

Requires improvement

South West Yorkshire Partnership NHS Foundation
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)
RXG36	Enfield Down	Enfield Down	HD9 6LL
RXG36	Lyndhurst	Lyndhurst	HX5 0QX

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



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

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Information about the service	8
Our inspection team	8
Why we carried out this inspection	8
How we carried out this inspection	8
What people who use the provider's services say	9
Areas for improvement	9

Detailed findings from this inspection

Locations inspected	10
Mental Health Act responsibilities	10
Mental Capacity Act and Deprivation of Liberty Safeguards	10
Findings by our five questions	12
Action we have told the provider to take	21

Summary of findings

Overall summary

We rated long stay/rehabilitation mental health wards for working age adults as requires improvement because:

- Staff at Enfield Down did not review the risk assessments that they had undertaken and did not update these to reflect changes in risks associated with changes in patient presentation. This placed patients at risk of harm from incorrect information being held about them, and their current risks not being managed effectively.
- Staff at Enfield Down did not always follow national guidelines and best practice with regards to medicines management. They did not review PRN medication (medication when required) regularly.
- Staff at Enfield Down had prescribed high dose antipsychotic medication for two patients but had not undertaken regular electrocardiograms; despite one patient being at high risk of cardiac problems. This meant patients on high dose antipsychotics where at risk of physical health complications because they were not being monitored appropriately.
- Staff at Enfield Down, did not hold regular multidisciplinary meetings to discuss the care of patients. The service held Care Programme Approach meetings on a three to six monthly basis and this would be when patients would be fully reviewed. This meant that staff might not meet the needs of patients in a timely and efficient manner.

- The services within the trust were led by a team of three senior clinicians. Within the rehab service the governance lead post was vacant and was out to advertisement. At Enfield Down, governance processes had failed to identify that there were insufficient monitoring of patients on high dose antipsychotic medication, that patients were not being reviewed in a timely manner, and that risk assessments were not being reviewed or updated as required.

However

- The average mandatory training rate for the whole service was 93% with both units achieving above the trust standard of 85%.
- Care plans were developed in collaboration with the patients, were holistic and covered a range of areas such as mental health, physical health, drug and alcohol issues and social issues. The occupational therapist also contributed to the care plans demonstrating a multidisciplinary approach.
- We saw interaction between staff and patients that was respectful, thoughtful, considerate, timely, and professional. Patients we spoke to told us that staff members were professional at all times. Staff members were praised by patients for being approachable, caring and always making time to talk.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- staff were not regularly reviewing or updating risk assessments following changes in presentation or as risk changed (risk assessments tools allow staff to assess, record and manage risks to patients). This placed patients at risk of harm from incorrect information being held about them, and their current risks not being managed effectively.
- Staff did not follow national guidelines and best practice in medicine management. PRN (medication when required) had not been reviewed regularly.
- The clinic room at one unit was small and did not allow for physical examinations of patients to take place.

However

- Nursing rotas at both units indicated that the minimum number of nurses required was met, and was amended dependent upon the needs of the unit.
- The average mandatory training rate for the whole service was 93% with both units achieving above the trust standard of 85%.
- Staff had a good understanding of safeguarding and were able to explain the safeguarding procedure to us.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

- We found two patients were prescribed high dose antipsychotic medication, but had not received regular electrocardiograms despite one patient being at high risk of cardiac problems. This meant patients on high dose antipsychotics were at risk of physical health complications because they were not being monitored appropriately.
- Patients did not have regular multidisciplinary meetings. The service held Care Programme Approach (CPA) meetings on a three to six monthly basis and this would be when patients would be fully reviewed. This meant patient's needs could not be met in a timely and efficient manner.
- Training in the Mental Health Act (MHA) and Mental Capacity Act was not mandatory at the trust. This meant that some staff were not adequately trained to provide effective care
- There were errors on six of the seven T2 (consent to treatment) certificates at one unit where prescribed medication had been missed off.

Requires improvement



Summary of findings

However

- Care plans were developed in collaboration with the patients, were holistic and covered a range of areas such as mental health, physical health, drug and alcohol issues and social issues.

There was a range of recovery focused activity and psychological therapies available on the wards.

Are services caring?

