Requires improvement

North Staffordshire Combined Healthcare 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)
RLY39	Florence House	Rehabilitation service	ST6 5UD
RLY87	Summers View	Rehabilitation service	ST4 3LR

This report describes our judgement of the quality of care provided within this core service by North Staffordshire Combined Healthcare 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 North Staffordshire Combined Healthcare NHS Trust and these are brought together to inform our overall judgement of North Staffordshire Combined Healthcare 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?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- There were ligature risks in a garden which are difficult for staff to monitor.
- There were recording errors on four consent to treatment certificates.
- Mental capacity assessments lacked detail to support judgements and were not always completed prior to treatment being started.
- Risk management plans lacked detail and were not always updated to reflect significant risk incidents or changes in the level of risk.
- Care plans lacked detail and it was not always clear that patients' views had been sought. Patients were not always offered a copy of their care plan.
- There was little evidence of meaningful physical health monitoring and little evidence of care plans to address specific physical health issues such as weight gain.
- There was poor recording of metabolic monitoring for patients prescribed clozapine medicine.
- Staff gender and skill mix was not always appropriate. There was one recorded and reported incident of staffing level and gender ratio not being sufficient to manage risk on the ward in a respectful and dignified manner.
- Risk incidents documented in patients' care records were not always reported and recorded as per the trust incident reporting procedure.
- One of the wards had no staff with specific training in working with people with autistic spectrum disorders (ASD), personality disorders (PD) or substance misuse issues.

However:

- Staff in the service were noted to be kind, caring and compassionate in their interactions with patients.
- Physical restraint is rarely used. All staff describe the use of de-escalation and distraction as the preferred response to any incidents of disturbed behaviour.

Summary of findings

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

Are services safe?

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

- There were ligature points on a fence and gate in a blind spot within the garden and on some communal doors in the ward area.
- All of the bedrooms were situated on one corridor.
- In the ward kitchen at Summers View there were sharp items (cutlery) in a drawer. Staff said the drawer would be locked but inspectors found it unlocked.
- In the ward clinic at Summers View, inspectors found out of date tubing (suction tube) in the emergency bag. The tubing was dated 2007. Liquid medicine was opened but no date of opening was indicated on the container. The manual resuscitator expired in March 2015.
- Three out of eight T2s & T3s (consent to treatment certificates) contained errors at Summers View. Medicines had been prescribed which were not authorised on the certificate. One T2 was incorrect at Florence House. Medicine was written on the T2 at a different dose than it was written on the prescription chart.
- The Operational Policy was unclear about who should be admitted and who should not. The only exclusions to both wards are people with an acquired head injury or pre-senile dementia.
- The Operational Policy isn't specific enough and can be interpreted to allow too broad a criteria for admission. There is a lack of clarity in terms of rehabilitation purpose of the unit.
- Staff have personal alarms within the unit at Summers View. The alarm system is linked to colleagues in the neighbouring day centre during the day. There is no immediate response to at time of risk. Staff may need to contact the police for support to manage any incidents of violence and aggression during these periods. The unit has the ability to access support directly from the duty senior nurse/on call senior manager as per out or hours cover arrangements.
- An incident form from July 2015 records Summers View as being short staffed and not gender appropriate despite three patients being on increased levels of observation due to identified risks.

Requires improvement

Summary of findings

- A risk incident involving an assault to staff at Florence House indicates that a contributory factor may have been low staffing levels at night. There are two staff on duty at Florence House at night.
- There is a lack of detail on risk assessments and management plans. These vary in quality. There is a lack of consistency and some plans do not demonstrate evaluation in response to risk incidents.
- Risk incidents recorded in patients' care records are not always reported and recorded on incident forms.

However:

- Physical restraint is rarely used. All staff describe the use of de-escalation and distraction as the preferred response to any incidents of disturbed behaviour. Staff say they have a de-brief following any incidents of violence and aggression.
- There is evidence from monthly staff meeting minutes to show discussion of incidents and any learning from them.
- All staff are familiar with Safeguarding procedures and understand the Mental Capacity Act (MCA). Staff had identified an issue with visitors bringing risk items into the ward for one of the patients. They followed all the correct procedures and the patient's safety has now been safeguarded.
- Despite challenges around staffing levels there is good evidence in patients care records of regular one to one time with staff.
- All staff receive supervision and appraisals in line with trust policy.

