The Copse

Quality Report

The Copse,
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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.

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

Summary of findings

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

Overall summary

We rated the Copse as good because:

- The provider used a daily management report titled safe staffing levels, and these were completed twice a day. Any incidents which had occurred were reviewed by managers and senior clinicians the following day in a multi-disciplinary meeting.
- The Copse did not have a seclusion room and the philosophy was one of de-escalation. There had been no recorded incidents of seclusion since opening in 2015. The care records had up to date, personalised, holistic, and recovery orientated care plans present.
- Admissions to the hospital were planned and involved a comprehensive pre-admission assessment including risk assessment and initial care planning. Efforts were made to ensure that patients were able to continue leave from the hospital where appropriate to reduce disruption to their recovery pathway.
- We saw evidence of a very comprehensive physical health examination on admission involving both the hospital doctor on the day of admission and the visiting GP the following day. All patients had a minimum of monthly physical observations, if they were needed more frequently; a care plan regarding this was drawn up.
- All new permanent staff carried out a 12-week induction programme which consists of e-learning, training sessions and workplace induction.The hospital, although providing a service for a small patient number, employed a full time social worker and a psychologist which helped to ensure a broad approach to patient recovery.
- Throughout the day, we observed positive interactions between staff and patients. Potential patients were able to visit the service prior to admission and were given a welcome pack with complaints information on admission.
- All patients had access to an independent advocacy service.There had been no external transfer of any patients requiring either acute of psychiatric intensive care unit beds over the last six months.
- All patient areas were light and reasonably spacious with new comfortable furniture. Patients were able to make their own drinks and snacks whenever they wanted, with support from staff.
- Staff appeared enthusiastic and engaged with the patients. They told us they felt able to report incidents and raise concerns. They said morale was good and that they felt supported both by local and regional managers.

Summary of findings

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Good

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

Summary of this inspection

Background to The Copse

The Copse is a locked rehabilitation hospital for men and women requiring a medium term placement focusing on rehabilitation in order to progress onto community placements. The service is run by Partnerships in Care (PiC). At the time of our inspection all of the patients were detained under the Mental Health Act.

There are 24 bedrooms arranged in four small units, with each unit offering a therapeutic environment. The Copse is situated in a residential cul-de-sac, providing access to activities in the wider community.

The hospital had not been inspected before by CQC, and was opened in March 2015.

Our inspection team

The team that inspected the service comprised a CQC inspector, an inspection manager and a professional advisor.

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?

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

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the environments and observed how staff were caring for patients;
- spoke with six patients who used the service;
- spoke with the registered manager and managers for each of the wards;
- spoke with nine other staff members; including doctors, nurses, psychologist and social worker;
- spoke with an independent advocate;
- attended and observed two hand-over meetings and two multi-disciplinary meetings;
- looked at eight care and treatment records of patients:
- carried out a specific check of the medication management on two wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

What people who use the service say

The patients that we spoke with were very positive about how staff treated them, and no negative comments were made by patients about staff behaviour.

Patients reported that toilets and bathrooms were always clean. One patient told us that a nurse was not always visible in the ward living area. The patients that we spoke to told us that escorted leave was rarely cancelled.

One patient told us that activities had been more limited around five to six weeks prior to the inspection and that there had been no weekend activities. This patient also told us that they would like more practical training or activities such as how to pay bills.

One patient explained it was difficult to access dental care as it had to be paid for, and therefore they were putting up with toothache. One patient expressed that the information provided to them prior to admission presented a better picture than the reality of the experience at the Copse.

One patient told us that they had not had the opportunity to be involved in decisions about the service, for example, to help recruit staff.

At the service users monthly forum for Ash ward on 15 July 2016, patients had identified the following issues: that they would like increased access to the exercise equipment, that morning planning meetings didn't always happen, that the activities calendar was not always followed and that they would like a trip into the town to go shopping. The patients had commented that staff were really helpful and that it was a nice place to be. The patient issues identified had been responded to in a 'You said – we did' poster which was displayed on the ward noticeboard.

