

Good**Affinity Healthcare Limited**

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Cheadle Royal Hospital	1-127893060	Elmswood Ward	SK8 3DG

This report describes our judgement of the quality of care provided within this core service by Affinity Healthcare Limited. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Affinity Healthcare Limited and these are brought together to inform our overall judgement of Affinity Healthcare Limited.

Summary of findings

Ratings

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

Overall rating for long stay/ rehabilitation services for adults of working age

Good 

Are long stay/rehabilitation services for adults of working age safe?

Good 

Are long stay/rehabilitation services for adults of working age effective?

Good 

Are long stay/rehabilitation services for adults of working age caring?

Good 

Are long stay/rehabilitation services for adults of working age responsive?

Good 

Are long stay/rehabilitation services for adults of working age well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The services had reliable systems, processes and practices in place to keep people safe and safeguard people from abuse. There was an openness and transparency about safety. Staff understood their roles and responsibilities to raise concerns and report incidents and near misses.

Individual and environmental risks were monitored and managed appropriately. Comprehensive risk assessments were carried out for patients and risk management plans developed in line with national guidance. Monitoring and reviewing risks enabled staff to understand risks and give a clear, accurate and current picture of safety.

There was a holistic approach to assessing, planning and delivering care and treatment for patients. Patient's individual care and treatment was planned using best practice guidance with the outcomes being monitored to ensure changes are identified and reflected to meet their care needs.

Consent practices and records were monitored and reviewed to improve how patients were involved in making decisions about their care. Patient's consent to care and treatment was sought in line with legislation and guidance of the Mental Capacity Act 2005. Patients who were subject to the Mental Health Act 1983 were assessed, cared for and treated in line with the Mental Health Act and Code of Practice.

Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff were supported by means of supervision and appraisal processes, to identify additional training requirements and manage performance.

Feedback from patients was continuously positive about the way staff treated patients and their families. We observed patients being treated with dignity, respect and compassion whilst receiving care and treatment. Patients and the ones who were close to them were involved in their care decisions. Patients and their families or carers told us they were supported emotionally during the care and treatment process.

Services were planned and delivered to take into consideration patient's individual needs and circumstances. Access to care and treatment services were timely. Effective management of waiting times and delayed discharges meant there was minimal impact on the patients' care and the service delivery.

The services managed complaints and concerns effectively. They listened to patient's concerns with a view to improving the services being provided.

The services had a good structure, processes and systems in place to monitor quality assurance to drive improvements.

The services had the processes and information to manage current and future performance. The information used in reporting, performance management and delivering quality care was timely and relevant. Performance issues were escalated to the relevant monitoring committee and the board through clear structures and processes.

Summary of findings

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

Are services safe?

We rated the longstay / rehabilitation services for adults of working age as **'Good'** for safe because:

- The ward regularly practiced scenarios for an event of an emergency situation
- The ward had a safe environment which was suitable for delivering recovery focused care to rehabilitation patients.
- There were good staffing levels and skill mix planned and reviewed to ensure patients received safe care and treatment.
- Staff managed and responded to changes in identified risks to patients. The star risk assessment was used. Patients were risk assessed regularly and positive risk management was evident to support rehabilitation.
- Staff we spoke with had safeguarding training and understood their responsibilities in raising concerns or alerts. They knew the procedure to escalate and report concerns.
- The service had good systems in place for reporting incidents and serious untoward incidents, investigation and feedback of any lessons learnt. Staff we spoke with understood their responsibilities in reporting incidents.

Good



Are services effective?

We rated the longstay / rehabilitation services for adults of working age as **'Good'** for effective because:

- Patients had their needs assessed, care planned and delivered in line with best practice.
- Patient's outcomes of care and treatment were routinely monitored.
- Staff had the correct qualifications, skills, knowledge and experience to deliver care and treatment.
- Arrangements were in place to support staff by means of clinical and management supervision, appraisal, handovers and team meetings.
- Multi-disciplinary teams managed the referral process, assessments, ongoing treatment and care by discussing best treatment and pathway options for individual patients.
- Care records contained up to date, individualised, holistic, recovery oriented care plans.

