Kent and Medway NHS and Social Care Partnership Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXY03	St Martins Hospital	Davidson Ward	CT11TD
RXY03	Rosebud Centre	Rosebud Centre	ME19 5HT
RXYT7	The Grove	The Grove	CT11 9SH
RXY1A	Ethelbert Road	Ethelbert Road	CT1 3ND
RXY1C	111 Tonbridge Road	111 Tonbridge Road	ME16 8JS
RXYR2	Rivendell	Rivendell	CT13 0JX
RXYF6	Medway Maritime Hospital	Newhaven Lodge	ME7 5NY

This report describes our judgement of the quality of care provided within this core service by Kent and Medway NHS and Social Care Partnership Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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 Kent and Medway NHS and Social Care Partnership Trust and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Partnership Trust.

Summary of findings

Ratings

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

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

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

We rated the long stay/rehabilitation mental health wards for adults of working as provided by Kent and Medway NHS and Social Care Trust as requires improvement because:

- Numerous ligature points were identified in all of the rehabilitation wards. Davidson unit did not have a copy of its ligature risk assessment. We were told that it had been completed but the staff member who had completed it was not on duty, so the assessment was not available. Staff told us that the majority of the patients were considered low risk as they were on their way to their way to being discharged and there fore would not be in rehabilitation if they were high risk. However, rehabilitation wards were regularly used to accommodate acute patients. Staff had little knowledge of risk assessments being carried out for these patients and so presented a potential risk.
- Rosebud Lodge did not have an activity plan in place for patients. Staff and patients told us one had not been developed following the move from Dartford to Leybourne.
- Food quality on Davidson unit was described as being very poor. We witnessed that food presented to patients was of poor quality and had an unpleasant texture. The PLACE survey rated the overall food score at St Martin's hospital site was 74%, the national average for mental health trusts is 89%.
- There was little evidence of sharing of best practice and learning across the rehabilitation services. All the wards appeared to work in isolation with little support offered across the service. Where good practice was evident in one ward it was not carried across the service into other wards. For example, The Grove was working pro-actively to support patients to safely access the internet and social media, but this is not being shared across the service.
- Davidson unit failed to comply with Department of Health requirements relating to same sex accommodation. Female patients' bedrooms were along the main corridor which also provided access to the ward and the mens' bedrooms were situated at the far end of the ward. Anyone entering or exiting the ward had to pass the female patients' bedrooms. There was a female only shower and toilet within the female corridor. Access to bathrooms for female patients on Davidson unit was along the corridor to the men's bedrooms.. The shower cubicles and the baths were small and cramped and would be difficult for use by larger patients.
- Medication management was a concern in Ethelbert Road, self-medication procedures were not evidenced and medication such as clozaril was seen left unattended in an unlocked patient's room.

However, we did see that the modified early warning score charts (MEWS) demonstrated good practice and this was embedded into health monitoring for patients.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- Numerous ligature points were identified in all of the rehabilitation wards. Davidson unit did not have a copy of its ligature risk assessment. We were told that it had been completed but the staff member who had completed it was not on duty, so the assessment was not available.
- There were multiple ligature points at Newhaven Lodge which were not an issue for the rehabilitation patients as the risk was managed well.
- We were told that at the Grove, ligature management relied upon patients being assessed as stable and at low risk.
- The rehabilitation wards were regularly used to accommodate acute patients to 'sleep out'. Staff had little knowledge of risk assessments being carried out for these patients and so presented a potential significant risk.
- Rosebud Centre had been re-located from a purpose built rehabilitation ward set in an urban environment in Dartford to a rural environment in Leybourne. Patients told us that they felt unsafe walking to the shop and bus stop as there was no footpath or street lighting. There had been one incident when patient had got lost and had to be returned to the unit by the police.
- Davidson unit and Newhaven Lodge failed to comply with Department of Health requirements relating to same sex accommodation.
- The trust must ensure that the storage and recording of medication, including self-administration processes, is safe and secure and must ensure that staff follow its policies for the safe management and administration of medicines

Are services effective?

Requires improvement

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

- The Recovery Star, a tool used to improve individual recovery planning, was in place at all sites but was only embedded in care planning in three locations. At Newhaven Lodge the peer support worker had really promoted this with patients and staff and felt it was meaningful, recovery focused and underpinned the rehabilitation process with short and longer term goals.
- Rosebud Lodge did not have an activity plan in place for patients. Staff and patients told us one had not been developed following the move from Dartford to Leybourne.

Summary of findings

- At Rosebud Lodge there was limited access to outside activities due to the location. Although one patient had gained access to a day care programme, previously three patients had attended a day programme in Dartford. Other patients were unable to transfer their attendance to new programmes near to Leybourne as no additional provision for this existed.
- Due to the limited access to activities and transport links at Rosebud Lodge, staff were expected to drive patients to appointments and activities. During the inspection we witnessed that a member of staff was absent from the ward for three hours due to transporting a patient to an appointment. Patients told us that staff spent less time with them since the move to Leybourne.

Are services caring?

