Weaver Lodge independent 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 and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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

Overall summary

We rated Weaver Lodge as good because:

- patients told us that staff were kind and respectful and that they felt supported
- activities were available seven days a week and patients were able to say what activities they wished to do
- we saw that patients were involved in developing their care plans and had a say in the types of treatments they could receive
- carers felt included in care and treatment and their views and opinions were considered
- the hospital was bright, clean and well maintained
- staffing numbers were adequate and it was rare for activities or one to one time with nursing staff to be cancelled
- as well as medical and nursing interventions patients had access to occupational therapy and psychological interventions
- physical health was being regularly reviewed and specialist healthcare staff regularly visited the hospital
- there were good links between the hospital and community mental health staff
- all staff had regular training, supervision and appraisals.

However:

- although regular medication audits were being undertaken, stock discrepancies were being reported and it was unclear what action the managers were taking.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Good 	Start here...

Summary of findings

Contents

Good

Weaver Lodge Independent Hospital

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

Summary of this inspection

Background to Weaver Lodge independent hospital

Weaver Lodge provides mental health inpatient rehabilitation in a 20 bedded treatment and recovery center for people aged 18 to 65 years. They admit both informal and formal patients who have been detained under the Mental Health Act (1983). Weaver Lodge is run by Alternative Futures Group Limited which is a registered charity. They are a North West based organization who provides a range of inpatient and community services for individuals with mental health and/or learning disability.

Due to service redesign, the registered manager and accountable officer roles had changed and new staff were being registered through Care Quality Commission processes. A director within the Alternative Futures Group was the nominated controlled drugs accountable officer until this process was finalised.

Weaver Lodge is registered to provide the following regulated activities:

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

Weaver Lodge registered with CQC in December 2010. There had been four previous inspections, with the most recent published in June 2014. At that time, the hospital met all the required standards and there were no compliance actions or changes to practice needed.

During this inspection there were 14 patients staying at Weaver Lodge, nine of whom had been detained under the Mental Health Act 1983. At the Mental Health Act review visit in March 2016, there had been no serious concerns but recommendations made about how Weaver Lodge should improve upon certain areas. During the course of this inspection those recommendations were reviewed to note if improvements had been made.

All patients had personal connections with Cheshire East or Cheshire West area and plans for the majority of patients were to be relocated back to their home areas. The service model had changed in the last 12 months. The hospital was now a treatment and recovery centre whereas previously it had been a long-term rehabilitation unit. Some patients were on a two-year care pathway, and would follow an intensive rehabilitation and recovery care pathway. There were a small number of patients who had remained at the hospital in excess of 10 years and who were remaining at Weaver Lodge as a long-term placement.

Our inspection team

Team leader: Paula Cunningham, CQC Inspector

The team that inspected the service comprised three CQC inspectors, a CQC pharmacist and an inspection assistant.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information.

During the inspection visit, the inspection team:

- Visited the hospital, looked at the quality of the hospital environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with four carers of patients using the service
- spoke with the registered manager and the clinical manager
- spoke with 10 other staff members, including a psychiatrist, nurses, domestic and administrative staff
- received feedback about the service from three community staff
- spoke with an independent advocate
- received feedback about joint working from the local GP
- attended and observed a clinical review meeting
- attended a recovery group along with four patients and one discharged patient
- looked at four medication records
- carried out a specific check of the medication management arrangements
- looked at six clinical records which included care plans and risk assessments
- looked at policies, procedures and other documents about the running of the service.

What people who use the service say

We spoke with five patients. Overall, they were positive about their experiences at Weaver Lodge. They told us staff were kind and respectful and they felt well supported. They felt the accommodation was of a good standard and they had access to a range of activities and support that they enjoyed. Patients described being involved in planning their own care and felt their opinions were listened to. This view not shared by all the patients. One patient felt his views were not considered in particular about the type of medication he was being prescribed.

Carers told us they felt included in their family members' care and their opinions and views were considered.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

although regular medication audits were being undertaken stock discrepancies were being reported and it was unclear what action the managers were taking.

However:

- the accommodation and facilities were of a good standard
- there were the right number of qualified and unqualified nurses on duty
- all staff were up to date with mandatory training
- staff had regular supervision and appraisals of their work performance
- staff received the training they needed to continue to improve in their role
- risk assessments and care plans were up to date and regularly reviewed
- there were effective incident recording systems and forums for learning from incidents and untoward events.

Are services effective?