Good



Summary of findings

- Overall we found good evidence to demonstrate that the Mental Health Act was being complied with.

However; staff had a limited understanding of how to apply the principles of the Code of Practice and the Mental Capacity Act.

Are services caring?

We rated the longstay / rehabilitation services for adults of working age as **'Good'** for caring because:

- We observed staff engaging with patients in a caring, compassionate and respectful manner.
- The patient we spoke to was positive about the support they received from the service.
- We saw evidence that patients, carers and family members were involved in the decisions about the care and treatment planned.
- Patients were supported to manage their own health and independence as possible.
- Care plans included carer support.
- Information leaflets were provided to carers to explain particular information in more detail.

Good



Are services responsive to people's needs?

We rated the longstay / rehabilitation services for adults of working age as **'GOOD'** for responsive because:

- Services were planned and delivered to meet patient's needs with an individualised approach that took account of their cultural needs and complex needs.
- Patients had access to care and treatment in a timely manner.
- Concerns and complaints were listened and responded to appropriately. Lessons were learnt to improve the future quality of care and treatment.

Good



Are services well-led?

We rated the longstay / rehabilitation services for adults of working age as **'GOOD'** for well led because:

- There were clear team and organisational objectives which reflected the provider's values and strategy.

Good



Summary of findings

- Staff knew who the senior management team were, they spoke about the management being visible within the organisation by undertaking ward visits. Staff spoke about being able to approach the management team with any concerns and felt they would be listened to.
- There was a good meeting structure in place to escalate and cascade information through all levels of staff. This included management review and improvements of risks, incidents and performance monitoring. Staff training, supervision and appraisal structures were set up to support staff at all levels.
- Staff understood their roles and responsibilities, including accountability. Staff felt respected, valued and supported by the management team and their peers.
- Patient's views and experience were gathered to drive performance.

Summary of findings

Background to the service

Elmswood ward was a 11 bed male open rehabilitation unit. Following the closure of an adjacent ward which was for long stay patients, the patient population on Elmswood was now a mix of patients undergoing more active rehabilitation and those with longer periods in hospital for which rehabilitation was likely to take much longer. At the time of our visit there were eight patients on the ward, who all had a detained status.

The ward had a model of care, it stated the following “We aim to offer a positive rehabilitation service that is recovery oriented. Our focus is on best practice with an integrated collaborative framework that will deliver quality clinical programmes with a person centred approach, which values individual’s cultural, spiritual and

religious beliefs. We value continuous relationships with integrated treatment providers and patients’ carers that ensure all individuals are treated with respect and dignity. We will strive to provide a safe and supportive environment that recognises patient individuality during the recovery process”.

The last mental health act review took place in June 2013. Provider actions from that report were to repeat explanations of patient’s rights to patients who had not understood the information, section 17 leave forms to have details of specified leave and a requirement for care plans to evidence direct patient involvement in their consent. At this inspection these had been met.

Our inspection team

Our inspection team was led by:

Team Leader: Sharon Marston, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a mental health nurse and a mental health act reviewer.

Why we carried out this inspection

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

How we carried out this inspection

We observed patients and staff interactions during our inspection visit. We spoke with one patient and three members of staff from a selection of disciplines and roles. We looked in detail at four care records.

To get to the heart of the experience of people who use services’ experience 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?

Before visiting, we reviewed a range of information we held about the core service and asked other organisation to share what they knew. We carried out an announced visit on 23 February through to 26 February 2015. During the visit we held focus groups with a selection of staff who worked within the service, such as senior managers, doctors, nurses, support workers and allied health professionals.

Summary of findings

What people who use the provider's services say

We observed staff treating patients with dignity, respect and compassion. The patient we spoke with felt involved in the decisions about their care and treatment.

