

Coventry and Warwickshire Partnership NHS Trust

St Michael's Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

St Michael's Hospital is a purpose built facility in Warwick, providing inpatient and outpatient adult mental health care.

Larches

Core service provided: Acute admission

Male/female/mixed: mixed

Capacity: 20

Willowvale

Core service provided: Acute admission

Male/female/mixed: mixed

Capacity: 20

The Rowans Ward

Core service provided: Psychiatric intensive care

Male/female/mixed: mixed

Capacity: 11

Rosewood

Core service provided: Long stay/forensic/secure services

Male/female/mixed: mixed

Capacity: 15

Hazlewood

Core service provided: Long stay/forensic/secure services

Male/female/mixed: male

Capacity: 12

We found that the two acute admission wards at St Michael's Hospital, Larches and Willowvale, had staff that wanted to deliver good-quality care, and this was confirmed by the people receiving care and treatment there. We saw some good examples of compassionate care that valued the individual needs of people on their roads to recovery. However, record keeping did not always reflect the personalised care that people told us they received.

Since CQC's inspection Larches Ward is now for men only.

The psychiatric intensive care unit provided a safe and secure environment for people who needed an intensive and supportive environment during their stay in hospital. The unit is for both men and women. As an intensive care unit, Rowans is exempt from national guidance on mixed sex accommodation. The Trust told us that it tried as far as practicable to ensure that suitable arrangements were in place to offer men and women separate toilet areas. At the time of the inspection this was not clear as a sign had been removed from a toilet door.

The Crisis teams provided a combination of crisis assessment and home treatment to people experiencing mental illness. The service also acts as a 'gatekeeper' for all referrals to mental health services. We saw good examples of multi-disciplinary working between the crisis teams and the acute admission wards, therefore ensuring that people had a seamless journey of care. We saw that the service regularly checked the views of people and the results of surveys were used to improve the crisis service.

Rosewood Terrace and Hazelwood Unit staff used a 'recovery' approach to empower people to identify their needs and the support required. There were systems, including risk assessments, to keep people safe and for reporting any issues of concern. Improvements were needed to record keeping to ensure all records were accurate, accessible and showed people's involvement. Systems were in place for people and staff to give feedback on the service, as were audits for measuring the quality and effectiveness of services. Staff helped people access community teams and services as part of their transition from hospital. Staff were given information and understood the trust's governance framework, such as systems for feedback after incidents. Staff told us they were supported by their teams and line managers and could give feedback on the service. They said they had direct contact with their managers, but did not meet trust executive team members.

During our visit to Rosewood Terrace and Hazelwood Unit we found 16 people were detained under the Mental Health Act (MHA) 1983. Some paperwork relating to the MHA and code of practice was not easily accessible. We

Summary of findings

identified that community leave plans had set conditions for people not detained under the MHA. This indicated they could not always access community leave when they wanted.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We saw that systems were in place to protect people from the risk of harm or abuse, and that these complied with fire safety regulations. There were some environmental risks, for example door closures that were visible when the door was open and window restrictors. Staff were aware and risk assessments undertaken.

The systems for reporting incidents enabled ward managers to review and grade the severity of incidents.

We found that staff assessed people's needs and provided safe care to meet those needs on the two acute admission wards, Larches and Willowvale. Staffing levels were consistently maintained on both wards.

Rosewood Terrace and Hazelwood Unit had systems to keep people safe and to report issues of concern. Risk assessments had been completed to keep people and the environment safe. Improvements to record keeping were needed to ensure all records were accurate, accessible and showed people's involvement.

We could not find some assessments of people's capacity to consent to their treatment, and some medication prescriptions were not clear. On Hazelwood Unit, bank and agency staff, who were being used to cover permanent staff vacancies, did not always know the people they were working with.

Are services effective?

We found that people's care and treatment needs were discussed at the time of their referral, and decisions made by professionals following a review of their needs.

Staff said they were happy and worked well as a team. We found staff had received training to effectively support their responsibilities and roles, ensuring the care and treatment of people with mental health needs were met.

Risk management plans promoted individual rights and choices, taking into account people's views about their treatment. This ensured they were involved in important decisions about their care and treatment.

There was good multi-disciplinary and collaborative team working and goals were set to meet people's aspirations, recovery and discharge from hospital. There was an active occupational therapy team and shared activity co-ordinators for the two wards.

The wards had lots of communal spaces, which meant that people could choose where they wanted to be and what they wanted to do.

We saw that the crisis team provided an evidenced-based service.

People and staff on Rosewood Terrace and Hazelwood Unit could give feedback, and audits were used to measure the quality and effectiveness of the service. Where possible, staff helped people to access community teams and services as part of their transition from hospital into the community. Improvements were needed to record keeping to ensure that all records were accurate and accessible.

Some paperwork on Rosewood Terrace and Hazelwood Unit, relating to the implementation of the Mental Health Act 1983 and code of practice, was not easily accessible when we visited. We identified that community leave plans had set conditions for people not detained under the MHA. This indicated they could not always access community leave when they wanted.

Summary of findings

Are services caring?

People we spoke to used words such as brilliant to describe the care they had received. The wards, although busy, were very calm. People receiving services and their families did not raise any concerns about the care they received.

Care plans in acute admission services reflected each person's needs, including their mental health needs, showing what impact this had on their social and psychological wellbeing. People's dignity and diversity was supported. On the long stay wards, care planning records did not always fully show people's involvement, and people told us that paperwork was completed with them but they did not know what it was for.

We saw staff across all three wards interact with people in a warm and friendly way.

Staff told us how their time in people's homes, during visits, was used to not only give medication but to listen to people and answer their questions about their treatment and care plans.

On Rosewood Terrace and Hazelwood Unit staff spoke of using a 'recovery' approach with people. People told us that staff gave them support and they could learn and maintain skills for independence.

Are services responsive to people's needs?

We found examples of consultant psychiatrists and ward staff working alongside the community crisis resolution/home treatment team to provide holistic care and treatment to people.

The crisis team would attend Larches Ward every Sunday to review people's care, treatment and facilitate discharge planning.

Wards for men and women had appropriate washing and toilet facilities. However we saw that the women's lounge was not open four mornings a week since it was used for the doctor's round and multi-disciplinary team. We were told that women wanting access to a female only lounge would be offered an alternative space during these times.

Staff worked with a range of external community teams and agencies to help people access services needed as part of their transition from hospital to the community. People could feed back on the service and raise complaints, and these were used to consider if any actions were required. The rehabilitation and recovery service had identified that it needed to develop its systems to obtain greater feedback from people and carers to influence the service.

Are services well-led?

We found that there was a general level of efficiency, that ward staff were supported by the ward manager, and that the standard of people's care indicated good leadership. Staff across all the wards told us they felt well supported by their respective line managers and their senior managers were 'in tune' with the challenges they faced on a day-to-day basis.

We found that the crisis team managers took an active role in the day-to-day operations of the team, both as active clinicians as well as team managers.

The psychiatric intensive care unit manager had a detailed knowledge of people on the unit and was aware of their needs.

