

Requires improvement 

West London Mental Health NHS Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RKL53	St Bernards and Ealing community services	Mott House	UB1 3EU
RKL14	Lakeside Mental Health Unit and Hounslow community services	Glyn Ward	TW7 6AF

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

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

Where applicable, we have reported on each core service provided by West London Mental Health NHS Trust and these are brought together to inform our overall judgement of West London Mental Health NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Requires improvement



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- This core service had been inspected in June 2015 as part of a comprehensive inspection of the trust. We had produced a list of actions the provider should take to improve following our last inspection. The service had managed to address most of these. However, we found that more work was needed in some of these areas.
- Whilst work had taken place to improve staff engagement across the trust, further work was needed on both wards to ensure staff felt able to raise concerns and feel respected by senior ward staff.
- We also said at the last inspection that the trust should ensure that maintenance and repairs are carried out in a timely way at Mott House. On this inspection it appeared that maintenance and repairs were being addressed at Mott House, but there were hold ups with maintenance and repairs at Glyn ward.
- During this inspection we also identified additional areas that required improvement. The practice of acute patients sleeping at night on the rehabilitation wards needed to stop as this presented potential risks to both groups of patients.
- There was more work needed to support the patients to access vocational and educational opportunities and to increase their self-help skills such as self-catering and self-administering medication as part of their rehabilitation process.
- More work was needed to measure outcomes for patients to ensure the wards were fulfilling their aims of supporting people to achieve greater independence.
- Restrictive practices were in place that could be further reduced for patients using a rehabilitation service, such as access to snacks and bedroom keys.
- The psychology post across both wards was vacant at the time of the inspection, although the service was working to recruit to this post.
- The dignity of patients at Glyn ward was compromised. Viewing panels into patient's bedrooms were covered

by an exterior curtain that could easily be opened by people in the corridor. Staff called out patients medications from a hatch in front of others. Patient confidential information displayed in the nurses office could be seen from the corridor.

- Staff had a poor working knowledge of incidents that had taken place on both wards because incident data couldn't easily be pulled from the computer system. There was mixed learning from incidents.
- Staff at Glyn ward were not all having regular supervision or an appraisal.
- Physical healthcare records were not consistently stored in the same location at Mott House, and staff had difficulty locating them. They would therefore be difficult to locate in an emergency situation or at short notice.

However:

- Despite ongoing challenges with nursing recruitment, staffing levels could easily be adjusted according to the changing needs of patients and the service was safely staffed. There was good access to occupational therapy input.
- Care plans were detailed and contained recovery oriented goals. Patients were positive about the care they were receiving and felt as though they were recovering.
- Patients could access a comprehensive programme of activities during the week. There were plenty of activity rooms and facilities available for patients to participate in art therapy and cooking activities.
- Work had taken place to reduce patients' length of stay. A graded discharge model ensured that patients could return to the ward during the weeks following discharge if required. The service had plans to offer more step down options such as an outreach service in the future.
- Medical staff were dynamic and flexible. They worked hard to find the best possible treatment for their

Summary of findings

patients. There was good access to physical health care and staff showed a good understanding of patients physical health needs. We observed good staff interactions and patients got on well with staff.

Summary of findings

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

Are services safe?

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

- There were potential risks involving patients from acute wards who slept on the rehabilitation wards when there were bed shortages, however these patients had been assessed for suitability and risk prior to the sleepover and often were patients who were on a discharge pathway. The ward environment contained ligature points and may have been unfamiliar to agency staff or staff accompanying the patient from their existing ward. Patients sleeping over who were acutely unwell also posed a potential risk of conflict to existing patients on the rehabilitation ward.
- There was scope to further look at whether restrictions on the wards could be further reduced, such as access to snacks and patients having a key to their bedroom.
- Staff did not know how to access details about previous incidents on the wards easily. Staff had a poor working knowledge of incidents that had taken place. Lessons learned from incidents were mixed.
- The cleanliness of the toilets on both wards needed to improve. The cleaning cupboard at Mott House was untidy and at Glyn ward not all the cleaning equipment was available.
- Some repairs and maintenance were taking too long to complete.

However:

- Although nursing vacancies were a continuing challenge for the service, use of regular agency nurses and substantive staff undertaking additional bank shifts meant that wards were safely staffed.
- Staffing levels could easily be adjusted if required and leave and activities were rarely cancelled due to short staffing.
- Thorough risk assessments were in place for patients and staff knew patients well.

Requires improvement



Are services effective?

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

- Staff appraisal and supervision levels at Glyn ward were low, though the service was already working to improve these.

Requires improvement



Summary of findings

- Psychology input to peoples care had stopped shortly before our visit, though the service was working to recruit to their psychology vacancy.
- The service was not using outcome measures and other means of assurance to robustly measure if patients were benefiting from the rehabilitation provided on the wards.
- Physical health documentation was not consistently stored in the same location on the electronic records system at Mott House and staff had trouble locating it.
- Staff were using the Mental Capacity Act appropriately but didn't have a clear understanding of Deprivation of Liberty Safeguards and when these may need to be applied.

However:

- Care plans were detailed and holistic. Patients at Glyn ward had been involved in producing these and their views about their care were captured.
- Comprehensive assessments were undertaken on admission and the occupational therapy admission assessment was subsequently used to measure progress.
- There was good access to physical health care. The medical staff were dynamic, sought to find the best possible treatments for their patients through discussing new research and guidance, and provided good medical cover. They had a very good understanding of patients physical health needs.
- Staff had good access to specialist training and opportunities for progression.
- Mental Health Act documentation was appropriately stored and patients understood their rights. Independent Mental Health Advocates were available and patients knew about their service.

Are services caring?

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

- The dignity of patients was compromised at Glyn ward. A board detailing personal patient information was displayed in the nursing office and could be seen from the corridor. Glass viewing panels in bedroom doors had exterior curtains that could be opened by people in the corridor, allowing them to see into bedrooms. Patients queued at a hatch for their medications which were called out by nurses, meaning that

Requires improvement



Summary of findings

patients knew which medications others were taking. Although the service had introduced a process to make keys available, patients told us they did not have keys to their rooms, despite having asked staff for them.

