Good

Norfolk and Suffolk NHS Foundation Trust

# Long stay/rehabilitation mental health wards for working age adults

## Quality Report

Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE
Tel:Tel: 01603 421421
Website:Website: www.nsft.nhs.uk

Date of inspection visit: 12 July 2016 - 22 July 2016
Date of publication: 14/10/2016

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| RMYMV | St Clements Hospital | Suffolk Rehabilitation and Recovery Services | IP3 8LS |

This report describes our judgement of the quality of care provided within this core service by Norfolk and Suffolk NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Norfolk and Suffolk NHS Foundation Trust and these are brought together to inform our overall judgement of Norfolk and Suffolk NHS Foundation Trust.

# Summary of findings

## Ratings

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

| | |
|---|---|
| Overall rating for the service | Good |
| Are services safe? | Good |
| Are services effective? | Requires improvement |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

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

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

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

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

# Summary of findings

## Contents

# Summary of findings

## Overall summary

We rated Suffolk Rehabilitation and Recovery Service as good overall because:

- The ward complied with the Department of Health guidelines on single sex accommodation.
- Managers completed ligature risk assessments, which were comprehensive and highlighted the risk areas; the ward had mitigated risk and promoted observation by installing CCTV in all day areas and corridors.
- The ward had a new response alarm system in place.
- There were no episodes of restraint within the last six months.
- There was a system in place for tracking and learning from safeguarding incidents and other reportable events.
- The managers used an acuity tool to identify and review staff numbers in accordance with need.
- Staff completed detailed risk assessments for most patients on admission and reviewed them regularly.
- We saw evidence of patient involvement in care plans; the plans were recovery-orientated and discharge planning was in place.
- We found staff to be caring and responsive to patients.

However:

- Staff did not follow the National Institute for Health and Care Excellence (NICE) guidance for patients on high dose antipsychotic medication.
- Doctors did not ensure that consent to treatment forms were adhered to when prescribing medication.
- Not all staff were not up to date with mandatory training.
- Managers did not ensure that all staff had keys to access all areas of the service.
- Staff did not record that they had monitored patients' physical health care.
- Only 44% of staff had received supervision in the previous 5 months.
- The ward was frequently unable to fill the second qualified staff member on night shift.

# Summary of findings

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

### Are services safe?

Good

We rated safe as good because:

- Managers completed ligature risk assessments, which were comprehensive and highlighted the risk areas; the ward had mitigated risk and promoted observation by installing CCTV in all day areas and corridors.
- The ward had a new response alarm system in place.
- Most patients had up to date risk assessments, which had been reviewed and were in date.
- There were no episodes of restraint within the last six months.
- Managers used a tool to identify and review staff numbers.
- Medicines were stored securely and within safe temperature ranges.
- Staff ensured that patients on antipsychotic medication had blood taken as per NICE guidance.

However:

- Staff did not follow the National Institute for Health and Care Excellence (NICE) guidance for patients on high dose antipsychotic medication
- Staff did not always follow safeguarding protocols and reporting periods as per trust policy.

### Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not record that they had monitored patients' physical health care.
- Clinical and managerial supervision was not taking place regularly across the service.
- Staff told us that the electronic case notes system difficult to use and took time away from patient care.
- 73% of staff had received an appraisal.
- Clinical audits were completed, but staff had not been involved.
- Doctors did not ensure that consent to treatment forms were adhered to when prescribing medication.
- Pharmacy visited the ward once a week but did not provide audit feedback.

However:

- 83% of staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

# Summary of findings

- Care plans were in place and reviewed. We saw evidence of patient involvement in care plans; the plans were recovery-orientated.
- Patients could access local GPs in the community.
- The ward handover included detailed discussions and reviews of patients care and treatment on a rotational basis.

**Are services caring?**

Good

We rated caring as good because:

- Patients reported that they were cared for and treated with respect.
- Patients were involved in planning activities and supported to plan and prepare their own meals.
- Staff interactions were positive and timely in response patients' requests and needs.
- Patients attended weekly community meetings and twice weekly team meetings.
- The ward had leaflets and guidance displayed for patient information.
- Patients understood their care, treatment and detention.
- Staff supported patients to develop and maintain social networks. Families could visit and attend reviews.