We found staff had an understanding of the trust's governance framework function, such as the mechanisms for reporting and learning from incidents, to prevent them happening again. They regularly received information, via email, with updates on issues in the service. Staff were able to raise any concerns at a local level, such as at team meetings or in supervision. They talked about changes and consultation events taking place in the trust and were concerned about the service's future. Some staff said that they did not know all the systems for giving feedback centrally on trust issues, and that they had limited contact with executive team members.

Summary of findings

What we found about each of the main services at this location

Mental Health Act responsibilities

In the acute admission wards, we saw that plans took into account people's views about their treatment, ensuring they were involved in important decisions about their care and treatment. Also, risk management plans reflected people's diverse needs and preferences. People told us there were no issues regarding their leave. This showed that Section 17 leave met people's needs and treatment plans.

During our visit to Rosewood Terrace and Hazelwood Unit we found 16 people were detained under the Mental Health Act (MHA) 1983. We reviewed eight care planning files. Some detention paperwork relating to the Mental Health Act and code of practice were not easily accessible. This meant that staff particularly temporary staff would not know the legal authority under which they were giving treatment.

We identified that community leave plans had set conditions for people not detained under the MHA. This indicated they could not always access community leave. On Hazelwood Unit, bank and agency staff were recently used to cover staff vacancies, but recruitment plans had been agreed. We found people had access to fresh air via excellent garden areas on Hazelwood Unit.

Acute admission wards

We found that the two acute admission wards at St Michael's Hospital, Larches and Willowvale had staff that wanted to deliver good quality care. People there told us that staff were caring. We saw some good examples of compassionate care that valued the individual needs of people on their roads to recovery. However, record keeping did not always reflect the personalised care that people told us they received.

Psychiatric intensive care units and health-based places of safety

The Rowans Ward provided a safe and secure environment for people who needed an intensive and supportive environment during their stay in hospital. The trust stated that as an intensive care unit, Rowans is exempt from national guidance on mixed sex accommodation however it tried as far as practicable to ensure that suitable arrangements were in place to offer men and women separate toilet areas. At the time of the inspection this was not clear as a sign had been removed from a toilet door.

Long stay/forensic/secure services

Rosewood Terrace and Hazelwood Unit had systems to keep people safe and for reporting any issues of concern. Risk assessments also related to keeping people, and the environment, safe. Improvements were needed for record keeping to ensure all records were accurate, accessible and showed people's involvement.

People and staff could give feedback on the service, and audits were used to measure the service's quality and effectiveness. Staff helped people access community teams and services to help them move on from hospital to live in the community.

Rosewood Terrace and Hazelwood Unit staff used a 'recovery' approach to empower people to identify their needs and support required. People told us staff gave them support and there were opportunities for people to maintain and learn skills for independence. Care planning records did not always fully show people's involvement. People gave us mixed views about their involvement and some people referred to paperwork being completed with them but not knowing what it was for.

Staff worked with a range of external community teams and agencies to help people access services, as required, as part of their transition from hospital to the community. People could give feedback on the

Summary of findings

service and raise any complaints. These were reviewed and actions considered to make any improvements. The rehabilitation and recovery service had identified that it needed to develop its systems to get greater feedback from people and relatives to influence the service.

Staff were aware of the aims and vision of the trust and governance systems monitored the performance in services. Whereas staff could talk about leadership within their service, they had limited contact with executive team members. Some staff did not know all the ways to give feedback centrally on trust issues.

Community-based crisis services

The crisis teams provide a combination of crisis assessment and home treatment to people experiencing mental illness. The service also acts as a 'gatekeeper' for all referrals to mental health services. We saw good examples of multi-disciplinary working between the crisis teams and the acute admission wards ensuring that people had a seamless care journey. The service regularly checks people's views and uses the results of surveys to improve the crisis service.

Summary of findings

What people who use the location say

As part of this inspection we looked at survey results where these had taken place, held groups with people using the services and their relatives, spoke with some individuals who requested to speak with us personally, and used comment cards before and during the inspection.

The Voluntary Sector Mental Health Trusts Forum group held on 13 January 2014

This group provided a varied response from people who use services. Some services were identified as 'caring', 'exceptional' and outstanding, in particular Willowvale.

The recent changes brought about in response to the trust's transformational change programme gave some

people concern. In particular the Cedarwood day hospital was described as excellent prior to closure. People expressed frustration that there had been no consultation prior to its closure. Cedarwood is planned to reopen in the new financial year.

The rehabilitation and recovery service strategy and implementation plan review in October 2013 identified that people and relatives were not involved in redesigning the service.

A project group was started to gain views from relatives and over 30 questionnaires were sent out, with three being returned. Feedback said that staff needed to work more on engaging their feedback.

Areas for improvement

Action the provider MUST take to improve

- Ensure that suitable arrangements are made to protect people's privacy and dignity is respected.
- For long stay/forensic/secure services, improvements are needed to ensure that people using services and staff records are easily accessible and secure, so that people using the service are not put at risk.

Action the provider COULD take to improve

We identified that community leave plans had set conditions for informal people. This indicated they could not always access community leave when they wanted. This should be reviewed.

Good practice

The crisis team operates a survey that seeks views from people using services and this feeds back into the service and is used to improve practice.

St Michael's Hospital

Detailed findings

Services we looked at:

Mental Health Act responsibilities; Acute admission wards; Psychiatric intensive care units and health-based places of safety; Long stay/forensic/secure services; Community-based crisis services;

Our inspection team

Our inspection team was led by:

Chair: Professor Patrick Geoghegan OBE

Team Leader: Jackie Howe, Care Quality Commission

The team included CQC inspectors, Mental Health Act commissioners, a pharmacist inspector, an analyst and a variety of specialists which included doctors, nurses, social workers, psychologists, and senior managers.

We were additionally supported by an Expert by Experience who had personal experience of using or caring for someone who uses the type of service we were inspecting.

Background to St Michael's Hospital

The Trust has a total of 21 active locations. There are three hospitals sites: Brooklands, St Michael's Hospital and Caludon Centre. 11 of these locations provide mental health services.

The Trust provides a wide range of mental health and learning disability services for children, young adults, adults and older adults as well as providing a range of community services for people in Coventry.

Coventry and Warwickshire Partnership NHS Trust has been inspected 21 times since registration. Out of these, there have been 10 inspections covering five locations which are registered for mental health conditions.

There are two acute admission wards, one psychiatric intensive care unit (PICU), rehabilitation wards and Crisis teams linked to the hospital.

Why we carried out this inspection

We inspected Coventry and Warwickshire Partnership NHS Trust during our wave 1 pilot inspection. The Trust was selected as one of a range of Trusts to be inspected under CQC's revised inspection approach to mental health and community services.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, 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?

Detailed findings

The inspection team always inspects the following core services at each inspection:

- Mental Health Act responsibilities
- Acute admission wards
- Psychiatric intensive care units and health-based places of safety
- Long stay/forensic/secure services
- Adult community-based services
- Community-based crisis services
- Other specialist services inspected

Before visiting, we reviewed a range of information we hold about the location and asked other organisations to share

what they knew about the location. We carried out an announced visit on dates between 21 and 24 January 2014. During our visit we held focus groups with consultants, a registrar and junior doctors, nurses and other health professionals.