Good

We rated caring as **good** because:

- Patients were mostly positive about the care they received on the wards and found most of the staff approachable and caring. Patients had one to one sessions with staff, although this could be difficult when staff were busy.
- Staff were able to demonstrate in depth knowledge of the patients' care needs, including their individual care plans and recovery goals.
- The Grove had a registered 'Pets as Therapy Dog',. Patients told us that it gave The Grove a more homely feel and the patients enjoyed having the dog around.
- The staff at the Grove had recognised that patients were making use of the internet and social media as part of their ongoing recovery and maintenance of support networks and so supported them to make safe use of the internet and social networking sites.

Are services responsive to people's needs?

Requires improvement

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

- Some staff on Rosebud Lodge and Davidson unit told us that they did not feel comfortable raising concerns within the trust. They were concerned that the Green Button system, which logged concerns electronically, could be traced back to them.
- Food quality on Davidson unit was described as being very poor. We witnessed that food presented to patients was of poor quality and had an unpleasant texture. The PLACE survey rated the overall food score at St Martin's hospital site was 74%, the national average for mental health trusts is 89%.

Summary of findings

- Patients on Rosebud Lodge experienced deterioration in facilities and activities as a result of the ward move. Both staff and patients told us that some independent living skills had been lost or had deteriorated as a result of the move. Patients were no longer able to cook or shop for themselves due to a loss of facilities and ease of access to shops.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- Staff told us that they felt that the senior executive team did not understand what they were trying to achieve in delivering rehabilitation services and therefore, as a service, it was undervalued within the trust.
- Staff had limited understanding of the governance arrangements in place.
- Staff across all locations told us that they did not know the executive team and they were not visible.
- There was little evidence of sharing of best practice and learning across the rehabilitation services. All the wards appeared to work in isolation with little support offered across the service. Where good practice was evident in one ward it was not carried across the service into other wards. Management supervision was not provided consistently across all of the sites.
- Staff on Rosebud Lodge told us that since the move from Dartford and the loss of facilities for patients their had been a significant negative impact on morale.

Summary of findings

Background to the service

The rehabilitation wards for adults of working age provided by Kent and Medway NHS and Social Care Partnership Trust are part of the community recovery service

Rehabilitation and long stay wards are provided across the county in a variety of hospital settings in both urban and rural location.

Davidson unit is a 10 bed unit on the site of a Victorian hospital in Canterbury. It is one of only two wards still open on the site. It is a mixed gender ward.

Rosebud Centre, Leybourne is a 10 bed unit sited in an isolated rural location. It is a mixed gender facility. Rosebud Centre was previously known as Rosewood Lodge and has been temporarily re-located from the purpose built rehabilitation ward at Dartford. Patients from an acute ward at Dartford have been moved into this facility so that the trust can refurbish another acute ward on that site. We were advised by staff that the temporary re-location could last up to two years.

The Grove is a 10 bed unit in Ramsgate. It is a large Victorian house in a residential area. The Grove is a mixed gender unit.

Ethelbert Road is a 10 bed unit. It is based in a Victorian house in central Canterbury. Ethelbert Road is a mixed gender unit.

Rivendell is a 10 bed mixed gender adult inpatient unit for adults with complex mental health difficulties. It is unit is situated in the village of Eastry near Sandwich.

111 Tonbridge Road is a nine bed inpatient adult mental health rehabilitation unit. It is based in a Victorian house in Maidstone. 111 Tonbridge Road is a mixed gender unit.

Newhaven Lodge is an eight bedded house with a private garden set in the grounds of Medway Maritime Hospital.

At the time of the last inspections, all locations had met the essential standards inspected.

Our inspection team

The team that inspected the long stay/rehabilitation mental health wards consisted of eight people:

- an expert by experience
- two inspectors
- one inspection manager
- two nurses with experience in rehabilitation
- one rehabilitation consultant psychiatrist
- an NHS manager with experience of managing rehabilitation services

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

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

During the inspection visit, the inspection team:

- visited six of the rehabilitation wards across the county sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 29 patients who were using the service
- spoke with the managers for each of the wards
- spoke with 14 staff members including doctors, nurses, healthcare assistants, therapists, psychologists and social workers
- spoke with one relative
- interviewed the senior management team with responsibility for these services
- attended and observed one multi-disciplinary clinical meeting.

We also:

- looked at 24 treatment records of patients
- carried out a specific check of the medication management on three wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients were mostly positive about the staff on most of the wards, and said they were approachable and caring, treated them with respect, and were able to meet their needs. However, some of the patients at the Rosebud Centre told us that the staff did not spend enough time with them since the move from Dartford. Some patients told us that staff tried to prevent them leaving the building since the move to Leybourne as staff did not feel that it was safe for them to go out in the local area.
- Patients told us that they had one to one sessions with staff, but this didn't always happen as staff were often too busy.

Good practice

- The peer support workers initiative; the trust employed people who had experience of using mental health services and were seen as a positive addition to the wards, and helped reinforce the patients' perspective.
- The Grove included photographs of regular agency staff on their staff board to enable patients to recognise agency and permanent staff on duty.
- The Grove had a pro-active approach to supporting patients to access social media sites and the internet as part of their rehabilitation into the community.
- The MEWS charts reviewed demonstrated good practice and this was embedded into health monitoring for patients.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- The trust must ensure that following incidents the care plans for the patients are updated to describe how to prevent manage and de-escalate potential future incidents. The trust must ensure that learning from serious incidents is shared across the rehabilitation service and must support staff to understand and use lessons to improve services.
- The trust must ensure that ligature risk assessments are carried out as a matter of routine for all wards and appropriate steps are taken to reduce ligature points and manage ligature risk for all patients.