However:

- Patients had good relationships with staff and felt well supported by them.
- Patients generally had a good understanding of their care and felt as if they were making a recovery.
- Patients knew how to give feedback about the service. There were examples of patients being consulted with about decisions about what to spend money on.

Are services responsive to people's needs?

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

- Patients were not being offered opportunities to develop skills associated with preparing for their rehabilitation. For example patients were not able to routinely self-cater or administer their own medication. There were also a significant number of patients who were not accessing vocational or educational opportunities.
- Although the average length of stay was decreasing, further work was needed. Six patients at Glyn ward had been with the service for longer than three years.

However:

- A graded discharge model was used, involving a seven day follow up, and patient's beds were kept for them four weeks after discharge in case they needed to return. Sleep over patients from other wards only slept in totally vacant bedrooms.
- A good range of activities were available during the week, and facilities were good. They included garden areas, art spaces and quiet areas.
- The service was aware of individual diverse needs and met people's needs well.

Requires improvement



Are services well-led?

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

- Further improvements to staff engagement were needed. Staff at Mott House felt unsupported. There was a blame culture and staff feared victimisation. Some staff at Glyn ward felt they were bullied.

Requires improvement



Summary of findings

However:

- Staff at Glyn ward felt well supported by their recently appointed ward manager, and morale had started to improve.

Summary of findings

Information about the service

The trust provided two high dependency rehabilitation units for adults of working age. They both provided inpatient rehabilitation on hospital sites to men and women over the age of 18 who had a diagnosis of severe and enduring mental illness and a need for rehabilitation.

Mott House was a 14 bed mixed gender ward at St Bernards hospital in Ealing. Glyn ward was a 23 bed mixed gender ward at Lakeside mental health unit in Hounslow.

Our inspection team

The team that inspected the long stay/rehabilitation mental health wards for working age adults consisted of one CQC inspector, one occupational therapist, one social worker, one CQC pharmacy inspector, one expert by experience and one Mental Health Act reviewer.

Why we carried out this inspection

When we last inspected this service in June 2015, we rated rehabilitation mental health wards for working age adults as **good** overall;

After the inspection, we made no requirement notices but we did recommend a number of areas where the service could improve.

This inspection was to follow up the findings of the previous inspection.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited both of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with 14 patients who were using the service
- collected feedback from 17 patients using comment cards
- spoke with the manager at Glyn ward and acting manager at Mott House
- spoke with the service manager
- spoke with both of the consultants for each of the wards
- spoke with 17 other staff comprising three junior doctors, four registered nurses, two unqualified support staff, two occupational therapists, two activity coordinators, two pharmacists, a clinical team leader and an administrator
- carried out a specific check of the medication management at Glyn ward
- looked at a range of policies, procedures and other documents relating to the running of the service
- looked at ten patient treatment records

Summary of findings

- observed a community meeting and looked at minutes from recent community meetings
- observed a breakfast club activity
- observed a handover meeting
- observed a ward management meeting

What people who use the provider's services say

We spoke with seven patients at Mott House and seven patients at Glyn ward. They all told us that the wards were generally clean and comfortable. However, five of the patients at Glyn ward told us that the toilets were frequently blocked and unclean.

It was felt that staff were pleasant, supportive and showed respect. On both wards patients told us that there was still a high turnover of agency staff which felt unsettling. Leave and activities weren't usually cancelled and patients felt that staffing levels were generally good.

Patients understood their rights and informal patients told us they could come and go easily as they pleased. Most of the patients felt that they were getting better and making progress. At Glyn ward patients had contributed to and had a good understanding of their care plans. At Mott House four of the seven patients we spoke with had seen and contributed to their care plan the day before our visit, the remaining three didn't have an awareness of their care plan. At Glyn ward none of the patients who we spoke with had a key to their bedroom, despite some of them having asked staff for one.

Food was perceived to be of very good quality on both wards, but whilst there were cooking activity sessions, patients were not able to cook their regular meals. None of the patients who we spoke with were engaged with voluntary or educational opportunities. Patients generally knew about ways in which they could provide feedback about the service.

At Glyn ward patients told us that their religious needs were respected and catered to. These patients also gave examples of physical health appointments and check-ups that they had recently attended.

At Mott House some patients told us they were searched for cigarettes and lighters when they returned from leave. Five of them told us that they were keen to store their cigarettes, tobacco and lighters on the ward rather than hiding them outside.

Areas for improvement

Action the provider MUST take to improve

- The trust must stop the practice of acute patients sleeping over on the rehabilitation wards. This is a potential risk to the acutely unwell patients and could also present a risk for the patients receiving rehabilitation care.
- The trust must ensure that staff at Glyn ward have access to regular supervision and appraisals.
- The trust must promote the privacy and dignity of patients at Glyn ward by ensuring that patient confidential information is out of public view, medications are administered in a dignified fashion, and viewing panels to bedrooms are only able to be opened by authorised staff when absolutely necessary and that patients can obtain keys to their bedrooms when appropriate.
- The trust must ensure that the wards offer opportunities for rehabilitation. For example they should improve access to educational and vocational opportunities, self-catering and the ability to self-administer medication.
- The trust must continue to work to improve staff engagement across the two rehabilitation wards. They must develop an open and supportive culture for staff at Mott House so that they feel able to raise concerns without fear of victimisation, and continue to improve staff engagement at Glyn ward.

