# Fir Trees Independent Hospital

## Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

## Ratings

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

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

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

# Summary of findings

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

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

## Overall summary

We rated Fir Trees as good because:

- Patients gave positive feedback about the service
- carers gave good feedback and told us their views were considered and that they felt involved in patients' care
- we observed caring, respectful and professional interactions between the staff and patients
- safe staffing levels were maintained and it was unusual for the unit to be short-staffed
- patients were involved in the development of their care plans
- patients benefited from a varied activity programme in and away from the hospital
- patients had good access to multidisciplinary team working, in particular psychological and occupational therapies
- the environment was of a good quality and the service was continuing to improve on this
- patients had good access to independent mental health advocates
- nursing staff received regular managerial supervision, had an annual appraisal of their work performance, had access to ongoing training and development, and were up to date with mandatory training

However,

- domestic staff had not received break away training
- Patients on high-dose anti-psychotic medications did not always have this clearly recorded as part of their care plans
- Stand-alone medication care plans related to the medication prescribed rather than the underlying physical health condition.

# Summary of findings

## Contents

Good

# Fir Trees Independent Hospital

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

# Summary of this inspection

## Background to Fir Trees Independent Hospital

Fir Trees Independent Hospital is a 14-bed mental health unit offering long-term rehabilitation to men and women with mental health needs. This could include people with an additional learning disability or substance misuse issues.

The hospital is in Wigan, close to local amenities and public transport. It has six en suite bedrooms and eight bed-sits, lounge areas, a spacious dining room, quiet areas, and gardens. A self-catering kitchen is available for the use of patients, who could have support from staff to cook meals. It is also used as part of a rehabilitation programme or for patients to make snacks or shared meals with a group.

The hospital is part of the Alternative Futures Group, a large registered charity providing not-for-profit inpatient care. There is a registered manager and an accountable officer. It is registered to provide the following regulated activities:

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

The Alternative Futures group was in the process of consultation about service changes at the time of this inspection. Key developments being considered included a redesigned integrated care pathway whereby hospital inpatient staff would continue to provide significant support for patients in their own homes after they left the hospital.

Our report of an inspection at Trees was published in November 2013. At that time, the hospital met all the required standards and there were no compliance actions or changes to practice needed.

At the time of this inspection, there were 10 patients staying at Fir Trees, five of whom were detained under the Mental Health Act 1983. A Mental Health Act review visit at the hospital in May 2015 found no serious concerns but some recommendations were made about how services could be further improved. This inspection looked at the hospital's response to those recommendations.

## Our inspection team

Team leader: Paula Cunningham, CQC Inspector

The team that inspected the service comprised of two CQC inspectors, a mental health inpatient nurse and an expert by experience (someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer).

## Why we carried out this inspection

We inspected this 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 this inspection

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

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the hospital and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with two carers of patients currently using the service
- spoke with the registered manager and the clinical lead
- spoke with six other staff members, including a doctor, nurses, domestic and administrative staff
- received feedback about the service from a care co-ordinator
- spoke with the director of quality and performance for Alternative Futures Group
- spoke with an independent advocate
- spoke with the lead pharmacist
- attended and observed a multidisciplinary team meeting
- looked at five care and treatment records of patients
- carried out a specific check of the medication management arrangements
- looked at policies, procedures and other documents relating to the running of the service.

## What people who use the service say

One patient told us that the atmosphere at the hospital was very calm, which was significantly different from their experience in other inpatient units. The patient said this atmosphere had a positive impact on them, helping them to feel calmer. Another told us that patients might be having a bad day but that it was handled well by the staff.

Patients told us that they were treated with care and compassion by the staff. Patients confirmed they were involved in their care plans and were well supported by the staff.

Carers said they felt involved in care and treatment and that they were considered when decisions were being made and kept informed and communicated with.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

Good

We rated safe as good because:

- the hospital was clean and well maintained
- there were adequate numbers of well trained staff on duty
- staff had regular team meetings, managerial supervision and appraisals of their work performance
- staff received the training they needed to continue to improve in their role
- there were no incidents of violence or aggression and staff were good at de-escalating tense or difficult situations
- risk assessments and care plans were up to date and regularly reviewed
- there were effective incident recording systems and forums for learning from incidents and untoward events

However,

- Domestic staff had not received break away training
- Patients on high-dose anti-psychotic medications did not always have this clearly recorded as part of their care plan as they should have. The plans should include outlines of key symptoms to be aware of, contingency arrangements, and guidance for management in a potential crisis.
- Stand-alone medication care plans related to the medication prescribed rather than the underlying physical health condition. They did not clearly detail the ongoing monitoring required or the signs and symptoms of deteriorating physical health of patients
- At the time of this inspection there was no women-only lounge provided. The manager rectified this when they were informed that must be provided.