Are services effective?

Requires improvement

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

- Care plans do not clearly show patient involvement. The language used is jargonistic and there is little evidence of plans being individualised.
- We saw minimal evidence of regular evaluations and reviews of care plans reflecting changes in care provided.
- There is an absence of focus on discharge planning.
- The multidisciplinary team (MDT) lacked focus with limited input from non-medical staff.
- There is evidence of one patient at Summers View having to wait lengthy periods for accommodation in the community.

Summary of findings

- Patients' paper care records are disorganised and it can be difficult to find specific documents.
- The service is currently transitioning from paper records to the CHIP electronic record system. There is a lack of coordination between the two systems.
- There was poor evidence of physical health monitoring or ongoing health promotion work with patients.
- There was no evidence of any motivational work being done with patients around issues such as substance misuse.

However:

- There are opportunities for staff development. Staff at Florence House have had specialist training in working with people with personality disorder, autistic spectrum disorders (ASD) and substance misuse. The ward manager at Florence House had used a training needs analysis to identify gaps and sourced individual training such as an acupuncture course.The ward manager discussed the evidence base supporting the use of acupuncture to reduce anxiety.
- All staff are familiar with Safeguarding procedures and understand the Mental Capacity Act (MCA).
- Patients and carers told us they had benefitted from team input. Carers told us they were very involved and staff were good at supporting them. We saw dedicated resources and assistance for carers.

Are services caring?

Good

We rated Long stay rehabilitation mental health wards as good because:

- We saw evidence during the inspection that staff were kind and compassionate. Staff are very caring and are trying hard with often limited resources.
- We heard very positive feedback from patients and carers about the service
- We saw evidence of referral to, and support from, advocacy
- Staff had meals with patients and used daily tasks such as ordering the food shopping as a house activity at Florence House.
- Patients' are supported to invite family for meals on the wards and to budget, shop and cook for their family at Florence House.
- Use of a white board on which patient's could scribble thoughts, comments cards and formal evaluation to collect patients' views.

Summary of findings

Are services responsive to people's needs?

Requires improvement

We rated long stay rehabilitation mental health wards as requires improvement because:

- There is a lack of clarity around admission decisions. Some senior staff say they have little control over who is admitted to the service.
- A number of patients appeared to be acutely mentally unwell but it was unclear how such patients might be referred to alternative services. It was also unclear as to how long this process might take.
- There was no documentation in any of the patients' care records we reviewed relating to the assessment undertaken prior to admission to the service.
- There was evidence that an acutely unwell patient had been admitted out of hours on an observation level of one to one nursing. This happened because there was no adult acute bed available. An adult acute ward would have been the preferred environment for this patient due to their level of need and requirement for 1:1 nursing observations.
- The environment in Summers View does not optimise recovery. It is small, cramped and outside of patient bedrooms little has been done to promote a homely feel.
- Activities are not well organised and there is little in the way of structured activities in the evenings and at weekends.

However:

- Patients' had their own room keys and were able to personalise their bedrooms with pictures, ornaments and televisions. There is access for wheelchair users and ready access to interpreting services.
- Staff are able to source spiritual support for patients from local denominations if patients wish to.
- Patients and carers are encouraged to have input into the service at Florence House. There is a good induction pack with lots of information about how to get involved in the service for patients and carers on admission.
- Across the rehabilitation services there are good links with Brighter Futures housing provider. The trust is working with this organisation to develop a range of accommodation options for people.

Are services well-led?