Summary of findings

Action the provider SHOULD take to improve

- The trust should ensure maintenance and repairs are carried out in a timely way at Glyn ward and that maintenance equipment is stored appropriately at Mott House.
- The trust should ensure cleaning cupboards are kept tidy; contain the right equipment and that toilet areas are kept clean at all times.
- The trust should ensure incident data can easily be accessed by ward staff to facilitate staff learning and that staff are updated about investigations into incidents and the learning from them.
- The trust should ensure full consideration is given to safeguarding issues and whether alerts should be made to the local authority.
- The trust should continue to review whether restrictions can be reduced, such as access to snacks, bedroom keys and searching people where there are concerns they are bringing tobacco onto the ward.
- The trust should ensure that the trust uses outcome measures and other systems of assurance to ensure patients are making progress with their rehabilitation.
- The trust should ensure the psychologist on both wards is replaced as soon as possible.
- The trust should ensure physical health documentation is consistently stored in the same location in the patient records at Mott House.
- The trust should ensure staff have an understanding of Deprivation of Liberty Safeguards.

West London Mental Health NHS Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mott House	St Bernards and Ealing community services
Glyn Ward	Lakeside Mental Health unit and Hounslow community services

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.

Staff had received training on the Mental Health Act, which was mandatory, and they showed a good understanding of consent.

We carried out a Mental Health Act review visit at Glyn ward. Detention papers reflected lawful detention, though one patient's care plan hadn't been updated to reflect their detention status, which could have led to unlawful detention.

Rights were read by patients' primary nurses on admission and were usually repeated thereafter; however the service had started analysing data to promote an increase in frequency of rights being repeated to patients.

Independent mental health advocates visited both wards and attended community meetings. Patients knew how to contact the advocate and staff also referred patients to the advocacy service.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Mandatory Mental Capacity Act training was in place for all staff. This had only been recently introduced and compliance was 67% across the service at the end of October 2016. Despite this, staff who we spoke with had a good understanding of capacity issues and the service was in the process of ensuring that everyone completed it. Doctors undertook capacity assessments.

None of the patients were subject to Deprivation of Liberty Safeguard authorisation (DoLS) at the time of our visit, and no DoLS applications had been made at either location. Staff didn't have a clear understanding of when these might need to be applied.

Capacity assessments for a range of specific decisions such as physical health decisions and financial decisions were undertaken.

Are services safe?

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

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

Our findings

Safe and clean environment

- Some areas of the environment at Glyn ward were not well maintained. We found three holes in corridor walls and a leak in the conservatory ceiling. At least one of the holes had been present for more than four months. Staff had reported it to maintenance but it had not been mended yet. The patient telephone had also been out of use for a few weeks at the time of our visit. Hold ups could be identified and escalated to the service manager, who would make contact with the estates department to follow up on issues, and any issues that directly impacted care delivery were added to the risk register. Although there were outstanding maintenance works at Glyn ward, there were none at Mott House.
- Patients on both wards told us they found the ward environments mostly clean and comfortable. When we visited Mott House it appeared clean and tidy, although the toilets in the male corridor could have done with a clean. At Glyn ward five patients told us toilets were often blocked and unclean. During our ward tour we saw that two toilets at Glyn ward were blocked and the floors in the corridors were sticky. The cleaning cupboard at Mott House was disorganised, and at Glyn ward only one of the four categories of cleaning bucket for specific areas was present.
- Staff had not stored all equipment safely. At Mott House they had stored a set of ladders inappropriately in the garden area, which enabled direct access to the roof.
- Staff could not see bedroom corridors from the nurses' station at Mott House. At Glyn ward most of the environment could be seen from the nurses' station, though there were some blind spots. Staff completed hourly environment checks on both wards to mitigate safety risks caused by blind spots, and nursing staff carried personal alarms. These measures were appropriate because this was a rehab setting where patients were assessed as being at lower risk of self-harm.

- Both wards had appropriate gender separation. They had female only corridors with separate lounges and bathroom facilities.
- Staff had completed a ligature audit identifying ligature anchor points, which was repeated annually. Staff undertook hourly observations to mitigate the risks these posed. These measures were appropriate because this was a rehab setting where patients were assessed as being at lower risk of self-harm.
- High risk patients often slept over from acute mental health admission wards on the rehabilitation wards. This was not safe for patients with these needs as there were more ligature points than an acute ward; patients were often accompanied by agency staff who may have not been familiar with the ward environment and potential ligature anchor points. Also, when we asked to see the ligature cutters at Glyn ward, they could not be found.
- Clinic rooms on both wards were clean and had handwashing facilities. Staff conducted regular audits of infection control and staff hand hygiene.
- Medical equipment was clean, well maintained and calibrated. Emergency 'grab bags' containing emergency medicines were available and resus equipment was checked daily.
- Staff completed quarterly workplace assessments to identify environmental hazards and issues that needed to be addressed. The only identified action at the time of our visit was for television cables in the lounge to be made less hazardous at Glyn ward.

Safe staffing

- Staffing levels on both wards were safe. Glyn ward had two registered nurses and two healthcare assistants during the day and two registered nurses and one healthcare assistant during night shifts. Mott had two registered nurses and one healthcare assistant during the day and one registered nurse and one healthcare assistant at night. At the time of our inspection the wards had a high number of vacancies, with a qualified nurse vacancy rate of 48% at Glyn ward and 43% at Mott House. The wards covered these vacancies using bank

Are services safe?

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or regular agency staff. Between April and September 2016 bank and agency staff had covered all 851 vacant shifts at Mott House. However, at Glyn ward 65 out of 1012 shifts had not been filled. On these occasions the ward manager supported nursing staff in carrying out their duties to maintain safe staffing levels.