We talked with people who use services and staff from all areas of the location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the location.

Mental Health Act responsibilities

Information about the service

The Mental Health Act (1983) allows a person to be admitted to hospital for assessment and treatment of their mental health. This imposes restrictions upon their liberty, for example, they may not be able to leave hospital without permission and they may be given treatment against their consent. This means important safeguards must be in place to make sure they know their rights to appeal against detention and systems are in place to ensure correct procedures are being followed in detaining and treating the person. The Mental Health Code of Practice gives guidance to hospitals on how to do this. We monitor the Mental Health Act and Code of Practice to ensure it is being adhered to.

There have been no MHA commissioner visits in the past twelve months to St Michael's hospital.

Summary of findings

In the acute admission wards, we saw that plans took into account people's views about their treatment, ensuring they were involved in important decisions about their care and treatment. Also, risk management plans reflected people's diverse needs and preferences. People told us there were no issues regarding their leave. This showed that Section 17 leave met people's needs and treatment plans.

During our visit to Rosewood Terrace and Hazelwood Unit we found 16 people were detained under the Mental Health Act (MHA) 1983. We reviewed eight people's care planning files. Some paperwork relating to the Mental Health Act and code of practice were not easily accessible.

We identified that community leave plans had set conditions for informal people. This indicated they could not always access community leave. On Hazelwood Unit, bank and agency staff were recently used to cover staff vacancies, but recruitment plans had been agreed. We found people had access to fresh air via excellent garden areas on Hazelwood Unit.

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

We found that people's risk management plans reflected their preferred choices and different needs. We saw that the use of section 17 'authorised leave of absence' was well integrated into people's care and treatment plans.

On Rosewood Terrace and Hazelwood Unit, four people detained under the Mental Health Act did not have documented capacity assessments in relation to medication. For one person whose treatment was authorised under 'T2' certificate dated 11 September 2013 they were consenting to treatment. The British National Formulary (BNF) category for one drug (oral hyoscine) was not specified. Whereas on their 'T2' certificate dated 15 August 2013 it was specified and it was unclear why the documentation was rewritten. For one person their prescription card did not correspond with treatment authorised under the 'T3' certificate which is for non-consenting people as the depot injection was not documented. For another their medication card was not easy to read and the medication was recorded over two cards, it was not clear that medication was still relevant to care.

It is important to have clear records to ensure staff help people get the right medication under the right legal authority.

The manager for Hazelwood Unit advised that sometimes staffing had impacted on section 17 leave accessibility as staff needed time to work with people rather than undertaking chores. There were some health care assistant vacancies which they could now recruit to, and bank and agency staff had been used.

Are Mental Health Act responsibilities effective? (for example, treatment is effective)

On Rosewood Terrace and Hazelwood Unit, we reviewed eight people's records who were detained under the Mental Health Act 1983 (MHA 1983). We saw valid Section 17 MHA documentation and saw comprehensive risk assessments took place with people before going on leave. Systems were in place for requesting a second opinion appointed

doctor (SOAD) for people assessed as lacking capacity to make decisions regarding their treatment. People could request appeal hearings with hospital managers and first tier tribunals to review their detention under MHA.

We found that some records were not easy to locate, such as two documents for people's section renewal under section 20 MHA (5a form) which were missing; however staff gained copies from the off-site MHA administrator. Five people's records did not hold evidence of people being informed about their rights whilst detained under section 132 MHA. There was no evidence that people had been routinely offered the right to access an Independent Mental Health Advocate (IMHA) service to assist them with communication and understanding their legal rights.

We found documents relating to people's initial detention under the MHA, and evidence of their nearest relative being consulted. However an Approved Mental Health Practitioner (AMHP) report was missing for one person and it was not clear what the circumstances were that led to their detention and if alternative least restrictive options had been considered.

We identified community leave plans had set conditions for people not detained under the MHA. This indicated they could not always access community leave. Inpatient rehabilitation services used a standard document specifying conditions of leave for people not detained under the MHA. People had signed these plans indicating their consultation and agreement. Conditions specified the frequency, duration, need for escorts and leave areas. Several records identified the person's mental health must be 'settled' before they could have leave, but there were no descriptors for this. One form detailed leave could not 'interfere' with the ward programme and detailed drug/alcohol restrictions. Another specified a person could have leave but 'to remain in the company of' family.

Staff told us that people not detained under the MHA could leave the ward at any time and would only be prevented if an assessment under the Mental Health Act 1983 was needed due to their mental health deteriorating. However the ward manager on Hazelwood Unit told us that people would not be able to access leave if they did not follow the conditions stated on the form.

Entrance doors were locked. We asked a senior manager if there was any evidence to show that people's leave was not being restricted, for example had an audit been

Mental Health Act responsibilities

undertaken on the leave taken by people. We were told that an audit had not been completed and leave records were kept in an individual's daily notes. The manager said they would consider looking at a system to check on people's access to leave.

Staff need to be aware that if non detained people are not being informed of their rights and told that they cannot access leave unless conditions are followed, that people could potentially be de facto detained.

Are Mental Health Act responsibilities caring?

We found weekday morning meetings took place with people and staff. The focus was for people to raise or discuss issues and plan activities. We found evidence of people being supported to complete the recovery star tool and influence their care plans. For one person their risk assessment was missing. From four people's notes reviewed on Rosewood Terrace, we could find no evidence that a recent physical health assessment had taken place.

One person told us they had been admitted to hospital to develop skills and to become more independent. One person told us they had been involved in care planning and had been able to give feedback regarding their medication and side effects. They reported attending adult education courses outside the hospital. There were opportunities for people to learn or maintain their skills and independence. Where people could manage, they were given a weekly allowance to buy food for cooking on the ward. People had access to smoking. We found excellent garden facilities on Hazelwood Unit.

Are Mental Health Act responsibilities responsive to people's needs? (for example, to feedback?)

We did not review this domain for this service.

Are Mental Health Act responsibilities well-led?

The trust has a Mental Health Act legislative group reporting to the Safety and Quality Committee, which in turn makes exception reports to the trust Board. The group reviews themes emerging from the reports made by CQC Mental Health Act Commissioner monitoring visits and monitor action plans, as well as sharing relevant findings with other governance sub-groups.

We found that the non-executive directors were unfamiliar with the themes emerging, due to the exception reporting process. Audits and trends in relation to restraint and seclusion were monitored by other governance sub-groups. No one on the legislative group knew who monitored rapid tranquilisation. This meant that information in the various sub-groups was being looked at separately. The Mental Health Act legislative group reported it intended to make greater links with these groups in order to obtain the results of audits and trends. The legislative group would benefit from receiving a holistic picture of the issues relating to detained people to ensure the least restrictive principle was always applied.

Acute admission wards

Information about the service

St Michael's Hospital has two acute admission wards and one Psychiatric Intensive Care Unit (PICU). All three wards are for men and women. The acute admission wards had 20 beds each and the PICU had 11 beds. The wards provided inpatient care and treatment for people admitted informally or detained under the Mental Health Act.