We rated caring as good because:

- We saw interaction between staff and patients that was respectful, thoughtful, considerate, timely, and professional.
- Patients we spoke with told us that staff were professional at all times. Staff were praised by patients for being approachable, caring and always making time to talk.
- The staff we spoke with during the inspection all knew the patients very well. They were aware of their care plans and their individual needs.
- Patients were assessed prior to being accepted to the service and were able to visit where appropriate to have a look around and meet some of the staff.
- Patients' families and carers were encouraged to engage in their care. This included attending meetings and reviews at the request of the patient. When family and carers attended they were given the chance to express their views.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- Patients going out on leave had access to a bed on their return.
- There was an acute unit available within the trust if a patient required more intensive nursing care.
- There were no out of area placements attributed to the service in the six months prior to the inspection.
- Patients average length of stay before discharge was within the national average
- There was a full range of rooms and equipment on the ward to support treatment and care.
- All patients at the time of our visit had their own mobile phones and could use these in the privacy of their own room.
- There was a wide range of activities available seven days a week during the day and evenings.
- Information leaflets were available in different languages on request.

Good



Summary of findings

- Staff showed knowledge of the complaints policy, explaining informal and formal ways to process complaints.

Are services well-led?

We rated well-led as requires improvement because:

- Governance structures were only partially in place. The Governance lead post was vacant and was currently being advertised.
- Governance processes had failed to identify that there were insufficient monitoring of patients on high dose antipsychotic medication, that patients were not being reviewed in a timely manner, and that risk assessments were not being reviewed and updated.
- Mental Health Act, Mental Capacity Act training did not form part of the trust mandatory training system, and not all staff were aware of changes to the code of practice.
- Staff remained unclear about the future of the services due to transformation that had been ongoing for two years.

However:

- At ward level all staff we spoke with told us that they felt supported by the clinical leadership team on the ward. They told us that they would never feel worried to approach them and voice any concerns. They told us they felt listened to and their opinions were all important. They felt they were encouraged to give their opinions in meetings and handovers about patient care and that these opinions were taken into account.
- The ward manager had sufficient authority to run the ward and was able to increase staffing numbers should this be required.

Requires improvement



Summary of findings

Information about the service

South West Yorkshire Partnership Foundation Trust has two long term and rehabilitation mental health ward for adults of working age.

Enfield Down Unit is a 31 bed rehabilitation service. It is commissioned by Kirklees Clinical Commissioning Group. Lyndhurst unit is a 14 bed rehabilitation service and is commissioned by Calderdale Clinical Commissioning Group. Both services are for male and female patients, some of whom are detained for treatment under the

Mental Health Act (1983). Both services provide care, treatment and rehabilitation following an acute phase of their illness. It offers a socially inclusive approach to recovery and a return to independent or supported living.

We have inspected the South West Yorkshire Partnership Foundation Trust seven times at four locations since registration. We had not previously inspected these two units.

Our inspection team

The team was led by:

Chair: Dr Peter Jarrett

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team leaders: Chris Watson, inspection manager (mental health), Care Quality Commission and Berry Rose, inspection manager (community health), Care Quality Commission

The team that inspected this core service comprised: a CQC inspector, a Mental Health Act reviewer and two specialist advisors a nurse and a psychiatrist who specialises in rehabilitation in mental health.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- Visited the two wards.
- Spoke with 10 patients who were using the service and spoke with one carer.
- Spoke with the ward managers.

Summary of findings

- Spoke with 16 other staff members; including doctors, nurses, occupational therapist, and clinical lead.
- Attended two Care Programme Approach meetings.
- Looked at 22 treatment records of patients.
- Looked at 17 medication charts.
- Looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

All patients told us that they felt safe on the ward. Patients were given the opportunity to give feedback on the service they received prior to our inspection via comment cards left at the ward. We did not receive any comment cards back from this service.

Patients told us that they were able to voice any concerns they had to the staff and at daily community meetings. Staff listened to their concerns and changes had been made following the meetings. For example there were

concerns raised due to the recent smoking ban within the trust. This was discussed with all the patients and a plan developed to manage the situation and provide access to smoking cessation support.