- The wards had recruited staff recently to reduce the number of vacancies. Glyn ward had appointed two members of nursing staff and at Mott House existing agency staff had been offered permanent posts. Management had also recently conducted a staffing review, which had suggested that an additional qualified nurse on all shifts would lessen the burden of responsibility on substantive staff members who sometimes worked alongside lots of agency staff members. Two qualified nurses were on duty during each shift at the time of our visit.
- Turnover of substantive staff at Glyn ward was 26%, which was high. Turnover was 12% at Mott House. At Glyn ward we were told about a staff member who had retired, and two staff members who had moved away from the local area for personal reasons.
- Both wards had a committed team of doctors who provided good cover. There was a duty doctor available 24 hours per day.
- On both wards the manager could adjust staffing levels easily according to planned activities or changes to case mix. We were told that section 17 leave for detained patients generally went ahead and was not cancelled due to short staffing, though this was not recorded or monitored. Patients told us leave and activities were not usually cancelled, because there was usually plenty of staff on duty. However, patients on both wards told us they found the turnover of agency staff unsettling.
- Staff had completed 88% of their mandatory training, which is slightly below the trust target of 90%. The wards had not met the 90% target for nine of the 19 courses. At the end of October 2016 Mental Capacity Act training compliance was 67%. Staff uptake of this training had increased recently due to a new training programme having been implemented across the trust. Prevention and management of violence and aggression training compliance was 73%. Staff told us sessions booked up very quickly, meaning that it had

taken a while for some staff to book a slot. The ward manager at Glyn ward frequently reminded staff about gaps in their training and allowed protected time so that they could undertake necessary mandatory training.

Assessing and managing risk to patients and staff

- Since the last inspection the staff across the trust had worked with patients to review and where possible reduce the use of blanket restrictions. However, some restrictions were in place. Routine searches were taking place linked to the implementation of the 'smoke free' policy. Patients who staff suspected had been smoking were checked to make sure they were not bringing cigarettes, tobacco and lighters into the ward. Patients could not store these items and were hiding items in the grounds outside Mott House. However, e-cigarettes had recently been permitted in patient bedrooms.
- Some other restrictions were in place. Although Glyn ward had introduced a process to make keys available, patients told us they did not have keys for their room, despite having asked staff for them. The kitchen at Glyn ward was locked, and although patients could make hot drinks in the lounge, they had to ask staff when they wanted a snack.
- Patients from acute mental health admission wards slept on both wards overnight when the trust had no other beds available. Six patients from Glyn ward had slept over from acute admission wards since July 2016. Staff chose lower risk patients to sleep over and the rehabilitation ward could refuse patients they thought were too acutely unwell. Staff from the patients' existing ward conducted a handover meeting with ward staff when a patient transferred. However, patients had not been specifically risk assessed for the rehabilitation environment and staff did not always have sufficient information to support patients. For example, in January 2016 a sleepover patient arrived at Glyn ward without a staff member from their existing ward and without sufficient information for staff to understand their risks. In another incident, in June 2016, a sleep over patient became agitated and verbally aggressive towards staff. Staff could not transfer the patient to a more suitable ward and the patient's existing ward could not provide an additional staff member to care for the patient.

Are services safe?

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

- At Mott House, 34 patients from other wards slept over between July and November 2016. To reduce the risks associated with this, a member of staff from the patients' existing ward would stay with them throughout the duration of their stay. There had been no sleep over patients at Glyn ward since the summer. When patients had slept over at Glyn ward, a staff member from their existing ward conducted a handover and did not stay with them throughout the duration of their stay.
- Staff restrained one patient at Glyn ward during the previous year. They did not use the prone, or face down, position in this case. Staff had not used seclusion on the wards. However, one informal patient from Mott House had been secluded illegally in May 2016 when staff transferred them to a seclusion room on a neighbouring ward without undertaking an assessment for emergency application of the Mental Health Act. This had been raised as part of a serious incident and recognised by the service. Staff had been trained and felt confident using verbal de-escalation to calm patients who became roused.
- We looked at ten patient care records. Individual risk assessments were undertaken on admission and updated at least every 6 months. Assessments included risks associated with physical health needs, such as risk of falls. Risks were clearly referenced in care plans where necessary and there was evidence that discussions about risk took place during ward rounds. However, Staff at Glyn ward did not ensure all patients had up to date risk assessments following incidents. Of the ten files we reviewed two risk management records had not been updated following incidents. Lack of updated risk management plans increased the likelihood that similar incidents could happen again, potentially putting patients and staff members at risk of harm. Staff felt that they had a good understanding of risk and could easily access risk assessments and discussed risk during handovers.
- Both wards were locked, but informal patients could leave promptly if they informed a staff member. Patients we spoke with told us that they could come and go as they pleased. There were clear signs on the main doors to each ward explaining informal patients' right to leave. At Glyn ward staff had trialled leaving the door open in the past when the patient group were settled enough.
- Staff understood what constituted a safeguarding incident and could identify different types of abuse. Safeguarding champions existed at ward level, and could be approached by any staff member for support or advice about safeguarding matters. There were also trust safeguarding leads that could be contacted by staff to discuss incidents with safeguarding implications.
- We looked at 12 incidents that featured aspects of safeguarding across both wards. Two incidents hadn't been identified as safeguarding. Ten of these had been raised internally as safeguarding concerns, but only two of these had been discussed with and referred to the relevant local authority. This meant there was a risk that safeguarding concerns had not been appropriately escalated and investigated.
- Lakeside mental health unit had a family room patients from Glyn ward could use to meet with young family members. There were also bookable rooms at the St Bernard's site for patients at Mott House to visit young family members.
- Ward pharmacists attended Glyn ward each weekday and Mott House twice per week. Appropriate medication disposal facilities and sharps bins were available and there were good medicines management practices in place. Staff stored most medicines appropriately, although at Glyn ward some fridge and ambient room temperatures were slightly above the guidance range. Staff completed prescription charts clearly and included patients' allergy status. The pharmacist screened prescription charts and identified patients taking high dose antipsychotics. Staff that made medication errors were sent for medicine management training.

Track record on safety

- Three serious incidents took place across the service during the 12 month period from November 2015 until October 2016. One of these happened at Glyn ward, but was downgraded from serious incident status following intelligence to confirm that the incident was due to a physical health issue rather than potentially avoidable injury causing harm. The other two incidents took place at Mott House. Thorough investigations took place which involved staff from services elsewhere in the trust. Recommendations for learning as a result of these serious incidents were recorded in both cases.

Are services safe?