Summary of findings

We found that the two acute admission wards at St Michael's Hospital, Larches and Willowvale, had staff that wanted to deliver good quality care. People told us that staff were caring. We saw some good examples of compassionate care that valued the individual needs of people on their roads to recovery.

Record keeping did not always reflect the personalised care that people told us they received.

Acute admission wards

Are acute admission wards safe?

Environment

We saw that doors to all the wards were locked from the inside to prevent entry by anyone not authorised to enter the ward. All visitors to the wards were required to sign in and out, to create a record of who was on the ward at any given time of the day. This meant systems were in place that protected people from the risk of harm or abuse and complied with fire safety regulation.

Our analysis of data from our intelligent monitoring before the visit showed that in the 2012 NHS staff survey, 46% of staff reported hand washing materials were available. We saw the wards were clean. Hand gel and washing facilities were available in the ward areas. We saw staff practising good hand hygiene, showing people were safeguarded from the risk of infections.

We had concerns that the current environment on the wards could compromise people's safety and required improvement. We saw there were some environmental ligature points that may place people at risk from harming themselves, for example some of the windows on the ward areas. Staff told us that the windows had been placed on the 'risk register' about three months ago. It was unclear when the work would be carried out to ensure that people's safety was not compromised.

Electronic reporting system

We saw the incident reporting system, completed following incidents, enabled ward managers to review and grade the severity of incidents. All staff spoken with were able to describe the system and how to use it.

Risk assessments

We saw there were procedures in place to keep people safe. Staff had assessed people's needs and provided safe care to meet those needs. For example, care plans generally set out the risks to people's health and wellbeing and said how these should be managed and reviewed. We also saw that information boards in the office area provided staff with 'at a glance' information about the risk indicators for each person. Staff we spoke with were able to tell us about the risks that some people needed to be safeguarded from, for example who may be vulnerable due to self-harm.

People we spoke with told us that they felt safe and comfortable during their stay on the wards. None of the people who used the services expressed any concerns in regard to their safety.

Physical Health

Our analysis of data from our intelligent monitoring before the visit showed that the percentage of falls with harm was higher at the trust in October 2013, than the national average. Although this had fluctuated during the year.

We looked at the medical notes for three people. We found risk assessments were in place to meet people's physical needs which included falls, tissue viability, nutrition and mobility. We found that the documentation at both wards were of a poor standard, with risk assessments to meet people's physical health not always signed and dated. Staff had access to a one day course on physical health training, however this was optional and there was poor uptake for both wards especially for new staff.

Staff on Willowvale told us that more people were coming onto the ward with complex physical health needs and thus they referred people to Warwick Hospital more often. One nurse stated that someone had been back and forth so many times for their heart disease, foot ulcers and diabetes.

We saw that the care and treatment of one person, who was on Larches Ward, was not as responsive as it could have been. For example this person had been admitted with an injury of unknown origin to their right arm. However staff had not arranged for this person's arm to be x-rayed to establish the severity of their injury. We also saw that staff had taken some blood from this person, but action to gain the blood test results was slow. Staff told us that they would ensure they find out the findings from the x-ray and blood test results as a priority so this person received the care and treatment they required without any delay.

Staffing

We found that staffing arrangements ensured that people's needs could always be met safely and appropriately with staffing levels consistently maintained on both wards. On Willowvale there were four staff during the day and three staff at night. We were told these were the minimum numbers of staff for the ward, but there was flexibility within staffing resources for additional staff to meet the people's needs where this was assessed as required.

Acute admission wards

The ward/deputy ward managers provided leadership to nurses and health care assistants. The full time nursing support ensured input was readily available to support any urgent reassessment of people's needs or if a change in medicine was required at any given time. We also found there were consultant psychiatrists aligned to each ward. This ensured people received consistent care and treatment, by consultants who knew their diagnosis and treatment pathway and clinical safety was promoted.

Safeguarding practices

We saw that staff training was planned to ensure staff were skilled and trained to provide safe care and treatment. The training included safeguarding vulnerable adults. Staff we spoke with on both wards demonstrated they had the knowledge to ensure people were protected from abuse and harm whilst they were on the wards.

We found that staff on Larches Ward demonstrated they knew how to manage and safeguard anyone admitted under the age of 18. The acting ward manager told us people under the age of 18 normally went to another ward specifically for young people. They said that if people under the age of 18 years were admitted onto the ward, special procedures were put into action, such as observations. They told us an incident report would be completed as per the trust policy on admission. In addition to these procedures a report would be made to the Care Quality Commission (CQC) to inform of an admission of a young person under the age of 18 years to an adult ward.

People using services experience and outcomes

We found that staff who worked on Larches and Willowvale wards delivered safe care to people who received care and treatment there. People commented that they felt safe and that staff were really friendly.

Are acute admission wards effective? (for example, treatment is effective)

Quality of care and treatment

We followed the care and treatment of some of the people on Larches and Willowvale wards at the time of our inspection. We found that people's care and treatment needs were discussed at the time of referral and decisions made among professionals following a review of the person's needs. There was a strong consultant presence on the wards and all staff worked together to provide the best outcome for people.

Medication management

We were told the on-site pharmacy was open from 2pm to 5pm each day. Staff told us it was extremely busy with medicines not always available and staff had to go off-site to a chemist. One nurse told us people, at times, had to wait until the following day. This issue was looked at by our pharmacy inspector who found time taken to receive medicines for discharge was long and upset people. Staff told them this had become worse within the last six months across the trust.

Working with others

We saw examples of good multi-disciplinary and collaborative team working. For example there were effective goal setting procedures to meet people's aspirations, recovery and discharge from hospital.

There was evidence that people were able to take part in day to day activities with activity schedules in place that were followed. There was an active occupational therapy team and shared activity co-ordinators for the two wards, Larches and Willowvale. We saw good use of facilities at the hospital and outside space.

Therapeutic environment

We saw there were many communal spaces on the wards so people could choose where they wanted to be and what they wanted to do. For example on Larches Ward there were televisions, a pool table, keyboard and dining rooms.

There was a bathroom with equipment to meet the needs of people with physical disabilities.

Qualified and competent staff

We interviewed six staff members across Larches and Willowvale. Staff stated they were happy and worked well as a team. We found that staff had received mandatory training to effectively support their responsibilities and roles ensuring the care and treatment needs of people with mental health needs were met.

We asked staff about arrangements to check their practice, understanding of policies and procedures and experience of working within the team. Staff told us that there was a formal supervision process but if they had any concerns, on a daily basis, they would speak to the ward manager.

Acute admission wards

Are acute admission wards caring?

Person-centred care

All the people we spoke with, on both wards, said that they were happy with the care they had received. We saw staff took their time to listen to people and answer questions, even when they were busy. People used words such as brilliant to describe the care they had received.

Staff were busy, attending ward reviews, completing paperwork, responding to and observing people, however the atmosphere on the wards was very calm. Neither people receiving services or their relatives raised any concerns about the care that they had received. People we spoke with said the staff had discussed their care and treatment with them. They also told us staff kept them informed and they felt listened to. Staff we spoke with understood the importance of involving people in decisions about their care and treatment.