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 had four wards, with two wards on the ground floor and two wards on the first floor. One side of the hospital was for female patients and the other for male patients. The wards complied with the Department of Health requirement around mixed sex environments. Male and female inpatient areas were completely separate.
- The Copse did not have a seclusion room and the philosophy was one of de-escalation. Patients who required periods of time out from the communal areas were asked to go their bedrooms. Staff we spoke to understood that if they prevented people leaving their rooms this may meet the definition of seclusion and there was no indication of de-facto seclusion. The hospital had the correct paperwork should seclusion monitoring ever need to occur.
- The provider used a daily management report titled safe staffing levels, and these were completed twice a day. They were also reported on a quarterly basis to the Clinical Commissioning Groups (CCG's), as the main commissioners of services.
- Any incidents which had occurred were reviewed by managers and senior clinicians the following day in a multi-disciplinary meeting. An example we saw of improvements to practice was the use of cigarette lighters attached to lanyards, rather than being given to patients.

Are services effective?

Good

We rated effective good because:

- We saw evidence of a very comprehensive physical health examination on admission. All patients had a minimum of monthly physical observations, if they were needed more frequently; a care plan regarding this was drawn up.
- The care records had up to date, personalised, holistic, and recovery orientated care plans present. Care plans were initially drafted as part of the pre-admission assessment. Care plans were reviewed monthly at the patient care reviews.
- New staff, including agency, completed an induction, which included security and access to keys. All new permanent staff carried out a 12-week induction programme which consists of e-learning, training sessions and workplace induction

Summary of this inspection

However,

- we saw evidence to indicate that supervision levels were between 59% - 70% over the last six months.The manager told us that they were in the process of ensuring all staff would get monthly supervision, and hoped to complete this within two months.
- Whilst recovery orientated patient activities were taking place around self-care, everyday living skills, and psychologically orientated activities such as mindfulness, relaxation and coping with hearing voices, we did not see evidence of structured approaches to keeping well such as wellness recovery action plans, support for staff to deliver evidence based psychosocial interventions or robust use of crisis and contingency plans to support leave and a successful community discharge.

Are services caring?

Good

We rated caring good because:

- Throughout the day, we observed positive interactions between staff and patients. Staff were respectful to the patients and provided a mixture of practical and emotional support.
- Potential patients were able to visit the service prior to admission. Patients we spoke with told us they were given an appropriate level of information about the service during the admission process. They had been given a welcome booklet which explained how the hospital worked, what treatments and therapies available, the roles of staff, and how to complain.
- All patients have access to an independent advocacy service. Generally, the advocates visited the wards every Friday. The advocates could be contacted on Monday-Thursday via the telephone to access support if required.

Are services responsive?

Good

We rated responsive good because:

- The hospital tried to plan admissions for a Monday as the GP visited every Tuesday.
- There had been no external transfer of any patients requiring either acute of psychiatric intensive care unit beds over the last six months. Managers told us they would agree with the host trust arrangements.
- Each patient participated in a range of group work and meaningful activity in addition toone to one sessions. This was aimed at supporting their recovery. Each ward had their own

Summary of this inspection

timetable which included social skills in the community, problem solving and group outings. Informal ward activities such as board games, art and crafts film afternoons also occured throughout the week.

- All patient areas were light and reasonably spacious with new comfortable furniture. The living areas looked homely and patients had access to the lounge and dining areas throughout the day. They were able to make their own drinks and snacks whenever they wanted, with support from staff.
- Information about how to make a complaint was included in the welcome pack for patients, and was on display in communal areas.Patients told us they could complain either formally through the complaints process or directly to staff.

Are services well-led?

Good

We rated well-led as good because;

- There was evidence of good leadership at a local and senior level. Managers were visible during the day-to-day provision of care and were accessible to staff.
- There were clear governance systems to ensure the monitoring and management of services provided.
- The hospital director participated in the monthly operations governance meetings. These were regionally based and directly fed into the provider's main governance group.
- Staff appeared enthusiastic and engaged with the patients. They told us they felt able to report incidents and raise concerns. They said morale was good and that they felt supported both by local and regional managers. They also told us that they knew how to raise any whistleblowing concerns through the company policy but felt they could get local issues addressed through the hospital manager.

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 Provider.

- Ninety per cent of the permanent staff and 84% of the total staff including bank staff had completed Mental Health Act training in date.
- The provider's legal department advised us that they offered training to each hospital site, and that corporate policies had been updated in light of the revised Code of Practice.
- Copies of consent to treatment forms were attached to medication charts where applicable. We saw assessments of patients' capacity to consent to treatment completed by the doctors.
- A Mental Health Act data dashboard had been introduced which recorded key dates for patient rights, consent to treatment and section expiry and was reviewed weekly by the management team.
- The Mental Health Act administrator told us that the regional Mental Health Act manager carries out regular audits.
- The Independent Mental Health Act Advocate (IMHA) attended the hospital every Friday and ran a monthly service user forum for each ward

Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a Mental Capacity Act policy in place and staff told us about the principles and how they applied to their patients.
- For patients who had impaired capacity, capacity to consent was assessed and recorded appropriately.
- The care records system did not have a tab for staff to record capacity assessments. Staff could record in the clinical notes section of electronic care records system; however it was not possible to search clinical notes to find capacity assessments, in light of this some staff had recorded capacity in care plans.
- The hospital's management of violence and aggression (MVA) training covered the law relating to restraint.
- The Copse reported no Deprivation of Liberty (DoLS) applications in the six months between 01 November 2015 and 30 April 2016. All patients at the Copse were detained under the MHA at the time of our 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 hospital had four wards, with two wards on the ground floor and two wards on the first floor. One side of the hospital was for female patients and the other for male patients. The upper floor areas were connected by an open roof garden but access between the ground floor areas was separated by locked doors. The offices were centrally based near the entrance to the hospital and at the time of the inspection a new reception area was in the process of being built. Each ward was exactly the same in layout and design. The bedroom corridors had mirrors to aid observation, and bedroom doors all had observation panels or small viewing apertures.
- Staff had conducted a ligature audit six months prior to the inspection. Ligature risks were mitigated through risk assessments and increased observation levels of patients. We saw how the garden areas had been identified as higher risk areas, and patients all had been risk assessed prior to using these spaces. The same approach applied to patients using the outside keep fit area.
- The wards complied with the Department of Health requirement around mixed sex environments. Male and female inpatient areas were completely separate.
- There was a small, fully equipped clinic room. There was an examination couch in it but other equipment in the room needed to be moved in order to use the couch. The dispensing pharmacy did a weekly audit of medicine stocks. We observed that all equipment including scales, thermometer and fridge were checked and calibrated. Medications were safely stored. Resuscitation equipment that included oxygen and ligature cutters were either side of the hospital, located in the stairwells. A defibrillator was located at the main entrance. Night staff completed equipment checks and recorded these on a daily basis, and we saw the recording sheets used.
- The Copse did not have a seclusion room and the philosophy was one of de-escalation. Patients who required periods of time out from the communal areas were asked to go to their bedrooms. Four bedrooms had viewing panels in the doors , and were used for more unsettled patients. Staff told us that they would not normally prevent a service user from leaving their bedroom if unsettled. Staff we spoke to understood that if they prevented people leaving their rooms this may meet the definition of seclusion and there was no indication of de-facto seclusion. The manager showed us the had the correct paperwork and a policy should seclusion monitoring ever need to occur. They had not recorded any incidents of seclusion since the hospital commenced operation in 2015.
- Space for private clinical sessions such as with psychology, was limited to the meeting room when free. Areas with chairs at the bottom of the stairwell which were separate from the ward, but not private had been used in the past.
- Hand washing facilities were available throughout the wards including by the main entrance.
- Equipment that we saw on the wards was well maintained, clean, and clean stickers were visible and in date.

- One housekeeper was employed full time to work across the hospital. We saw cleaning records were up to date and the environment was clean and tidy on the day of the inspection.
- Personal alarms were available for staff. Each member of staff carried an alarm which was linked to a central call system to contact staff on other wards, if they needed assistance. Alarms were also available for visitors.