Good

We rated effective as **good** because:

- patients had regular physical health checks and there was evidence of good interagency working with GPs and other external health care providers
- all patients had an up-to-date and detailed care plan that was holistic and personalised
- patients had access to a range of therapies, including psychological interventions and occupational therapy
- staff used standardised assessment tools to support interventions and treatments
- there were good quality multi-disciplinary team meetings and regular reviews which included community staff
- there were effective systems for ensuring compliance with the Mental Health Act and Mental Capacity Act requirements.

Are services caring?

Good

We rated caring as **good** because:

- we observed caring and respectful interactions between staff and patients

Summary of this inspection

- carers said patients received good quality care and treatment from the staff
- patients were encouraged to share their views and make suggestions at regular meetings they attended with staff.

Are services responsive?

Good

We rated responsive as **good** because:

- staff supported patients to access a range of activities both in the hospital and within the local community. These were available seven days a week
- there were good links between the hospital and other services
- patients and carers told us the food was good
- complaints when made were handled swiftly.

Are services well-led?

Good

We rated well-led as **good** because:

- there were good links between Weaver Lodge and the senior management structure at Alternative Futures which assisted with maintaining quality standards
- clinical and other audits were being undertaken regularly and the outcomes shared with staff
- there had been significant improvements in sickness levels were low and vacant posts had been recruited to
- there were systems ensuring good quality supervision, appraisal and continued personal developments for all staff.

Detailed findings from this inspection

Mental Health Act responsibilities

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

A Mental Health Act review visit occurred four weeks before this inspection. At that time, the hospital was providing care in line with Mental Health Act and Code of Practice however, the following issues were raised:

- Not all of the paperwork associated with the detention was available within the patient files or accessible on the hospital site.
- There was inconsistency in the recording of patient involvement in their own care and risk management plans and how often these were being reviewed.
- Although the outcome of section 17 leave was being recorded, the patients' view of how successful or difficult their leave had been was not being regularly recorded.
- It was not clear that informal patients were able to leave the unit. This was important as the doors to the unit were locked.

Weaver Lodge were finalising an action plan to address the issues raised. This was to be submitted to Care Quality Commission a few days after this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We reviewed six care records. These showed patients' capacity to make decisions about their care was considered and recorded appropriately.

All of the staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This training was part of the support essentials training covered during induction and then updated every two years. Staff understood the core principles of the Mental Capacity Act.

One patient had been deprived of their liberty subject to DoLS. Care Quality Commission had not been notified when the application was approved as required under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The care quality commission has received a retrospective notification regarding this since this inspection was completed.

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Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Requires improvement

Safe and clean environment

The hospital was single storey and purpose built, in a horseshoe shape. Each side of the horseshoe was male or female accommodation. This included bedrooms, bathrooms, lounges, rehabilitation kitchen, and laundry. There was an inner courtyard with a large garden area, which patients could freely access. There were two shared activity lounges and a large dining room. In the centre of the horseshoe was the staff office, clinic room, interview rooms and meeting rooms. There was a designated low stimulus room located directly opposite the staff office. This room was a place for patients to go if they wished to be in a quiet area but not necessarily in their own room.

There were 18 ensuite bedrooms and two bedsits with ensuite facility and kitchenette areas. There were additional male and female bathrooms, including access to an adapted bathroom with full wheelchair access and hoist. Bedrooms had nurse call systems and these were located along the main corridors. There had been significant recent investment in to the environment and the bedrooms and bedsits had been completed to a high standard. Bedrooms included televisions, and built in sockets so patients could use their gaming devices and laptops. The garden areas were well designed and pleasant. There were multiple seating areas; including quiet spaces, outdoor gym equipment and garden activities including a bowling alley.

The hospital and its gardens were clean and tidy. The furniture was good quality and well maintained. There was hospital standard furniture such as weighted sofas, but these were in a bright non-uniform design and were of a good quality. There were ample seating areas and comfortable spaces including quiet places where patients could go to sit. These included separate male and female lounges, conservatories, kitchen areas, a joint use dining area, activity rooms and meeting rooms. There were multiple blind spots throughout the building and staff described how staff were allocated key areas throughout the building to maintain observations and so to keep the environment safe.

The clinic room was fully equipped and was where the automated external defibrillator was stored along with oxygen. All staff were trained in the use of these. A sign indicated the location of ligature cutters and the emergency resuscitation equipment. All staff knew where this equipment was located.

Staff made regular checks to ensure all required equipment, including for emergencies was in place and in date. The nurse in charge confirmed these checks had been made and recorded this on the daily hand over sheet. There was an infection control lead within the nursing team. Staff completed regular handwashing assessments. Staff checked the temperature of the fridge weekly. This was where some medications were being stored. This ensured medicines were being stored safely.

There was a nominated fire warden and staff understood the emergency planning arrangements in the event of a fire or other serious incident. Arrangements were in place with the older adults care home located a short distance away so this could provide a safe evacuation point in the event one may be needed.