Good practice

- The ward regularly practiced scenarios for an event of an emergency situation.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure staff have the appropriate training and understanding of the application of mental capacity assessments in respect of the Mental Capacity Act and the Mental Health Act.

Affinity Healthcare Limited

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Elmswood Ward	Cheadle Royal Hospital

Mental Health Act responsibilities

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

Overall we found good evidence to demonstrate that the MHA was being complied with.

The person we spoke with told us about how they could access advocate services if they wanted assistance. They discussed consenting to their medication and the side effects.

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found some concerns with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguardings (DOLs).

Staff we met with did not have a clear understanding of their responsibilities in undertaking capacity assessments and continuous monitoring to ensure health decisions

were made based on mental capacity or in the best interest of the person. An example of this was a patient had a mental capacity assessment completed in February 2015 but the T3 (consent to treatment form) was dated January 2015.

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean ward environment

The ward had recently moved into the building set on the main hospital site. It was recently refurbished and generally well maintained with a safe environment for delivering care.

There was CCTV in place within the communal areas of the ward. Patients had been informed about this and notices were in place to advise visitors. The ward manager explained how this aided monitoring of the ward environment and reviewing of incidents if they occurred. It was not used to replace staff observations of patients.

The ward manager had encouraged patients to personalise the environment by selecting a range of transfer prints being added to the walls.

Clinic and activity rooms were well positioned being separate from the bedroom ward environment across a garden area to another building. The ward manager explained how this encouraged a more home style life in the ward environment, which was a house style setting. Medical emergency equipment was available and checked routinely as were fridge temperatures.

The ward regularly practiced scenarios for an event of an emergency situation.

Safe staffing

Key Staffing Indicators at January 2015

Establishment levels: qualified nurses (WTE) 7

Establishment levels: nursing assistants (WTE) 7

Number of vacancies: qualified nurses (WTE) 1

Number of vacancies: nursing assistants (WTE) 0.3

Full hospital staff sickness rate site (%) in 12 month period 5.4%

The hospital used an establishment tool to set the staffing levels for each ward. There was a core staffing level with additional staff being added to support observation levels or activities such escorted leave or trips.

Staffing levels and skill mix were planned, implemented and reviewed to keep patients' safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff could manage identified risks to patients.

The service had low levels of usage of bank and agency staff. The figure for shifts covered by bank staff for November 2014 was 19, December 2014 it was one and January 2015 it was 25. The figure for shifts covered by agency staff for November 2014 was zero, December 2014 was zero and January 2015 was three. This meant that patients had continuity of care as the usage of bank and agency staff was minimal therefore they knew their staff team and could build confidence within their relationship with them.

Staff reported they felt the staffing levels were adequate.

The ward manager told us that leave was not cancelled due to staff or transport shortages. The ward has access to a number cars belonging to the service for patient's escorted leave. If the vehicles were not available to use for planned trips then the ward staff would re-arrange a more local trip rather than cancel planned leave.

Assessing and managing risk to patients and staff

Medications were stored appropriately in a securely lockable room within a locked cupboard. Stock levels of medication were audited on a weekly, monthly and quarterly basis.

Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviour that challenges. Patients were involved in managing risks and risk assessments were person-centred, proportionate and reviewed regularly. STAR risk assessments were completed on each person on admission to the service and reviewed regularly to monitor any changes in risk. The risk assessments were updated following any identified changes and a full review was held within the multi-disciplinary team (MDT) meeting.

Are services safe?

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

The ward completes a three part ligature audit estates summary to assess environmental risks; this is completed on an annual basis, last being completed in January 2015. Ligature points had been identified and were managed through patient risk assessments to support positive risk management.

The ward had no seclusion facility and did not use restraint. De-escalation techniques were used when required to support patients. Staff had personal alarms for safety but they told us they had not had cause to use them. Staff knew the patients and their triggers to help recognise indicators of a patient's mental health deteriorating before it became a crisis. On occasions patients have been moved to a secure setting if it became apparent that Elmswood was not a suitable setting to provide the appropriate care and treatment.