Requires improvement

We rated long stay rehabilitation mental health wards as requires improvement because:

Summary of findings

- Staff do not undertake specialist training in ASD, personality disorder (PD) or substance misuse at Summers View. There was no indication in the care records that staff on the ward sought specialist guidance, or advice regarding any patients with these diagnoses. Both wards admit patients with a diagnosis of personality disorder (PD), autistic spectrum disorder (ASD) and substance misuse. Substance misuse is a common issue for patients admitted to the services. Substance misuse problems are more frequent in the local area than the England average.
- Patients' care records were poor on both wards. They were disorganised and often incomplete or wrongly filed.
- The service is currently transitioning from paper records to the CHIP electronic record system. There is a lack of coordination between the two systems.
- Three out of eight medicine charts that we saw at Summers View had errors on the T2s and T3s (consent to treatment certificates). One of the eight medicine charts we saw at Florence House had an error on a T2.

However:

- Staff at Florence House told us the ward manager was extremely supportive. They knew who the Service Manager was. The Chief Executive and members of the senior management team visit the ward. The senior managers have undertaken shifts on the ward and attended team meetings.
- Staff at Florence House told us they feel part of the trust. They were nominated by the medical director for Psychiatric Team of the Year. They have also had numerous nominations for the trust internal Reach Awards including the ward manager and support workers.
- Staff Morale is good and sickness absence rates are low on both wards. Sickness absence rates have been declining since March 2015. Staff say they do not fear being victimised in the event that they want to express any problems or raise any concerns. All staff know how to whistle blow.
- The ward manager at Florence House is part of the Listening in Action team. All staff have an awareness of the 'Dear Caroline' scheme which is used if they wish to raise any issues of concern directly with the Chief Executive.
- Both wards have AIMS accreditation.

Summary of findings

Information about the service

The rehabilitation wards for adults of working age provided by North Staffordshire Combined Healthcare NHS Trust are part of the trust's rehabilitation service.

Summers View had 10 beds and accommodates male and female patients. The average length of stay at Summers View is two years.

Florence House has 8 beds and accommodates male and female patients. The average length of stay at Florence House is 12 months or less.

Summers View provides care for those with more complex needs. Patients can then move to Florence House which provides a 'step down' service for patients who are working towards independent living in the community.

Neither ward had seclusion facilities.

Our inspection team

The team inspecting this service comprised one inspector, one Mental Health Act reviewer, one occupational therapist, one consultant psychiatrist and one nurse.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Is it well-led?

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

During the inspection visit, the inspection team:

- visited both 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 six patients who were using the service.
- spoke with one carer.
- spoke with the managers for each of the wards.
- spoke with 15 other staff members; including doctors, nurses, psychologists, occupational therapists and domestic staff.
- interviewed the service manager with responsibility for these services.
- attended and observed two multi-disciplinary team (MDT) meetings.

We also:

- looked at 14 sets of patients' care records.
- carried out a specific check of the medicines management on each ward.

Summary of findings

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Most patients that we spoke with told us the service is good and they are satisfied. They told us staff listen to them and they are able to have input to their care.

One patient told us the care was "second to none".

Some patients at Summers View told us they do not think they are appropriately placed in the service. One patient told us they are fearful on the ward when other patients are being aggressive. One patient told us they had not been offered a copy of their care plan but they would very much like to have one.

All patients that we spoke with at Florence House told us they felt involved in their care and had copies of their care plans.

One carer told us she was very satisfied with the service her relative was receiving at Florence House. She told us she feels listened to and involved in her relative's care. She told us that staff at Florence House keep her fully informed regarding any changes to her relatives care.

Good practice

- Summers View and Florence House have AIMS accreditation until February2018.
- Staff at Florence House have training in working with people with PD, ASD and substance misuse.
- Florence House have adopted a dog with the Dogs' Trust and have regular visits from a therapy dog. This was in response to patient requests.
- Florence House actively seeks feedback about the ward from patients.
- Florence House provides acupuncture to alleviate anxiety.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that wards are safely and appropriately staffed at all times.
- The trust must take action to improve the quality of patients' risk assessments and risk management plans to ensure consistency.
- The Trust must take action to ensure accurate prescribing as per T2 and T3 forms.
- The trust must take action to improve the reporting and recording of all incidents.