Long stay/rehabilitation mental health wards for working age adults

Good

The registered manager completed an environmental risk assessment in June 2015. This identified ligature points throughout the unit. A ligature point is somewhere patients who are intent on self-harm could tie something to strangle themselves. There were a number of ligature points within the building and the garden area. Staff had identified these and had detailed strategies to help reduce the risk identified. These included vision panels within bedroom doors and staff could override locked doors due to anti-barricade systems. Rooms such as laundry and assisted bathroom remained locked when not in use and there was restricted access around parts of the building that staff accessed using swipe cards. Staff assessed the risk of individual patients using ligatures through individual risk assessments. Two bedrooms had additional anti-ligature measures and these bedrooms were used when patients were identified as a high risk of using a ligature.

Domestic and kitchen staff kept daily weekly and monthly cleaning schedules. Kitchen staff maintained accurate and up to date logs of fridge temperatures, food storage, and temperature of all food before serving. Domestic staff confirmed they had access to required personal protective equipment. The nurse in charge provided a daily handover to ensure any risk issues were communicated and staff were issued with personal alarms.

There were good systems for the storage of potentially hazardous cleaning products, and colour coding and appropriate cleaning cloths and mops for different areas. Domestic staff were given a daily handover by the nurse in charge and there were effective systems to ensure staff communicated information about risk or infection. Staff and patients told us maintenance work was regularly undertaken and if there were any building emergencies, such as burst pipes, there was emergency maintenance support 24 hours a day.

Safe staffing

Weaver lodge provided the following staffing detail for between February 2015 to February 2016:

- There were a total of 28 full time staff
- Eight staff had left in the previous 12 months
- There had been 8.6 full time staff vacancies in February 2016
- The staff sickness rate was 5.2%

At the time of the inspection, staff had been recruited to fill vacancies except for two full time support workers and a qualified nurse. These vacancies were being advertised. The clinical manager and two senior nurse practitioners provided clinical leadership for nursing staff. The multi-disciplinary team had a consultant psychiatrist and an occupational therapist. The team manager oversaw the operational management of the hospital.

Rotas were designed to make sure named nurses would be able to attend clinical review meetings. Staff, patients and carers told us the staffing levels were adequate to meet the requirements of the patients. Weaver Lodge brought in staff from their own bank to cover shortfalls in staffing or to supplement staff on duty if additional staff were needed to meet clinical need. There had been increased use of bank staff because of staff vacancies, however the majority of these were now filled. Nurses told us it was rare for the hospital to be short staffed. The independent advocate confirmed it was unusual for patients to miss out on leave or other activities because of low staffing.

During the day there were two qualified and four unqualified nurses on shift. At night, there was one qualified and two unqualified staff on duty. At weekends, there was one qualified and two unqualified nurses on each shift. As well as the core nursing staff, the clinical lead, two senior nurse practitioners, an occupational therapist and team manager were supernumerary and supplemented the daily staff levels, predominantly Monday to Friday. The two senior practitioners covered seven days a week providing senior clinical leadership. We reviewed the staffing rotas over the six weeks before the inspection and noted staffing levels were of the correct numbers and skill mix on each shift except for five occasions. We were informed staffing numbers would increase if patient numbers increased.

There were a number of bank staff who worked regularly at Weaver Lodge. The patients and their carers were familiar with these staff. Most patients had unescorted leave. Patients told us it was rare for their leave to be cancelled because of staff shortages. They also told us one to one meetings with their named nurses took place regularly.

All staff were up to date with mandatory training which included automated external defibrillator training and basic life support. There was a procedure for staff to follow in the event of an emergency life-threatening incident and staff understood this.

The clerical officer maintained an effective system for monitoring compliance with mandatory and other necessary training. Training was booked via an electronic system. This was also used to record completion of managerial supervision and appraisals. This supported the team manager to ensure all supervision and staff training was up to date.

Assessing and managing risk to patients and staff

A consultant psychiatrist attended Weaver Lodge three times a week. Outside of those times, the psychiatrist was available for contact and discussion at the other Alternative Futures sites. The psychoatrists across the Alternative Futures Group provided cover for each other if they were not in work. At night and weekends, there was a service level agreement for staff to contact the psychiatrist on call at 5 Boroughs NHS Foundation Trust. They would provide advice and telephone consultations. In the event of a psychiatric or physical health emergency staff would summon emergency services via 999.

There was a list of items that were not allowed on to the premises. These included drugs, alcohol and knives. There was no restriction around personal phones or the amount of personal belongings, and patients had been able to personalise their rooms. The main entrance to the hospital was locked and there was a sign explaining that informal patients were able to leave. Patients had keys for their rooms which they could lock, although staff could gain access in the event of an emergency. There was unrestricted access to bedrooms at all times.