Patients told us they enjoyed the activities available to them on the ward. They did not report any leave being cancelled due to shortages of staff and felt they got out of the ward with staff on a regular basis to their local communities.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that risk assessments are completed on admission and updated at regular intervals in addition to being updated following incidents and changes in presentation.
- The trust must ensure that patients who are prescribed high dose antipsychotic medication are subject to physical health monitoring including electrocardiograms in line with national guidance.
- The trust must ensure that patients have regular multidisciplinary review meetings to ensure timely and appropriate review of care and treatment.

- The trust must ensure that appropriate leadership is in place to ensure that governance structures in place to monitor and improve the service.
- The trust must ensure that request for second opinion doctors are made in a timely manner.
- The trust must ensure T2 certificates are completed accurately and reviewed for errors.
- The trust must ensure all staff receive training in the MHA and MCA.

Action the provider **SHOULD** take to improve

- Ensure there is adequate space in the clinic room to carry out physical health examinations and care.

South West Yorkshire Partnership NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Enfield Down	Enfield Down
Lyndhurst	Lyndhurst

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.

Mental Health Act (MHA) training did not form part of the trust mandatory training system. However the service had begun to roll out training in MHA but not all had completed the training. Not all staff were aware of the changes to the code of practice.

Capacity and consent to treatment was clearly recorded in all patient records. We found Not all T2 certificates were completed correctly and some prescribed medication was not listed. There was a failure by the service to request second opinion doctors in a timely manner.

Independent Mental Health Advocates (IMHA) were available. All patients we spoke with confirmed that they knew how to contact the IMHA should they require advocacy support.

MHA paperwork was scrutinised by a senior practitioner (band 6) on admission and there was a central MHA administration team for support.

Patient records demonstrated attempts to provide patients with information on their legal status and rights under the MHA. Capacity to consent to treatment was recorded in care records.

There were clear records of leave with care plans incorporating contingency and crisis plans.

Detailed findings

The service worked in the least restrictive manner and there were no blanket restrictions in place All staff were trained and competent in managing difficult patient behaviour, including de-escalation techniques as well as physical restraint.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act (MCA) training did not form part of the trust mandatory training system. However the service had begun to roll out training in MCA but not all staff had completed the training. Not all staff were aware of the changes to the code of practice.

There were no deprivation of liberty safeguarding applications in the 12 months leading up to inspection.

Are services safe?

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

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

Our findings

Safe and clean environment

Enfield Down and Lyndhurst units provided a clean and spacious environment for patients. This included photographs on notice boards of the local area. Cleaning records were up to date and completed regularly. There was access to an outdoor area which was open for patients to use at all times. There smaller lounges on all floors which patients could utilise for activities, 1-1s with staff (where patients meet individually with a named member of staff to discuss their care and treatment) or just generally time alone.

The units both had an up to date ligature risk assessment completed annually by the ward manager. Ligature risks were highlighted and plans were in place to mitigate these risks via observations and admission criteria.

The unit layouts did not allow staff to observe all parts of the ward. This was mitigated by the use of observations by staff being placed upstairs and downstairs, which was effective in managing this risk.

The clinic room at Enfield Down was small and did not allow for physical examinations of patients to take place. However, the trust told us that plans had been submitted by the Unit for a larger clinic room and they were awaiting capital expenditure approval. In the meantime, physical examinations of patients took place on the Unit in their bedrooms. At Lyndhurst the clinic room was adequate size and allowed for patient examination. At both services emergency resuscitation equipment was accessible to staff including an automated external defibrillator. The clinic rooms contained emergency medication that was checked on a regular basis.

There were no seclusion room facilities on the unit and seclusion was not used. If a patient became unwell they were transferred to one of the acute mental health wards within the trust or a psychiatric intensive care facility.

Handwashing facilities were available throughout the ward. Staff were observed to wash their hands at appropriate times for example after giving out medication.

Both units complied with same-sex Guidance (Department of health, 2000) with segregated sleeping areas and separate lounges for men and women. Toilet arrangements also met the required standard.

Safe staffing

The trust provided us with the following information about staffing levels on Long stay/rehabilitation mental health wards for working age adults:

For Enfield Down Unit

Establishment levels: qualified nurses 19 whole time equivalents (WTE). There were two vacancies.