Safe staffing

- There were six whole time equivalent (WTE) registered nurses in post with an additional two in the process of being recruited to permanent positions. There were 16 WTE health care workers in post with another 1.0 WTE being recruited to. There were 3.8 senior staff who managed the hospital, 0.4 wte Psychology, 0.8 wte Social Work, 0.6 wte consultant psychiatrist and O.2 GP. There was also a range of support staff.
- The provider had not used an establishment tool to set the staffing levels. Managers showed us how they had increased staff as more patients were admitted over the last 12 months. They explained they were able to adjust numbers dependant on patient's needs, such as increased levels of observation or activities such as escorted leave or day trips. . The provider used a daily management report titled safe staffing levels, and these were completed twice a day. They were also reported on a quarterly basis to the CCG's, as the main commissioners of services. The ward managers and charge nurses always worked on the same wards, but all other staff were allocated each day dependant on ward needs. One member of staff was identified as a security lead each day.
- Sickness rates within the last 12 months were reported as 1%.
- Bank and agency staff were used to ensure that sufficient staff were available to meet variable needs on the wards. The managers told us they used regular agency staff from only three local agencies. Between January 2016 and the end of March 2016, a total of 21 shifts were covered by bank and agency staff.
- A member of staff was located within the communal areas during the day. A computer for staff to record on was located in a small desk area adjacent to the patient lounges. This was used to ensure staff were not in a separate office away from the ward when doing patient records.
- Staff we spoke with told us that patients had a one to one session weekly with their primary nurse. Although two patients we spoke with told us this happened, we did not see regular recording in care records to indicate this occurred.
- Staff we spoke with told us that escorted leave or activities are rarely cancelled. There was an activities coordinator who worked from Monday to Friday. They provided a full week of meaningful activity as part of the commissioned activity. Weekends activities were done by the ward staff. These would include such things as shopping, sporting activities, gardening or relaxation sessions.
- Staff advised us if there was an unexpected shortfall in the number of management of violence and aggression (MVA) trained nurses on shift, staff in other roles in the hospital (such as administration or maintenance) could assist as they were also MVA trained.
- The hospital employed one consultant psychiatrist who worked two and a half days a week. The current consultant was due to leave their post, and there was a newly appointed consultant psychiatrist who will work three days a week. There was also a locum staff grade psychiatrist. Out of hours cover was provided by a rota of seven consultant psychiatrists. A psychiatrist would normally take one and a half to two hours to attend the hospital due to travelling distances. The GP employed by the provider was also on-call. Alternatively the hospital could access the accident and emergency department at the general hospital, which was located nearby.
- Online mandatory training had been introduced via a system called iLearn. Staff accessed the system whether they were on or off-site. The hospital had an 81% completion rate for mandatory training which included; equality and diversity, health and safety, infection control, medication management, risk management, safeguarding adults and children, prevention and management of violence and aggression.

Assessing and managing risk to patients and staff

- We reviewed eight care records, two from each ward of The Copse. All care records reviewed had an up to date risk assessment present. Admissions to the service were planned, and were usually subject to a pre-admission assessment where the patient was visited prior to admission by one of the senior nurses, or the consultant, if the patient was subject to Ministry of

Justice restrictions on their detention under the Mental Health Act. We saw some examples of pre-admission assessments which included preparation of risk assessments and initial care plans. We saw evidence of risk assessments being routinely updated every three months.

- The hospital reported seven incidents of restraint from December 2015 to May 2016, involving four different patients. Of these none were in the prone positon and none resulted in the administration of rapid tranquilisations (RT) medications.
- Patients had an historical clinical risk (HCR20) risk assessment completed by the hospital clinical psychologist. The HCR20 is a recognised risk assessment tool helping the assessment of the risk of present and historical violence. All the 8 care records reviewed had a START risk assessment which we were told was used across the provider's hospitals, and was completed by the nursing staff. START is a comprehensive risk assessment tool which required risk to be considered across a wide range of domains such as mental state, substance use, impulse control and social support. The tool required a patient's strengths and vulnerabilities to be recorded. Some patients also had specific risk assessments completed by an occupational therapist, such as a falls risk assessment.
- Blanket restrictions existed in order to maintain security. These consisted of locked doors on the downstairs wards and the front entrance. There were clear notices in place for patients, staff and visitors explaining why this was necessary.
- There were no informal patients in the hospital at the time of our inspection. The unit was locked however staff we spoke with had a good understanding of the Mental Health Act and patient rights.
- The hospital had policies on 'Safe and Supportive Observation and Engagement' and a 'Search policy'. Staff told us that there were three levels of observation, hourly, every 15 minutes or constant. There was an approach of random searches on entry to the unit; patients' consent for this was taken on exiting the unit. Staff told us that they would also search patients if they were suspicious that they may need to do so. Staff told us that searches were always in private and usually occurred in the clinic room.
- There were eight incidents of restraint between December 2015 and May 2016, none of these were recorded as prone restraint. The staff we spoke to told us that the response team within the hospital are all trained in therapeutic management of violence and aggression (MVA). We were told that the MVA training equips staff with skills in de-escalation. As the hospital is a small service serving a maximum of 24 patients, with a small staff team, members of the maintenance and administration team were also trained in MVA and could assist if required.
- A senior nurse told us that rapid tranquilisation had been used once in the past year. On checking records, rapid tranquilisation had not been used for nearly one year. We reviewed the rapid tranquilisation policy which made the correct references to NICE guidance.
- There had been no recorded incidents of seclusion since opening in 2015, and the hospital did not have a dedicated seclusion facility. Staff we spoke did have an understanding of circumstances which might meet the definition of seclusion and when they might need to commence seclusion monitoring. The hospital did have a 'seclusion pack' which contained paperwork regarding monitoring of seclusion if required. This pack had been provided to the hospital by Partnerships in Care.
- Safeguarding adult and children training was delivered to staff by the hospital's social worker as part of mandatory training. The social worker as safeguarding lead was available to all staff for advice regarding safeguarding matters, and kept a log of safeguarding incidents and their outcome. The safeguarding lead described a good working relationship with the local authority safeguarding team.
- A dispensing pharmacy supplied the medicines for the Copse. The dispensing pharmacy did a weekly audit. Due to the rehabilitation nature of the service, many of the patients undertook some degree of self-medication. The Copse used a stepped system for self-medication (Nomad). Patients were assessed for their suitability and adherence to self-medicate either on a daily or weekly basis. Patients who self-medicated had their medications securely locked in their bedrooms.
- There were safe procedures for children that visit. The hospital had a policy on contact between children and patients. Child visiting took place in a meeting room off the ward and was pre-arranged and subject to approval from the hospital's social worker.