Action the provider SHOULD take to improve

- The trust should take action to reduce the potential for patients' to abscond from Summers View by way of the recently installed garden gate.
- The trust should take action to improve physical health care and health promotion for all patients.
- The trust should take action to improve metabolic monitoring for patients taking clozapine medicine.
- The trust should review the alarm system to ensure that staff are able to get support for incidents at all times of the day including weekends and bank holidays.
- The trust should review the manner of the provision of mixed sex accommodation.
- The trust should ensure that the gender ratio of staff on shift reflects the needs of a mixed sex patient population.
- The trust should provide greater clarity around the referral and admission process to the service.

Summary of findings

- The trust should take action to improve attendance on clinical risk training.
- The trust should take action to ensure risk managements plans contain primary, secondary and tertiary strategies to manage identified risks.
- The trust should improve the appearance of the environments and try to make them as homely as is safely possible..

North Staffordshire Combined Healthcare 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
Summers view	
Florence House	<Placeholder text>

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.

Summers View:

- Three patients were being prescribed medicines which were not detailed on their T2/3. There was no Section 62 documentation for the patient on the T3. Section 62 documentation allows staff to give urgent care treatment to patients.
- Transfer documentation was missing from two of the files that we viewed.
- Ministry of Justice authority for Section 17 leave was missing from one patient's care records.
- There was some evidence of patients' Rights under Section 132 being completed. For some patients this was undertaken every two months despite the schedule on the ward indicating it ought to be done monthly. There was no rationale documented for this departure from the ward schedule.
- Some people we spoke with confirmed that their rights under the MHA had been explained to them. We saw evidence of this in patients' care records.This showed that the trust had made some progress towards improving issues identified after the last inspection.
- Section 17 leave authorisations were in place as needed.
- Staff knew how to contact the Mental Health Act (MHA)office for advice when needed.
- Patients' were able to access advocacy services if they wished to do so.

- There was no evidence of risk management plans following a positive behaviour support (PBS) model (or something similar) as recommended in the MHA Code of Practice (2015, 26.15). Chapter 26 of the MHA Code of Practice sets out how staff must respond to any identified risks of aggression or violence. Staff must seek to identify any triggers for the behaviour along with any recognisable early warning signs for the behaviour. In drawing up a plan to guide staff in how to respond to the behaviour, staff must clearly outline primary strategies, secondary strategies and tertiary strategies.There was no evidence of any imminent planned changes in the service to adhere to this recommended practice.

Florence House:

- One T2 was at variance with the patient's prescription chart. Medicine had been prescribed on the prescription chart at a higher dose than was permitted on the T2. The medicine had not been given to the patient at this higher dose.
- There was evidence of patients' Rights under Section 132 being done regularly. It was not always clearly documented whether or not the patient understood.
- One patient was being given covert medicine following a Best Interests assessment. All the associated documentation was present and correct.
- Some people we spoke with confirmed that their rights under the MHA had been explained to them. This showed that the trust had made some progress towards improving issues identified after the last inspection.
- Section 17 leave authorisations were in place as needed.
- There was an incident of a patient failing to return from leave at the appointed time whilst displaying high risks. This was not discussed in the MDT meeting and there were no changes noted in leave entitlement.
- Staff knew how to contact the MHA office for advice when needed.
- Patients' were able to access advocacy services if they wished to do so.
- There was no evidence of risk management plans following a PBS model (or something similar) as recommended in the MHA Code of Practice (2015, 26.15). There was no evidence of any imminent changes to this practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Summers View:

- The service showed good adherence to the MCA. Most staff were up to date with training and all staff were able to explain the main principles.
- The service showed good adherence to the MCA. MCA assessments were completed by the RC but lacked any fine detail.
- There were no Deprivation of Liberty Safeguards as there were no patients' in this service who were appropriate for this process.

Florence House:

- The service showed good adherence to the MCA. Most staff were up to date with training and all staff were able to explain the main principles.
- MCA assessments were completed by the RC.
- There were no Deprivation of Liberty Safeguards as there were no patients' in this service who were appropriate for this procedure at this time.