### Are services effective?

Good

We rated effective as **good** because:

- there was evidence that patients had regular physical health checks, reviews and interventions
- all patients had an up-to-date and detailed care plan that was holistic and personalised
- patients had good access to therapies, including psychological interventions and occupational therapy
- staff followed systems for monitoring the effectiveness of medication management and compliance with the safe prescribing, ordering, storing, and dispensing of medications

# Summary of this inspection

- the hospital had arrangements for clinical case supervision and complex case discussion, which ensured that the team were reviewing quality, effectiveness and the evidence base for interventions
- patients attended good quality multidisciplinary team meetings and had regular reviews.

## Are services caring?

Good

We rated caring as **good** because:

- we observed caring, warm and professional interactions between staff and patients, who told us that was how they were always treated
- carers were confident about the care being provided
- patients told us the process of pre-admission visiting over a two-week period alleviated many of their fears and concerns about admission to the hospital
- patients were encouraged to share their views and make suggestions at regular meetings they attended with staff
- there was a comments box for patients, carers, and visitors to make their views known and comment cards could be completed anonymously if preferred.

## Are services responsive?

Good

We rated responsive as **good** because:

- patients assessed to be appropriate for admission were not subject to delays in being allocated a bed
- staff supported patients to make or redevelop links with their local community and this was an important part of developing plans towards discharge
- patients were assisted to maintain good relationships with care co-ordinators, and staff had good links with local community mental health services
- the physical premises, facilities and quality of fixtures and fittings were of a very high standard
- there was a range of activities that patients valued and these were available seven days a week
- patients and carers told us the food was good.

## Are services well-led?

Good

We rated well led as good because:

- there were good links between Fir Trees and the senior management structure at Alternative Futures
- staff felt valued and part of a good and supportive team; they described job satisfaction and enjoying their work

# Summary of this inspection

- clinical and other audits were being undertaken regularly and the outcomes shared with staff
- sickness levels were low and vacant posts were filled quickly.

# Detailed findings from this inspection

## Mental Health Act responsibilities

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

A Mental Health Act review was undertaken at Fir Trees independent hospital in May 2015. At that time, the hospital was providing care in line with MHA and code of practice but the following issues were raised:

- Women who lived on the unit (during the review) had told staff they did not need a women-only day room on the unit . A female-only lounge has been required in line with the Mental Health Act Code of Practice and has been mandatory for services since 2000.
- Minutes from the community meetings did not clearly show that issues and ideas had been acted upon.
- Care programme approach documentation was not dated in three clinical records.
- Capacity to consent to treatment assessments were missing in one case and incomplete in another.
- Healthcare improvements profiles were inconsistently completed.

Fir Trees submitted an action plan detailing how they would deal with the issues raised. We noted the improvements during this inspection.

The only outstanding issue related to the hospital providing a women-only lounge. This was discussed with the provider. The requirement to provide female-only lounge areas in outlined in Regulation 10 (2)(a) HSCA (RA) Regulations 2014 dignity and respect. The provider took immediate action and a female-only lounge was reinstated.

## Mental Capacity Act and Deprivation of Liberty Safeguards

We reviewed five care records. These showed that patients' capacity to make decisions about their care, therefore giving informed consent, was considered and recorded appropriately.

100% of staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), which ensure that where patients' freedoms need to be restricted, those restrictions are the minimum necessary. There had been no applications for authorisation to use DoLS in the six months before the inspection.

## Overview of ratings

Our ratings for this location are:

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

# Long stay/rehabilitation mental health wards for working age adults

Good

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

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

Good

**Safe and clean environment**

The ward was hexagonal, with short corridors. There was an inner courtyard with a large garden area, which patients could freely access. There were two large lounges, and smaller interview and quiet rooms. The bedroom corridors were near the staff office and were well observed.

The registered manager and a member of the estates department for the Alternative Futures group completed ligature audits. A ligature point is somewhere patients who are intent on self-harm could tie something to strangle themselves. There were a number of identified ligature risks within the unit and the garden area. The plan identified potential ligature risk areas within the building and the garden and identified strategies to help the hospital staff reduce the risk identified. The risk of individual patients using ligatures was also assessed. At the time of this inspection, no one was considered to be at high risk of using ligatures. Two of the upgraded bedrooms had additional anti ligature measures in place. Staff told us that if people's risks were to change they would ensure patients of higher risk would be moved to these identified rooms.