Establishment levels: nursing assistants 21 WTE. There were two vacancies.

Staff sickness rate in 12 month period - 9%.

Staff turnover rate in 12 month period - two.

For Lyndhurst Unit

Establishment levels: qualified nurses eight WTE. There was one part time vacancy.

Establishment levels: nursing assistants eight WTE. There were no vacancies.

Staff sickness rate in 12 month period - 8%.

Staff turnover rate in 12 month period - two.

Nursing rotas at both units indicated that the minimum number of nurses required was met, and that this was amended dependent upon the needs of the unit. Unit managers were able to request staff and adjust staffing as the case mix required.

Enfield Down Unit had not used agency staff in the 12 months leading up to our inspection. Lyndhurst had a small amount of agency use equalling an average of one shift a month. There was high use of bank staff on both units with bank staff being used on every shift. These were covered by the ward staff doing extra shifts and regular bank staff who knew the patients well.

Are services safe?

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

Staff and patients told us that they spent regular one to one time with each other both on the unit and whilst out on leave. During our inspection staff were observed staff to be sat with patients and engaging with them. Care records demonstrated this to be the case.

The average mandatory training rate for the whole service was 93% with both units achieving above the trust standard of 85%.

Assessing and managing risk to patients and staff

In the six months leading up to our inspection, there were no episodes of seclusion. There were 21 episodes of restraint, of these one was recorded as prone restraint on Enfield Down. Staff members understood the need to use de-escalation to manage violent and aggressive behaviour and that restraint should only be used as a last resort in line with the Department of Health positive and proactive care (2014).

Risk assessments tools were used across both services (risk assessments tools allow staff to assess, record and manage risks to patients). Of the 15 care records examined on Enfield Down, risk assessments were completed prior to admission by the care coordinator in the community. Staff explained that risk assessments were not managed by the ward staff and that they were managed by the care coordinator and updated at six monthly care programme approach (CPA) meetings. This meant that risk assessments were not being reviewed regularly and were not updated following change in presentation and when risk changed. This placed patients at risk of harm from incorrect information being held about them, and their current risks not being managed effectively. At Lyndhurst risk assessment were updated regularly, and following incidents.

The trust had policies for observations of patients and searching of patients. Staff were able to explain these to us. Searching of patients was not routine, but where it was felt to be necessary due to risk to self or others, they were carried out in accordance with the trust policy. The policy complied with the MHA code of practice in relation to searches.

Staff had a good understanding of safeguarding and were able to explain the safeguarding procedure to us. Across the service, 94% of staff had received training in safeguarding of vulnerable adults. There had not been any safeguarding concern raised in the service in a 12-month period prior to the inspection.

Medicine on the wards was found to be stored safely in locked cupboards, and stock checks were taking place. However, on Enfield Down we found one medication in the stock cupboard to be out of date. This was reported to the staff and was disposed of immediately.

Track record on safety

There were no serious incidents reported by the long stay/rehabilitation mental health wards for working age adults in the 12 months leading up to our inspection.

Reporting incidents and learning from when things go wrong

The trust had an electronic incident reporting system in place. All staff were able to tell us how this worked and how they would access it to report an incident.

There were regular community meeting at the units where patients and staff discussed any issues they may have and activities they could get involved in. During our inspection we looked at community meeting records, and saw evidence of planned activities Staff told us that during meetings they would discuss any incidents that involved the patients and used this as a debrief should this be appropriate. This enabled the patients to discuss incidents in a calm and controlled environment.

Staff told us they learnt outcomes from incidents in a number of ways. This included feedback at staff meetings, in supervision and via weekly incident review meetings. The ward manager and band 6 nurses also ensured that debriefs happened following incidents. This involved a discussion of what happened, what could have been done differently and ensuring staff were supported.

Senior staff were aware of duty of candour and the need to be open and transparent when an incident occurred.

Are services effective?

Requires improvement 

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

Our findings

Assessment of needs and planning of care

We reviewed 22 care records during our inspection. Care plans were developed in collaboration with the patients, were holistic and covered a range of areas such as mental health, physical health, drug and alcohol issues and social issues. The occupational therapist also contributed to the care plans demonstrating a multidisciplinary approach. This allowed the care plans to be truly patient focused and personalised. The care plans were recovery focused.