Safeguarding vulnerable adults was given priority by the services. Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse from occurring, responded appropriately to any signs or allegations of abuse and worked effectively with others to implement protection plans. Safeguarding

leads were identified within the service and there was a trust policy and procedure in place. Safeguarding alerts were recorded on the incident reporting system and any local alerts were discussed at the twice weekly safeguarding meetings.

There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.

There was 75% of nursing staff and 78% of health care assistants on Elmswood who had completed their safeguarding vulnerable adult's mandatory training. There was 88% of nursing staff and 78% of health care assistants on Elmswood who had completed their safeguarding children mandatory training.

Reporting incidents and learning from when things go wrong

Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Staff were aware of the process for reporting incidents using the e-compliance system. Any lessons learnt were discussed at the ward meetings.

Are services effective?

Good 

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

Summary of findings

Our findings

Assessment of needs and planning of care

Risk assessments formed part of the initial assessment and were completed using the STAR tool. Risk assessments were reflected in the care plans and treatment interventions. If any risks were identified or had changed then this triggered a full review and case discussion within the MDT. The risk assessments were held electronically on the computer system and updated regularly.

Care plans contained up to date, personalised, holistic, recovery focused information to support the treatment pathway. A discharge summary was included within the care plan and a copy offered to the patient.

Each patient had a separate physical health care record with evidence of on-going monitoring of health conditions.

Best practice in treatment and care

The ward followed best practice based on National Institute for Health and Care Excellence (NICE) guidance. They attended national networks and shared good practice, discussions around NICE guidance and implementation within each of the services was cascaded via the team meetings.

The ward used a range of outcome measure tools which included HONOS and STAR recovery.

Skilled staff to deliver care

The ward staff had access to a range of mental health disciplines which included psychiatrist, psychologists, occupational therapists, social workers, community psychiatric nurses, consultants, advanced nurse practitioners, medical secretaries and administration support.

There was a core programme for mandatory training which included fire safety, infection control, safeguarding children, safeguarding adults, introduction to health, basic life support, break away training, confidentiality and data protection, crisis management, deprivation of liberty safeguarding, food safety for food handlers, IT security,

mental capacity act, moving and handling, PMVA (restraint), suicide prevention / self-harm, mental health act, emergency procedures awareness, and safe handling of medicines.

Elmswood staff were meeting the training requirements at February 2015 as follows;

- Fire safety for nursing staff was 38% and for health care assistants 100%
- Infection control for nursing staff was 63% and for health care assistants 89%
- Safeguarding children for nursing staff was 88% and for health care assistants 78%
- Safeguarding adults for nursing staff was 75% and for health care assistants was 78%
- Introduction to Health and safety for nursing staff was 75% and for health care assistants 89%
- Basic life support for health care assistants was 100%
- Break away training for nursing staff was 62% and for health care assistants 89%
- Confidentiality and data protection for nursing staff it was 100% and for health care assistants 100%
- Crisis management for nursing staff was 75% and for health care assistants 89%
- Deprivation of liberty safeguarding for nursing staff was 37% and health care assistants 78%
- Food safety for food handlers for nursing staff was 75% and for health care assistants 89%
- IT security for nursing staff it was 75% and for health care assistants 89%
- Mental capacity act for nursing staff was 50% and for health care assistants 86%
- Moving and handling for nursing staff was 88% and for health care assistants 100%
- PMVA (restraint) for nursing staff it was 50% and for health care assistants 88%
- Suicide prevention / self-harm for nursing staff was 88% and for health care assistants 89%
- Mental health act for nursing staff was 63% and for health care assistants 89%.

There was a supervision tree in place to ensure the appropriate clinical and management supervision programme was effective. Management supervision took place on a monthly basis with a group debrief session as

Are services effective?

Good 

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

required. Clinical supervision took place on a 4-6 weekly basis. Sample supervision records were reviewed as part of the inspection process. Compliance with supervision and appraisals was good on the ward.