There were policies and procedures for the use of observations and searching patients. Staff told us searches were rarely undertaken and would only be carried out if there were risk concerns. There was a lone worker risk policy and this outlined strategies for all staff to follow to reduce personal risk. An up to date fire evacuation plan was accessible in the staff office and a fire drill had been recently completed.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely with access restricted to authorised staff. There were secure medication storage facilities in each room and patients were at different stages of self-medicating. Fridge temperatures were checked daily to ensure they were working effectively.

We reviewed four medication charts and found in three cases medicines were given as prescribed, and in accordance with the Mental Health Act. One patient had missed their diabetic medication for one day as it was not in stock. The same patient had been given two doses of a medication on subsequent days that should have been a week apart. This was raised during the inspection. Patients had comprehensive care plans to support their self-medicating. The four patients had also had regular blood tests and routine monitoring for medicines they were taking.

Controlled drugs, which are medicines that require extra checks and special storage arrangements because of their potential for misuse, were stored, managed, and recorded appropriately. There was evidence of routine balance checks of controlled drugs. Other types of medicine audits, including balance checks, were carried out regularly.

Staff described strategies they would use to support patients who were agitated or increasingly distressed. These included ensuring access to the lounge areas or interview rooms within the unit, and use of the outdoor space, including the extensive grounds. There were no seclusion facilities at the hospital. These strategies were in line with Alternative Futures Group management of violence and aggressions policy. There was telephone access to a psychiatrist for advice and guidance 24 hours a day and there was a senior staff member of call at all times.

There had been no seclusion incidents and no long-term segregation of patients. Weaver Lodge informed us there had been eight incidents of restraint between August 2015 and March 2016. Staff informed us restraint was directly linked to the administration of a monthly depot medication. We reviewed the risk assessment, care plans and clinical reviews. Restraint to administer medication was identified as the last resort and other strategies were detailed first. Staff were hopeful there were signs of improvements and a likelihood that depot medications could be given without restraint in the near future.

Between April 2015 to December 2016 there had been eight incidents where Weaver Lodge had raised safeguarding concerns. On each occasion Weaver Lodge had notified Care Quality Commission as required and all appropriate actions had been undertaken in response to the concerns. Staff members had received recent adult and child

safeguarding training. Alternative Futures Group held a monthly safeguarding forum that representatives from each of the locations attended and learning from incidents was shared across the service.

Children could visit if this was planned. This meant a dedicated area could be made available for the visit. Staff supported patients to visit children at alternative locations to the hospital wherever possible. Many patients maintained close contact with friends and family, including visiting family at their own homes or meeting in the local area. Staff had set up a facility to video call relatives who were not easily able to visit to support maintaining contact.

Track record on safety

There had been 11 incidents requiring investigation between February 2015 and January 2016. These were failure to return from leave, medication errors, missing money, allegation of assault and incident of staff injury. One incident had been appropriately reported to the health and safety executive due to an injury sustained to a staff member.

When we spoke with patients, they told us they did not have concerns for their personal safety. They also confirmed their belongings were safe. Carers told us they were confident that their family member received the care and treatment they required.

Reporting incidents and learning from when things go wrong

Staff recorded incidents on an electronic recording system. Staff could tell us what should be recorded and they knew how to do so. Incidents were reviewed and discussed at staff meetings. Senior clinical staff provided feedback and shared outcomes of investigations. These included feeding back about actions taken and lessons learned not only at Weaver Lodge but also from the provider's other locations.

Staff a good understanding about safeguarding and whistleblowing. They knew how to report these both using the electronic system as well as referring to the local safeguarding team, if this was needed. Unqualified staff described how they would report concerns to the nurse in charge, or the manager. There had been no whistleblowing incidents.

There were 42 medication errors reported on the system from October 2015 to April 2016. Most of these had been identified during the weekly medication audits and were stock discrepancies. The review did not identify a pattern or relationship to a specific patient. In each incident, it was either one or two tablets above or below what should have been there on that day. Two incidents related to administration of incorrect dose one of which was by a patient self-medicating. It was not clear what action the provider was taking in relation to these discrepancies other than raising the issue in team meetings and individual supervisions.

Five incidents related to non-recording of signatures on patient self-medication forms. These were identified during an audit in January 2016. There had been no further incidence of this since that time.