Care plans provided details of people's mental health needs, including the impact of these needs upon their social and psychological well-being. For example, some people who required support to move on from the hospital to continue their lives in the community, had assistance provided to find them suitable accommodation. We found other people needed support to maintain their close relationships when they were particularly unwell due to their mental health conditions/being in hospital.

Staff told us they ensured people's physical needs were assessed and would make referrals to other professionals, if required, to ensure needs were met. Staff told us that they had supported one person, when they were unwell, and who required chemotherapy treatment. Staff attended hospital appointments with the person and provided a 'listening ear' to ensure the person's emotional needs were promoted during this time.

There was evidence the planning of care promoted people's rights and choices. Care plans took into account people's views about their treatment ensuring they were involved in important decisions.

Staff approach

We found staff involved people in their care and to make decisions about their aims and goals as part of their recovery. Documentation reflected people's views about care and treatment.

People's dignity and diversity was supported. Staff on Larches Ward gave us examples demonstrating that people's individual dietary needs were met. This included people who required a vegan or gluten free diet. Staff provided support to people in going to the local shops to buy their individual food promoting people's independence and choices.

Are acute admission wards responsive to people's needs? (for example, to feedback?)

Privacy and dignity

We looked at the facilities people use on both Larches and Willowvale Wards. We saw there was accommodation for men and women with appropriate washing and toilet facilities. This meant the Department of Health's guidance on delivering single sex accommodation to ensure each person's privacy and dignity had been promoted.

Physical health

We saw mixed wards had appropriate same gender washing and toilet facilities. We saw the female lounge was inaccessible to people who used the services four days per week from 9am to 12pm as this was used for the doctors round and by the multi-disciplinary team (MDT).

Response to feedback and complaints

Staff said there was a 'complaint, suggestions and compliments' policy in place that was monitored and managed by a head of complaints within the trust. In addition the trust promoted the Complaints and Patient Advice and Liaison Service (PALS) within the hospital. People who used the services also had access to an Independent Mental Health Advocacy' (IMHA) should they wish.

The Data returns to the Health and Social Care Information Centre showed 107 written complaints were submitted to the trust in 2012/13, of which 44 (41%) were upheld. This was a 16% decrease from the 128 complaints in 2011/12. Non-executives have undertaken a process of deep dives in to a complaint to review the lessons learnt and challenge if they find the complaint should have been upheld. The PALS service plays a good part in ensuring that complaints are locally resolved. The trust also monitors the number of compliments received.

Acute admission wards

Bed management

Both Larches and Willowvale had more people according to their ward list, than beds. Larches Ward had 20 beds, all occupied, with three people on leave. Willowvale Ward had 16 beds, all occupied, with four people on leave and one person sleeping over on Hazlewood rehabilitation ward.

Are acute admission wards well-led?

Leadership

We found there was a general level of efficiency, affirmation of support by the ward manager to ward staff and people's care that was indicative of good leadership.

Staff we spoke with across all the wards told us they felt well supported by their respective line managers.

They told us they felt senior managers were 'in tune' with the challenges they faced on a day to day basis. One nurse on Larches stated they sometimes did not receive the management support they required.

Psychiatric intensive care units and health-based places of safety

Information about the service

The Rowans Ward is a psychiatric intensive care unit for men and women. The unit provides care and treatment for people who experience mental illness and present behaviours that need to be managed in a specialist area with staff trained and experienced in management of actual and potential aggression (MAPA) and de-escalation skills.

Summary of findings

The Rowans Ward psychiatric intensive care unit (PICU) provided a safe and secure environment for people who needed an intensive and supportive environment during their stay in hospital. The unit provides care for men and women.

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units safe?

We found the Rowans Ward well-staffed with a good staff to people using the service ratio. The unit was calm during our inspection. People using the service told us that they felt safe on the unit. One person told us, "I am OK here".

We were told that there was a low usage of bank and agency staff on the unit which helped to ensure that people received consistent care and treatment from staff who were knowledgeable about their mental health conditions.

All staff who worked on the unit were trained in management of actual and potential aggression (MAPA). This meant that people who needed support with their behaviour due to their mental health received this in the most effective and safe way to meet their needs.

The unit accommodated both men and women. We saw that females were safeguarded from abuse through the use of close observation while they were on the ward.

Are psychiatric intensive care units effective?

(for example, treatment is effective)

We found that people's care and treatment needs were discussed at the time of referral and decisions made among professionals following a review of the person's needs. There was a strong consultant presence on the wards and all staff worked together to provide the best outcome for people.

We looked at some medical notes and found that risk management plans promoted people's rights and choices. We found evidence that plans had taken into account people's views about their treatment, ensuring they were involved in important decisions about their care and treatment. There was evidence of risk management plans reflecting people's diverse needs and preferences. This meant that people's views had been considered, and included, to manage risks and promote their recovery.

There was evidence people were able to take part in day to day activities with schedules in place. There was an active occupational therapy team and shared activity co-ordinators for the wards.

Are psychiatric intensive care units caring?

We found staff involved people in making decisions about care and their aims and goals as part of each person's recovery. Documentation reflected people's views about their care and treatment.

People we spoke with said the staff had discussed their care and treatment with them. They also told us staff kept them informed and they felt listened to. Staff we spoke with also understood the importance of involving people in decisions about their care and treatment.

Are psychiatric intensive care units responsive to people's needs?

(for example, to feedback?)

We looked at the facilities for people to use on Rowans Ward, which had accommodation for men and women.

The Trust told us that as an intensive care unit, Rowans is exempt from national guidance on mixed sex accommodation however it tried as far as practicable to ensure that suitable arrangements were in place to offer men and women separate toilet areas. At the time of the inspection this was not clear as a sign had been removed from a toilet door.

People told us there were regular activities organised, stopping them from being bored. The unit had an activity coordinator who worked with people on the types of activities they enjoyed.

We saw people received support with the activities of daily living and the interaction between staff and people using the service was very good. Staff treated people with dignity and respect.

People had access to a courtyard where they are able to smoke and get fresh air, with all trips to the courtyard supervised by staff.

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units well-led?

The manager had detailed knowledge of people on the unit and was aware of their needs. We found there was a general level of efficiency, affirmation of support by the ward manager to ward staff and peoples' care that was indicative of good leadership.

Staff had a formal supervision session every four to six weeks, during which support was offered around their clinical work and any management issues that may have arisen.

Long stay/forensic/secure services

Information about the service

There are four units providing rehabilitation and recovery services in Coventry and Warwickshire. Rosewood Terrace and Hazelwood Unit are two of the four rehabilitation and recovery units. People are informal or formally detained under the Mental Health Act 1983 (MHA). Referrals are from community mental health or inpatient services.

Rosewood Terrace is a 15 bedded mixed sex rehabilitation ward. There are five beds identified for people needing more support.

Hazelwood Unit is a 12 bedded male only locked rehabilitation unit for people with challenging behaviour. It has features of an airlock comprising of two locked doors set opposite to each other at the main entrance.