All care records we reviewed showed the patient had a routine physical examination on admission and ongoing physical health monitoring. This included height, weight and blood pressure along with health promotion reviews such as advice around smoking cessation.

All care records were accessed via electronic system, and all staff reported that they were able to access this system when they needed.

Best practice in treatment and care

Medicine management in the Enfield Down service was reviewed by pharmacists during the inspection and was found not to follow NICE guidelines (medicine optimisation 2015, and psychosis and schizophrenia in adult 2014) and best practice. Staff did not review the PRN ('as required') medication regularly. There was also no system in place to monitor the physical health of those prescribed high dose antipsychotic medication.

At Enfield Down we found that they were not following the guidance issued by the Royal College of psychiatrists (Consensus statement on high-dose antipsychotic medication November 2014). Two patients were prescribed high dose antipsychotic medication, but had not received regular electrocardiograms despite one patient being at high risk of cardiac problems. The consultant informed us that the responsibility for monitoring of high dose antipsychotic monitoring was the responsibility of the junior doctor. The post for junior doctor at was currently vacant and was out to advertisement. This meant patients on high dose antipsychotics were at risk of physical health complications because they were not being monitored appropriately. We raised this concern with the trust at the

time of the inspection. The Trust have added this issue to the risk register for the service and have introduced a specific medication monitoring clinic whilst continuing its efforts to recruit a junior doctor.

There is best practice guidance provided by the Royal College of Psychiatrists for rehabilitation services in mental health. The focus of this guidance is around the individual gaining support in recovery with patient involvement and social inclusion in order to successfully transfer back into the wider community. We found during our inspection that there was a range of recovery focused activity available on the unit and a range of psychological therapies. The national institute for health and care excellence recommends cognitive behavioural therapy for people with a long term diagnosis of a psychotic illness. There were full time occupational therapists on the units who were trained in these techniques and were using these with patients. Other staff members had also undertaken additional psychosocial therapy training and were using these with patients.

Enfield Down had some slow stream rehabilitation patients that had been there for a number of years. The manager explained that it had been difficult to find alternative placements for these individuals. The trust was working with commissioners to undergo transformation of the service to meet the needs of the local population.

The staff on the ward were involved in clinical audits and were able to describe these to us and show us the outcomes. These included MHA 132 rights, and care records audits.

The service used the model of occupational therapy screening tool to measure and record severity and outcomes for patients using the service.

Skilled staff to deliver care

There was a full range of healthcare professionals providing input into the wards across the service, including psychiatrists, psychologists, occupational therapists, speech and language, nurses and health care assistants. The pharmacist visited the ward weekly and was available on the telephone during working hours. There were also administrative and domestic staff who worked on each ward.

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.

There was a robust induction for new starters and staff attended training before starting on the ward. Bank and agency staff had an induction when starting work on the ward. Staff described the induction as very helpful.

There were monthly team meetings and minutes of team meetings were made available for people who were unable to attend so information was passed on. There was regular supervision in place for staff which was a minimum of six weekly, and supervision rates were at 100 % across the service. There was a clear format used to document supervision and managers were encouraged to take part in leadership training to support their development in the role.

The trust provided us with data of non-medical staff performance appraisals for the twelve months leading up to our inspection. This was currently at 98% for the service which shows good compliance.

There were structures in place for senior staff to manage performance within the team. The manager and senior staff, which included senior nurses and occupational therapists, were confident in the way they would approach this. They were able to give examples of how cases had been managed in the past. This included the management of staff sickness levels.

Multi-disciplinary and inter-agency team work

There were a number of multi-disciplinary meetings on the ward. There was clinical handover at the start of every shift and then a further clinical handover at 09.00 to include the manager's occupational therapist and band six nurses. This ensured that all information was handed over as needed.