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

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and how to report them. All staff were able to report incidents via an electronic form on the trust intranet system. If incidents had safeguarding implications, this could be selected on the form. Staff at different levels told us about what sorts of things counted as incidents and understood what should be categorised as a safeguarding incident. We looked at incident records from November 2015 to October 2016 for both wards. A range of different incidents had been reported, demonstrating that staff had a good understanding of what should be reported. Incidents that had taken place were included in detail in patient progress notes, where references to the incident record were usually included.
- Staff could not access information about previous incidents easily. Staff did not know what incidents that had taken place over the past year and the themes, learning or changes which had resulted from them. For example, the ward manager at Glyn ward could not recall details of a restraint on the ward or an incident where a patient absconded during a day trip that had happened within the last year.
- On both wards the evidence that staff learned from incidents was mixed. There were processes in place to cascade learning. For example learning points were discussed at handovers and emailed to the team for implementation. Learning from incidents that had happened elsewhere in the trust were communicated to staff via bulletins on the trust computer system. Learning from elsewhere in the service was discussed at quarterly clinical improvement meetings, though these were only attended by senior staff. We found that on occasions this led to changes. On both wards staff were able to talk about some changes that had been made following incidents. Staff at Glyn ward now checked with the nurse in charge which medications patients who were going out on leave needed to take. The nurse in charge shared this responsibility to check the medications of those who were going out on leave. This was in response to an incident where a patient was taken out for a trip and missed their medication because they were away from the ward. In contrast we heard about incidents on both wards of detained patients who frequently went absent without leave. Here the learning was not shared across the two wards.
- We were given some examples of formal debriefs taking place for staff and patients following incidents, however none of the staff who we spoke with had been updated about any investigation or learning that had resulted from this incident, and some staff felt poorly supported following the incident. Two staff members told us about a recent incident that was subject to an internal investigation. They weren't updated about the incident and didn't know about the outcome of the investigation.
- Staff who we spoke with understood the importance of being open and transparent and applying the duty of candour. We were given an example of staff being open with a patient who had wrongfully been administered an incorrect medication dose.

Are services effective?

Requires improvement 

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

Our findings

Assessment of needs and planning of care

- Staff carried out comprehensive assessments of each patient's risk on admission, including physical health examinations and assessments for each professional discipline. Occupational therapy assessments were subsequently used to measure progress. Staff completed care plans within 72 hours of admission on both wards and set initial recovery goals.
- All care records were stored on one electronic record system. At Mott House Staff did not store physical health reports consistently in the same location on the system. This meant staff had difficulty finding them, which may have compromised the delivery of prompt and effective care, particularly in emergency situations.
- Staff completed comprehensive, holistic, and detailed care plans, which mostly recorded patients' views. Different members of the multidisciplinary team had contributed to care plans. For example, the occupational therapist had contributed to a plan around mobility issues. Staff had developed short and long term goals with the patients.
- Staff supported patients with their physical health needs. All the records we reviewed included ongoing physical health reports and updates. Staff supported patients to attend physical health appointments.

Best practice in treatment and care

- Other than the occupational therapy assessments which measured individual progress the service did not effectively monitor outcomes and did not have an overall picture of the progression patients were making. At Mott House outcomes had been measured by monitoring readmission rates over a six year period. However, the last six year period ended in 2014 and the service had not conducted any further analysis of outcomes to measure how effective the service was at the time of our visit.
- A number of audits were carried to provide assurance and identify areas for improvement. Audits that took place included monitoring patients' length of stay, care

plans, care programme approach, risk assessments, infection control and medication. There was an audit of staff compliance with reading patient's rights under section 132 of the Mental Health Act.

- The wards did not have any psychology input at the time of our visit. The psychologist had recently left and the service was working to recruit to their post. Reflective practice sessions had been put on hold because it was the psychologist who had led on these. There was good access to occupational therapy and therapies such as pet, art and music therapies at both locations.
- Staff followed guidance when prescribing medication. Medical staff regularly came together to discuss National Institute of Clinical Excellence (NICE) and Maudsley guidelines, and discussed recent research and literature to seek the most appropriate new approaches to the use of medication. We observed a ward round at Mott House where staff discussed NICE guidance and held detailed case discussions, showing that they understood the needs of their patients.
- Access to physical healthcare was good. Patients at Glyn ward gave us examples of appointments they had recently attended, such as GP, optician and dentist. Both wards were situated next to acute hospital sites with accident and emergency departments, and a rapid response team was available to be contacted in an emergency at the St Bernards site. Medical staff were able to investigate physical health issues and make relevant referrals, and duty doctors were available 24 hours. There was a primary healthcare suite on the St Bernards site where patients could visit the GP, optician or chiropodist. Two staff members on each of the wards were trained in smoking cessation, and there was lots of information available to patients who wanted to stop smoking. A smoking cessation lead visited each ward weekly.

Skilled staff to deliver care

- Only 17% of supervisions had taken place at Glyn ward at the end of September 2016. Staffing levels had been low in the months prior to our visit which had resulted in a lack of direct line management for some of the more junior staff members. We were also told that not all supervisions had been recorded correctly, and staff had been given a specific timeframe at a recent meeting in

Are services effective?

Requires improvement 

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

which to access training on how to record supervisions and to complete their records. Supervisions at Mott House took place regularly and staff told us that it was useful.

- Only 56% of staff had received an appraisal at Glyn ward, and 73% had received one at Mott House at the end of September 2016. There were staff members at Mott House who still needed to approve their appraisal on the electronic computer system.
- Staff could access specialist training opportunities. Staff told us about training they had attended, including caring for people with diabetes, smoking cessation and courses on different mental health conditions. An occupational therapist told us about training they had attended to help them to work with patients with specific physical health needs. Regular agency staff could access training provided by the trust, such as training to help them use the electronic patient records system. We also heard that staff had opportunities for career progression. We spoke with a clinical team leader who had progressed to their role from starting out on the ward as a newly qualified nurse, and two long term agency staff members at Mott House had just been given substantive positions. Staff told us about training they had attended at a local university and that the mentorship programme was very helpful.
- Some meetings took place for staff to come together and discuss issues and provide feedback about the service. The matron for Mott House ran weekly staff meetings for all staff members, where they could provide feedback about the service, though these were a relatively new initiative. At Glyn ward monthly nurse meetings took place, where nurses could provide feedback, were told about updates and were encouraged to keep up to date with training. There were monthly MDT clinical improvement meetings at Glyn ward where thorough discussions about service delivery took place. Reflective practice sessions were on-hold whilst the service worked to recruit a new psychologist.
- Agency staff received thorough orientations before they worked on the wards. This included a tour, attending a handover, an introduction to all of the patients, joining a substantive staff member during environmental checks to learn about the environment and ensuring that a registered nurse was available during their shift for support.