Summary of findings

- The provider must ensure it provides care in accordance with the Department of Health's same-sex accommodation requirements.
- The trust must ensure that the storage and recording of medication, including self-administration processes, is safe and secure and must ensure that staff follow its policies for the safe management and administration of medicines

Action the provider SHOULD take to improve

- The trust should ensure that patients at the Rosebud Centre have appropriate access to activities that support their recovery, including supporting them to go outside and visit local amenities safely.
- The trust needs to ensure that staff on all wards are following the self management of medicines policy.
- The trust needs to ensure that on Rivendell ward the fridge temeparature is within the recognised temperature range.

Kent and Medway NHS and Social Care Partnership Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Davidson Unit	St Martins Hospital
The Grove	The Grove
Rosebud Centre	Rosebud Centre
Ethelbert Road	Ethelbert Road
111 Tonbridge Road	111 Tonbridge Road
Rivendell	Rivendell
Newhaven Lodge	Medway Maritime Hospital

Mental Health Act responsibilities

The last MHA visit report was date 21/11/2014, the visit was on Davidson unit where we found:

- patients were unable to access independent mental health advocacy (IMHA) service regularly with irregular visits and insufficient information provided to patients
- insufficient evidence of copies of leave form/care plan given to patient or carer
- patient discussion of rights was not undertaken or explained or updated
- privacy, dignity and respect issues

- a lack of records about second opinion appointed doctor (SOAD) visits

During this inspection we found that patients had good access to the IMHA services and that there were leaflets and posters explaining the service available for patients.There was evidence that leave forms and care plans were being given to patients. There were still some privacy and dignity issues that had not addressed due to the layout of the ward and the location of the female bedrooms and bathroom.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy for the implementation of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Most staff had completed mandatory training on MCA and DoLS. The staff we spoke with had an understanding of some of the fundamental aspects of the Act, such as best interest and acting in the least restrictive way. Staff had less understanding of when DoLS applied, and when it should be used. There were no patients subject to DoLS at the time of our inspection.
- The implementation of the MCA and DoLS was monitored through the Mental Health Act office.

Inadequate

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

- Numerous ligature points were identified in all of the rehabilitation wards. Davidson unit did not have a copy of its ligature risk assessment. We were told that it had been completed but the staff member who had completed it was not on duty, so the assessment was not available.
- There were multiple ligature points at Newhaven Lodge which, we were told, were not an issue for the rehabilitation patients as the risk was managed well and all patients were low risk
- We were told that at the Grove, ligature management relied upon patients being assessed as stable and at low risk.
- The rehabilitation wards were regularly used to accommodate acute patients to 'sleep out'. Staff had little knowledge of risk assessments being carried out for these patients and so presented a potential significant risk.
- Rosebud Centre had been re-located from a purpose built rehabilitation ward set in an urban environment in Dartford to a rural environment in Leybourne. Patients told us that they felt unsafe walking to the shop and bus stop as there was no footpath or street lighting. There had been one incident when patient had got lost and had to be returned to the unit by the police.
- Davidson unit and Newhaven Lodge failed to comply with Department of Health requirements relating to same sex accommodation.
- The trust must ensure that the storage and recording of medication, including self-administration processes, is safe and secure and must ensure that staff follow its policies for the safe management and administration of medicines

Our findings

We rated Long stay/rehabilitation mental health wards as **requires improvement** because :

- Numerous ligature points were identified in all of the rehabilitation wards. Davidson unit did not have a copy of its ligature risk assessment. We were told that it had been completed but the staff member who had completed it was not on duty, so the assessment was not available. We were told that at the Grove, ligature management relied upon patients being assessed as stable and at low risk. Staff at Newhaven Lodge told us that all patients were low risk and had been assessed and plans in put in place to mitigate risks.
- The rehabilitation wards were regularly used to accommodate acute patients to 'sleep out' form acute ward when there was pressure on beds. Staff had little knowledge of risk assessments being carried out for these patients, there were no individual plans in place to manage the risk for these patients; this presented a potential significant risk. The trust told us that staff on acute ward undertook risk assessments and wouldn't allow high risk patients to 'sleep out' on rehabilitation wards.
- Rosebud Centre had been re-located from a purpose built rehabilitation ward set in an urban environment in Dartford to a rural environment in Leybourne. Patients told us that they felt unsafe walking to the shop and bus stop as there was no footpath or street lighting; the trust said it was addressing this with Malling Council. There had been one incident when patient had got lost and had to be returned to the unit by the police. Prior to the move the trust had undertaken a consultation and told us that the option to move the service had not been selected lightly but was required to make comprehensive improvements to a number of services, including the rehabilitation service. The consultation took into account patients, carers and staff concerns. The chief executive had visited the unit shortly after the move to review first hand how the service was adapting to its temporary environment. However, patients, carers and staff said that whilst they had expressed some concerns during the consultation the safety and unsuitability of the location had only been fully realised after the move. They said they felt their concerns had not been fully listened to.
- **Safe and clean ward environment**

Inadequate

Are services safe?