However:

- Some patients told us that staff did not always knock before entering their bedrooms.

**Are services responsive to people's needs?**

Good

We rated responsive as good because:

- Managers ensured patients placed out of county were prioritised for admission.
- The facilities and premises were appropriate for the service being delivered. The ward was spacious with several lounges, activity rooms and two kitchens.
- Patients had access to spiritual support and were able to visit a church.
- Patients were able to prepare and cook their own food. They were able to access the kitchen areas up until midnight for drinks and snacks.
- Patients were able to personalise their bedrooms.
- Admissions were planned; patients had the opportunity to visit the ward prior to their transfer to meet staff and see the environment.

# Summary of findings

- Staff supported patients to move into independent living accommodation when they were ready.
- An occupational therapist had been appointed to fill an identified gap in staffing.

However:

- There was no clear process or timeframe in place for referral to admission.
- Some patients reported that activity levels had reduced because of a reduction in occupational therapy and that since the gym had closed opportunities to exercise had reduced.

**Are services well-led?**

Good

We rated well-led as good because.

- Staff were aware of the trust's visions and values.
- The ward manager had sufficient authority to make changes to the ward staffing levels when needed and was visible on the ward.
- The ward manager felt supported by senior managers.
- The ward manager had access to a clinical dashboard.
- Staff were able to submit items to the trust risk register.
- Ward managers met monthly with senior managers to discuss governance, and audits were completed.

# Summary of findings

## Information about the service

There is one long stay/rehabilitation mental health ward for working age adults provided by Norfolk and Suffolk Foundation Trust. All other wards have closed.

Suffolk Rehabilitation and Recovery Service (SRRS) provided 10 beds for both men and women. At the time of inspection, they had only male patients. The ward was located over two floors; however, on inspection only the ground floor bedrooms were being used. There was capacity to re-open the first floor bedrooms to create an additional six beds if required. The ward had reduced its bed numbers as part of the redevelopment of the service: moving from a long stay to short stay rehabilitation service.

The ward aimed to help individuals who had severe and enduring mental illness build functional living skills to enable them to move from an inpatient to a community based setting.

The trust has had 15 inspections since July 2010. The last inspection was in October 2014. The outcome of this inspection was that the trust received an overall rating of 'Inadequate' and it was recommended that the trust was placed under special measures in February 2016. Long stay/rehabilitation mental health wards for working age adults had not been inspected previously as its own core service.

## Our inspection team

**Chair:** Paul Lelliott, Deputy Chief Inspector (Lead for mental health), CQC

**Team Leader:** Julie Meikle, Head of Hospital Inspection (mental health), CQC

**Inspection Manager:** Lyn Critchley, Inspection Manager (mental health), CQC

The inspection team consisted of two CQC inspectors and two specialist advisors.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and fair with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

## Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

## 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?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the ward, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- interviewed the ward manager and matron

# Summary of findings

- spoke with five other staff members; including doctors, nurses and rehabilitation support workers
- reviewed six care records
- carried out a specific check of the medication management on the ward
- looked at eight physical health records
- observed a ward round
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the provider's services say

- Most patients we spoke with were positive about their experience of care on the ward. They told us that they found staff to be very caring and supportive, and most people were involved in decisions about their care. Staff listened to them and supported and encouraged them.

## Good practice

Suffolk rehabilitation and recovery service provided an outreach service for recently discharged patients. We heard of a recent discharge where the patient had benefited from the continuity and therapeutic relationship developed whilst an inpatient to support his transition to independent living.

## Areas for improvement

### Action the provider MUST take to improve

- The trust must address compliance with monthly supervision and ensure staff receive annual appraisals in accordance with its own policy.
- The trust must ensure that physical health is monitored in accordance with its policy.
- The trust must ensure that signed consent to treatment forms are accurate and reflect the current treatment provided.