Requires improvement

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

Summers View

Safe and clean environment

- There are ligature points on the garden gate which was installed in May 2015 within a blind spot in the garden and on some communal doors in the ward area. There were no potential ligature risks in patients' bedrooms identified by inspectors. Potential ligature risks inside the ward are reduced by staff observation and the use of a mirror. There are lights in the garden area to allow staff to see the gate and fence in the dark. There are no mirrors or cameras present to reduce the potential ligature risk posed by the new garden gate. The gate cannot be observed by staff unless they are out in the garden area and around the corner. The potential ligature risk posed by the gate is noted on the ward environmental risk assessment completed on 09/08/2015. It is judged to present a moderate risk which is unlikely to occur on that assessment. This risk is also noted on the ward ligature assessment completed on 18/08/2015 and reviewed on 09/09/2015. The measures to reduce the potential risk posed by the gate on the ward ligature assessment are the presence of outdoor lighting, individual risk assessments for patients to decide observation levels and staff knowledge of trust policy and procedure. However, there is one incident of a patient absconding from the ward over the gate. This incident is documented in the patient's care record but was not listed on the the trust incident log requested as part of this inspection. There have been nine recorded and reported incidents of a patient attempting to self ligature at Summers View since May 2015 but none have taken place outside of the ward.
- All staff are issued with Pin-point electronic personal alarms. The alarm system is linked to the neighbouring day service. Staff from the day service are able to respond to alarms on Summers View Monday to Friday between the hours of 9 – 5 but there are no staff in the day service after 5pm or at weekends or bank holidays. There was no system in place for staff to get support from other mental health units outside of working hours. The ward manager told us staff would have to summon the police if they were unable to manage an incident.
- The bedrooms are all on the same corridor. All patients have their own bedroom key. There is no gender segregation . We did not find any issues to suggest this had presented any risks to any patients to date. The trust web-site makes a commitment to ensuring that no patients will have to pass through opposite sex areas to reach their own facilities. However, at Summers View male patients walk past female bedrooms to access the outdoor smoking facilities and vice versa.
- In the ward kitchen on Summers View there are sharp items (cutlery) in a drawer. Staff said the drawer would be locked but inspectors were able to open it without a key. Some patients on the ward had been risk assessed as being at risk of self harm with items which cut. There were a number of incident forms since March 2015 for incidents of self harm from cutting. There had been an incident of a patient using a weapon to threaten staff.
- The ward environment was clean and free from clutter. The ward cleaning rotas were up to date. Staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins. These bins were not over-filled.
- The clinic room was clean and tidy. There is no examination couch but there are weighing scales and blood pressure monitoring equipment. The resuscitation equipment is recorded as being checked regularly but two items of emergency equipment were past their expiry date. The expired equipment was a suction tube which had expired in March 2007 and a manual resuscitator which had expired in March 2015.
- The emergency medicines are present, in date and regularly checked. The medicine cupboard and fridge were in good order and regularly checked but liquid medicines had no date recorded to indicate when they had been opened.
- The garden area was unkempt. The grass needed to be cut.

Safe staffing

- The trust had carried out a review of the nursing establishment. Staffing levels on the ward had been

Requires improvement

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calculated using the safer nursing care tool and benchmarking guidance from the Royal College of Nursing . This had set staffing levels on Summers View as four on day shift and three on night shift. The day shift comprised two registered nurses and two support workers. The night shift comprised one registered nurse and two support workers. The only exceptions occurred in response to late notice sickness absence where replacement un-registered support staff could not be found in time. There was always at least one registered nurse on all shifts. The ward manager supported staff to use additional resources to cover any gaps on shifts.

There were low levels of staff vacancies on Summers View ward. Staff retention was good with little staff turnover. There is currently one vacancy for a support worker on the ward. There was high use of temporary staff to ensure there were enough staff on each shift to maintain standards of quality and safety. The ward manager explained that temporary staff were used on almost every shift. These temporary staff worked on the ward regularly and had a good knowledge of the patients and the ward. Temporary staff, who had not worked on a ward before were given a brief induction to the ward.