At the time of the inspection, there were two female patients and eight male patients. Women's bedrooms were together in a corridor area. Women did not need to walk through areas where men's bedrooms were in order to use the main facilities such as kitchen, clinic, and lounge, outside gardens, exit door, reception, payphone, or bathroom. There was no women-only lounge at the time of the inspection. Staff were regularly reviewing the female-only lounge issue with the patients and it appeared the lack of a female provision was based on patient preference. During this inspection it was pointed out that female-only lounge provision was a requirement in order to meet same sex accommodation guidance. The provider reinstated the female-only lounge with immediate effect.

The clinic room was fully equipped with resuscitation equipment and emergency drugs. These were checked regularly. Staff followed infection control principles: a qualified staff member was the hospital infection prevention lead. Staff completed regular handwashing assessments. Emergency equipment was checked on a daily basis to ensure everything required was in place and in date. Staff checked the temperature of the fridge where some medications were being stored on a weekly basis. This ensured medicine was being stored appropriately. A sign clearly indicated the location of ligature cutters and the emergency resuscitation equipment. All staff knew where this equipment was located.

All areas of the hospital, including the gardens and smoking area, were clean, with good furnishings, which were well maintained. There was hospital standard furniture, such as weighted sofas but these were in a bright non-uniform design and were of a very good quality. Different designs of this furniture type were used throughout the hospital.

Fir Tree independent hospital was nearing completion of a long-term building refurbishment. All areas of the building

had been upgraded and some areas completely redesigned. There were clear signs and guidance for staff, patients, and visitors to the hospital about areas being out of bounds during the refurbishments.

Domestic staff kept accurate cleaning records. These detailed the daily weekly and monthly cleaning schedules and demonstrated that the hospital was regularly cleaned. Domestic staff confirmed they had access to personal protective equipment to enable them to fully undertake their duties.

A new nurse call system was being installed as part of the refurbishment. There were also plans to upgrade the current staff incident alert alarm. There were no personal alarms for staff but there was a nurse call system within each of the bedrooms / bed-sits. Domestic staff had not received breakaway training. There had been no incidents of potential violence or aggression towards them but they felt it would be helpful to undertake breakaway type training. We were told that they had received training around violence and lone working from the organisation that employed them. The domestic staff were sub-contracted to the hospital and were line managed by the chef on site.

**Safe staffing**

The hospital staff worked a full day, 12.5 hours, or a half day of 6.25 hours. During the week, each day shift would have two qualified and two unqualified nurses on duty. At night, there would be one qualified and two unqualified nurses on duty. At weekends, there was one qualified and two unqualified nurses on each shift. However, an additional qualified nurse would work from 9:30am to 4:15pm each day. This was to ensure all planned activities and outings could be accommodated. In addition to the core nursing staff, the clinical lead, senior practitioner and manager were supernumerary and supplemented the daily staff levels, predominantly Monday to Friday.

The following nursing staff were in post at November 2015 (whole-time equivalent - WTE)

- qualified nurses 7
- nursing assistants 10

During the same time period:

- qualified nurses vacancies 1
- nursing assistants vacancies 0

A senior practitioner and a clinical lead provided clinical leadership for the nursing staff. The multi-disciplinary team also had a consultant psychiatrist and an occupational therapist. These staff worked across three of the Alternative Futures locations.

There was a dedicated chef and three housekeeping staff providing cover over seven days. The domestic staff were line managed by the chef and described feeling supported.

A total number of 108 shifts had been filled using bank staff between July and October 2015. There had been no incidents of bank or agency staff failing to fill vacancies or absences. Staff sickness rates were low at 2.4%. Staff turnover rate was 14% over the previous 12-month period.

Staffing levels were adequate to meet the requirements of the patients. There were dedicated bank staff who worked regularly at Fir Trees. These staff had become well known to the patients and their families. The majority of patients had extensive unescorted leave

Rotas were planned to ensure that named nurses would be on duty and therefore usually able to attend review meetings for specific patients.

The GP, who covered the hospital, completed a physical examination on admission. Details of the full assessment were recorded within the GP notes and not the patients' mental health records. Blood results and electrocardiograph results were routinely sent to the hospital to retain details in the mental health records and staff told us the GP would report any concerns or problems to them.

A consultant psychiatrist attended Fir Trees for two sessions per week. Outside of those times, the doctor was available for contact and discussion at the other Alternative Futures sites. At night and weekends, there was a psychiatrist on call. In the event of a psychiatric or physical health emergency staff would summon emergency services via 999. The doctors across the Alternative Futures group provided cover for each other if they were not in work.