### Action the provider SHOULD take to improve

- The trust should ensure that staff follow the National Institute for Health and Care Excellence (NICE) guidance for patients on high dose antipsychotic medication

Norfolk and Suffolk NHS Foundation Trust

# Long stay/rehabilitation mental health wards for working age adults

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Suffolk Rehabilitation and Recovery Service | St Clement's Hospital, Foxhall Road, Ipswich IP3 8LS |

## 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.

- 90 % of patients were detained under the Mental Health Act (MHA).
- 71% of staff had been trained in the Mental Health Act.
- Staff we spoke to had a good understanding of the MHA, the code of practice and the guiding principles.
- Copies of consent to treatment forms were attached to all medication charts where applicable. However, three forms were incorrect.
- Staff read patients their Section 132 rights to them on admission and routinely thereafter. This was reflected in patients care records.
- The trust provided administrative support and legal advice on implementation of the MHA and code of practice when required.
- We reviewed eight sets of detention paperwork. Staff ensured detention paperwork was completed correctly, was up to date, and stored appropriately.
- The trust carried out regular audits to ensure that the MHA was being applied correctly.
- Patients had access to Independent Mental Health Advocacy (IMHA) services.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

- 83% of staff had training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with showed some understanding of MCA, in particular the five statutory principles.
- The service had made one DoLS application in the last six months.
- The trust had a policy on MCA, that included DoLS, which staff were aware of and could refer to if needed.
- We saw evidence that staff recorded capacity assessments in patients' care records for people who might have impaired capacity. Staff completed the assessments on a decision-specific basis about significant decisions.
- Staff knew where to get advice regarding MCA, including DoLS, within the trust.

Good

# Are services safe?

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

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

## Our findings

### Safe and clean environment

- Staff could not observe all parts of the wards due to its layout. Managers mitigated this risk by using closed circuit television (CCTV) and observation.
- Managers completed ligature audits to identify ligature points throughout the wards. The audits recorded actions to reduce the risk but there was no set timeframes for the work to be completed.
- The ward complied with the Department of Health guidelines on single sex accommodation, although at the time of inspection there were only male patients.
- The wards had fully equipped clinic rooms with accessible resuscitation equipment and emergency drugs that were accessible to all staff. Staff checked these regularly to ensure medication was fully stocked, in date and equipment was working effectively.
- The ward had no seclusion room.
- All ward areas were clean, with good furnishings that were well maintained.
- The PLACE survey scored the ward 100% for cleanliness. This was above the national average of 97%. The PLACE score for condition, appearance, and maintenance was 93.55%.
- Staff adhered to infection control principles, including handwashing.
- Staff ensured that equipment was well maintained, clean and clean stickers were visible and in date.
- Cleaning records were up to date and demonstrated that staff regularly cleaned the environment. We saw a dedicated team of domestic staff working throughout the service during the inspection.
- Managers ensured that environmental risk assessments were undertaken regularly and they shared these with staff in monthly meetings.
- Staff carried personal alarms, which they used to summon help in an emergency.

### Safe staffing

- The trust set the core staffing levels for the service. The established level of qualified nurses for the service was 12 whole time equivalent (WTE). The established level of unqualified nurses was seven. At the time of the inspection, there were no vacancies. In addition to this, the service had two activity coordinators.
- The ward manager used a safe staffing risk assessment to establish the staffing ratio.
- The trust had not provided data for the number of shifts unfilled, however, the ward manager reported difficulty with filling the second qualified on night shifts. Duty rotas between June and August 2016 showed 25 unfilled shifts.
- The trust did not provide data for the use of bank or agency staff for this ward; however, the ward manager estimated that the current establishment was unable to cover between 25 and 30% of shifts.
- The trust did not provide data for staff sickness or staff turnover rates; however, the ward manager reported some long-term sickness.
- There were enough staff to provide patients with regular 1:1 time and staff informed us that leave was not cancelled because of staffing levels. Patients also confirmed that leave was facilitated.
- The ward manager was able to adjust daily staffing levels to account for patient needs.
- A consultant psychiatrist offered two sessions per week. There was no junior doctor cover.
- Overall compliance with mandatory training for the service was 89%. This was slightly below the trust compliance rate of 90% in 13 out of 28 training topics.
- The ward manager was aware of the non-compliance in mandatory training and had taken appropriate action to book staff onto key training.