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- All ward areas we observed were clean. We reviewed some cleaning rotas which demonstrated planning and completion of cleaning tasks.
- All wards except Davidson unit had areas where staff could not observe all areas of the ward as there were poor lines of sight in parts. This was due to the nature of the buildings; the majority of the wards were in Victorian style housing. Most patients were assessed as low risk and not requiring constant observation. However, staff expressed concern that patients who were on temporary transfer from acute wards posed a higher level of risk and could not be observed easily in the wards.
- Davidson unit and Newhaven Lodge failed to comply with Department of Health requirements relating to same sex accommodation. This was made difficult because of the buildings in which the wards were located. For example, Davidson unit was in a hospital setting. It was a long, narrow ward with bedrooms set along a corridor separated by the nursing office. Female patients' bedrooms were along the main corridor which also provided access to the ward and the men's bedrooms were situated at the far end of the ward. Anyone entering or exiting the ward had to pass the female patients' bedrooms. There was a female only shower and toilet within the female corridor. Access to bathrooms for female patients on Davidson unit was along the corridor to the men's bedrooms. Whilst we acknowledged the limitations of the ward environment, we found that this arrangement risked compromising patients' dignity and respect. At Newhaven Lodge two bedrooms were on the ground floor, at the time of our inspection one woman was being cared for at the unit in a ground floor bedroom. To get to their bedroom they had to walk directly past a male patient's bedroom. The ground floor bathroom had been designated for female use only, but again they had to walk directly past the male bedroom to access this. The trust told us that it accepted that Davidson ward and Newhaven Lodge did not meet Department of Health guidelines but it had worked hard to manage the situation given the environments. A programme of upgrading facilities was planned but it was no yet known when this would be carried out.
- Staff and ward managers reported that temporary transfers from acute wards had a negative impact on the safety of the rehabilitation wards. Temporary patients often had more complex needs, required a different type of intense care and therefore had a negative impact on patients receiving rehabilitation care. The temporary transfer of acute patients was a regular occurrence and therefore much time was taken cleaning and preparing bedrooms to accommodate them which meant staff had less time to engage with and undertake activities with rehabilitation patients.
- All the wards had equipment and medication for use in the event of a medical or psychiatric emergency. Most of the wards regularly checked the equipment, and ensured it was accessible and in working condition.
- There were no seclusion rooms on the wards.
- All furnishings were clean and in good repair.
- On Davidson unit all patients, apart from those temporarily transferred, had a thorough risk assessment prior to admission, temporary transfers had a less detailed risk assessment and in some areas staff had little knowledge of any risk assessments for these patients.
- There was limited evidence of incidents being reviewed or staff learning lessons from incidents to prevent them happening again. Some incidents were recorded on the appropriate system; however there was limited evidence of care plans and risk assessments being updated following incidents. Newhaven Lodge did not have access to the Datix system and kept a handwritten log. Although a copy of this was provided to the service manager periodically incidents were not automatically fed through to central governance systems. The manager reported that this had been identified as an issue, and Datix was in the process of being ordered and would be connected 'soon'. Thirteen incidents had been recorded on the log in last 12 months which is lower than would be expected in this type of service.
- Not all staff expressed confidence in incident reporting and the team meeting minutes dated 19/1/2015 for Davidson unit identified that incident reporting was considered to be low and staff had been reminded to complete incident reports, update risk assessments and care plans as required following incidents.
- The same meeting minutes detailed a discussion about medicines being stored under the wrong patient names; this had not been logged as an incident. Again, staff had to be reminded to be more vigilant and check that medicines were being stored and logged appropriately.
- Risk assessments had not been completed for patients at Rosebud Lodge since the transfer from Dartford, a month before the inspection.

Inadequate

Are services safe?

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

- Medication management was a concern in Ethelbert Road, self-medication procedures were not evidenced and medication such as clozaril was seen left unattended in an unlocked patient's room.

Safe staffing

- Staffing levels had become a concern at Rosebud Lodge since the transfer from Dartford; there were issues for staff travelling to Leybourne and covering shifts with agency workers was not always possible. We were told that on one weekend recently the shift had been staffed by a student nurse and a staff nurse. The student and the staff nurse had been expected to cook lunch for all of the residents in addition to meeting all of the care needs of the patients. This was not corroborated at the time of the inspection
- Staff told us that they had vacancies at band five level for two years. This was having an impact on staff morale as staff felt under pressure to cover the shifts.
- Staff told us that they are experiencing pressure to cover shifts, except at Newhaven Lodge. We saw evidence on one rota of a member staff having worked 13 out of the last 14 days. For the three months prior to 31/10/2014 Rosewood Lodge, (now Rosebud Centre) had failed to fully staff 10 shifts, the two shifts at the Grove two shifts and 14 shifts at Tonbridge Road.
- For the three months prior to 31/10/2014 Rosewood Lodge (now Rosebud Centre) had covered 164 shifts with agency or bank staff, the Grove 132 shifts and Tonbridge Road 108 shifts.
- Shift gaps were filled by bank and agency staff, which were used regularly on all the wards. Staff told us they tried to book agency staff who were familiar with the ward, but this was not always possible.
- All the ward managers told us they were able to vary their staffing levels depending on the needs of patients on the ward. At Newhaven Lodge two peer support workers (staff who had experience of using services) had recently been appointed. This was seen by staff and patients as innovative. Staff and patients said that leave and activities usually went ahead, but there were some occasions when these were cancelled.