100% nursing staff were up to date with mandatory training. The annual updates included training in the use of the automated external defibrillator located in the building and basic life support. There were efficient systems in place for ensuring staff were booked to attend mandatory training on or before a date that an annual update was due. Domestic staff had not received break away training.

The clerical officer maintained a database detailing who required mandatory training and timescales for complying with this. Training was booked via an electronic system called PAL. This was also used to record completion of managerial supervision and appraisal. This supported the team manager to ensure that all supervision and staff training was up to date. Domestic staff training and supervision data was held separately to this data base as those staff worked for a different organisation.

**Assessing and managing risk to patients and staff**

Staff reported no restraint or segregation incidents in the six months prior to the inspection. There were no seclusion facilities at the hospital. Staff said if a patient became agitated or unhappy they would be encouraged to leave the unit for some fresh air and space or to spend time in their own room. A room had been designed for patients as a quiet therapeutic area and would provide a low stimulus environment. This was being completed during this inspection. Staff confirmed this would not be used as a seclusion facility.

During this inspection, five clinical case records were reviewed in detail. Fir Trees used the short-term assessment of risk (START) tool. This was completed at admission and our review found that these were regularly reviewed.

The hospital did have a list of items that were not allowed on to the premises. These included illicit drugs and knives. There were no blanket restrictions at the hospital. The main entrance to the hospital was locked but informal patients could ask to be allowed to exit and there was a sign explaining this in the reception area. Patients had unrestricted access to their rooms, could use their own mobile phones, and could get a hot and cold drink and snacks throughout the day and night. There was Wi-Fi access at the hospital. All bedrooms had a television and entertainment unit where games consoles, laptops and charger units could be safely connected. There were secure medication storage facilities in each bedroom to enable patients to self-medicate safely. Patients had keys for their rooms. Staff could gain access in the event of an emergency.

There were policies and procedures for the use of observation and searching patients. Staff told us it was unusual for searches to be undertaken due to the patient population generally being of low risk of harm to self or others. Searches would therefore be undertaken on an individual basis. We were told that room searches were more usual than personal searches. There was a lone worker risk policy and this outlined strategies for all staff to follow to reduce personal risk. An up to date fire evacuation plan was accessible in the staff office and a fire drill had been recently completed.

Between January 2014 to October 2015 there were four safeguarding referrals made by staff at Fir Trees. The most recent had been a medication error. This was reported to the Care Quality Commission (CQC) as required. Alternative Futures group held a monthly organisational safeguarding forum and the registered manager or clinical lead were expected to attend these. In addition to undertaking safeguarding training as part of the structured induction programme for all staff, further training had been received from Wigan safeguarding team. Staff told us this helped them develop local knowledge of the safeguarding team as well as improving staff understanding of what to do if concerned.

Local GPs prescribed medications. This would be part of a GP assessment and treatment review with a patient, or on recommendation from the psychiatrist. Adequate pharmacy provision was in place including dispensing arrangements, transport and medication returns. Medicines were dispensed using medication administration records that were up to date and correctly completed. There were systems for medicines reconciliation on admission.

Nursing staff undertook medication reconciliation on admission. They checked that all required medicine were included on new prescriptions and then transcribed these on to medication administration records.

Qualified nurses were responsible for checking medication stocks and undertaking audits of compliance with medication management within Fir Trees. A specialist pharmacist provided input to Alternative Futures group and was available for advice and guidance for all staff via telephone or email query. The pharmacist had provided direct clinical input on site at Fir Trees where required.

During this inspection, we observed a medication round and saw that good practice guidelines and safe

# Long stay/rehabilitation mental health wards for working age adults

Good

administration of medications were undertaken. Patients self-medicated as part of their rehabilitation programme. There was a policy and procedure outlining the progression through the different stages of self-medication.

There were three patients on high dose anti-psychotic medications. There was documentation detailing the clinical reason for prescribing these medications above the usual levels recommended in the British National Formulary (BNF). The prescription charts had an alert sticker to highlight this. However, there was no corresponding high dose care plans in place. Arrangements were in place for patients on high dose medication to have their physical health monitored more frequently through ECGs and blood tests. One patient refused to allow staff to monitor routine physical health observations and additional monitoring. Medical staff were having regular discussions about this with the patient. Attempts to encourage their agreement were clearly recorded.

Children were allowed to visit as long as this was planned so a dedicated area could be made for the visit to be conducted. There was a policy in place for ensuring this was undertaken in a safe manner. The majority of patients maintained close contact with friends and family, including visiting family at their own homes or meeting in the local area.