Senior staff detailed debrief sessions that were implemented following restraint incidents. Other staff told us that these sessions were helpful. Staff understood the core principles of duty of candour, specifically an open and transparent admission in the event of an incident or near miss and the importance of apologising when things went wrong. Senior managers told us they were in the process of rolling out training for all staff in the implementation of the new policy.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Each patient had a clinical file with current care plan, risk assessment, and contemporaneous notes. Risk assessment, risk management, and care plans were uploaded to the electronic record by the nursing staff . Contemporaneous notes were uploaded retrospectively. Weaver Lodge had introduced individual portfolios for patients to hold in their room. These included a copy of key documents including care plans and risk assessments.

Staff used the short-term assessment of risk and treatability tool risk assessments. We reviewed four clinical records in detail. These included the risk assessment, risk management plan, and care plans. Care plans were comprehensive, personalised, covered a range of areas of

need and identified recovery orientated goals. The care plans had been signed by the patient, or staff had recorded why the patient declined to sign and the patient had been offered a copy of it. Risk assessments were up to date and comprehensive and outlined strategies for reducing identified risk. Named nurses completed these on admission and then they were regularly reviewed.

The local GP undertook physical health examinations on admission and there was ongoing physical health care. In one case the patient was refusing to undertake routine physical observations such as blood pressure and blood tests. Staff were encouraging the patient to reconsider this decision. There was evidence of effective joint working with other health professionals in response to long-term health conditions. Care plans outlined guidance for the nursing team to ensure compliance with required specialist health interventions. Community care coordinators told us they were kept up to date about physical health issues and outcomes from blood tests and other routine health tests would be reviewed in the clinical review meetings. Nursing staff had recorded physical health status including body mass index and height measures, smoking status and glucose levels in clinical records.

GPs at the local health centre carried out physical health assessments, including yearly health checks. These were recorded within the GP clinical records and not in the Weaver Lodge clinical patient record. Copies of results from physical health tests were sent to Weaver Lodge for the clinical record. Staff said the GP would inform them quickly of any physical health concerns. Patients confirmed they received regular attention to their physical health care. GPs were notified of medication changes made at clinical reviews. The psychiatrist advised there were good working relationships with the local GP practice and frequent telephone contact and discussions between doctors from both services where required.

Local GPs prescribed medications. This was part of a GP assessment and treatment review with the patient, or on recommendation from the psychiatrist. Adequate pharmacy provision was in place including dispensing arrangements, transport and medication returns provided by a local pharmacy. Medicines were dispensed using charts that were up to date and correctly completed.

Best practice in treatment and care

Senior clinical staff outlined the evidence upon which interventions were based. Most were from the National Institute for Health and Care Excellence and covered best practice for schizophrenia, medication management, and risk management. Alternative Futures Group had a central therapy hub that provided individual psychological interventions across all the locations. The team manager informed us the psychological resource was to move into each of the locations as part of the organisation redesign rather than operating from a central hub. Some nursing staff had additional skills in psychosocial interventions. This informed the recovery-focused work they carried out with patients. An external facilitator attended the unit on a weekly basis to provide dance therapy.

An occupational therapist provided input three days per week. They devised individual programmes to be implemented and supported by the named nurse and support workers. These were reviewed in the multi-disciplinary meeting that the patient, nurse and occupational therapist attended. The occupational therapist provided groups including social skills training, anxiety management, confidence building, as well as a range of other groups provided by internal and external staff. There were plans to convert a support worker post into an occupational therapist assistant post to support the work.

Staff completed Health of the Nation Outcome Scales for all patients. This is a measure widely used in mental health to monitor mental health improvements and other changes for an individual patient. Other structured assessment tools were being completed. These included Beck depression inventory, medication side effects rating and Krewiecka, Goldberg and Vaughan (KGV) psychosis symptom rating scale.

Regular local audits were taking place including risk and care plan audits, infection prevention, service user feedback, and monitoring of Mental Health Act compliance. Other clinical audits were being coordinated within the Alternative Futures Group. These included borderline personality disorder and experience of psychosis and schizophrenia in adults.

Two senior nurse practitioners were responsible for checking medication stocks and undertaking audits to ensure compliance with policy for medication management. It was noted that there were regular occurrences of inaccurate stock being identified in these

audits. A local pharmacy provide weekly on-site support A specialist pharmacist provided input within the Alternative Futures Group and was available for advice and guidance for staff via telephone or email query. The pharmacist provided strategic support to the Alternative Futures Group.

Skilled staff to deliver care

Staff received line management supervision in line with the hospital policy. There was a standardised agenda covering areas including health and safety, workload, team working, patient and service issues and objective setting. The senior practitioner provided supervision to each of the qualified nurses, who in turn provided it to the unqualified nurses. Clinical supervision was provided via regular one to one sessions and staff had access to peer group supervision. This was for both qualified and unqualified staff to attend and discuss specific clinical cases. The occupational therapist was attempting to locate an occupational therapy from outside the organisation to provide clinical supervision to staff.