Multi-disciplinary and inter-agency team work

Ward and multi-disciplinary staff worked together to plan ongoing care and treatment in a timely way through the MDT meetings and handover structures which were in place. Care was co-ordinated between wards and other services from referral through to discharge or transition to another service.

MDT meetings were used to collaboratively manage referrals, risks, treatment and appropriate care pathways options. Any discharge planning was also managed via the MDT or CPA review meetings. Staff attending the MDT meetings included support workers, nurses, occupational therapists, psychologists and doctors. Other professionals such as dietician, social workers or physiotherapist would attend as required. Each patient was discussed at length and invited to attend their part of the meeting.

Adherence to the MHA and the MHA Code of Practice

Overall we found good evidence to demonstrate that the MHA was being complied with.

Patients told us about how they could access advocate services if they wanted assistance. They discussed consent issues regarding their medication and the side effects.

Overall the services had effective systems in place to assess and monitor risks to individual patients who were detained under the Mental Health Act.

Staff were appropriately trained on Mental Health Act and the Code of Practice. Patients had access to the independent mental health advocacy (IMHA) services and staff supported engagement with the service.

Good practice in applying the MCA

Although staff had received training on the Mental Capacity Act, they had a limited understanding of how to apply the principles of the Code of Practice and the Mental Capacity Act. There had been some confusing communication within the hospital which had impacted on the application of the mental capacity assessment. Staff we met with had limited understanding of their responsibilities in undertaking capacity assessments and continuous monitoring to ensure health decisions were made based on mental capacity or the best interest of the person.

We discussed this with the provider and they provided assurance they would provide the clarity staff required.

Are services caring?

Good 

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

Summary of findings

Our findings

Kindness, dignity, respect and support

Feedback from patients was positive about the way staff treated them. Patients told us they were treated with dignity, respect and kindness during all interactions with staff. We observed good interactions between staff and patients during our visit.

Patients told us that staff understood their needs and respected their privacy and confidentiality.

The involvement of people in the care they receive

Patients were involved and encouraged to be part of their care and treatment decisions with support when it was needed.

Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients were supported to maintain and develop their relationships with those close to them, their social networks and community.

Patients were provided with copies of their care plans and it was recorded in the care records when a copy had been declined by the patient with an explanation.

Patients were provided with information leaflets on advocacy services.

Are services responsive to people's needs?

Good 

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

Summary of findings

Our findings

Access, discharge and bed management

Referrals were received from several sources which included internally within the hospital site from acute wards. Each referral was discussed and prioritised at the multi-disciplinary team (MDT) meeting which took place each day.

The ward had a bed occupancy level of 75% over the past 12 months. There was a process in place to admit and discharge patients from the ward. A referral criterion was used to assess patients from acute wards who may be suitable for the next stage of their care pathway to recovery. The strict criterion enabled the ward to assess if they were able to meet a patient's needs.

Assessment of the patient for a place within the rehabilitation ward was undertaken by an appropriate selection of staff, which could include the ward manager, consultant or occupational therapist.

There was a transition period to assist the patient with the orientation of the ward, to support family members with a visit prior to the transfer and where possible enable the patient several visits prior to the admission.

We reviewed a patient's file that was a plan for discharge shortly. We saw how the patient had been supported during the build up to their discharge by staff escorting them to a day centre and how the patient was now attending on their own by travelling by bus. The patient was aware of their discharge plan and their goals.

The last admission to the ward was approximately 18 months ago. There were currently no delayed discharges within the ward.

The ward manager told us that there are no movements between wards unless this was justified on clinical grounds and in the best interests of the patient. An example would be if a patient had a relapse and would be referred back to an acute ward setting.

The ward manager advised that there was no waiting list but they had four referrals awaiting assessment. These assessments were to see if the patient met the criteria for the rehabilitation ward care delivery before a place was allocated.