### Track record on safety

There had been no serious or untoward incident in the 12 months prior to this inspection. Incidents of concern had been identified as safeguarding concerns and incidents dealt with appropriately through safeguarding procedures. Patients told us that they did not have any concerns regarding their personal safety or the safety of their possessions. Carers told us they were confident that their family member was receiving the care and treatment they require

### Reporting incidents and learning from when things go wrong

Staff recorded incidents on the CARISTA electronic recording system. Staff knew what should be recorded and how to do it. Incidents were reviewed and discussed at staff meetings under a specified agenda item of lessons learned. These included raising about key issues and actions taken and lessons learned.

The pharmacist had set up a system for qualified staff at Fir Trees to be notified of any national patient safety alerts. This ensured staff were aware of any safety concerns and could take required actions in a timely manner. This could reduce any possible risks for the patients. These were in a central file for all staff to see.

Qualified nurses, the clinical lead, registered manager, and occupational therapist held a six weekly professionals meeting. Issues relating to practice, risk concerns and any consequent themes and incidents were regularly discussed at these meetings.

Staff demonstrated good understanding of their responsibilities regarding duty of candour. The duty of candour ensures that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.

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

(for example, treatment is effective)

Good

### Assessment of needs and planning of care

Physical health assessments happened on admission to the hospital. The GPs at the local health centre undertook subsequent physical health assessments, including annual health checks. These were recorded within the GP clinical records and not in the Fir Trees clinical patient record. Staff said the GP would inform them quickly of any physical health concerns. The qualified nurses used the modified early warning score with patients as part of routine physical health care monitoring. All patients confirmed that they received regular attention to their physical health care.

We reviewed five clinical records. These included a risk assessment, risk management plan and care plans. Each completed risk assessment and care plan was up to date and comprehensive. Patients had signed to confirm their acknowledgement of the care plans in three of the five reviewed. The care plans addressed a range of areas and were recovery focused. Each care plan was personalised to the patient.

# Long stay/rehabilitation mental health wards for working age adults

Good

One set of clinical notes were for a patient at the hospital for trial leave. Care plans and risk assessments were created by the hospital that the patient was on leave from and the unit specific documentation was in the process of being completed.. This would be up dated and the assessment outcomes would inform documentation in line with other hospital clinical records once the patient became resident at Fir Trees.

Physical health care plans were held with prescription charts in a separate care plan file. These were in the clinical room to ensure access for the nurses dispensing medications and completing physical health interventions. There was evidence of good quality care plans in place for some physical health problems such as a chronic obstructive pulmonary disease care plan. Some physical health care plans related to the medication for the condition rather than the condition itself.

Staff completed records in paper format and these were held as clinical files for each patient. Key documents including risk assessments and management plans and care plans were uploaded in to the electronic CLARISTA record. Contemporaneous notes were uploaded retrospectively. Information Governance issues, including safe storage and confidentiality was part of the mandatory training for all staff. All staff required a password to access the electronic records. Paper clinical files were retained in a suitably secure area within a locked office.

**Best practice in treatment and care**

Alternative Futures Group had a central therapies team. Individualised psychological interventions were available for patients. Some nursing staff had additional skills in psychosocial interventions informed the recovery focused work they undertake with patients. The average wait to commence psychological interventions with a nurse therapist was two weeks.

Staff from the central therapies team provide a complex case advisory group. Individual staff from across Alternative Futures, including Fir Trees, could refer in a potentially complex clinical case and the group, comprising psychology staff, nurse therapists, and the groups clinical risk lead would offer guidance and advice around formulation and case management. The clinical lead detailed a complex case referred for advice where substance misuse issues played a significant role in mental health issues and relapse.

The local GP provided all routine physical health care. The doctor at Fir Trees advised that there were good working relationships between the local GP practice and Fir Trees and frequent telephone contact and discussions between doctors from both services. We saw that some physical health investigations were detailed within individuals care plans, such as weekly physical observations or regular electrocardiograms.

We observed an effective multi-disciplinary team meeting. Staff attending the meeting had access to the electronic and paper clinical records. Notes, discussion, and agreed actions were updated into the electronic patient record during the meeting.

Staff undertook regular audits. The majority of these were about ensuring minimum standards were being adhered to and good practice identified. Other clinical audits were being coordinated within the Alternative Futures group. Currently underway were clinical audits looking at clinical risk assessment and management, borderline personality disorder and experience of psychosis and schizophrenia in adults.

**Skilled staff to deliver care**

All staff had a comprehensive induction when commencing work with Alternative Futures group. Non-qualified staff were encouraged to have a regular full day training every 12 weeks. This was part of their ongoing development. Each personal file had a detailed induction checklist, signed to demonstrate completion. In addition to a four-day induction programme clinical staff also attended a five-day management of violence and aggression course.