Summary of findings

Rosewood Terrace and Hazelwood Unit had systems to keep people safe and for reporting any issues of concern. Risk assessments also related to keeping people, and the environment, safe. Improvements were needed for record keeping to ensure all records were accurate, accessible and showed people's involvement.

People and staff could give feedback on the service, and audits were used to measure the service's quality and effectiveness. Staff helped people access community teams and services to help them move on from hospital to live in the community.

Rosewood Terrace and Hazelwood Unit staff used a 'recovery' approach to empower people to identify their needs and support required. People told us staff gave them support and there were opportunities for people to maintain and learn skills for independence. Care planning records did not always fully show people's involvement. People gave us mixed views about their involvement and some people referred to paperwork being completed with them, but not knowing what it was for.

Staff worked with a range of external community teams and agencies to help people access services, as required, as part of their transition from hospital to the community. People could give feedback on the service and raise any complaints. These were reviewed and actions considered to make any improvements. The rehabilitation and recovery service had identified that it needed to develop its systems to get greater feedback from people and carers to influence the service.

Staff were aware of the aims and vision of the trust and governance systems monitored the performance in services. Whereas staff could talk about leadership within their service, they had limited contact with executive team members. Some staff did not know all the ways to give feedback centrally on trust issues.

Long stay/forensic/secure services

Are long stay/forensic/secure services safe?

Learning from incidents

There were procedures in place for staff and people using the service, to report both low level and serious incidents, for these to be reported to relevant agencies, investigated and reviewed to prevent a reoccurrence.

Staff told us there was learning from incidents for their service and other areas of the trust. They were kept informed by the trust via emails and learning briefs. Non-executive 'deep dive' investigations identified further learning following an incident. A recent serious incident occurred on Hazelwood Unit and staff gained external emergency response and took action to make the person and others safe. An interim management review (IMR) took place to consider any immediate risk issues. Airlock door specifications were reviewed to ensure the replacement was safe.

On Hazelwood Unit, we saw that incidents were recorded on paper and then transferred to an electronic record. Staff told us there was a delay in transferring the information, which the trust had previously highlighted as a potential risk elsewhere in services. We found one person did not have two incidents on the electronic record. It was not clear how quickly records were reviewed to see if further action was needed. Staff were receiving training so the information could be input directly and improve the reporting system.

People and staff reported a safe environment. We were told of an incident on Rosewood Terrace where a person collapsed but staff could not easily access them as the bedroom door was not anti-barricade. This was later replaced. We saw that a maintenance plan was in place to replace bedroom doors and reduce this risk.

Safeguarding people

Safety checks on the management of medicines and emergency medical equipment were routinely undertaken and staff had training for this. There were systems ensuring the unit was clean, there was the prevention of infection control and the Control of Substances Hazardous to Health (COSHH) were in place to keep people safe.

Staff we spoke with had access to training to safeguard adults. Information from staff and records indicated some

staff had access to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. We found assessments of people's mental capacity to make decisions regarding care and treatment, and best interest meetings took place for specific treatment issues.

Safeguarding reporting processes were not clearly visible for people on the ward. Most staff spoken with were aware of the need to report abuse, but not always aware of the processes for this or whistleblowing. An identified safeguarding lead was contactable for advice and information.

Risk management

Systems were in place for assessing people's needs on admission, developing care plans and risk assessments and reviewing these. We found risk issues were discussed by the multi-disciplinary team (MDT) and influenced care and treatment plans.

We saw staff were not consistently maintaining accurate and locatable records in relation to people's care and treatment, meaning people were not fully protected against the risks of unsafe or inappropriate care and treatment. A complex system was in place where there were separate files and systems for professionals to record in. On Rosewood Terrace psychology session notes were held off the ward and not accessible to ward staff. Any feedback from the psychologists to nurses was not evident in notes.

There was inconsistency in people's records and some people's risk assessments and care plans were not available. Some plans did not have completion or review dates for example Clozapine antipsychotic medication or plans detailing family support. One person's care plan for medication/injection was dated 2009 and it was unclear if the needs were still current.

Some files lacked physical health assessments whereas some people had detailed ones. Two staff members on Hazelwood Unit reported there were problems with easily recording, reviewing and finding information on the person's records.

Safe staffing

A multi-disciplinary team delivered care and treatment to people. There were systems in place to ensure adequate nursing staff and flexibility to ensure people's needs were met. On Rosewood Terrace a person with complex needs had additional nursing support to reduce the risk of them

Long stay/forensic/secure services

falling. Occupational therapist and psychologist support was available. Referrals could be made to external dietetic/speech and language therapy services. A chiropody service was being sourced.

A doctor reported their staffing had reduced and it was challenging to provide cover during the day, such as taking blood for Clozapine monitoring tests. We were however advised that nurses were being trained to address this issue. Whilst a duty doctor went on leave, interim cover from elsewhere in the trust was provided.

The trust's integrated performance report of October 2013 to the executive performance committee SCMh, reported agency use was routinely monitored across services and had reduced for a second month in a row, from 7.81% (September) to 6.48% (October) with plans to reduce further achieving the trust target of 3.6%. On Hazelwood Unit there were some nursing vacancies which the manager was told they could now recruit to, but bank and agency staff had been used.

Are long stay/forensic/secure services effective?

(for example, treatment is effective)

Guidance and standards

The manager for Rosewood Terrace had received specialist training to assist them in promoting a recovery approach across the wards. Staff used the mental health recovery star assessment linked with recovery plans in people's care planning files. The recovery star is often used as a key-working tool where staff are supporting people so they can work with them to understand their recovery and evaluate their progress.

Staff worked with people using a 'Recovery' approach in the service. 'Recovery' is a word commonly used by people with mental health problems to describe their struggles to live meaningful and satisfying lives. The principles of 'Recovery' are used in other mental health services in England and other countries such as the USA. The rehabilitation and recovery service strategy and implementation plan review - October 2013 - detailed a recovery approach as underpinning staff work with people.

The strategy referenced its service in line with national Department of Health, 2011, Mental Health Strategy 'No Health without Mental Health', and the trust's strategic objectives.

The trust is a member of Implementing Recovery for Organisational Change (ImROC). Through a framework of ten key challenges, the ImROC programme works with mental health services and their partners to focus services around the principles of recovery and to help more people recover.

Multi-disciplinary working

Senior staff reported effective working relationships with other disciplines and agencies such as community mental health teams and multi-agency public protection arrangements (MAPPA). Staff on both wards reported good working relationships with each other, where staff resources were shared, and inter ward training took place on recovery. If people's mental health deteriorated they were assessed and, if required, admitted to another unit.

The rehabilitation and recovery service strategy identified a mapping exercise was taking place to identify resources including social care and third sector agencies, across Coventry and Warwickshire to improve the care pathway and identify other potential working relationships to help people move on from hospital.

Measuring quality

Systems were in place for people using the service, staff and others to give feedback such as reviews, suggestions boxes, NHS and trust surveys.