At Enfield Down patients did not have regular multidisciplinary meetings. We were informed by the ward manager, the consultant and the band six clinical leads that the service held Care Programme Review (CPA) meetings on a three to six monthly basis and this was when patients were fully reviewed. We were informed that if patients wished to see the consultant between CPAs then they could request this. We reviewed 15 care records during our inspection visit and saw that three to six monthly CPA meetings were taking place. We saw evidence in patient records of individuals requesting to see the consultant and the request being facilitated. However, this meant that patients who didn't request to see the consultant could go up to six months without being seen and reviewed by the multidisciplinary team. This meant that patients' needs

were not being met in a timely and efficient manner. We requested evidence from the trust of multidisciplinary meetings taking place more regularly. We reviewed all 26 care records sent by the trust. Of the 26 records only seven records demonstrated regular and timely reviews taking place. Out of these seven reviews three involved patient request for reviews and two had only recently been admitted. The other 19 care records had three to six monthly reviews occurring, with some additional reviews carried out by the duty doctor for minor health ailments such as chest infections and swollen limbs. Six patients had received MHA assessments at the end of 2015 which had been prompted by the commissioning team concerns around individual capacity to consent to treatment.

The community mental health teams for the patients at the service remained involved during their admission, and were invited to and attended the CPA meetings.

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

Training in the Mental Health Act (MHA) was not mandatory at the trust. However, the services had an action plan in place and were rolling out training to staff. This was noted in minutes from the service leads meeting in January 2016.

Discussions with staff and managers showed that staff had a good knowledge of the MHA.

People had their rights explained in good time, and if they were not able to understand their rights then further attempts to explain were carried out and documented.

MHA administrators were employed across the trust, ensuring a central contact point for information, advice, and the audit of paperwork relating to the MHA.

During our inspection a Mental Health Act reviewer looked specifically at the care records of people who were detained under the MHA. We found that all patients had a T2 (certificate of consent to treatment) or T3 (certificate of second opinion) in place to authorise their medical treatment and these were attached to the medication charts. The recording of capacity and consent to treatment was recorded in patient's records. There were errors on six of the seven T2 certificates at Enfield Down where prescribed medication had been missed off, this was brought to the attention of the manager and corrected immediately.

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.

At Enfield Down there were three service users who required a T3 (certificate of second opinion): in one of these cases there had been a short delay requesting the second opinion doctor to review the medication.

We saw posters on the ward containing information about people's rights under the MHA and how to contact the Care Quality Commission to make a complaint.

Independent Mental Health Advocates (IMHA) were available. All patients we spoke with confirmed that they knew how to contact the IMHA should they require advocacy support

Good practice in applying the Mental Capacity Act

Training in the Mental Capacity Act (MCA) was not mandatory at the trust. However, the services had an action plan in place and were rolling out training to staff.

There were no deprivation of liberty safeguarding applications in the twelve months leading up to inspection.

Senior staff we spoke to (band six and above) understood the principles of the MCA and were able to give us examples of how they had appropriately assessed people's capacity. We saw examples of capacity assessment and then a best interest decision in patient records. All patients were presumed to have capacity unless it was proven otherwise and independence was promoted on the ward.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

We saw interaction between staff and patients that was respectful, thoughtful, considerate, timely, and professional. On Enfield down, we saw a patient who was clearly unhappy about something, and staff immediately and calmly dealt with the situation in a manner that allowed the patient to de-escalate and return to their activity safely.

Patients we spoke with told us that staff were friendly at all times. Staff were praised by patients for being approachable and caring. We spoke with nine patients during the inspection and all told us that they felt safe on the ward. Patients told us they felt listened to by the staff.

The staff we spoke with during the inspection all knew the patients very well. They were aware of their care plans and their individual needs. We observed staff in a pre care programme approach (CPA) meeting and staff had an in-depth discussion about the individual and their needs.

The involvement of people in the care that they receive

There was an in depth pre admission process that ensured patients were orientated to the ward. Patients were assessed prior to being accepted to the service and were

able to visit where appropriate to have a look around and meet some of the staff. Once admitted patients were shown around and introduced to the other staff and patients on the unit.

We saw evidence of active involvement in care planning; the review of 22 care records across the service showed a holistic approach to care.

We attended one CPA meeting in which the patient entered with a list of considerations. The team discussed these with the patient, Advocacy were also invited to CPA meetings at patient request.

Patients' families and carers were encouraged to engage in their care. This included attending meetings and reviews at the request of the patient. When family and carers attended they were given the chance to express their views. One patient at Enfield Down was nursed with a bespoke package in a self-contained area with staff but was free to leave at any time. There was evidence of family involvement in the development of the bespoke care package.