- Use of temporary staff had increased from 648 hours worked by temporary staff in February 2015 to 1221 hours in July 2015. This does not reflect staff sickness absence as there was higher sickness absence of between 10% and 15% in January, February and March 2015 compared to between 5% and 7% in April, May and June 2015. There is evidence from six months of ward rotas of staffing levels being increased above the allocated basic staffing levels to cover enhanced observations for a small number of patients.
- Short staffing was recorded and reported as per the trust's incident reporting procedure on a night shift in July 2015. The ward had only three staff on duty after midnight and these staff were all female. There were three patients on increased levels of observation. Two of these patients were on 1:1 arms length observations with no privacy in toilets and bathrooms.
- The ward manager acknowledged that people using the service could not always take up agreed escorted leave at the time they wished to. This was because there were not always enough staff to escort them. Staff tried to organise escorted leave so that as many people as possible were able to go out as agreed.
- There was good evidence in care records of patients being offered regular 1:1 time with staff.
- Medical staff told us that there was adequate medical cover available day and night to attend the ward quickly in an emergency. Out of hours medical cover is provided by a community mental health team on call junior doctor.

Assessing and managing risk to patients and staff

- There is no evidence of Positive Behaviour Support Plans (PBS) (or something similar) as described in the MHACoP (2015, 26.15), and 'Positive and Safe' (DH 2014) to address identified risks around aggression or violence.
- We looked at six sets of patients' care records and we found that there is a lack of detail on risk assessments and risk management plans. These vary in quality. Some have superficial management plans in place. Some plans do not demonstrate evaluation in response to risk incidents.
- Staff had received training in safeguarding vulnerable adults and children and most staff we spoke with knew how to recognise a safeguarding concern. Staff were aware of the trust's safeguarding policy and could name the safeguarding lead. They knew who to inform if they had safeguarding concerns. Staff provided examples of safeguarding referrals that had been made. Safeguarding was also discussed at ward team meetings.
- Staff told us there were problems with illegal substances, alcohol and 'legal highs' on the ward. This could clearly be seen from care records and recorded and reported risk incidents. Substance misuse is higher in the local area than the England average. There was evidence within one patient's care records that staff had allowed the patient to access Section 17 leave whilst intoxicated with unprescribed substances in August 2015.
- Outcomes from Section 17 leave were poorly recorded. This meant that risks were not always accurately recorded. This meant that future decisions regarding Section 17 leave could not involve consideration of any previous risks displayed in relation to leave. Equally, there could be no consideration of any positive outcomes in relation to leave taken.
- A patient's care records describe a significant risk incident involving staff being threatened with a bike chain in August 2015 . Staff had documented in the

Requires improvement

Are services safe?

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patient's care record that a member of staff felt fearful and intimidated. There is no incident reporting form to reflect this incident on the incident log requested from the trust. Staff were unable to explain to inspectors how the patient had managed to take the item on to the ward.

- Staff told us there was a greater emphasis within the trust on the use of de-escalation techniques rather than physical restraint. Most staff (89% as of August 2015) were up to date with their violence and aggression training. Staff told us they feel confident in their ability to manage aggressive or violent incidents. There have been 13 recorded and reported incidents of physical restraint being used with patients in response to aggression and violence. There has been one recorded and reported incident of the use of the prone position during a physical restraint.
- There has been no use of physical interventions (physical restraint) which may allow the deliberate application of pain or discomfort to encourage compliance. This approach is recommended in the Mental Health Act Code of Practice (MHACoP 2015), NICE Guideline 10 (2015) and 'Positive and Safe' (DH 2014) to address identified risks around aggression or violence.
- There were no recorded and reported incidents of prone restraint being used.
- Most patients told us they feel safe on the ward. One patient told us they do not feel safe when others become loud, aggressive or violent on the ward.
- Appropriate arrangements were in place for the management of medicines. Prescriptions were well written, signed and dated. We reviewed the medicine administration records of several patients on Summers View ward. Patient medicine records showed a tendency towards regular use of night sedation which was prescribed as 'as required' (PRN) medicine. Three patients were prescribed medicine at doses above the 100% recommended in the British Nationa Formulary (BNF) but not significantly. We saw that none were above 133%.
- Three patients were being prescribed medicine which was not detailed on their T2 or T3 (T2 – Section 58 (3)(a), certificate of consent to treatment. T3 – Section 58 (3)(b) Certificate of second opinion). There was no Section 62 form written for the T3 patient.