Assessing and managing risks to patients and staff

- All wards used a standard risk assessment tool that was recorded on the RIO (the electronic records system). Patients had a risk assessment carried out when they were admitted to the service. However, the risk assessments were not always reviewed, or updated following incidents or changes in risk behaviour. The risks identified were not always included in their care plan, and it was not always clear what action staff should take to manage risk.
- The trust had policies on the management of violence and aggressive behaviour, and the use of de-escalation and restraint. Most staff were trained in techniques to use physical restraint safely. Restraint had not been used on any of the wards we visited. Staff and patients told us that de-escalation methods were adopted to remove the need for restraint.
- The trust had safeguarding policies that were accessible to staff. Staff had completed safeguarding training, and knew which concerns could be considered as safeguarding concern and how to make a referral. There was confusion on Davidson unit regarding how a safeguarding referral would and could be made. We were advised that health care assistants (HCAs) did not make safeguarding referrals and that only registered staff made referrals.
- Patients who were not detained under the Mental Health Act told us that they understood their rights and could leave the ward whenever they chose to.
- Rapid tranquilisation was not in use on any of the wards visited.
- There were no seclusion rooms on any of the wards visited.
- On Tonbridge ward care plans were not being completed for patients managing their own medication. There was a trust policy which included the need for a care planned approach for self-management of medicines; the policy was not being followed.
- One patient on Tonbridge ward was storing medication in his room which was left unlocked and therefore posed a risk as any patients could access the room and take the medication. This was discussed with the manager who stated that they were in the process of getting keys for lockers to enable the safe storage of medication.
- On further investigation it was found that this patient had no care plan for self-medicating, no updated risk assessment of the information needed to effectively manage self-medicating and there were no up to date care plans or risk assessments in the paper notes. The registered nurse on duty told us that up to date paper

Inadequate

Are services safe?

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

care plans and risk assessments were kept in the notes in case the RIO system dropped out. None of the steps of the self-medication policy was evident in files; the ward was not following the trust policies

- Prescription charts were not always signed, on Tonbridge ward we saw one example of a gap in a patient's record of 30 days, this included prescriptions of insulin.
- The medication fridge temperatures on most of the wards were within the acceptable range (2-8 degrees Celsius), and were checked regularly. However, on Rivendell ward the fridge was logged as being at 11 degrees Celsius for a month. There was no evidence that this had been logged as an incident, or that any action was taken to remedy this. Staff told us that the manager had purchased an additional thermometer to check the accuracy of the readings.

Reporting incidents and learning from when things go wrong

- The trust had policies for the reporting and management of incidents. The trust currently had a paper-based incident reporting system. The paper forms were completed by staff, and reviewed and approved by the ward and service managers. The forms were then sent to a central team for review. The trust collated this information but not all staff knew what happened to this information. We did not see any analysis of themes or trends. For example, if there were specific times of day or areas of a ward where repeated incidents tended to occur. Staff told us that the paper-based system was due to be replaced by an electronic system in April 2015, which they thought would make the process quicker and easier to audit.
- Due to a combination of paper and electronic record keeping it was not always easy to view the most up to date risk assessments or care plans. Staff had to move between systems to gain a full picture risks and care needs.
- There were gaps in the recording of incidents on RIO. For example, on Davidson unit we saw one incident logged in the paper incident report but not logged in RIO.
- On Davidson unit we were told about a patient who had been hiding medication behind a radiator cover. This was not reported as an incident. However, we saw that staff were reminded in a team meeting to be more vigilant when administering medication.
- There was limited evidence of lessons learned exercises being completed or any learning from incidents being disseminated to staff teams. Risk assessments were not updated on RIO following incidents.
- Staff across the wards told us that they did not know what happened once they had submitted an incident report.
- Staff told us that they used the reflective practice sessions to discuss and learn from any incidents that happened on the wards
- None of the wards we visited had experienced any serious incidents in the last year.

Are services effective?

Requires improvement

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

Summary of findings

- The Recovery Star, a tool used to improve individual recovery planning, was in place at all sites but was only embedded in care planning in three locations. At Newhaven Lodge the peer support worker had really promoted this with patients and staff and felt it was meaningful, recovery focused and underpinned the rehabilitation process with short and longer term goals.
- Rosebud Centre did not have an activity plan in place for patients. Staff and patients told us one had not been developed following the move from Dartford to Leybourne.
- At Rosebud Centre there was limited access to outside activities due to the location. Although one patient had gained access to a day care programme, previously three patients had attended a day programme in Dartford. Other patients were unable to transfer their attendance to new programmes near to Leybourne as no additional provision for this existed.
- Due to the limited access to activities and transport links at Rosebud Centre, staff were expected to drive patients to appointments and activities. During the inspection we witnessed that a member of staff was absent from the ward for three hours due to transporting a patient to an appointment. Patients told us that staff spent less time with them since the move to Leybourne.