All staff had completed a comprehensive induction when commencing work with Alternative Futures Group. There was evidence of these in the personnel files. There was a four-day induction programme and clinical staff attended a five-day management of violence and aggression course. Training in management of violence and aggression focused upon non-physical interventions and de-escalation. Staff undertook a range of other training including recovery star training, leadership training, personality disorder and learning disability awareness, medication management and diabetes awareness. Training needs were identified during appraisal and staff members had personal development plans. All staff had an up to date appraisal.

Information governance, including safe storage of clinical records and patient confidentiality, was part of mandatory training. All staff required a password to access the electronic records. Paper clinical files were retained in a suitably secure area within a locked office. Senior staff outlined how poor performance should be managed and provided examples of where was implemented.

Multi-disciplinary and inter-agency team work

There were effective handovers between nursing shifts where key information was shared. Key points were documented on a pre-printed handover sheet and staff could refer to this as needed. These sheets were signed by both the handing over nurse and the nurse in charge of next shift to confirm information has been shared. The multi-disciplinary team met twice weekly. The patient and nursing staff, psychiatrist, carers, and staff from the central therapies attended. Community care co-ordinators attended regularly for review meeting. Discussions and actions were recorded within the clinical records and care plans and risk management plans amended accordingly.

Staff had good links with local services. Patients maintained contact with community mental health team care co-ordinators. One care co-ordinator confirmed regular communication with the hospital and they were kept updated regarding progress or problems. They attended multi-disciplinary team meetings and reviews and felt well informed and included in ongoing care and treatment. A range of external professionals regularly attended clinical reviews including commissioners, community staff, probation, and forensic team members, where appropriate. Support workers from Weaver Lodge told us they feel included in multi-disciplinary team meetings and that their feedback and involvement was valued.

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

Representatives from each Alternative Futures Group locations attended a monthly Mental Health Act forum. At this forum staff provided advice and guidance around complex Mental Health Act issues, reviewed audit outcomes and issued action plans where required. There were monthly Mental Health Act audits on site. This was to ensure detention paperwork and other required documentation were present, risk assessments had been completed before patients had section 17 leave and patients' rights under section 132 were reviewed and explained regularly. Staff at Weaver Lodge checked the treatment authorisation (T2 and T3) forms on a weekly basis. These recorded consent to treatment (T2) and stated what prescribed medication should be administered (T3). During this visit T2 and T3 forms were correctly completed. All of these areas demonstrated improvements since the Mental Health Act review visit the previous month.

Nine patients had been detained under Mental Health Act. Staff had a good understanding of the Mental Health Act,

Long stay/rehabilitation mental health wards for working age adults

Good

the Code of Practice and the guiding principles. Mental Health Act training was part of staff induction and there were yearly refresher training courses. All of the staff had completed this required training.

There were posters advertising the availability of an independent mental health advocate and they visited the unit regularly. This service was provided by Winsford citizens advice service. Patients confirmed they had contact with the independent mental health advocate who would attend their reviews if they requested it. Patients confirmed they had received a booklet explaining their rights under the Mental Health Act.

Second opinion assessments were undertaken appropriately and there was evidence of hospital manager hearings and first tier tribunals occurring. Detention paperwork was available to review within the clinical files. There was evidence that section 132 rights were discussed with patients routinely. Outcomes of section 17 leave were discussed with patients on their return. These areas were all improvements that staff had made following feedback from the most recent Mental Health Act review visit in March 2016.

Good practice in applying Mental Capacity Act

Capacity and consent were being reviewed, documented and considered in all care and treatment. Weaver Lodge used a 'capacity assurance log' that was held in the contemporaneous record. This was completed in all instances and showed capacity was being regularly reviewed.

Nursing staff had Mental Capacity Act training during induction and then two yearly as a refresher. Staff could describe the core principles of the Mental Capacity Act, including assuming patient capacity and the right for patients to make their own decisions. Capacity to consent to treatment was assessed on admission. This decision was periodically reviewed. Each clinical record had a 'capacity assurance log', which prompted the clinical team to regularly review. There were senior staff at the hospital and at the larger hub who could provide advice and guidance when needed.

We observed a clinical review where a detained patient articulated why they were continuing to decline a range of medications for long-term physical health conditions. Patient views were central to the discussions and the way staff presented information to the patient demonstrated honest and open joint working.

The independent advocate was regularly invited to meetings by staff as well as meeting individually with patients. They described the staff team as knowledgeable about the Mental Health Act and Mental Capacity Act and described that the team had good knowledge around Deprivation of Liberty Safeguards and best interest meetings.