Track record on safety

- There have been no serious incidents (SIs) in the past 12 months.
- There have been no 'never events' in the past 12 months.

Reporting incidents and learning from when things go wrong

- Staff we spoke with at Summers View knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the ward manager and forwarded to the trust's clinical governance team who maintained oversight. The system ensured that senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.
- The service manager told us how he assures himself that he knows what's happening on the ward and how he knows staff and service users are safe. He advised that he visits the ward two or three times per week and talks with staff. He supervises the ward manager and has discussions with the deputy. He receives copies of all incident forms and discusses with the ward manager.
- The ward manager told us how they maintained an overview of all incidents reported on the ward. However, the ward manager was not able to give detail of significant incidents such as absconsion or violence when asked about incidents in the three months prior to this inspection. He was able to give great detail about incidents involving deliberate self harming on the ward.
- There was evidence of a risk incident not being recorded and reported as an incident in August 2015 despite being recorded in the patient's care records.
- There was little evidence of learning from incidents which occurred on the ward or from those occurring elsewhere in the trust. There was some evidence of discussion in team meetings but this was variable. There was no evidence of a robust 'feedback loop' for learning from incidents.
- Staff and people using the service were provided with support and time to talk about the impact of significant incidents on the ward.

Florence House

Safe and clean environment

Requires improvement

Are services safe?

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

- Florence House is a small unit with little space. All the bedrooms are along one corridor. Patients told us that they can see into each other's rooms. One female patient told us she was afraid during a recent incident as she could see a male patient becoming aggressive.
- There are a number of potential ligature risks identified on the Florence House environmental risk assessment. These potential risks relate to fixtures and fittings such as door handles, door hinges and towel rails. Detail is provided regarding how the potential of these risks may be reduced by individually risk assessing patients and providing levels of observation to reduce any identified risk. Some environmental work such as replacing the fixed towel rails with magnetic ones which would collapse if any weight is put on them is also indicated as scheduled on the environmental risk assessment.
- The clinic room was clean and well organised. There was an examination couch, weighing scales and blood pressure monitoring equipment. The resuscitation equipment was recorded as being checked regularly.
- The emergency medicines were present, in date and regularly checked. The medicine cupboard and fridge were in good order and regularly checked by pharmacists for any un-used or out of date medicines. Nursing staff checked the clinic room and fridge temperatures daily to make sure medicines were stored at the correct temperature..
- The ward cleaning rotas were up to date. Staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins. These bins were not over-filled.
- The ward décor and lay-out was clean and organised with dedicated areas for advice and support. Staff had clearly done everything within their powers to make the environment light, friendly, welcoming. However, there was no designated female only lounge.
- There was a notice board of information to tell patients and visitors what activities were happening and which staff were on duty. There was a notice board to tell staff, patients and visitors what people using the service had said and what had been done as a result.
- Staffs' electronic Pin-point alarms are linked to the Community Mental Health Team (CMHT) during the day. We witnessed staff from the CMHT respond swiftly and effectively to an alarm on the ward. The alarm system also links into the CMHT adjoining service. During the evening & weekends staff also wear additional devices which link staff to a call centre. The call centre can summon what ever support for staff such as colleagues from the Harplands site or the police if necessary.
- Staff told us there is no cancellation of leave or activities due to low staffing. Patients confirmed this. There is evidence of regular 1:1s in care records and patients confirmed that staff had time for them.Staff had good awareness of safeguarding procedures and how to identify any abuse. There was evidence of referral to local MASH (Multi-Agency Safeguarding Hub) in care records.