Our findings

We rated Long stay/rehabilitation wards as **requires improvement** because:

- Rosebud Centre did not have an activity plan in place for patients. Staff and patients told us one had not been developed following the move from Dartford to Leybourne.
- At Rosebud Centre there was limited access to outside activities due to the location. Although one patient had gained access to a day care programme, previously three patients had attended a day programme in Dartford. Other patients were unable to transfer their attendance to new programmes near to Leybourne as no additional provision for this existed.
- Due to the limited access to activities and transport links at Rosebud Centre, staff were expected to drive patients to appointments and activities. During the inspection we witnessed that a member of staff was absent from the ward for three hours due to transporting a patient to an appointment. Patients told us that staff spent less time with them since the move to Leybourne.
- At Newhaven Lodge the peer support worker had really promoted the Recovery Star with patients and staff and felt it was meaningful, recovery focused and underpinned the rehabilitation process with short and longer term goals. There was good access to activity programmes and patients told us that these were very rarely cancelled, even if there were shortages of staff. Patients also commented that there was support to develop daily living skills such as planning, shopping and cooking meals. They also felt there was an emphasis on getting people into the community to engage with community based services, for example, swimming and socialising.

Assessment of needs and planning of care

- We reviewed 24 care records across the six wards, all care records demonstrated that an assessment was completed at the time of admission, the majority of records also demonstrated that a risk assessment was completed on admission.
- MEWS charts were being used appropriately to monitor physical health care needs.
- Multidisciplinary team meetings (MDTs) occurred weekly and were attended by a range of mental health professionals including psychiatrists, psychologists, OT's, ward staff and the patient.

Best practice in treatment and care

- Due to a combination of paper and electronic record keeping it was not always easy to view the most up to date risk assessments or care plans. Staff had to move between systems to gain a full picture risks and care needs.

Are services effective?

Requires improvement

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

- The majority of patients told us that they felt involved in their care planning and that they had received a copy of their care plan.
- Care plans reviewed demonstrated that patients had been involved in the discussions and there was evidence of effective discharge planning, involving both patients and carers, where appropriate.
- There was evidence of positive risk taking in care plans. Patients were supported to achieve their goals even when this was a cause for concern for their family members. The Grove described a patient who had chosen to be discharged to her own flat despite a history of experiencing debilitating flashbacks; her family considered this to be a high risk strategy. Following a multidisciplinary discussion and agreement on management involving staff, care co-ordinator, occupational therapist (OT) and psychologist the patient was successfully discharged to her own independent accommodation.
- When reviewing medicine cards we identified that one patient that was self-medicating and given each days supply of medication (clozapine) at the beginning of the day by staff. There were 27 unsigned entries in this medication chart.
- One note showed that self-management of medication was care planned but there was no mention of where this medication should be kept. One patient was given three days' worth of medication but there was no evidence of checking this to ensure that it was being taken.

Best practice in treatment and care

- There was access to dialectical behaviour therapy (DBT) and mindfulness across all of the wards.
- Patients were supported to access dental and health care services as required. One patient on Rosebud Centre was being supported by staff to complete dental treatment which meant staff had to transport them across the county to visit their own dentist who was based in Dartford. the patient would normally go independently but could not as a result of the re-location. Staff told us that this was putting pressure on the team to adequately staff the service.
- The rehabilitation service were using the health of the nation outcome scales (HoNOS) to record severity and outcomes for patients.
- On Davidson unit there were no hard copies of MHA forms in patient notes. Records were not in the correct section of RIO. Eight files were reviewed. Two had up to date MHA paperwork. Of the 6 not up to date one was documented on RIO as having been completed but was not present in the notes.
- Staff and patients told us that Rosebud Centre was not fit to meet the rehabilitation needs of the patients; prior to the move patients were shopping and cooking independently. Since the transfer patients were not able to shop or cook due to isolation and limited facilities to store and cook food for themselves.
- Three of eight patient records on Rosebud Centre did not have mental capacity forms on RIO.

Skilled staff to deliver care

- Management supervision files were up to date in some wards but not all; we saw from the supervision records that a member of staff on Tonbridge ward had not had supervision since commencing their employment in July 2014. All management supervision files were up to date at the Grove. On Rosebud Centre we were told that supervisions had occurred but the notes hadn't been written up.
- 100% of staff on all rehabilitation wards had received their annual appraisal.
- Mandatory training was at an average completion rate of 90% across all the wards.
- Staff and managers told us that poor performance was addressed and where necessary disciplinary processes were utilised to improve performance. Managers told us that they felt supported by their line managers to performance manage staff as required.

Multi-disciplinary and interagency team work

- There was evidence of multidisciplinary admission and discharge planning; patients were able to attend their reviews. At the Grove patients were asked who they wanted to attend their reviews as the staff recognised that a meeting of professionals could be daunting for patients. The multidisciplinary team included an OT,

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psychologist, ward manager and care co-ordinator, consultant and ward manager, IMHA. The multidisciplinary team meetings at Newhaven Lodge were attended, on a weekly basis, by representatives from acute ward and crisis team.

- Staff on all wards told us that they experienced difficulties in engaging with care co-ordinators and that care co-ordinators often did not attend care planning approach meetings (CPA's). The Grove had adopted a system of scheduling meetings at six weekly intervals to ensure that identified goals were achieved, this was felt to be a positive approach to enable effective discharge planning.
- Positive ideas and good practice were not shared across the rehabilitation wards, all wards complained about the difficulties accessing care co-ordinators, The Grove had identified a strategy for improved interaction but this had not been rolled out across all rehabilitation wards.
- The Grove staff have developed close working relationships with the local safeguarding team and liaised with them to support patients to safely access social media and internet dating sites as part of their discharge planning process. Two out of eight patients at The Grove did not have MHA consent to treatment forms in either their care folder or in the RIO subsection. All MHA paperwork for detained patients at The Grove was present in care folders and on RIO. Staff at Newhaven Lodge had a good understanding of the MHA and there as evidence that all patients had their right explained to them on a regular basis. Staff knew who advocates where, when they visited (each week) and how to contact them.

