept in care records and with prescription charts.
- Where there were concerns that patients may not have capacity to consent to treatment a second opinion appointed doctor (SOAD) had been consulted and attended the service to discuss the patients care and treatment.
- Patients had access to independent mental health advocacy services (IMHA's). There were leaflets and posters throughout the service promoting the local IMHA service and staff in ward round discussed the use of this service with patients and offered to assist them with accessing it.

Good practice in applying the MCA.

- At the time of our inspection 80% of staff had received training in the deprivation of liberty safeguards (DoLs) and the mental capacity act (MCA). The manager was able to show us that two further dates had been put in place to ensure all staff could receive training in this.
- There had been one DOLs application made in the last six months. The manager had sought advice from the local social services DoLS lead and a best interest assessment for the patient was being planned.
- Some staff we spoke to were able to discuss the five key characteristics of the mental capacity act (MCA) 2005 and the principles of DoLS. The manager had recognised training needs amongst staff and put in place plans to address this including future training opportunities.

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

Good

Kindness, dignity, respect and support:

- Throughout the inspection we observed care from staff that was respectful and promoted dignity and choice. One patient we spoke to told us that "if you need to talk, staff always make the time. All patients said that staff were supportive and approachable and that they took the time to understand their individual needs.
- Staff and patients had developed a positivity board in the communal area to promote patients philosophies. The positivity board provided patients with the opportunity to describe their views of how they wished to be cared for and what they believed the culture of the service should be, this included a focus on recovery and for staff to see the person and not their illness.
- Patients were involved in the risk planning and assessment process through 1:1 sessions with named nurses, MDT meetings and care programme approach meetings. Of the six care records reviewed, all had a detailed and personalised risk assessment with factors identified that increased individual patients risk levels and a graded action plan of how this could be managed.
- The success of escorted and unescorted section 17 leave was evaluated by staff and patients following completion to evaluate how well it had gone, identify any issues that had arisen and to inform the care planning process for future leave use. Staff and patients views were recorded as part of the section 17 leave documentation in all six of the care records reviewed.

The involvement of people in the care they receive:

- Staff and patients were able to describe the admission process and steps taken to inform and orient a new

Long stay/rehabilitation mental health wards for working age adults

Good

patient to the environment. Patients were able to visit the unit prior to moving in and have overnight stays to ensure they would be happy when they moved to the service.

- Patients had an active role in the care planning process. All care plans that were reviewed as part of the inspection process had been signed by patients to say they had received a copy and care plans were individualised and reflected the needs and wishes of patients. Care plans were recovery focussed with clear aims and goals identified and the steps needed for patients to achieve them.
- There were opportunities for patients to apply for work roles within the service. The manager was recruiting at the time of our inspection for a patient to work on reception and patients were also able to work in the bistro assisting the chef with food preparation.
- The provider promoted local advocacy services and there were posters and leaflets available with the details of what their remit was and how to contact them. Patients were also offered advocacy services as part of the ward round process, this had been documented in patients care records.
- Carer involvement was promoted throughout the service. An interpreter service had been provided the week prior to our inspection to enable the carer of patient to participate fully in a planned review of their care and express their views where English was not their first language.
- Most carers we spoke to said that they felt well supported by staff at the unit and they had the opportunities to attend regular meetings and be involved in the care planning process.
- A weekly "tea and talk" meeting took place. This provided a forum for patients to provide feedback on the service, plan activities and develop the service philosophy. There were service user feedback boxes in the bistro area for people to post their comments, ideas and compliments in. This was opened during the weekly "tea and talk" meeting and reviewed to promote patient involvement in the running of the service .

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge:

- There were nine admissions to the service in 2015 and five discharges. Three patients were discharged to community placements and two were transferred to psychiatric intensive care units (PICU's) or acute mental health wards due to an increase in their care needs.
- Average bed occupancy for the six months prior to inspection was 65%. The service had historically had low bed occupancy with 50% of beds occupied since it opened in 2013. Following the change in provider and the appointment of the new manager, referrals to the service had increased and 5 patients had been admitted in the previous 2 months.
- Plans had been put in place to manage the increasing numbers of referral and admission to the unit. New admissions were limited to 2 per week and were planned with at least a weeks notice to allow staff to familiarise themselves with the patients historical information and risk assessments. A care pathway was in place for patients to step down from the enhanced support staffed flats to the self contained and more independent bungalows. All changes in support levels took place following care planning meetings and MDT reviews with patients and were documented within care records.
- A multi disciplinary approach to assessing the suitability of referrals to the service was taking place. We reviewed the data relating to time taken from a referral to the service being received and an assessment of the patient taking place. The average waiting time for the four most recent referrals was five days indicating that the service was being responsive in assessing patients that may benefit from their input.
- Discharge planning was evident in all six of the care records reviewed. Patients that we spoke to had clear goals as part of the rehabilitation work they were undertaking with staff from the service and this was reflected in their care records.