Track record on safety

Long stay/rehabilitation mental health wards for working age adults

Good

- There was one serious incident recorded at the hospital over the last 12 months. Managers we spoke with told us they would review any serious incidents in conjunction with the regional director and the provider's governance team.
- An example of a lesson learnt was following an incident of self-harm occurring whilst on leave. As a result staff would check all parts of returned razors and sign to confirm this had happened. The information was shared at the clinical governance meeting? and disseminated to all staff.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were able to accurately describe what would constitute an incident.
- Staff showed us the computerised incident reporting system called IRIS, which enabled the provider to set up national and regional reporting to clinical governance groups.
- Staff were aware of the need to be open and transparent and explain to patients when things went wrong. The provider's policy also included reference to completing an entry on the patients care notes when this had occurred.
- Staff told us they received feedback from incidents in the team meetings which included key themes and action plans to make changes. A debrief session was arranged after an incident, and reflective sessions would also take place to support staff.
- Any incidents which had occurred were reviewed by managers and senior clinicians the following day in a multi-disciplinary meeting. An example we saw of improvements to practice was the use of cigarette lighters attached to lanyards, rather than being given to patients.
- Staff told us that the psychologist offered de-briefing to staff following incidents, or internal debriefing with peers was available.

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

- We reviewed eight care records. All records reviewed contained a comprehensive and timely assessment. The assessment was typically completed as a pre-admission assessment by senior staff and was written in the form of a comprehensive report which is available on the electronic care record system. The assessment considered both needs and risks. A psychiatric assessment was undertaken within 24 hours of admission.
- Care records demonstrated a full physical health examination on admission. Where applicable we saw evidence of ongoing physical care. The medical 'clerking in' of a patient on the day of admission included some screening for physical health issues. The hospital tried to plan admissions for a Monday as the GP visited every Tuesday. We saw evidence of a very comprehensive physical health examination on admission. All patients had a minimum of monthly physical observations, if they were needed more frequently; a care plan regarding this was drawn up. Patients had a physical health care plan.
- The care records had up to date, personalised, holistic, and recovery orientated care plans present. Care plans were initially drafted as part of the pre-admission assessment. Care plans were reviewed monthly at the patient care reviews. We noted that only one patient had a crisis/ contingency plan and discussed this with the lead nurse. The lead nurse agreed that this was something that they could introduce for all patients. One of the records we reviewed was for a patient who was commencing overnight leave to a care home. We noted that this patient did not have a crisis/ contingency plan regarding action to be taken if experiencing problems on leave and discussed this with the provider. Care programme approach (CPA) meetings usually took place every six months and external professionals would normally attend these meetings.
- Records were stored on the hospital's electronic care record system. Case notes were password protected.

Patients also had a paper folder which contained historical information not on the electronic record. The paper folder was stored in a locked cabinet. All records were readily available for staff.