Good

Are services caring?

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

Summary of findings

- Patients were mostly positive about the care they received on the wards and found most of the staff approachable and caring. Patients had one to one sessions with staff, although this could be difficult when staff were busy.
- Staff were able to demonstrate in depth knowledge of the patients' care needs, including their individual care plans and recovery goals.
- The Grove had a registered 'pets as therapy dog',. Patients told us that it gave the Grove a more homely feel and the patients enjoyed having the dog around.
- The staff at the Grove had recognised that patients were making use of the internet and social media as part of their on-going recovery and maintenance of support networks and so supported them to make safe use of the internet and social networking sites.

Our findings

We rated caring as **good** because:

- Patients were mostly positive about the care they received on the wards and found most of the staff approachable and caring. Patients had one to one sessions with staff, although this could be difficult when staff were busy. Patients' relatives were involved in their care where appropriate. There were community meetings on most of the wards.
- Staff were able to demonstrate in depth knowledge of the patients' care needs, including their individual care plans and recovery goals. All patients were assessed prior to admission and encouraged to visit prior to admission.
- The Grove had a registered 'pets as therapy dog', who was around during the inspection interacting with patients. Patients told us that it gave The Grove a more homely feel and the patients enjoyed having the dog around.
- The staff at the Grove had recognised that patients were making use of the internet and social media as part of their on-going recovery and maintenance of support networks .and so supported them to make safe use of the internet and social networking sites. Advice and support was sought from the local safeguarding team to assist with this.

Kindness, dignity, respect and support

- There was evidence of IMCA activity across all locations and details of the IMCA name and contact details were displayed on patient noticeboards.
- We observed positive interactions between patients and staff on all of the wards. We witnessed patients and staff joking with each other and engaging in conversation about television programmes and current affairs.
- Patients consistently told us that staff respected their privacy, treated them with respect, and knocked on bedroom doors before entering the room.
- Patients had access to advocacy services.
- We saw positive interactions between staff and patients when on most of the wards. We observed some positive interactions in the Grove and Davidson ward. At the Grove an activity was in progress during the inspection visit and there was laughter and positive interaction between patients and between patients and staff. Patients at the Grove told us that they felt the activity programme was positive and that staff listened to their views.

The involvement of people in the care they receive

- All patients were assessed prior to admission and encouraged to visit prior to admission where possible, patients we spoke to told us that they had been shown around before being admitted to the ward. Patients told us that they had been given leaflets in an information pack which helped them to learn about the routines of the ward.
- Patients told us that they were involved in their care planning and had the option to have a copy of it if they want it.
- Where appropriate carers were involved in CPA's and discharge planning processes.
- There was evidence of positive risk taking in care plans. Patients were supported to achieve their goals, even when this was a cause for concern for their family members. The Grove described a patient who had chosen to be discharged to her own flat despite a history of experiencing debilitating flashbacks, her family considered this to be a high risk strategy.

Good

Are services caring?

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

Following a multidisciplinary approach involving staff, care co-ordinator, OT and psychologist the patient was successfully discharged to her own independent accommodation.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

We rates responsive as requires improvement because;

- Some staff on Rosebud Centre and Davidson ward told us that they did not feel comfortable raising concerns within the trust. They were concerned that the green button system, which logged concerns electronically, could be traced back to them.
- Food quality on Davidson ward was described as being very poor. We witnessed that food presented to patients was of poor quality and had an unpleasant texture. The PLACE survey rated the overall food score at St Martin's hospital site was 74%, the national average for mental health trusts is 89%.
- Patients on Rosebud Centre experienced deterioration in facilities and activities as a result of the ward move. Both staff and patients told us that some independent living skills had been lost or had deteriorated as a result of the move. Patients were no longer able to cook or shop for themselves due to a loss of facilities and ease of access to shops.

Our findings

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Access, discharge and bed management

- Average bed occupancy was 93.3%, all wards had a bed occupancy of more than 85%.

The ward optimises recovery, comfort and dignity

- Patients told us that they did not have private space to make or receive phone calls or receive visitors. There was no dedicated visitor meeting space in any of the wards. There were rooms that could be used, but other patients could access them during a visit if they wished.
- Activity programmes were limited at weekends on all wards, staff told us this was to improve independence and enable patients to develop their interests and activities. Patients told us that they often feel bored on weekends
- Rosebud Centre is set over two floors, there was a lift to transfer patients with disabilities between floors, staff advised us that this regularly broke down. During the inspection visit an engineer was called out to repair the lift, but it was not repaired during our visit. The ground floor facilities did not include a bathroom, therefore without a lift the disabled patient whose bedroom was on the ground floor could not have a bath or shower.