### Assessing and managing risk to patients and staff

- The ward had no seclusion facilities.
- There were no incidences of restraint in the last six months.
- Risk assessments were reviewed and updated in ward round meetings. We looked at six care records and five had risk assessments in place; the patient without the risk assessment had only recently been admitted.
- There were no issues regarding blanket restrictions and informal patients could leave voluntarily.

Good

# Are services safe?

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

- There were policies and procedures for observation; the ward had mitigated risk and promoted observation by installing CCTV in all day areas and corridors.
- All staff had completed safeguarding adult and children level one training; 88% of staff had completed safeguarding children level two.
- Medicines were stored securely and in accordance with the provider's policy and manufacturer's guidelines.
- Staff ensured that patients on antipsychotic medication had blood taken as per NICE guidance.
- The ward provided areas for family and child visits. Visits in the grounds or community were encouraged and one patient reported that he had home visits.

### Track record on safety

- In the last 12 months, there had been no serious incidents.

### Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. Staff reported incidents using electronic forms, which were forwarded to managers who then had to review the information before the incident could be closed. This meant managers had an overview of incidents. Managers ensured staff were aware of lessons learnt and action plans, to reduce the risk of repeated incidents and maintain patient safety.
- We observed a delay in reporting a recent safeguarding incident and staff did not appear to understand the expectations on timeframes for reporting externally, as per trust policy.
- Staff were able to describe duty of candour as the need to be open and honest with patients when things go wrong.
- Managers gave feedback to staff in monthly meetings on the outcomes of incident investigations both internal and external to the service. There was evidence of managers implementing changes because of feedback, for example, increasing staffing on some days to facilitate more activities.
- The ward manager reported that staff debriefs would be provided if required.

# Are services effective?

**Requires improvement**

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

## Our findings

### Assessment of needs and planning of care

- Staff completed comprehensive assessments for all service users in a timely manner. All six care records we reviewed were up to date, personalised, holistic and recovery orientated.
- Two patients had little or no information on their physical health recording forms. Staff were unable to confirm whether patients had electrocardiograms (ECG's). Staff did not record this information on case records. Two patients did not have bloods tests and there was no record of patient refusal.
- There was no system in place to ensure that staff monitored those patients on a high dose of anti-psychotic medication.
- The information needed to deliver care and treatment effectively was stored securely within computer-based records. However, we found that electronic patient records were difficult to navigate, making it difficult for staff to locate requested information during the inspection.

### Best practice in treatment and care

- Staff followed NICE guidance when prescribing clozapine and lithium.
- Staff were not following NICE guidance for monitoring high dose anti-psychotic medication. There were no monitoring forms for four patients on high dose medication. Staff were unable to locate monitoring forms and were not able to confirm that a system was in place. Pharmacy was unable to locate these forms or confirm if a system was in place. There was no process in place to identify on treatment cards if patients were on high dose medication.
- Managers completed safe staffing level assessments that were based on the Royal College of Psychiatrist Guidance on safe staffing levels in the UK.
- GP provision was available in the community. There was no junior doctor provision to the ward.
- Consultant psychiatrist input was two sessions a week which was considered sufficient for the patient group.
- The occupational therapist was due to commence in post in August 2016. Psychology offered one session a week. The ward had submitted a capital bid for a physical health care nurse. Managers ensured that staff attended medication training.
- The trust did not provide data for qualified nurses trained in compliance with medication or rapid tranquilisation administration.
- Staff used the mental health-clustering tool, which included health of the nation outcome scales, to assess and record severity and outcomes for all patients.