On Enfield Down Unit, 'patient own' files are maintained and we saw an example file that contained information on the unit, copies of care plans, and activity plans. Patients could keep these files in their room or could request that they were kept in the office

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

The average bed occupancy over the six months leading up to our inspection was 54%. Enfield down had 31 beds but three beds were commissioned as acute care beds. This meant that patients requiring short term respite could access these beds urgently if needed. During our inspection 24 beds were occupied at Enfield down and at Lyndhurst 10 out of the 14 beds were occupied.

Patients going out on leave had access to a bed on their return. The majority of the admissions to the ward were from the adult acute wards within the trust although there have been referrals from forensic services, psychiatric intensive care units (PICU) and from people currently in the community.

There was a psychiatric intensive care unit available within the trust if a patient required more intensive nursing care.

The service had no out of area placements in the six months prior to the inspection.

In the six months prior to inspection there had been six delayed discharges, these were all attributed to Enfield Down. Staff told us delayed discharges occurred as a result of funding for appropriate placements.

In the six months prior to inspection, there had been four readmissions within 90 days. There were two attributed to Enfield Down and two attributed to Lyndhurst. Staff informed us that patients were transferred to the acute ward to commence clozapine (antipsychotic medication) titration as this could not be facilitated at the service. Once clozapine titration had been completed they would then be transferred back to the rehabilitation service, and this accounted for the readmission rates. This did not accurately reflect the services readmission rate or national practise.

Average length of stay for patients discharged in the twelve months prior to inspection was 251 days. The Lyndhurst service had an average length of stay of 531 days, Both units average length of stay was in line with the national average of one to two years for community mental health rehabilitation services (Guidance for commissioners of rehabilitation services for people with complex mental health needs, 2012).

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms and equipment on the ward to support treatment and care. There were small lounges on both floors where patients could go to spend time alone or to meet with staff. There was a large activity room with access to games equipment. Patients could access the external garden area at any time.

All patients at the time of our visit had their own mobile phones and could use these in the privacy of their own room if they wanted to make a private phone call. However, if patients did not have access to their own mobile phone there was also a phone on the wards for patients to use in a private area.

Both sites had kitchenettes that could be used by patients at any time during the day. This allowed patients to access drinks and cooking facilities. There were also activities in the daily living kitchens at Lyndhurst that allowed patients to practice cooking full meals. On Lyndhurst we observed patients baking with staff.

All bedrooms in the service were personalised, Patients had access to their rooms at all times, unless their care plan recommended otherwise. Patients all had their own key for their bedroom and could lock this when they were not using it.

There was a wide range of activities available seven days a week during the day and evenings. This was led by the patients and the occupational therapist. Patients completed an interest checklist given to them by the occupational therapist and this allowed them to highlight areas of activity they may already be interested in or would like to try. The occupational therapists were able to take patients to these activities with other staff if required.

Meeting the needs of all people who use the service

The ward was accessible for people in a wheelchair. There was a lift to upper floor and walk in showers. There were allocated bedrooms on the ground floor which could be used for wheelchair access.

Information leaflets were available in different languages on request. There were posters on the ward telling the patients this in different languages and how they could ask for them. There was also access to interpreters. This was booked online via the trust intranet.

Are services responsive to people's needs?

Good 

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

Patients could buy their own food if they wanted to which meant they could plan for and buy any particular food that met their own dietary requirements. This included vegan, vegetarian and coeliac diets as well as kosher or halal meat if required.

There was a chaplain that visited the service on a regular basis. The service was also able to request different faith representatives such as a rabbi or an imam if this was required. Patients were supported to access their faith of choice in the community and a number of patients attended the local church on Sundays.

Listening to and learning from concerns and complaints

There were two complaints across the service in the 12 months prior to inspection, one at Lyndhurst and one at Enfield Down, both complaints were upheld. There was information on how to complain on display within the wards.

Staff showed knowledge of the complaints policy, explaining informal and formal ways to process complaints. Staff told us that although they have had not received many formal complaints about the service they still discussed any issues that come up. Concerns and complaints were discussed with patients in community meetings. For example there were concerns raised due to the recent smoking ban within the trust. This was discussed with all the patients and a plan developed to manage the situation and provide access to smoking cessation support.