Meeting the needs of all people who use the service

- There was access to interpreting services and a choice of food for people with special dietary requirements. The Grove had accessed halal food and appropriate pots and pans for a patient within three hours of their admission to the unit. The same patient had also been given money to purchase Halal appropriate food as it was recognised that this could be more expensive than non-halal foods**.**
- Tonbridge Road and Davidson ward locked their kitchens at night so drinks were not freely available 24 hours a day.
- Patients told us that they could access spiritual support appropriate to their needs if they wished to.

Listening to and learning from concerns and complaints

- There were posters and information leaflets which included how to complain, how to access advocacy and local facilities and support services.
- The majority of patients told us that they had never been asked for feedback on the care they received. No

Are services responsive to people's needs?

Requires improvement

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

patients could recall being asked to take part in a patient survey. The majority of patients did not know how to make a complaint, although most felt that they could talk to a member of staff if they had concerns.

- We saw a complaint written to the manager of Rivendell ward, the manager addressed the concerns that the patient had raised and outlined the actions that would be taken as a result of the complaint being investigated.

Are services well-led?

Requires improvement

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

We rated well-led as **requires improvement** because:

- Staff told us that they felt that the senior executive team did not understand what they were trying to achieve in delivering rehabilitation services and therefore, as a service, it was undervalued within the trust.
- Staff across all locations told us that they did not know the executive team and they were not visible.
- Staff had limited understanding of the governance arrangements in place.
- There was little evidence of sharing of best practice and learning across the rehabilitation services. All the wards appeared to work in isolation with little support offered across the service. Where good practice was evident in one ward it was not carried across the service into other wards. Management supervision was not provided consistently across all of the sites.
- Staff on Rosebud Centre told us that since the move from Dartford and the loss of facilities for patients their had been a significant negative impact on morale.

Our findings

We rated well-led as **requires improvement** because:

- There was little evidence of sharing of best practice and learning across the rehabilitation services. All the wards appeared to work in isolation with little support offered across the service. Where good practice was evident in one ward it was not carried across the service into other wards. For example, the Grove was working pro-actively to support patients to safely access the internet and social media, but this is not being shared across the service.
- Staff told us that they felt that the senior executive team did not understand what they were trying to achieve in delivering rehabilitation services and therefore, as a service, it was undervalued within the trust when asked if staff knew what the 'clinical cabinet' was we were told it was in the clinical room. Staff across all locations told us that they did not know the executive team and they were not visible.
- Management supervision was not provided consistently across all of the sites.
- Staff on Rosebud Centre told us that since the move from Dartford and the loss of facilities for patients their had been a significant negative impact on morale.

Vision and values

- Staff told us that they received good support from their individual ward managers but that they did not have contact with senior managers**.**

Good Governance

- The monitoring processes had not identified gaps and problems in the services. For example: there were gaps in updating risks assessments and care plans; we found fridge temperature monitoring to be ineffective as out of range temperatures were not addressed.
- There was limited learning evident from incidents, feedback and complaints. We did not see evidence of lessons learned exercises being carried out at a local level. Staff told us that they entered incidents onto the systems but they did not know what happened to it after they had entered the detail.
- Ward managers told us that they felt that they had sufficient authority to fulfil their roles, five out of six managers told us that they felt they had positive line management support.
- Managers at all sites demonstrated a detailed knowledge of their units and the needs of their patients and staff teams.

Leadership, morale and staff engagement

- Staff told us that the inability to fill vacancies had an impact on staff morale, some staff told us that they felt under pressure to cover shifts.
- The manager on Rosebud Centre told us that staff morale had been low since the move from Dartford. The example given by staff that was supported by rotas we saw; staff were working long hours with one member of staff who had worked 13 days in a row without a day off. The manager identified that there was often difficulty in covering shifts and was finding it difficult to cover the next day's shift.
- Some Rosebud Centre and Davidson ward staff told us that they did not feel comfortable raising concerns within the trust. They were concerned that the green button system, which logged concerns electronically,

Are services well-led?

Requires improvement

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.

could be traced back to them. However, staff at Newhaven Lodge felt that they could raise concerns and that these would be acted upon in a timely manner. Morale was good and staff felt they had been engaged in the development of the service.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises We found that Kent and Medway NHS and Social Care Partnership Trust had not ensured that service users were protected against the risk associated with unsafe or unsuitable premises. Same sex accommodation did not meet the requirements of the Department of Health requirements on Davidson ward and Newhaven Lodge Ligature risk management did not manage risks for all patients This is a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Premises and equipment This corresponds to Regulation 15 HSCA (Regulated Activities) Regulations 2014 premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not have effective operations to regularly assess and monitor quality of the services and identify, assess and manage risks. The provider had not protected people at risk of inappropriate or unsafe care. There was not an effective system to ensure that all staff were aware of when and how to report incidents and how to ensure incidents were minimised in the future. Systems for learning from incidents were ineffective.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not take measures to ensure that service users were protected against the risks associated with the unsafe use and management of medicines. The provider had not protected people against the risks associated with the unsafe use and management of medicines. Staff were not following the trust policies and procedure in the storage, and recording of medication, including self-medication. This is a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines This corresponds to Regulation 12 (Regulated Activities) Regulation 2014 Safe care and treatment
	This is a breach of Regulation 10 HSCA 2008 (Regulated Activities)Regulations 2010 Assessing and monitoring the quality of service providers This corresponds to Regulation 12 (Regulated Activities) Regulations 2014 Safe care and treatment