Staff received four one to one supervision sessions per year. The manager provided managerial supervision to the clinical lead and the senior practitioner six weekly. The senior practitioner provided supervision to each of the qualified nurses, who in turn provided it to the unqualified nurses. Peer group supervision was available for qualified and unqualified staff to attend and discuss specific cases. There was a standardised agenda in use. This covered a range of areas including health and safety issues, workload, team working, patient and service issues and objective setting. Both supervisor and supervisee signed completed supervision forms. All nursing staff had an appraisal completed within the previous 12 months.

Staff told us that they could undertake a range of training including leadership training. Training needs were

discussed during annual appraisal and incorporated into each staff member's personal development plan. All staff had an up to date appraisal except for very new starters who were employed less than three months.

Senior staff outlined requirements for addressing poor performance and provided examples of where poor practice had been addressed.

**Multi-disciplinary and inter-agency team work**

The clinical team met twice weekly. In addition to attendance by the patient and nursing staff the doctor, family or carers, and staff from the central therapies were involved, could also attend. Community based care co-ordinators could attend regularly and most usually attended for a care programme review meeting every three months as a minimum. Discussions held and actions agreed were recorded within the clinical records.

Effective handovers took place ensuring key information was communicated between staff on shifts. There was a handover book where issues were recorded and staff could refer to this as required.

Patients maintained contact with care co-ordinators. Staff had made good links with local community mental health services. A co-ordinator confirmed there was regular communication with the hospital and they were kept up to date. Staff from the local community teams were invited to attend multi- disciplinary team meetings and reviews.

**Adherence to the MHA and the MHA Code of Practice**

Five of the 10 patients were detained under the Mental Health Act (MHA). Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. Staff had MHA training as part of their induction and annual refresher training. At the time of this inspection 89% qualified staff had undertaken recent training. The remaining staff were to attend the next arranged training.

A MHA forum met monthly. Representatives attended from each of the Alternative Futures Group locations. The forum monitored standards and provided advice and guidance. Fir Trees had a lead for MHA issues within the nursing team. They undertook monthly audits to ensure all paperwork and documentation was in place. These included reviewing risk assessments completed before patients had section 17 leave and ensuring there was evidence that patients' rights under section 132 were regularly reviewed and explained and reviewed treatment authorisation (T2 and T3) forms. These recorded consent to treatment (T2) and stated what prescribed medication should be administered (T3).

Nurses ensured patients understood their rights when admitted to the hospital and revisited these every three months for the duration of their stay. Patients confirmed they had received a booklet explaining about their rights. Administrative support and advice on implementation of the Act and the code of practice was available from a central team within Alternative Futures Group. Detention paperwork had been reviewed during the MHA review visit in May 2015. Documentation was up to date, accurate, and stored appropriately.

There were posters advertising the availability of an independent mental health advocate (IMHA). Patients and staff told us the local IMHA visits the unit regularly. The service was provided by Wigan family welfare services. Patients told us they found the service was very helpful. There was a poster in the staff office detailing the IMHA roles and services they provide.

There were policies and procedures in place but these were not checked to confirm they had been amended in line with the changes to the Code of Practice.

**Good practice in applying the MCA**

All staff had training in the Mental Capacity Act (MCA) as part of their induction and an annual refresher. At the time of this inspection, 100% staff had recent training. Staff told us that they would seek advice either from the Alternative Futures Group safeguarding lead or from Wigan safeguarding team if they needed additional guidance or support.

Staff had a good understanding of the Mental Capacity Act. They were able to explain the core principles, which included patients are presumed to have capacity and they have the right to make their own decisions. Staff understood about Deprivation of Liberty Safeguards but there had been no applications under this framework in the previous 12 months. Capacity to consent to treatment was assessed on admission and reviewed in line with any changes or actions. This was documented by the psychiatrist.

# Long stay/rehabilitation mental health wards for working age adults

Good

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

Good

### Kindness, dignity, respect and support

We saw positive, warm, and professional interactions between staff and patients. Patients told us they were treated with care and compassion by the staff at Fir Trees and staff were always calm in manner. We were told staff always knock before entering a patient's room. Carers said they felt involved in care and treatment and they were considered when decisions were being made. They had confidence in the treatment and care their family member was receiving for their physical health. They described they were kept informed and were clearly communicated with.

### The involvement of people in the care they receive

Representatives from the multi-disciplinary team undertook pre admission assessments. Where admission was appropriate, informal visits were facilitated. This enabled the patient to spend time at the hospital. These visits extended over a two-week period and included overnight stays. Patients told us this process of induction eased their admission to the hospital and alleviated many of their fears and concerns.