We noted a patient had been subject to Deprivation of Liberty safeguards. All required process had been followed although care quality commission had not been notified. This is required under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The newly appointed registered manager agreed to ensure a retrospective notification to the care quality commission was made. This has been received this since this inspection was completed

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

Good

Kindness, dignity, respect and support

Patients said they were treated with care and kindness by staff at Weaver Lodge and that staff were around if needed. We were told staff knock before entering bedrooms. Patients told us they would feel able to speak out if they were unhappy about things. There were positive interactions during our visit and the staff and patients clearly knew each other well.

Carers felt appropriately involved in care and treatment and their views were considered when important decisions were being made. They had confidence in the treatment and care their family member received for their mental and physical health. Staff communicated with carers and kept them informed. They told us that the staff were kind, helpful and respectful. Staff went out of their way to

Long stay/rehabilitation mental health wards for working age adults

Good

facilitate patients and carers meeting up. These included supporting visits very early on Sunday mornings to fit around work commitments and supporting patients to attend regular football matches with family.

The involvement of people in the care they receive

There was a daily community meeting and patients were encouraged to raise their views and concerns. Minutes of these meetings were available for anyone not able to attend. Actions were agreed and feedback was given at subsequent meetings. There was a monthly service user forum meeting. Patients told us they felt confident to raise concerns or issues directly with staff either at the community meetings or during one to one meetings with their named nurse. Their views were listened to and they felt included in their care planning arrangements. However, this was not the view of all patients and one said he did not feel his views about his care and treatment were taken seriously. Patients confirmed they knew how to contact the mental health advocate and they would attend their reviews if they requested it.

The quality of care plans and risk assessments were reviewed in individual staff supervision to ensure patients were central to care plans and risk assessments. Patients were encouraged to share their views and opinions in clinical reviews and their views were given due regard and respected. Good quality information was provided by the clinical team to ensure informed choice.

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

Good

Access and discharge

In the 12 months before February 2016 Weaver Lodge had an average occupancy of 64%. During the same time, there had been one delayed discharge. That patient had been discharged by the time of the inspection. The average length of stay for the 14 patients during the inspection was 1342 days. Three patients had been at Weaver Lodge over 10 years. We were told these patients declined to consider moving to an alternative accommodation and that commissioners were satisfied with the ongoing placement. These admissions had been prior to the move of the unit to a treatment and recovery centre. Commissioners and community mental health staff were working to identify appropriately supported accommodation in preparation for discharges. Commissioners regularly attended clinical reviews and were part of those ongoing discussions.

Alternative Futures Group had amended admission criteria and developed the service from a long-term rehabilitation unit to a treatment and recovery centre. This meant patients admitted would receive intensive input focusing upon developing independent living skills, and so discharge planning and a quicker discharge was in place at the point of admission. Two newly developed bedsits were being used as a step down facility for patients moving toward discharge.

The facilities promote recovery, comfort, dignity and confidentiality

There were quiet areas and places where patients could meet visitors at the hospital. There were lounges and meeting rooms, and no restrictions on using these. Patients had unrestricted access to their rooms, could use their own mobile phones, and could get hot and cold drinks and snacks throughout the day and night. Bedrooms had a television and entertainment unit where games consoles, laptops and charger units could be connected. Patients had personalised their rooms. They had a key so that their rooms were secure, although staff could access their room if there were risk concerns. Patients said their belongings were safe and secure. There was a safe for the storage of high value items if this was needed. There was a well-designed outdoor space with some gym equipment.

Patients and carers told us the food was of a good quality. Patients undertaking meal preparation and cooking as part of their rehabilitation plan had a budget to purchase ingredients for a meal and staff supported patients to develop and maintain these skills. At the time of inspection, food was prepared and cooked on site. However, the chefs' posts were to be redundant at the end of that week and Alternative Futures Group were moving to a new system for providing food to patients. Prepared meals would be delivered by contractors and preparation completed on site. Domestic staff were to undertake additional food hygiene training in preparation for this change, and would be serving the meals. The staff leaving stated they were

Long stay/rehabilitation mental health wards for working age adults

Good

concerned the benefits of on-site catering such as meals and food choices would be lost with the new system. Patients told us they were also concerned about this change.

Meeting the needs of all people who use the service

The single storey building had wide corridors and large doorways and could accommodate people with a physical disability, including wheelchair users who may be visiting. The bedrooms could not accommodate wheelchairs. There was an adapted bathroom with hoist if needed.