Best practice in treatment and care

- Psychology input was provided by a consultant clinical psychologist who was employed for two days a week. The hospital no longer provided a service for patients with a personality disorder, so the focus of the psychologist's work had shifted to working with people with psychosis. The psychologist was keen to promote the role of psychology in patient care. The range of psychological recovery interventions was limited. We did not see evidence of structured approaches for patients to keeping well such as wellness recovery action plans (WRAP).
- The psychologist undertook HCR20 risk assessments soon after patients arrived, and input into the clinical formulation of patient's needs. One to one working was offered to all patients, although engagement had been identified as an issue previously by staff.
- The psychologist ran a weekly reflective practice meeting for staff, which she stated was to encourage psychological thinking about patients. She also ran various groups for patients which included sessions on mindfulness, coping with hearing voices and mental health recovery.
- We saw specific care plans for patients with nutritional needs such as diabetes. The hospital had recently employed a dietician to provide three hours input per month. The senior nurse told us that the dietician would hold clinics for patients, and educational training for staff. A patient told us that they were very confident about the physical healthcare they received.
- Staff told us that the hospital doctors completed HoNOS secure for patients. We saw evidence of this being used in the assessment part of the electronic care record.
- The hospital had carried out a range of audits over the last year. These included least restrictive practice, suicide prevention, data protection, medication management. Action plans were developed and implemented from these audits.

Skilled staff to deliver care

- The hospital had a range of mental health disciplines providing input. This included a psychologist, nursing staff, consultant psychiatrist, and a social worker. There was a vacancy for an occupational therapist, and the post was advertised at the time of the inspection.
- Staff skills and experience were appropriate to the patient group, and there was a significant range of skills and knowledge across all staff groups.
- New staff, including agency, completed an induction, which included security and access to keys. All new permanent staff carried out a 12-week induction programme which consists of e-learning, training sessions and workplace induction. Healthcare assistants completed a portfolio to evidence meeting standards in the care certificate.
- Ward managers told us they aimed to have formal supervision for their staff every month. Staff we spoke with said they could get informal supervision when needed. However, we saw evidence to indicate that supervision levels were between 59% - 70% over the last six months. The manager told us that they were in the process of ensuring all staff would get monthly supervision, and hoped to complete this within two months.
- Seventy one per cent of staff had a formal appraisal in the previous year.
- Managers we spoke with told us they were supported by the human resources department to address any staff performance issues effectively. Each member of staff had an electronic staff record.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings took place every week on each ward and were attended by medical, nursing, psychology, and social work staff. Individual patients were reviewed and attended the meeting every four weeks. From these meetings, action plans included who was responsible for carrying out the actions and the due date for completion.
- Care programme approach (CPA) or discharge planning meetings took place for each patient every six months. These were attended by the patient and the multidisciplinary team, and where possible staff from the patients' home area and family.
- There were handovers between the two shifts, which included an action sheet to make clear what needed to

happen during the shift. During this meeting staff wereallocated to each of the four wards. Following this there was a daily handover meeting with senior staff across the hospital.

Adherence to the MHA and the MHA Code of Practice

- Ninety per cent of the permanent staff and 84% of the total staff including bank staff had completed Mental Health Act training in date. Training was 1.5 hours annually and was for all grades of staff.
- Part of the mandatory Mental Health Act training included an overview of key changes relating to the Code of Practice when it was revised in 2015. We were shown the staff presentation regarding this. The provider's legal department advised us that they offered training to each hospital site, and that corporate policies had been updated in light of the revised Code of Practice.
- We reviewed six patient medication folders in the clinic room and observed that medication was given in accordance with the MHA. Copies of consent to treatment forms were attached to medication charts where applicable. We saw assessments of patients' capacity to consent to treatment completed by the doctors.
- If a patient arrived at the hospital from another provider, they were given their rights on admission. If they had transferred from another of the providers hospitals, the staff would check when the patient last had their rights explained. They were explained to them monthly thereafter.
- We met with the hospital's Mental Health Act administrator who undertook this responsibility alongside other functions in the hospital. They described being well supported in the Mental Health Act function, via the legal department and regional Mental Health Act manager. Following an incident where a patient's section had unintentionally lapsed without renewal, a Mental Health Act data dashboard had been introduced which recorded key dates for patient rights, consent to treatment and section expiry and was reviewed weekly by the management team. The hospital social worker was also a source of advice regarding the Mental Health Act.
- We reviewed eight Mental Health Act files and detention paperwork was in order. Mental Health Act paperwork was stored in a paper folder held by the Mental Health Act administrator.
- The Mental Health Act administrator told us that the regional Mental Health Act manager carries out regular audits. These had been done collaboratively with the Mental Health Act administrator as part of their development.
- All patients were detained under the Mental Health Act at the time of our inspection, and therefore eligible for Independent Mental Health Act advocacy (IMHA). The IMHA service was provided by an external agency. The IMHA attended the hospital every Friday, going to each ward. The IMHA ran a service user monthly forum for each ward with a 'you said, we did' summary of action points was displayed on the ward notice board. The IMHA service was run as an opt in not opt out service; however patients who lacked capacity were seen automatically by the IMHA. The IMHA would attend CPA meetings if they were involved with the patient.