Multi-disciplinary and inter-agency team work

- The multi-disciplinary team (MDT) consisted of medical staff, nursing staff, and an activity coordinator, occupational therapist and pharmacist at each ward. There was no psychologist at the time of the inspection. Some external staff delivered sessions during the week, such as a pet therapist. On both wards staff had good relationships with consultant psychiatrists and felt they could easily approach them for support and advice.
- We also attended a comprehensive handover meeting for nursing staff at Mott House. The activity coordinator routinely attended morning handovers as well. Staff were updated about patient's mental and physical health, changes to risks and medication needs.
- Staff communicated well with social workers and community mental health teams and they often attended meetings to discuss future placements for patients.
- We attended an effective ward round at Mott House which was attended by three medical staff, an agency nurse and the matron. However, healthcare assistants felt that they weren't fully updated on changes to patients' risks, because they weren't able to attend ward rounds. The pharmacist didn't attend ward rounds because their workload didn't allow for the time. Staff actively sought advice from the pharmacist when they had queries about medications.

Adherence to the MHA and the MHA Code of Practice

- Mental Health Act training was mandatory and staff had a good understanding of the act.
- An independent mental health advocate (IMHA) worked on each of the wards and all patients could contact them for advice. Staff also referred patients to the IMHA. There was information displayed about the IMHA on both wards and patients who we spoke with knew about them. The IMHA also attended community meetings.
- Staff met their legal duty under section 132 of the mental Health Act to explain patients' legal position and rights on admission. Junior doctors completed regular audits to check staff had read patients their rights. Staff at Glyn ward had recently designed a spreadsheet to monitor

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the frequency of reading people's rights. All but one of the patients who we spoke with had a good understanding of their rights under the Mental Health Act or as informal patients.

- Clinical team leaders undertook checks for section expiry dates to flag when patients' detention needed to be reviewed. At Glyn ward we reviewed four sets of detention papers and the patient's corresponding care records. These reflected lawful detention and were in line with the MHA code of practice. Staff completed risk assessments prior to patients taking leave. However, one care plan had not been updated to reflect the change in a patient's legal status. This may have resulted in the patient being unlawfully detained or treated without her consent.
- Medical staff told us they received good administrative support and legal advice from the Mental Health Act office.

Good practice in applying the MCA

- Mental Capacity Act (MCA) training was mandatory, but as this training had only been recently introduced

compliance was 67% across the service at the end of September 2016. Despite this, staff who we spoke with showed a good understanding of capacity and when patients' capacity should be assessed.

- Only doctors routinely undertook decision specific capacity assessments. Other staff members were not able to do these assessments. Decisions recorded in patients notes included consent to treatment, physical health best interest decisions and consent to share information. We were given specific examples of cases when capacity assessments had been undertaken for specific decisions, for example, to establish whether or not a patient had capacity to attend a court hearing. At Glyn ward a capacity assessment was completed to establish whether a patient had capacity to make a significant financial decision.
- The MCA trainer worked within the trust and could be contacted at any time by staff for advice about the application of the MCA.
- Staff who we spoke with did not have a good understanding of Deprivation of Liberty Safeguards (DoLS) or when they may apply them. At the time of the inspection no patients were subject to DoLS.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff did not ensure they maintained patient confidentiality when giving patients their medication. At Glyn ward patients queued at a hatch to receive their medication. Staff verbally checked medicines in the clinical room, meaning other patients queuing up at the hatch could hear the names of the medicines being taken by other patients. Confidential patient information displayed on a board in the nurses' office at Glyn ward, could also be seen through the window from the corridor.
- Staff did not always maintain patient privacy. Glass viewing panels in bedroom doors at Glyn ward had curtains attached the outside of the door. Most of these were open, or could easily be opened by people walking along the corridors, which significantly compromised the dignity of patients who may have wanted private space. The PLACE scores for privacy, dignity and wellbeing were 85% at St Bernard's hospital where Mott House was located, and 85% at Lakeside Mental Health unit, where Glyn ward was located. These scores were higher than the trust average, but lower than the England average of 89%.
- Staff were supportive, respectful and knew the patients well. Patients told us that they got on well with staff, who generally listened to their feedback about the service and knocked before entering their bedrooms. We observed staff interacting positively with patients on both wards. For example, at Mott House we saw staff members enjoying their lunch in the company of patients. Staff at all levels demonstrated a good understanding of individual needs when we spoke with them. However, two staff members who we spoke with at Glyn ward were concerned about the poor attitude towards patients of one of the senior nurses. These concerns were fed back to the trust at the time of the inspection.
- Of the seven patients we spoke with at Mott House, three did not know about their care plan and four had only contributed the day before the inspection. Staff had given patients their care plans at the community meeting the day before the inspection and asked them to tell a member of staff if there were any aspects of it they didn't agree with. However, patients at Glyn ward told us staff actively involved them in developing their care plans.
- Carers/relatives were able to attend ward rounds with permission from the patient.
- The ward had a welcome booklet to help newly admitted patients settle in. The patients who we spoke with could not recall being given a welcome booklet, but some of them had been staying on the ward for a long time.
- An independent mental health advocate was available for all patients to speak with on both wards. They attended the weekly community meetings and visited the wards ad-hoc, where patients could either approach them or staff could refer patients to them. There were information posters present on both wards to inform patients about the advocacy service and most of the patients who we spoke with knew who the advocate was.
- Patients generally knew how to give feedback about the service, and felt that they could contribute to the running of the service through community meetings. We saw that specific issues brought up at community meetings were then discussed again at subsequent meetings and a progress update given at Glyn ward. A sum of money had recently been allocated to Mott House to enable them to purchase new furniture. Patients were being consulted during community meetings about what they wanted the money to be spent on. However, at Mott House there was only one example of feedback that was given to a patient about an issue they raised at a previous community meeting over the three week period before our visit. Whilst feedback was given, the issue itself had not yet been resolved.