The facilities promote recovery, comfort, dignity and confidentiality:

- There was a full range of facilities to support treatment and care. The communal area was used as focal point

for patients and staff to carry out activities together. There was a snug area that patients could use if they preferred an quieter environment and this was equipped with comfortable furniture.

- A self contained bungalow had been converted into a therapy bungalow and patients could access this with support from staff and the occupational therapist to carry out daily living skills assessments and practice.
- Patients had access to privacy if they wished to use the unit phone and we observed staff supporting them with this. There was access to well maintained outdoor spaces equipped with benches.
- Facilities were available for patients to make hot drinks and snacks at all times, the majority of patients lived in self contained bungalows with their own kitchen facilities, those that lived in the enhanced care supported flats had access to communal kitchens.
- A bistro was available for patients to use and provided hot and cold meals and drinks during daytime hours that patients could purchase with their own funds. This was supplementary to meals and refreshments provided by the service.
- Living spaces and bedrooms were personalised and most apatients that we spoke to told us that the environment felt therapeutic and welcoming and that it was a positive change from previous placements that had felt too clinical.
- Staff promoted individual choice and supported patients to maintain roles and activities that they valued. We met with one patient who was able to keep a pet bearded dragon in their bungalow with assistance from staff when required, they told us that this had a positive impact on their mental health and well-being.
- Patients were able to lock their bungalows and had their own keys. Staff had a master key for emergency access but did not use this unless required. Patients told us that staff knocked on their doors and waited for an answer before entering and said they felt treated with dignity and respect.
- Patients could access activities at weekends. A weekly activity timetable was displayed in the communal area which included arts and crafts, cooking and relaxation groups. Patients told us that they were involved in volunteer work in the community and that planned day trips took place using public transport to promote independence.

Meeting the needs of all people who use the service:

- Adjustments had been made for people requiring disabled access. A lift was in place and we saw evidence of the service schedule being maintained according to manufacturers recommendations. There was a disabled access bathroom and facilities available, and disabled access parking.
- Throughout the service there were posters and information leaflets advertising activities, advocacy services and helplines. There were also posters showing the units organisational structure to promote accountability.
- There was a poster advertising interpreter services in the communal area and this had information in a range of languages. We did not see information leaflets in alternative languages however and made staff aware of this during our visit.

Listening to and learning from concerns and complaints:

- The service had received no formal complaints following the change in provider in spring 2015. A log book for informal complaints was held in the nursing office and all complaints made informally by patients were reviewed daily at the communication meeting each morning. Patients that raised concerns received feedback in verbal and written format and were able to comment whether they felt this had been dealt with to their satisfaction.
- Patients attended a weekly tea and talk meeting which enabled them to provide feedback directly to service manager, All patients we spoke to said that concerns they raised were dealt with immediately with explanations and apologies offered by the management team if mistakes had ben made.
- All patients we spoke to were aware of the process for making a complaint if they had concerns about the quality of care provided. Patients received information on the complaints process as part of the admission procedure, there were also easy read leaflets and the providers policy on complaints was displayed in communal areas.

Long stay/rehabilitation mental health wards for working age adults

Good

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

Good

Visions and values:

- The providers values were on display in multiple locations across the service, staff were able to discuss with us what these values were and how they used them to influence their care.
- We saw evidence in the minutes from the weekly "tea and talk" meetings that staff and patients had been encouraged to reflect and develop the service philosophy. Key themes identified by patients included respect, individuality, seeing the person and not their illness and demonstrating community spirit towards each other.
- Staff told us that they were aware of who the senior managers were in the organisation and that the senior management team had visited the service recently.
- The chief executive of the service had visited the location the week before our inspection.

Good governance:

- All staff had not received mandatory training at the time of our inspection. The manager had recognised this since taking up post and put arrangements in place to address this. MCA training had been sourced through an outside provider and 80% of staff had attended this. The manager was able to provide us with evidence that further training sessions had been booked which would enable all staff to be trained in MCA by December 2015.
- All staff had received an appraisal in the four months that the manager had been in post. Prior to this staff had not been having annual appraisals and there had been no systems in place to monitor this.
- Most staff had received clinical supervision in the month prior to our inspection. Regular supervision had not previously happened on a monthly basis in line with the providers supervision policy. The new manager had recognised this and developed a supervision strategy with other senior staff to ensure that this was now taking place.
- During our visit we saw a supervision passport for clinical staff was being implemented. The supervision passport differentiated between whether supervision was managerial or clinical, the source of supervision and its frequency.
- The clinical lead nurse had developed a monthly staff supervision forum. The aim of this was to provide educational opportunities for staff about the purposes and theory of supervision and to promote a meaningful and effective supervision culture within the service.
- We observed rotas and spoke to staff and patients who informed us that shifts were being regularly covered by sufficient staff of the right grade and experience. Residential support staff said that nursing colleagues on shift were available and visible and the clinical lead nurse supported all staff in conjunction with the unit manager if required.
- During the inspection process we saw staff interacting positively with patients, making plans to go shopping and planning activities. Staff and patients spontaneously planned to cook for another group of patients and were also jointly working on preparing decorations for upcoming Halloween celebrations. Alternative options were also given for patients not wishing to be participate in Halloween festivities which promoted individual choice.
- Records showed that incidents were being reported. All staff were able to describe what should be reported, to whom and the processes in place for doing so. We were able to review incident forms that had been completed and what outcomes had taken place as a result. Patients we spoke to told us that when they had raised concerns with staff they had been dealt with promptly and effectively.
- The service manager reported previous difficulties in establishing effective communication links with the local GP practice and that the outcomes of patient's physical health assessments were not always received. The responsible clinician for the service had taken steps to resolve this by meeting with the practice manager and staff fed back that communication between the services had improved as a result of this.
- A key performance indicator procedure had been put in place following the manager taking up post. This was based on the five key questions that the CQC ask of services and covered areas including access to psychological therapies for patients, management of complaints and staff training compliance.