Good practice in applying the MCA

- There had been 55% of staff who had training in the Mental Capacity Act.
- There was a Mental Capacity Act policy in place and staff told us about the principles and how they applied to their patients.
- For patients who had impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis with regards to significant decisions, and patients were given assistance to make a decision for themselves.
- We reviewed eight care records, there was evidence of the assessment of capacity to consent to treatment in that doctors were completing a form to indicate this and a copy was in each patient's medication file. The other area of decision making that was routinely considered was a patient's ability regarding their finances. We discussed recording of capacity assessments with the senior nurse and social worker. The care records system did not have a tab for staff to record capacity assessments. Staff could record in the clinical notes section of electronic care records system; however it was not possible to search clinical notes to find capacity assessments. For this reason, the social worker had written finance care plans for all patients, which incorporated an assessment or observation of capacity, so that staff could easily find them.
- The staff we spoke with told us that the prevention and management of violence and aggression (MVA) training covered the law relating to restraint.

Long stay/rehabilitation mental health wards for working age adults

Good

- Staff could seek advice on the MCA from the hospital's social worker who was freely available for advice, and delivered the MCA training. Additionally the provider's legal department was available for advice.
- The Copse reported no Deprivation of Liberty (DoLS) applications in the six months between 01 November 2015 and 30 April 2016. All patients at the Copse were detained under the MHA at the time of our inspection.
- In the data pack provided to CQC, the hospital had responded that clinical audits to demonstrate compliance with the MCA had been not been necessary as all patients had been detained under the MHA. The MCA would still apply however for certain decisions that patients detained under the MHA would make.

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

Good

Kindness, dignity, respect and support

- Throughout the day, we observed positive interactions between staff and patients. Staff were respectful to the patients and provided a mixture of practical and emotional support.
- Patients we spoke with told us that staff treated them well and they generally found them with very positive attitudes.
- Staff showed a good understanding of individual patient needs during team discussions and handovers which we attended.

The involvement of people in the care they receive

- Potential patients were able to visit the service prior to admission. Patients we spoke with told us they were given an appropriate level of information about the service during the admission process. They had been given a welcome booklet which explained how the hospital worked, what treatments and therapies available, the roles of staff, and how to complain.
- We saw evidence of active involvement of patients in care planning and admissions process. This included patient participation in multi-disciplinary reviews and care programme approach meetings. Patients had copies of their care plans.
- All patients have access to an independent advocacy service. Generally, the advocates visited the wards every Friday. The advocates could be contacted on Monday-Thursday via the telephone to access support if required.
- Patients said they were able to have visitors to the wards. Although some patients did not like being placed so far away from their homes and families, which had caused some travel difficulties.
- There were weekly community meetings on each of the wards. Patients had raised concerns and made decisions about issues on the wards. This included changes to the timetable on the ward, and decisions about activities or changes to the menus for those patients not self-catering.

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

Good

Access and discharge

- The hospital tried to plan admissions for a Monday as the GP visited every Tuesday
- The average bed occupancy across the hospital was 70% over the last six months prior to the inspection.
- The catchment area for the hospital was predominately across the south west region of England. Staff had regular communication with the patients' referring home trust and liaised with bed managers, care coordinators and home treatment teams to manage any planned discharge. Short periods of leave were arranged to visit local shops and facilities.
- There had been no external transfer of any patients requiring either acute of psychiatric intensive care unit beds over the last six months. Managers told us they

would agree with the host trust arrangements. However, in the records we reviewed we only found evidence for one crisis plan and what to do if a patient required a transfer.
- There were no delayed discharges from the hospital in the six months prior to the inspection.

The facilities promote recovery, comfort, dignity and confidentiality

- All patient areas were light and reasonably spacious with new comfortable furniture. The living areas looked homely and patients had access to the lounge and dining areas throughout the day. They were able to make their own drinks and snacks whenever they wanted, with support from staff.
- Staff supported identified patients to shop for and cook their own food and budgets were available for this. This occurred mainly on the two upper wards, as patients here had progressed further along the rehabilitation pathway. There was a four-week rolling menu for other patients.
- Each ward had a private telephone room where patients could make phone calls.
- Wards had access to outdoor areas that were well maintained and accessible to patients.
- All patients had their own individual bedrooms and had a lockable cupboard for personal items. Patients were encouraged to personalise their bedrooms. Each ward had its own separate toilets, shower and an assisted bathroom.
- There was a variety of activities available to patients but space for these was limited. These included; gardening, arts and crafts, music and therapeutic groups, and smoking cessation. Activity focused on promoting recovery and developing skills to improve and maintain independence.
- We were shown a 'meaningful week timetable' for Elm ward that showed activites such as a breakfast group, money ordering, health promotion, sports activities, social work clinic, smoking cessation, mental health recovery group, activities of daily living, self –catering shopping, gardening, film afternoon, pamper session, mindfulness, relaxation and DVD afternoon.