Patients were involved in their care planning and had received copies of plans. Patients confirmed they knew how to contact the mental health advocate and they would attend their reviews if they requested it.

Staff were reviewing information provided to support carers. They were seeking carer feedback about how they could improve support for and involvement by carers. A carer day was being planned to facilitate this.

Patients were encouraged to raise their views in the regular community meetings. The minutes for these were available for anyone to read who had not been able to attend. Actions were agreed to address these concerns and attendees were updated at subsequent meetings. A comment box, enabling people to leave anonymous or named feedback, was available in the dining room. Patients confirmed this comments box was always there.

Patients told us they would feel confident to raise any concerns or issues directly with staff either at the community meetings or during one to one meetings with their named nurse.

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

Good

### Access and discharge

During this inspection there were 10 patients. The staff at the Fir Trees had authority to determine who would be appropriate for admission and were supported by commissioners in any disagreements about this. The average length of stay was 14 months.

All patients were from the Wigan area. Patients were supported to make, or redevelop links, with the local community. This was an important part of discharge planning. Patients had an allocated care coordinator from the community teams who were involved in care and treatment whilst at Fir Trees and responsible for coordinating future discharge. Feedback from local community mental health services was good. They described reviews and multi-disciplinary meetings being coordinated in a timely way. Staff from the community teams told us that communication was good. Care coordinators maintained regular contact and worked with the patients and staff throughout the admission. Fir Trees staff provided follow up during the initial discharge period. All ex patients were able to maintain regular contact post discharge via patients' football group and informal contact with the service.

There had been two delayed discharges at the Fir Trees in the six months before the inspection. These were due to commissioners trying to identify appropriately supported accommodation.

### The facilities promote recovery, comfort, dignity and confidentiality

There were quiet areas and places where patients could meet visitors at the hospital. There were a range of activity

# Long stay/rehabilitation mental health wards for working age adults

Good

rooms and therapy rooms. One patient told us the atmosphere at the hospital was very calm which was significantly different to their experience of other inpatient units. The patient said this atmosphere had a positive impact on them helping them to feel calmer. Another told us that patients might experience having a bad day but that it was handled well by the staff.

Patients were able to make private phone calls using their own mobile phones or a public phone. Patients confirmed they could make hot and cold drinks any time of the day or night. Patients told us they were able to personalise their rooms. They had a key so that their rooms were secure, although staff could access their room if there were risk concerns. Patients confirmed that their belongings were safe and secure. There was a safe for the storage of high value items if this was needed. There was a well-designed outdoor space. The design was such that it would be possible to sit out in part of the garden and be sheltered from the rain. There were large comfortable outdoor chairs and these were in use by the patients during our visit.

Patients and carers told us the food was of a good quality. An on-site chef devised varied menus that were cooked on the premises. Menus were available each day and patients indicated their choice of meals for the following day. For patients undertaking meal preparation and cooking as part of their rehabilitation plan, staff provided a budget to purchase ingredients for a meal. Patients confirmed that they were satisfied with the food and the size of the portions. The chef would adapt menus to meet dietary preference and needs.

There was a range of activities including at weekends. Patients told us they were pleased with the range of activities and were able to contribute to discussions about what type of activities they would like to do. The hospital had purchased some bicycles to be used by the patients either alone or accompanied by a staff member. Some patients had season tickets enabling them to attend football games. Carers were satisfied with the range of activities that were available over seven days per week. They felt the activities and treatments facilitated recovery and developed independence. There was a recovery journey display in the main lounge. This featured personal accounts of patients' experiences of recovery.

We saw that a camping holiday had been organised earlier in the year. Patients' told us they had enjoyed this and there was to be a similar trip in the future.

**Meeting the needs of all people who use the service**

All patients were from the local area so had a good knowledge of local area and resources. Staff were able to access interpreters for people whose first language was not English. There was access to British sign language interpreters if required.

The single storey building provided appropriate access for people with a physical disability, including wheelchair users. There were a range of leaflets in a folder in the reception area. These contained information about Fir Trees, including welcome booklets for new people, information about advocacy, information about the CQC and specialist community based groups such as the hearing voices network. There was a noticeboard with activities such as cinema trips and football group. These were in English and staff told us a similar range of information leaflets would be available in a range of different languages or formats dependent upon the changing needs of the patient group.

The on-site chef would be able to adapt daily menus to accommodate preferences based on either dietary or religious requirements.