The ward environment optimises recovery, comfort and dignity

The ward was calm and had a comfortable feel as we undertook the ward tour. We saw that there were a range of rooms to support patients' involvement in activities, therapy rooms, kitchenette, quiet rooms and main TV lounge areas. There were rooms where patients could take their family and visitors for privacy. The ward had access to a garden area.

Patients told us how they could personalise their rooms and had a key to be able to lock their rooms when they were out of the ward.

Patients had access to the kitchenette to make themselves hot drinks and snacks 24/7.

Ward policies and procedures minimise restrictions

With the ward being a rehabilitation ward it was an open ward for informal patient to leave as they liked. Detained patients also had leave which was unescorted, where section 17 leave procedures would be followed.

Meeting the needs of all people who use the service

During the tour around the ward we observed information was available for patients, carers and family members. Information was available on advocacy services for patients to access help and support.

The ward manager advised us that interpreters were available if required so that patients, family members or carers could understand what care and treatment was provided.

We were also told how patients' cultural and religious requirements could be supported and this was confirmed when we spoke with patients. Patients told us how they attended local church services and other patients advised they had visits on the ward from the local vicar.

Are services responsive to people's needs?

Good 

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

The ward had access to a number of cars belonging to the service to support patients' escorted leave. If the vehicles were not available to use for a planned trip then the staff would re-arrange a more local trip rather than cancelling planned leave.

Listening to and learning from concerns and complaints

Complaints were usually addressed at a local level to attempt a resolution. If a local attempt at resolution failed then it was escalated through the provider's formal complaints process. There was a complaints policy and procedure in place to support this process.

Staff told us that there had been no formal complaints raised in the last six months. The patients had raised issues that staff had addressed, an example of this was the patients wanted different prizes in the pool and darts competitions.

Are services well-led?

Good 

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

Summary of findings

Our findings

Vision and values

The provider's visions and strategies for the services were evident and most staff considered they understood the vision and direction of the organisation. Staff were able to tell us about specific initiatives such as the seven C's which included the principles of care, compassion, commitment, communication, courage, consistency and competence that the organisation had compiled.

Good governance

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the senior managers to the frontline services were mostly effective and staff were aware of key messages, initiatives and priorities of the service.

The ward had strong governance arrangements in place to monitor the quality of service delivery. They had regular meetings for management staff to consider issues of quality, safety and standards. This included oversight of risk areas in the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients.

Leadership, morale and staff engagement

Staff spoke of a strong culture of openness and honesty with effective mechanisms in place to disseminate lessons learnt. Staff felt valued and supported by the management and their peers.

The senior management team was active within the hospital being involved in quality walk arounds. Staff also spoke of a project regarding a listening group which they valued. They felt the senior management team was approachable and they had no concerns in speaking to any of them if they had any concerns.

Sickness and absence rates across the hospital were 5.4% at January 2015.

Commitment to quality improvement and innovation

There were a range of key performance indicators which were monitored for quality assurance. These were managed via the ward managers meeting with the clinical service manager on a weekly basis.

There was a series of audits completed including the infection prevention and control audit which was last completed for Elmswood ward in August 2014. This is an annual audit. There were two audits for the quality of the care records and care plans to ensure all records were up to date with the appropriate documentation being compiled; these were completed on a monthly basis.

There was also a three part ligature audit estates summary, this was last completed for Elmswood in January 2015.

Audits had action plans in place to assist the monitoring of any requirements to meet compliance via the ward managers meeting with the clinical service manager.

Compliance with training, incidents and complaints were managed and monitored by the ward managers meeting to review lessons learnt and monitor themes.

Patient experience surveys were completed; we reviewed a survey which had been completed in November 2014. This was particular to the Elmswood ward with eight patients completing and returning the survey. Examples of the outcomes are as follows;

All stated that they could make suggestions about their own care

All stated that the staff were available to ask questions regarding their care;

87% stated there was a variety of activities

85% stated that their privacy and dignity was respected each day

71% stated they had been offered a copy of their care plan.

All stated they felt there was enough staff on the ward

All stated that they can practice their spiritual beliefs with support from staff if necessary.