Meeting the needs of all people who use the service

- The hospital enabled patients with disabilities to access all areas. There were lifts to the upstairs wards and corridors and doorways were spacious. Other facilities included wet rooms and accessible toilets.
- Managers told us that information leaflets or access to interpreters was available via the provider's head office. There was a range of information available relating to activities, treatment, safeguarding, patients' rights and complaints information. This was either in folders or on notice boards in patient areas.
- Each patient participated in a range of group work and meaningful activity in addition to one to one sessions. This was aimed at supporting their recovery. Each ward had their own timetable which included social skills in the community, problem solving and group outings. Informal ward activities such as board games, art and crafts film afternoons also occured throughout the week.
- A choice of food was available to patients in accordance with their dietary and ethnic requirements for example halal food. Some patients were self-catering as part of the rehabilitation programme.
- The hospital was visited weekly by a chaplain who could access a variety of multi faith services.

Listening to and learning from concerns and complaints

- There had been eight complaints received across the four wards over the last nine months. Of these two had been upheld.
- Information about how to make a complaint was included in the welcome pack for patients, and was on display in communal areas. Patients told us they could complain either formally through the complaints process or directly to staff.
- There was a complaints policy, and a guide for managers in how to deal with complaints effectively. Complaints were discussed and monitored in the daily management meetings as appropriate.
- The hospital's social worker was the complaints lead and kept a log of all complaints and their outcomes. The social worker showed us copies of feedback letters to patients following the investigation, and explained to us that they would arrange mediation sessions if required.

Long stay/rehabilitation mental health wards for working age adults

Good

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

Good

Vision and values

- The Partnerships in Care values were published on its website, and were on display on the wards. These were valuing people, respecting our staff, patients, their families and communities. Caring safely- caring safely for ourselves, our patients, our customers and communities. Integrity- uncompromising integrity, respect and honesty. Working together- working together with everyone. Quality- taking quality to the highest level.
- Staff we spoke with knew who the local regional managers were and told us they visited every month.

Good governance

- There were clear governance systems to ensure the monitoring and management of services provided.
- The hospital director participated in the monthly operations governance meetings. These were regionally based and directly fed into the provider's main governance group.
- We saw the electronic quality dashboard system for reporting on management information including; training rates, absences, supervision and appraisal rates, CPA meetings, risk assessments, clinical audits, incidents and complaints. This information was summarised and presented monthly as a key performance indicator. Examples of audits carried out included, patient engagement and standard of care plans.
- The managers told us they felt they were involved in the decisions about service developments, and how they were well supported by the senior management team.
- The hospital manager showed us the hospital risk register and described how they could ensure risks were identified and managed via this process.

Leadership, morale and staff engagement

- There was evidence of good leadership at a local and senior level. Managers were visible during the day-to-day provision of care and were accessible to staff. Patients and staff knew the hospital director and said they were familiar with them walking around the hospital and engaging with patients and staff.
- Sickness absence rates had been reported as 1% of the total staff group over the last nine months.
- There were no bullying and harassment cases we were made aware of.
- Although appraisals were all up to date, nursing staff were not all getting monthly supervision in line with the provider's policy. This had ranged from 59% - 84% each month.
- Staff appeared enthusiastic and engaged with the patients. They told us they felt able to report incidents and raise concerns. They said morale was good and that they felt supported both by local and regional managers. They also told us that they knew how to raise any whistleblowing concerns through the company policy but felt they could get local issues addressed through the hospital manager.
- Senior staff we spoke with told us the provider was supportive in helping them develop their leadership skills.

Commitment to quality improvement and innovation

- The hospital did not participate in any national service accreditation or peer-review schemes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure that:

- All staff have access to the monthly supervision session in line with their policy.
- Psychological therapies as recommended by NICE are available to the patients.
- Patients have robust collaborative crisis/contingency plans which reflect changes in circumstances such as community leave or discharge, and which are shared with the patient and relevant parties involved in leave or discharge arrangements.