**Listening to and learning from concerns and complaints**

There was one complaint received by Fir Trees in the 12 months prior to this inspection. This complaint was not upheld. The process for responding to complaints was clear. There was a poster detailing how to raise concerns or make a complaint in the main reception area and comment slips for patients, family or visitors to complete anonymously if they preferred. Patients and carers confirmed that they knew how to make complaints.

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

Good

**Vision and values**

Staff were aware of the organisational values which were:

- Valuing people
- caring safely

- integrity at all levels
- working together
- ensuring quality in the services they provide.

The organisation used values based recruitment. There were posters displaying Alternative Futures Group core objectives. Staff knew who the senior staff within the organisation were and how their roles fit within Alternative Futures group. The regional director and the governance lead had been invited and attended the most recent team development day. The minutes covered the workforce plan, governance, team building, organisational update, reward, and recognition with the team. The director of performance regularly attended the hospital. They were well known to the staff on duty. They director had a good knowledge of the patients and the patients acknowledged them by name when they arrived at the hospital.

**Good governance**

There was a system in place for monitoring the completion of mandatory training. All staff had received or were booked on annual refresher training within four weeks of this inspection. There were regular audits to ensure standards were being maintained. These included health and safety audits, clinical audits and checks that supervision and appraisal were in place. There were reporting structures in place for providing feedback from these audits.

Clinical leads were responsible for ensuring clinical audit was undertaken. Audit subjects were identified at a meeting where clinical leads from all locations within Alternative Futures group attended. Audit outcomes were discussed at the clinical manager's forum. This forum agreed an action plan to address issues raised and these were communicated back to the services for auctioning.

Incidents were recorded on the CLARISTA electronic record system. Dependent upon the type of incident qualified staff, clinical lead or manager would be notified of the need to review the incident and to process it through the electronic system.

Staff knew about safeguarding and whistleblowing. They could explain what to do in the event of an incident and how to report these both via the electronic systems and directly to the local safeguarding team. Non-clinical staff described how they would report their concerns to the nurse in charge, or the manager.

A pharmacist adviser for the hospital group chaired a monthly medication management meeting attended by the clinical lead from all locations within Alternative Futures Group. Medication management issues, included medication errors, were discussed. This group reviewed and updated medicine policies. The pharmacist produced a monthly lessons learned newsletter that was circulated to all staff.

The hospital was required to submit regular evidence to the Wigan clinical commissioning group. These included evidence of physical health, mental health and independent living outcomes. The audits supporting these were noted during this inspection. These audits enabled commissioners to monitor practice and progress.

We reviewed minutes of meetings including staff meetings, quality assurance meetings contingency planning meetings, service user meetings, and weekly breakfast meeting minutes. These demonstrated the team routinely reviewed data and outcomes from a range of incidents, audits and feedback and took actions in relation to these.

There was a risk register highlighting issues and the action taken to reduce those risks. The risk register had been reviewed at six monthly intervals. It was up to date and reflected current risks.

**Leadership, morale and staff engagement**

Staff described high levels of job satisfaction. Sickness rates were below national average. Staff spoke positively about their role and demonstrated dedication to providing high quality patient care. Staff described they were supported by their line manager and were offered opportunities for clinical and professional development courses. Staff knew of the whistle blowing procedures and said they would be unafraid to raise issues or concerns. There was evidence staff were encouraged to contribute to ongoing service development through various meetings.

Staff described good morale generally although they were feeling unease during the period of consultation and service redesign. Staff said they were worried about the implications of the service redesign. The consultation was being undertaken during this inspection. Staff understood the manager would not feature in new service and told us this had created a significant amount of worry. They told us that the situation was stressful and was having an impact on morale within the clinical team.

# Long stay/rehabilitation mental health wards for working age adults

Good

**Commitment to quality improvement and innovation**

Fir Trees did not participate in the accreditation for inpatient mental health services (AIMS). This is a non-mandatory national programme whereby a service reviews itself, and others through peer review, against a set of best practice standards. The staff intended to commence participation in 2016. A formal link with the project had been made and a site visit to an AIMS accredited site organised.

# Outstanding practice and areas for improvement

## Outstanding practice

Patients were encouraged to maintain contact with the hospital post discharge. The aim was to ensure some social contacts and peer support during the transition to their own accommodation. Patients could continue to play for the unit football team.

In addition, one patient had recently undertaken smoking cessation training with the intention of offering those interventions to his peers and continuing to do so post discharge.

## Areas for improvement

**Action the provider SHOULD take to improve**
**The provider should:**

- ensure that staff use appropriate care plans to manage the care of all patients on high-dose medications
- ensure that staff complete physical health care plans for patients that focus on management of the condition as well as the medication used
- ensure domestic staff are provided with break away training.