The trust's integrated performance, safety, quality and service user experience report 2013/14, October 2013, reported audit compliance was 96% above their threshold of 90%. We saw there were a range of audit and governance systems at ward and trust level to monitor and review the service provided. For example, at ward level there were systems for monitoring the management of medication, ligature risks, infection control and reported incidents. Information was displayed for people using the service and others on areas of performance and improvement.

Supporting Workers

Systems were in place for new or bank/agency staff to receive induction to the ward and trust. There were systems in place to ensure staff had training and support as relevant to their role such as risk assessment, care planning, MAPA (physical intervention) and using

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de-escalation/safe breakaway techniques. Most staff reported feeling supported in their work and all staff said their manager/supervisor was accessible for advice and guidance as required. We saw information promoting independent staff counselling support.

A system was being developed to ensure 'recovery' orientated supervision, appraisal and competencies based on the 'Ten Top Tips for Recovery Orientated Practice' (Centre for Mental Health). Staff told us they had opportunities for individual and group supervision although one staff member reported this was infrequent.

Systems were in place for tracking staff attendance at training, their supervision and appraisals. The manager on Rosewood Terrace advised us that they did not check staff appraisal documents to ensure they were meeting standards but kept a log of completion. The trust's integrated performance, safety, quality and service user experience report 2013/14, results for October 2013 showed an increase in appraisals in the last 12 months up to 88.4%. The threshold was 100% for the trust. Operational managers regularly reviewed appraisal data and discussed with managers to check they had systems in place for ensuring staff had appraisals. Staff told us that these had taken place.

Are long stay/forensic/secure services caring?

Choice and involvement

Weekday morning meetings took place with people using the service and staff. The focus was for people to raise and discuss any issues and plan activities. Staff told us that they supported people to complete the recovery star tool and this influenced their care plans. Care plans were developed using the care programme approach (CPA) and people had named nurses or, as relevant, community care coordinators. Some care planning and risk assessment documents were not signed, or comments were not completed with people's views and it was unclear if the person was consulted or not, or had a copy. People gave us mixed views about their involvement and some people referred to paperwork being completed with them but not knowing what it was for.

There were opportunities for people to learn, or maintain their skills and independence, to the level they felt they were able to manage. For example, people could carry out

laundry, cooking, money management and travel by public transport. In addition to looking after themselves and their room there was a ward rota for people to take turns in household chores. Where people could manage, they were given a weekly allowance to buy food. If people were unable to do any activities of daily living (ADL), staff supported them.

An advocacy service was available for people providing general and independent mental health advocacy (IMHA). Visits were dependent on people/staff requests.

People using the service and others were able to give feedback to influence areas, such as the environment, through people-led assessments of the care environment (PLACE) and other surveys.

Developing trusting relationships

Multidisciplinary team reviews of people's treatment and care were referred to as recovery meetings and these were held on the ward. People could request their community care coordinators and relatives to attend these or CPA reviews. The ward manager on Rosewood Terrace told us there was no system in place for how often people were seen in recovery meetings and advised people could choose not to attend.

The ward manager on Rosewood Terrace told us staff used the six 'C's in their work. Care, compassion, competence, communication, courage and commitment. The six 'C's are set out in the Chief Nursing Officer's 2012 consultation paper, 'Developing the culture of compassionate care: Creating a new vision and strategy for nurses, midwives and care-givers'.

Getting the right support

We received several positive comments from people on the service provided and they told us staff gave them the support they needed. One person told us that they had a different view to their doctor regarding their medication and they were able to give them feedback. One person told us how they felt more positive about themselves and had got support to stop smoking. Another said staff were going to support them with reading and writing. Where bank or agency staff were required, the aim was to get staff who knew the ward and people to ensure consistency of approach.

Each week ward activity programmes were developed with people's involvement and activities discussed at morning meetings. Groups such as understanding mental health

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and dealing with anger took place. Community activities at local community resource centres were available such as adult education, the gym and voluntary work. At weekends social outings were sometimes arranged. People told us they had opportunities for community leave although on Hazelwood Unit some stated staff were busy at times and a recent bowling trip was cancelled. Another person told us they had been authorised to have up to three hours leave but never got the full amount. One person on Rosewood Terrace told us group outings took place every three to four months. There were designated smoking areas with shelters. Wards had an outdoor gym and small vegetable patch which people could access.

Privacy and dignity

We found that people shared communal facilities such as kitchens and bathrooms. We saw that staff knocked on people's doors before entering. One person told us that staff were helpful, mild mannered and good in a friendly way.

Rosewood Terrace

Not all bedrooms on Rosewood Terrace had observation panels and therefore staff had to open the door at night to check on people, however people we spoke with said this was not a problem for them. We saw that some people chose to leave doors open. There were gender specific areas of the ward although people preferred mixing in the communal area. Women in the five higher supported bed areas shared an assisted bathroom identified for men or had to walk to the women's bathroom situated at the other end of the ward. Staff told us they would review the signage for this to ensure they were meeting the standards identified in the revised Operating Framework for 2010-2011.

Hazelwood Unit

We found that the kitchen was locked but was opened at people's request. Several people told us there was flexibility with ward rules, for example they could have breakfast when they wanted to and could make themselves a snack anytime.

Are long stay/forensic/secure services responsive to people's needs?
(for example, to feedback?)

Meeting individual needs

We received differing information during and after our inspection about the pathway of care for people across some of the rehabilitation and recovery services. Staff told us there had been changes across the service and were awaiting information relating to this. The trust's website and information also gave differing information regarding the rehabilitation service. We spoke with a senior manager and were advised there was a strategy for the service and that information for people using the service and others was in the process of being updated. It is important that staff, people using the service and others have information about its role and function.

We saw that there were systems to track people's attendance at Care Programme (CPA) reviews. The trust integrated performance, safety, quality and service user experience report 2013/14, reported for October 2013 that 95.58% of people had received CPA reviews, a slight dip since the previous month of 96.29%, but still on track. Systems were in place to identify areas that needed support, improvements and ensure reviews took place.

Transition to other services

A 'Single Point of Entry' multi-professional meeting was implemented in June 2013 across all rehabilitation and recovery services. Its focus included reviewing the rehabilitation service's waiting lists and bed occupancy, considering transfers between units and identifying any delayed discharges. The aim being to offer a responsive and effective service to people and not cause delays in their care pathway.

Staff told us people on both wards stayed usually for over a year. If people's mental health deteriorated and a higher level of support was needed they would liaise with other acute admission wards such as the Rowans Ward, Psychiatric Intensive Care Unit (PICU). One person told us they were keen to be discharged and they had routine contact with their community care coordinator with placements being explored.

Staff helped people to move on where possible to live in the community. They helped people access community

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teams and services as part of their transition from hospital. Additional to the mapping exercise taking place considering community resources, the rehabilitation and recovery strategy October 2013 identified that staff were working to develop information on the intranet around what placements and accommodation was offered from the private and voluntary sector. This would provide people and staff with information about community services and accommodation available when considering people's care pathway.