The involvement of people in the care they receive

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Requires Improvement

Access and discharge

- The service was in the process of working to reduce patients' length of stay. Length of stay dropped significantly at Glyn ward from 2695 days for patients discharged during the 12 month period July 2015 to June 2016, to 1142 days for current patients at August 2016. This was due to the recent discharge of some patients to more suitable placements in the community where they would require continuing care. The service was working towards a model consisting of a two year and a three year pathway with a single point of access. During our visit there were six patients at Glyn ward who had been there for longer than three years, the longest having spent nine years on the ward. Two patients at Mott House had stayed there for four years. This indicated that some patients may have been better suited to alternative placements. At the time of the inspection bed occupancy was 65% at Glyn ward and 70% at Mott House.
- There had been four of delayed discharges at Mott House between January and June 2016. Staff told us these were due to social services struggling to find suitable accommodation. There was one six month delayed discharge at Glyn ward because there was a hold up with the approval of the patients housing benefit.
- The service adopted a 'graded discharge' model, where the patient's bed would be reserved for them four weeks post discharge, a seven day follow up would be conducted and doctors would continue to prescribe if there was no GP involvement. The occupational therapists also produced a discharge report containing follow up recommendations. There was always access to beds on return from leave.
- Monthly referral meetings took place where patients on the waiting list were discussed and triaged. Consultation and advice was offered to patients who were waiting for an assessment.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards did not provide an optimal environment for recovery and rehabilitation. For example patients could not self-cater on the ward. Staff prepared meals and served them at set meal times. Some patients could cook for themselves on overnight leave and staff provided cooking activities, but patients did not have the opportunity to self-cater. Although patients said the food provided was very good, some of them told us that they enjoyed cooking and would like to cook for themselves. We observed a breakfast club which didn't involve patients in its preparation.
- The wards did not provide educational and vocational opportunities to patients. All of the 14 patients who we spoke with across the service told us they weren't involved in any education, employment or voluntary work. However, we were told that there was a vocational team that could work with Glyn ward to find placements for some patients at charity shops, and small duties were delegated to patients on the ward, such as feeding the fish. Some patients had received training to enable them to sit on staff interview panels.
- Patients did not self-medicate. We were told that patients had to ask about self-medication before a pharmacist would do an assessment. Some patients were able to self-medicate on overnight leave, but did not have the opportunity to develop this as part of their daily living skills this when they returned to the ward. Patients didn't have appropriate lockable space inside their bedrooms to store medicines.
- Laundry rooms were present at both wards and staff encouraged patients to do their own laundry, but this was supervised and each patient was restricted to a weekly slot.
- However, care records included individual goals, and occupational therapists followed the human model of occupation in their work, which sought to address how occupation is motivated, patterned, and performed.
- A good range of therapeutic activities were available during the week, but activities were lacking at weekends because nursing staff weren't contributing to the delivery of activities. Although cancelled activities were rare, when they did arise this was often due to absence

Are services responsive to people's needs?

Requires improvement 

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

of the activity coordinator and nursing staff being unable to step in. Although days out took place at weekends and the service had access to a minibus, these only took place once per month.

- Activities that did take place included cooking groups with occupational therapists that included trips to the shop to buy ingredients, a come dine with me competition, smoothie groups, sports, projects, gardening, communication group and memory group. Patients told us that they enjoyed the activities available and that they felt as though they were gaining skills to help them recover. Some patients at Mott House had been referred to the occupational therapy service that operated across several of the wards at St Bernards hospital on weekdays, which enabled them to attend additional activities such as music therapy and art group.
- A good range of rooms were available at both locations to support treatment and care. Both wards contained clinic rooms and separate activity rooms as well as quiet spaces for patients to use if they wanted to spend time away from the main lounge areas. A large kitchen was used for cooking activities at Mott House and an occupational therapy kitchen shared by wards at lakeside mental health unit could be used for cooking activities at Glyn ward. There were also additional activity rooms containing art and pottery facilities that Glyn ward shared with neighbouring acute mental health wards. Both wards had access to pleasant garden areas that were also used for activities.
- Patients could make telephone calls in private. Mobile phones were permitted and there were phone booths on both of the wards. The phone booth at Glyn ward was out of service during our visit but patients could use a cordless phone from the nurses' office. There was limited internet access available to patients. There were plans to install new computers and wireless internet for patients to use.

Meeting the needs of all people who use the service

- The service ensured they met people's diverse needs. Patients told us staff met their individual religious and dietary needs. Special arrangements had been made at Mott House for Muslim patients to eat at night when observing Ramadan. A Chaplin and Iman could be contacted to conduct visits. At Glyn ward the chaplain

also served as a general spiritual leader, and ran a weekly spiritual group for patients. Religious texts weren't available on the ward, but the chaplain could access these at patients' request. The service was able to notify the local catering departments at each site to ensure meals were prepared in accordance with people's cultural needs.

- There had recently been events to celebrate black history month at both of the wards. There was a display board which marked the event at Mott House and lots of different foods from various cultures were available for everyone to taste. Glyn ward also celebrated world mental health day, where the group held discussions about famous people with mental health issues.
- Information leaflets could be printed in any language via the trust's intranet system, and signs to tell informal patients that they had the right to leave were provided in the most commonly spoken languages. Interpreters could be easily accessed at both locations, and the same individual could usually be requested for consistency.
- The service manager demonstrated a good understanding of transgender needs and explained how transgender patients would be cared for appropriately. At Glyn ward we were given examples of times when the service had worked closely with transgender admissions to ensure they allocated the patient a room where they felt most comfortable and offered any necessary support to help integrate them into the ward environment.
- Mott House did not have accessible toilets or bathrooms for people with physical disabilities. At Glyn ward there was an accessible bathroom in the male corridor. There was no accessible bathroom for female patients. Most females with a physical disability would therefore be excluded from the service.