If there was a complaint or problem that was not patient related then staff would receive feedback in their supervision and team meetings. The ward manager would also send out updates via email in case anyone missed this information.

The service received three compliments during the 12 months prior to inspection; two of those compliments were for Enfield Down Unit.

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.

Our findings

Vision and values

The trusts values were displayed in staff and patient areas of the units. Staff told us there was lots of publicity about them and staff commented how they liked the fact they were simple

Staff were able to tell us the names of the some senior people in the organisation. The staff felt that their immediate managers were approachable and easily contactable should they need to speak to them.

At ward level all staff we spoke with told us that they felt supported by the senior nurses and ward manager. They told us that they would not feel worried to approach them and voice any concerns. They told us they felt listened to and their opinions were important.

Good governance

Governance structures were only partially in place. The services within the trust were led by a team of three senior clinicians. Within the rehab service the governance lead post was vacant and was being advertised.

At Enfield Down, governance processes had failed to identify that there was insufficient monitoring of patients on high dose antipsychotic medication, that patients were not being reviewed in a timely manner, and that risk assessments were not being reviewed and updated.

The governance meeting minutes demonstrated a failure of the two current clinical leads attending governance meetings on regular basis together with the consultant being missing from seven out of nine meetings reviewed.

The clinical governance meeting minutes had unclear information as to what actions needed to be carried out, by who and by when and how this would be checked.

Mental Health Act and Mental Capacity Act training did not form part of the trust mandatory training system, and some staff lacked knowledge in this area.

The trust used key performance indicators to measure performance. Ward managers reported that they received feedback where performance needed to be improved; an example given was when they were not meeting mandatory training targets.

There was a good appraisal and supervision processes reaching 93% compliance rates. The average mandatory training rate for this service was also 93%.

Staff knew how to report incidents and records showed they did this in accordance with policy. There were three formal complaints about this service, and patients told us they were aware of the process they needed to complete should they wish to complain. Staff learnt from incidents via staff meetings and one to one supervision.

The ward manager had sufficient authority to run the ward and was able to increase staffing numbers when required.

Leadership, morale and staff engagement

The staff sickness rate across the service averaged 6%. There were no ongoing reports of bullying or harassment cases in the service.

Staff stated that they knew how to apply and use the whistle-blowing process. There were no recorded reports of whistle-blowing in this service. Staff told us they felt able to raise concerns without fear of victimisation or reprisal.

Staff told us that morale and job satisfaction was good in the service, but that staff remained unclear about the future of the services due to transformation that had been ongoing for two years, and felt that this uncertainty was impacting on recruitment and therefore this increased bank and agency usage.

Managers stated they had opportunities for leadership training. Staff reported that they felt team working in the service was good, and that support was available if needed.

The trust had a duty of candour policy, and senior staff were able to show knowledge of the need to inform patients and carers when something went wrong.

Commitment to quality improvement and innovation

The trust was currently reviewing its services and therefore due to the uncertainty of the service staff told us that they had not applied for Accreditation for Inpatient Mental Health Services (AIMS)

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met:

We found that at Enfield Down the clinical team did not undertake regular reviews of patient risk assessments following incidents or when there was a change in presentation. They did not undertake physical health monitoring including electrocardiograms for patients prescribed high dose antipsychotic medication.

This is a breach of Reg 12(2)(a)(g)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the regulation was not being met:

We found that at Enfield Down did not undertake regular MDT reviews to ensure timely and appropriate treatment plans.

This is a breach of regulation 9 (1)(a)(b)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

We found that the long stay / rehabilitation service did not have sufficient governance structures in place ensure effective monitoring of the service. The service currently lacked governance lead post and had failed to identify failings in the service.

This is a breach of regulation 17(1)(2)(b)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

We found that the long stay / rehabilitation service did not ensure staff were adequately trained in the MHA and MCA

This is a breach of regulation 18 (2)(a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

How the regulation was not being met:

We found that at Enfield Down, staff did not ensure that T2 (consent to treatment) forms were completed accurately.

This was a breach of regulation 11 (1)