### Skilled staff to deliver care

- Patients received care and treatment from a range of professionals including nurses, doctors, psychologists, activity coordinators, and pharmacists. An occupational therapist had been appointed.
- 73% of staff had received an annual appraisal.
- Staff were not receiving regular supervision.
- 85% of unqualified staff had completed the care certificate training.
- Staff said that they were encouraged to develop their clinical skills and that there were opportunities for career progression.
- Managers addressed poor staff performance promptly and effectively with the support of human resources.

### Multi-disciplinary and inter-agency team work

- Handovers were detailed and a focused patient discussion took place on a rotational basis. Staff discussed patient status, current progress and issues.
- The multi-disciplinary team held weekly ward rounds where patients care and treatments were discussed. We observed a patient participating in a ward round and he was aware of his care plans, care and treatment.
- There were good links with other agencies, for example, community mental health teams to support patients during discharge. Managers attended weekly bed management meetings and referrals meetings to discuss patients' movements through the service and patients who needed admission or discharge from the service.
- Managers reported effective working relationships with teams outside of the organisation, for example, local authority social services.

# Are services effective?

**Requires improvement**

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

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

- 71% of staff had received training in the Mental Health Act (MHA).
- Staff demonstrated a good understanding of the MHA and the code of practice.
- Consent forms and current medication forms were kept together so staff could check patients' consent for medicines. Three patients consent to treatment forms were incorrect; one had consented to 100% British National Formulary (BNF) limits, however, was prescribed 50% over this. One patient had consented to 100% but was prescribed 8% over this. One patients consent to treatment form did not cover all of their medication.
- Staff read patients their Section 132 rights on admission and routinely thereafter. Staff evidenced this in care records.
- The trust provided administrative support and legal advice on implementation of the MHA and code of practice when required.
- We reviewed all detention paperwork. We found that it was completed correctly, up to date and stored appropriately.
- The trust carried out regular audits to ensure that the MHA was being applied correctly.
- Patients had access to Independent Mental Health Advocacy (IMHA) services. Staff supported patients to access this service.

### Good practice in applying the Mental Capacity Act

- 83% of staff had completed Mental Capacity Act (MCA) and DoLS training.
- Staff had an understanding of the MCA. We saw evidence that staff recorded capacity assessments in patients' care records for people who might have impaired capacity. Staff completed the assessments on a decision-specific basis about significant decisions.
- Staff knew where to get advice from within the trust regarding MCA and DoLS and could name the trust's MCA lead.
- There was a trust policy on MCA, including DoLS, which staff were aware of and could refer to when required. The ward had made one DoLS application.
- The service had made one DoLS application within the last six months.

Good

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- Staff were caring in their approach to patients and responded quickly to requests.
- Staff were aware of patients individual needs.
- Patients said they were well looked after and were treated with respect.
- We saw staff interactions that were positive and calm.
- Staff supported patients to attend activities both on and off the ward.
- We saw staff responding to patients requests in a timely manner.
- The PLACE survey score for privacy, dignity and wellbeing was 85%.

### The involvement of people in the care that they receive

- Staff encouraged patients to take part in their care planning and to attend weekly multidisciplinary meetings. However, we found that not all patients had signed their care plans.
- Posters and leaflets with details of how to access advocacy services were displayed on the wards. Patients knew how to contact advocacy.
- One patient told us that he often went on leave and staff supported him to do this.
- Staff supported patients to develop and maintain social networks. Families could visit and attend reviews.

# Are services responsive to people's needs?

Good

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

## Our findings

### Access and discharge

- From 1 October 2015 to 31 March 2016, the average bed occupancy was 77.82%. The ward had closed six beds as part of the programme of transition; the ward focus was moving from a long stay ward to a short stay rehabilitation and recovery service.
- The ward prioritised referrals from patients that were currently in out of county placements, however, there was no set timeframe from point of referral to admission.
- Beds were available when needed for people living in the catchment area.
- Patients had access to a bed on return from leave.
- Staff ensured patients were moved and discharged at an appropriate time of the day.
- The trust did not provide details about delayed discharges. Staff told us that one patient was recently discharged under section 17 leave to avoid delaying his discharge from the service.