Listening to and learning from concerns and complaints

- The service had received no formal complaints or compliments during the year to June 2016. Patients could give feedback about the service at community meetings. At Glyn ward, feedback about issues raised and what action was being taken was shared at subsequent meetings. 'You said we did' boards also demonstrated ways in which feedback had been

Are services responsive to people's needs?

Requires improvement 

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

addressed. For example, at Mott House patients had requested a fridge in the female lounge. This had just been given the go ahead at the time of our visit. At Glyn ward there was a feedback box which was emptied monthly. A patient experience representative also took feedback from patients to clinical improvement group

meetings. Patients at Glyn ward had requested for the winter curfew on those entitled to section 17 leave to be lifted. Staff considered this request and subsequently lifted the curfew.

- Leaflets about the trust complaints procedure were available on the wards. Staff knew about the complaints procedure and how to help patients with formal complaints should they want to make one.

Are services well-led?

Requires improvement 

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

Our findings

Vision and values

- The local head of nursing and service director sometimes visited the wards. The chief executive visited both of the wards on one occasion when she was newly appointed. Otherwise, the executive team were not visible and staff couldn't remember any other times when they had visited the wards.
- The service manager and clinical team leader at Mott House showed a good understanding of the trust's vision and values and how the service's objectives aligned with them.

Good governance

- Ward managers could not extract incident data off the internal computer system and had to request this information centrally. As a result, both the manager at Glyn ward and acting up manager at Mott House had a poor working knowledge and understanding of incidents that had happened over the past year.
- Monthly key performance indicators (KPIs) mostly related specifically to service delivery, such as bed occupancy, care programme approach review compliance and timely admission assessments. Other than length of stay, none of the KPIs were specifically aligned to rehabilitation ward performance. The ward manager and lead consultant at Glyn ward told us that they hoped to create some rehab specific performance indicators in the near future, but no other quality indicators existed at the time of our visit. There were no significant issues around meeting the KPIs that were in place.
- Monthly clinical improvement group meetings took place on each of the wards. More meaningful, in depth discussions about improvements to the service and lessons learned took place at Glyn ward than Mott House. Quarterly service level clinical improvement meetings took place for senior staff and medical staff. Items could be referred from local meetings for discussion, such as waiting times, which had been discussed at this meeting so that a joint protocol could be developed. Other than this the two wards rarely got

the opportunity to meet to ensure consistency and share good practice. The service manager recognised that more could be done to ensure consistency and share good practice across the service.

- A system of risk registers were in place, which enabled risks to be escalated according to severity. The ward manager was responsible for adding risks to the local risk register. The service manager was able to escalate risks to a service level risk register. Risks could then be further escalated to directorate level or trust level depending on severity.

Leadership, morale and staff engagement

- Staff at Mott House told us that they felt unable to raise concerns due to fear of victimisation. Staff felt that the team culture didn't allow for constructive, challenging professional conversations to take place during case discussions and assessments, and there was a blame culture on the ward as a result. Staff said they held back during professional discussions, and we were told about staff members who had been blamed when decisions that had been made didn't go according to plan. We spoke with two members of staff at Mott House who had not received adequate support following incidents involving them. The service manager had recently been made aware of the concerns.
- Staff at Glyn Ward staff told us that they felt bullied by a particular senior nurse. We were told that this had caused a clique in the staff group, and some staff were given bank shifts over other staff members because of favouritism. The ward manager and service manager were aware of this and told us about ways they were addressing performance issues and working to improve staff morale.
- Some staff felt that they could offer suggestions about the service and were listened to. One member of staff at Mott House told us about a suggestion for improvement they had made. They didn't receive any feedback about their suggestion and felt as though it hadn't been welcomed.
- The ward manager at Glyn ward had been in post since February 2016. Morale and staff engagement had improved since they had come into post. Staff felt well supported and able to raise concerns with them. There was also a staff support group on the ward which was led by a staff member from elsewhere in the trust.

Are services well-led?

Requires improvement 

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

Commitment to quality improvement and innovation

- Medical staff at both wards were passionate and committed to finding the most appropriate treatments for patients. At Glyn ward they regularly met to discuss new literature and potential novel uses of medication for their patients.
- There were no immediate plans to relocate or refurbish either of the wards, though staff told us that the long term 'capital plan' aspiration was to have the two wards co-located so the service could be better tailored to patient's needs and provide a step down outreach service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

Regulation 9 HSCA (RA) Regulations 2014 Person centred care

The trust had not provided care and treatment that was appropriate and meet the needs of patients.

This was because the wards did not provide sufficient access to educational and vocational opportunities and for patients to self-cater and self-administer their own medication.

This was because at Glyn ward patients' individual needs and dignity was compromised by people not having keys to their own rooms, people having glass panels in their bedroom doors and curtains on the outside that could be opened by staff and people queuing for their medication.

This was a breach of regulation 9(1)(3)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

Regulation 12 HSCA (RA) Regulations 2014

Safe care and treatment

Care and treatment was not always provided in a safe way.

Patients who were from the acute wards were sleeping on the rehabilitation wards. This presented potential risks for both groups of patients.

This was a breach of regulation 12 (1)(2)

This section is primarily information for the provider

Requirement notices

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014

Good governance

The trust did not have effective systems on place to seek and act on feedback from relevant persons.

This was because staff on the rehabilitation wards did not feel adequately engaged and improvements in staff being able to give feedback and open communication were needed.

This was a breach of regulation 17(1)(2)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust had not ensured that staff received the support and supervision as is necessary to enable them to carry out their duties.

Staff at Glyn ward were not receiving regular supervision and at the end of September 2016 only 56% had a completed an appraisal.

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