Long stay/rehabilitation mental health wards for working age adults

Good

- The unit manager was supported well by administrative staff and felt that they had sufficient authority to do their job. It was evident during inspection and through discussions with staff that there had been a recent focus on governance and training from the manager and the senior team. Recent developments included the training and development programme, appraisal process and a focus on effective supervision of all staff.

Leadership, morale and staff engagement:

- A clinical leadership structure was embedded in the service, medical leadership was provided by the responsible clinician and there was a service manager and clinical lead nurse in post at the time of our inspection.
- A comprehensive clinical audit and compliance plan was in place and included audits of medication, care plans, physical health checks and mental health act paperwork. During the inspection process we reviewed a range of these audits and found them to be complete and up to date. Action plans had been developed as a result of the auditing process with time scales for when outcomes should be achieved and we saw that the service was meeting these.
- In the six months prior to the inspection there had been fifteen individual episodes of staff sickness, this meant the service had an average sickness rate of 10%. When staff had been absent through sickness there were sufficient staff to cover shifts and ensure that staffing numbers remained at planned levels.
- At the time of our inspection there were no grievance procedures being pursued within the team and there were no allegations of bullying or harassment.
- Staff were aware of the providers whistleblowing policy and process and said they would feel able to raise concerns using this. We saw posters and information leaflets in prominent places throughout the communal areas advising staff on how to raise concerns and with details of how to contact senior management.
- Staff felt able to raise concerns without fear of victimisation and we were able to see this process had been followed.
- All staff felt well supported by the service manager and expressed that positive changes had happened in the service following their appointment.
- The manager promoted an open door policy and staff were encouraged to utilise this. Staff told us that the service was now very open in the way it was run and promoted a collaborative culture between staff and patients. All people we spoke to shared positive views about the impact of the new manager on the service, this included an increase in staff training opportunities and improved clinical governance and audit processes.
- There were opportunities for development and leadership. For example, one member of staff was due to start an internal leadership and development programme. Another staff member had been encouraged to undertake vocational training through the national vocational qualification (NVQ) scheme and had been supported and funded by the provider to do so.
- Staff identified a strong team working ethos within the service. One staff member told us that "we are a team, its really nice that everyone works together, its really well led". All the staff we spoke to said that morale had improved and they felt valued by the provider and the senior management team.
- Patients said that staff were open and transparent with them and that if and when things did go wrong they were given an explanation as to why this had occurred. During the inspection process we reviewed the minutes from six of the recent weekly "tea and talk" community meetings held with staff and patients. Duty of candour was evident where there had been delays in patients receiving previous meetings minutes and explanations were given when patients queried processes and policies.

Commitment to quality and innovation:

- A weekly staff reflection meeting had been set up and was being promoted to increase staff engagement in reflective practice.
- Staff and patients had developed a positivity board in the communal area to promote patients philosophies. The positivity board provided patients with the opportunity to describe their views of how they wished to be cared for and what they believed the culture of the service should be, this included a focus on recovery and for staff to see the person and not their illness.

Outstanding practice and areas for improvement

Outstanding practice

The patient positivity board in the bistro was identified as an area of outstanding practice. Patients told the inspection team that they felt the opportunity to express their views and wishes about the philosophy of the service and how they wished to be cared for gave them a sense of empowerment and they felt valued and respected by staff.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure that:

- Clinic room equipment is working correctly and appropriately maintained in line with the manufacturers instructions.
- Effective communication links are established and maintained with primary healthcare services and that information regarding patients physical health care examinations are routinely shared to provide continuity of care.
- Adequate lighting is provided in outdoor areas of the service to ensure the safety and wellbeing of staff working at night.
- Leaflets in different languages are available for patients and their relatives.
- Supervision and statutory and mandatory training is available and staff attendance is of a frequency that meets the service providers requirements.