There was a range of leaflets in the reception area. These contained information about Weaver Lodge and information for people newly admitted. Information available included advocacy, Care Quality Commission and local groups and activities. Although all the information was in English, we were told this reflected the current patient population and other formats could be made available when needed. This would include information in different languages or braille when required. There were noticeboard with activities such as cinema trips and football group and patients had listed their names against the activities they wished to do. Staff could access interpreters for people whose first language was not English. There was access to British sign language interpreters if needed.

In a recovery group, facilitated by the OT, patients were encouraged to express their views about a range of things. These included the types of food and drinks available. There was a varied range of activities such as community visits to cinema, shopping, and games evenings to be held at Weaver Lodge and activities were available throughout the week and at weekends. Patients and carers told us they were pleased with the range of activities and were able to contribute to discussions about what type of activities they would like to do. They felt the activities and treatments facilitated recovery and developed independence. Patients and nurses told us it was rare for activities or leave to be cancelled because of staff shortages.

Listening to and learning from concerns and complaints

Weaver Lodge had a clear procedure for dealing with complaints. Staff made attempts to resolve any complaints at the earliest opportunity. A poster detailing how to raise concerns or make a complaint was in the main reception area and there were leaflets available. Patients and carers confirmed they knew how to raise concerns and make complaints.

Weaver Lodge informed us they had received three complaints between February 2015 and February 2016. Two complaints were upheld. All complaints had been resolved to the satisfaction of all parties.

Start here...

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

Good

Vision and values

Staff knew the senior staff within the organisation and said some of the senior team visit the staff and patients at Weaver Lodge. Staff knew about Alternative Futures Group vision and values along with the strategic aims which were to:

To put people in control

To make a positive difference

To be sustainable

Alternative Futures Group had completed a staff consultation process and this had resulted in changes to the management arrangements within the organisation. These include changes to the role of the clinical leads to incorporate the role of the registered manager.

Good governance

Personnel files were in good order. There was evidence that disclosure and barring service checks were completed prior to being appointed and references followed up. There were efficient systems to check qualified nurse registration requirements were up to date. All files had a copy of the most recent appraisal, except where the staff member was new in post. These files had evidence of a probation review. Files showed staff had a comprehensive induction when new in post.

Long stay/rehabilitation mental health wards for working age adults

Good

There was a monthly medication management meeting attended by the clinical lead from all locations within Alternative Futures Group. At this meeting staff discussed medication issues, including audit outcomes and incidents such as included medication errors. Staff reviewed and updated medicine policies. The pharmacist produced a monthly lessons learned newsletter that was circulated to all staff. However, we found issues with medication management. We found similar mistakes were being repeated despite these systems being in place. Actions to reduce the likelihood of similar incidents were not being fully embedded into practice.

Senior staff were responsible for completing clinical audits. We saw examples of the audits that had taken place. These included quality of care plans, risk assessments and management plans, infection control and hand washing, physical health and a range of medication audits. At the Alternative Futures Group hub group staff reviewed audit outcomes and agreed any action plans to address issues raised. The Weaver Lodge representative communicated these back to the services. We reviewed minutes of meetings including staff meetings, service user meetings. The team routinely reviewed outcomes from incidents and audits and took actions about these. It was not clear what else was being considered in relation to the continued stock discrepancies in the medications stocks.

Leadership, morale and staff engagement

We reviewed five management supervision records and saw standard agenda items were used covering professional standards, personal development, team, and organisational issues. All staff had received regular supervision. Appraisals focused upon areas of good or excellent performance and areas where performance was less than satisfactory. Strategies for supporting staff and their ongoing personal development included identifying on site coaching, matching with a more experienced buddy and structured learning and training. One hundred percent of staff had an up to date appraisal.

The three senior nursing staff within the team met monthly and discussed professional issues, reviewed audit outcomes and agreed action plans in response to audits or lessons learned following incidents.

Alternative Futures Group carried out a staff survey in 2015 and we reviewed the outcomes for Weaver Lodge. Eighty percent of staff who responded, stated they felt able to speak out if something was not right, 94 percent of staff stated that they had standards in the work they do and 94 percent of staff stated the team were always looking for ways to improve. Less positive feedback from staff included knowledge of what was happening within the larger organisation.

Commitment to quality improvement and innovation

Weaver Lodge did not participate in the accreditation for inpatient mental health services (AIMS).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must review incidents of medication errors to understand what additional action must be taken to reduce these.

Action the provider SHOULD take to improve

The provider should notify Care Quality Commission in a timely manner of any completed applications of Deprivation of Liberty Safeguards in line with Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was identifying that medication errors were occurring and reporting these as incidents appropriately. It was unclear what actions were in place to reduce similar incidents from reoccurring. This was a breach of regulation 17(2) (f)