We found that the trust had systems to track if there were any delays in people's transfer of care. The trust integrated performance, safety, quality and service user experience report 2013/14 reported that 'Delayed Transfer of Care (Mental Health and Learning Disability Services)' had increased during October 2013 to 1.69% from 1.31% in September but remained on target.

Learning from concerns and complaints

Systems were in place for people using the service, staff and others to make complaints and give feedback on the quality of care, such as reviews and suggestions boxes. Information was not clearly displayed to people about how they might raise any complaints or safeguarding concerns. We saw that the trust had systems in place for investigation of issues reported.

Systems were in place for senior staff to be able to track and identify any themes and actions to be taken. An 'Annual Complaints Compliments and PALs' (Patient Advice and Liaison Service) report gave feedback on the trust process and analysis of reported complaints and compliments. Additionally the trust's website gave access to independent sites for people to give feedback such as 'www.patientopinion.org.uk' and NHS choices. When issues were raised by people across the service, feedback was shown via notice boards in a 'You said.... we did...' style. We noted that some trust information displayed for people was 20 months old.

The 'rehabilitation and recovery strategy October 2013' identified areas of improvement for involving people and carers in the service. This included initiatives for the development of 'Peer Experts', people using the service to act as consultants and encouraging applicants with 'lived experience of mental ill health' to apply for staffing posts.

Are long stay/forensic/secure services well-led?

Governance

Staff referred to involvement with groups and forums relating to governance. An example given related to reporting externally on incidents and also learning via feedback from events in other trust services. There were lead staff identified for areas such as people using services safely, and staff reported that others were available for advice and expertise. Staff reported getting feedback on issues via staff team meetings and information via email about trust issues.

Rosewood Terrace staff reported a lack of secure record storage space and some staff supervision records were not accessible and not held on trust property. This was in breach of the Data Protection Act 1998. The Safety and Quality Forum Secondary Care Mental Health (SCMH) report September 2013 risk register identified that records storage had been identified as a potential risk area for SCMH services and actions were identified including having a standardised care record, risk assessments taking place for areas and off-site storage access were all required. We were not able to see that this had taken place on these wards.

Some staff reported infrequent team meetings but stated they could contact senior staff if required. Some staff we talked with were not fully aware of all the procedures for them to give feedback on the service and of the whistleblowing procedure.

Leadership

Systems were in place to manage staff, including supervision and appraisals, to review staff ability to carry out their role. Some staff gave feedback on Rosewood Terrace that supervision was not always taking place at the frequency specified in the trust's policy and records were not easily accessible.

Managers spoke of the support and guidance they received from their immediate line manager. We found there were opportunities for staff to undertake training, such as leadership and supervision, supporting them in their roles.

Staff engagement

Staff identified that they received information about the trust vision. A member of staff told us the 'vision'

Long stay/forensic/secure services

statements only came to the ward just before the announced CQC inspection. Staff reported having contact with and knowing their immediate managers, however reported having little face to face contact with executive members. They had access to corporate services for development and learning, such as mandatory training, as well as access to human resources departments and support such as occupational health.

Several staff talked of changes taking place within the organisation, such as restructuring of the psychology

service and awareness of staff consultation events. We received negative feedback from some regarding changes in the organisation and clinical staff feeling disconnected from senior managers. They did not feel listened to.

One member of staff reported that staff were being discouraged from speaking to the CQC about issues. Another staff member commented that the service was manager dominated rather than clinical staff feeling they had a sense of influence. Another reported wanting more systems to raise issues for their ward.

Community-based crisis services

Information about the service

The Crisis service responds to urgent psychiatric referrals and provides assessment and home treatment care for people in their home. The service is the first point of referral into mental health services and everyone has to be assessed by this team before accessing admission to St Michael's hospital.

Summary of findings

The crisis teams provide a combination of crisis assessment and home treatment to people experiencing mental illness. The service also acts as a 'gatekeeper' for all referrals to mental health services. We saw good examples of multi-disciplinary working between the crisis teams and the acute admission wards, ensuring that people had a seamless care journey. The service regularly checks people's views and uses the results of surveys to improve the crisis service.

Community-based crisis services

Are community-based crisis services safe?

We saw that the teams carried out risk assessments for everyone taken on by the crisis team. The risk assessments were comprehensive and person centred. We found that people were involved in the assessments and formulation of their care plan.

Staff training was planned and we found that they had the skill to provide safe care and treatment. Their training included safeguarding vulnerable adults. The staff that we spoke with demonstrated that they had the knowledge to ensure people were protected from abuse and harm whilst they were on home treatment.

The teams had regular review meetings with the medical team to review the ongoing treatment plan for all people and to ensure the appropriate interventions are planned for the next contact.

We saw that the service undertook regular surveys and the results of the surveys are used to improve the service so that people get the best possible service from the crisis team.

Are community-based crisis services effective? (for example, treatment is effective)

We saw good multidisciplinary team collaborative working. For example there were effective goal setting procedures to meet people's aspirations and recovery goals.

We saw the crisis team provided an evidenced based service. People were supported for up to six weeks through a mixture of medication management and psychological interventions. Risk assessments were completed for all people and the plan of care is formulated with the person and their carer.

The service uses a survey to gain insight from people using the service, into the service provided. The results of the survey were regularly reviewed and used to help improve the service.

We found staff had received training to effectively support their responsibilities and roles ensuring the care and treatment needs of people with mental health needs were met.

Are community-based crisis services caring?

All of the staff we spoke with told us how their time in a person's home during visits was used not only to give medication, but to listen to them and answer their questions about treatment and care plans.

We saw care plans provided details of people's mental health needs, which included the impact of these needs upon their social and psychological well-being. There was also evidence the planning of care promoted people's rights and choices. Care plans did take into account people's views about their treatment to ensure they were involved in important decisions about their treatment.

Are community-based crisis services responsive to people's needs? (for example, to feedback?)

We found examples of how consultants and ward staff worked alongside the community crisis resolution/home treatment teams to provide holistic care and treatment to people. We saw that the crisis team would attend Larches Ward every Sunday to review care, treatment and to facilitate discharge planning. This meant people had a streamlined service from hospital into the community which benefited a consistency of care and treatment. Staff told us this assisted people to reach their goals upon hospital discharge.

The service was entirely responsive to the needs of people and their family. In agreement with the person using the service, visits were arranged and carried out up to four times during the day. An on-call service was available for people to contact in times of crisis.

Are community-based crisis services well-led?

We found that the crisis team managers took an active role in the day to day operation of the team, both as active

Community-based crisis services

clinicians, as well as team managers. We saw they were visible and accessible to their staff. They were knowledgeable about people using the service and the challenges they faced on a day to day basis.

Some staff we spoke with said they regularly saw the manager and received excellent support. We saw that the Consultant Psychiatrist had an active presence in the team. There were regular review meetings held with the crisis team in attendance.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HCSA 2008 (Regulated Activities) How the regulation was not being met: People who use services were at risk of unsafe or inappropriate care and treatment from a lack of proper information about them and the safe keeping of their information. Records -Regulation 20(1)(a)(b)(i)(2)(a).
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HCSA 2008 (Regulated Activities) The manager had not as reasonably practicable made suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17(1) (a)