### The facilities promote recovery, comfort, dignity and confidentiality

- The service had a range of rooms and equipment available. The ward had access to outside space that was accessible at all times.
- Snacks and hot and cold drinks were available throughout the day. We saw patients access the kitchen independently.
- There was a programme of activities during weekdays and at weekends. However, patients reported that the numbers of activities had recently reduced due to a reduction in occupational therapy and that since the gym had closed opportunities to exercise had reduced.
- Patients were able to personalise their rooms. Patients had access to secure drawers in their rooms for their belongings. There were quiet areas on the wards for visiting. Patients had access to computers, mobile phones and the internet.
- Staff supported patients to plan, shop and prepare their own meals. Patients confirmed that staff would support them in this.
- The ward had phones for patients, however, most chose to use their own mobile phone.
- Patients had a choice of two lounges and there was a separate activity/craft room.
- Patients were encouraged and supported to plan their own time and activities. We observed section 17 leave taking place.
- The PLACE survey score for food was 80%, which was below the national average of 88%. Patients reported being happy with their meals.

### Meeting the needs of all people who use the service

- The ward was accessible for patients with disabilities; four bedrooms had adapted bathrooms.
- Information leaflets were available in a variety of languages upon request.
- Accessible information was available on treatments, local services, patients' rights, and how to complain.
- Patients were able to access an interpreter or signer when required.
- Patients were supported to purchase and prepare their own food in accordance with their spiritual, cultural and specific dietary needs.
- There was access to spiritual support through the trust's chaplaincy service. Patients were able to visit community places of worship.

### Listening to and learning from concerns and complaints

- The service had received no formal complaints in the last 12 months.
- Patients we spoke with knew how to complain to staff. Information and leaflets about how to complain were on display.
- Staff held weekly community meetings to discuss common issues and any individual concerns.
- Staff knew how to respond to complaints in line with the trust policy.

# Are services well-led?

Good

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

## Our findings

### Vision and values

- Staff were aware of and could describe the trust's vision and values. Posters describing the trust's vision were on display.
- Staff knew who the senior managers were and described them as supportive and visible.

### Good governance

- Managers monitored their teams' compliance with mandatory training.
- 73 % of staff had received appraisal. The trust did not provide supervision data for this ward. The ward manager told us that supervision was non-compliant with the trust's target. A new supervision structure had been introduced to address this.
- A sufficient number of staff of the right grade and experience covered the majority of shifts. Managers staffed shifts to the agreed safe level of nurses; they often used bank staff to achieve this.
- We observed staff maximise shift-time on direct care activities as opposed to administrative tasks.
- There was no evidence that staff participated actively in clinical audits.
- There had been no high level incidents on the ward. Managers had a clear oversight of low level incidents and concerns and ensured that staff learnt from incidents and complaints by discussing them in monthly team meetings.
- Managers ensured that MHA and MCA procedures were followed by staff. We observed a delay in reporting a safeguarding incident externally.
- Ward managers had sufficient authority and administrative support to carry out their role.

### Leadership, morale and staff engagement

- There were no reported cases of bullying and harassment.
- Staff said that team morale was good and that they were happy in their role. Some staff reported that there had been too many changes on the ward.
- Staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation.
- Ward managers said that they felt supported by senior managers, and they had sufficient authority to make changes to the ward staffing levels when needed.
- Staff were aware of the duty of candour.
- Staff said that there were opportunities for personal development and training.

### Commitment to quality improvement and innovation

- The service was working towards registering for Accreditation for Inpatient Mental Health Service for Rehabilitation.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**The trust did not ensure that all staff received appraisal and supervision.**<br>**This was in breach of Regulation 18** |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**The trust must ensure physical healthcare needs of patients are recorded and addressed**<br>**This was in breach of Regulation 12** |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br>**Copies of consent to treatment forms were not all correct.**<br>**This was in breach of Regulation 11** |