Safe staffing

- Staffing levels on the ward had been calculated using the safer nursing care tool and benchmarking guidance from the Royal College of Nursing to be three staff on a day shift and two staff on a night shift. The day shift comprised one registered nurse and two support workers. The night shift comprised one registered nurse and one support worker. Staffing levels on the ward are currently under review following an incident on 03/08/2015.
- There are low vacancy levels on the ward. The vacancy level is equivalent to less than one support worker. There are low levels of sickness absence. Sickness absence rates were 4.8% in June 2015 according to the trust safer staffing Board report. These Board reports are produced every six months. There is some use of temporary staff to cover any staffing shortfalls. Staffing shortfalls are usually due to short notice sickness absence. Every effort is made to ensure that any temporary staff used are staff regularly working on the ward. The ward manager supports staff to use additional resources in order to cover any shortfalls.
- There is an open operational risk in relation to a serious assault on a member of staff on 03/08/2015 when there were only two staff on duty. The actions highlighted to reduce the potential for this risk to occur again were for there to be a review of the alarm system, and a review of staffing levels. The alarm system has been reviewed and the procedure for use has been re-inforced with staff. The review of staffing levels in response to clinical need is ongoing. We could not find the incident on 03/08/2015 listed on the evidence request from the trust for all incidents which have been recorded and reported since March 2015.

Requires improvement

Are services safe?

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

- We saw no evidence of Section 17 leave being cancelled due to low staffing numbers. Patients told inspectors Section 17 leave is never cancelled due to low staffing levels.
- There is evidence in care records of patients having regular 1:1 time with staff. Patients told inspectors they have regular access to 1:1 time with staff.
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Assessing and managing risk to patients and staff

- Although all patients had risk assessments and risk management plans, we saw that they lacked detail and did not always reflect changes in levels of risk.
- We saw evidence that risk management plans are not always updated following risk incidents.
- Lack of evidence of review of Section 17 leave following problems with leave taken. We saw evidence in patients' care records of risk incidents such as substance misuse occurring when patients had taken leave. We did not see consistent evidence of these issues being considered when reviewing leave entitlement and conditions of leave.
- There is a weekly team review of risk incidents. The team looked for patterns and attempted to anticipate any future potential risks.
- There was evidence of positive risk taking. In one patient's care records we saw that positive risk taking had reduced incidents of deliberate self harm. The MDT had encouraged the patient to accept responsibility for their own safety and well-being. The patient had been supported to develop alternative coping strategies around self harming behaviour. There was evidence of MDT review and action plans in this patient's care records.
- One T2 was at variance with the patient's prescription chart. Medicine had been prescribed on the prescription chart at a higher dose than was permitted on the T2. The medicine had not been given to the patient at this dose.
- There has been no use of physical interventions (physical restraint) which may allow the deliberate application of pain or discomfort to encourage compliance. This approach is recommended in the Mental Health Act Code of Practice (MHACoP 2015), NICE Guideline 10 (2015) and 'Positive and Safe' (DH 2014) to address identified risks around aggression or violence.
- There were no recorded and reported incidents of prone restraint being used.

Track record on safety

• There have been no serious incidents (SIs) in the past 12 months.

• There have been no 'never events' in the past 12 months.

Reporting incidents and learning from when things go wrong

- Staff we spoke with at Florence House knew how to recognise and report incidents on the trust's electronic incident recording system. All reported incidents were reviewed by the ward manager and forwarded to the trust's clinical governance team who maintained oversight. The system ensured that senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.
- We could find no evidence of an incident which occurred in August 2015 being recorded and reported on the incident log we requested from the trust. The incident had resulted in an open operational risk regarding night staffing levels.
- The service manager told us he works closely with the ward managers at Summers View and Florence House. He and other senior managers have worked shifts at Florence House so that they can gain an understanding of what the staff team do on a daily basis. The service manager visits the ward two or three times a week and talks with staff.
- The service manager supervises the ward managers of both wards and has regular discussions with the deputies on both wards.
- People using the service were provided with support and time to talk about the impact of significant incidents on the ward.
- There is a weekly team review of risk incidents. The team look for patterns and attempt to anticipate any future potential risks.
- Incidents are discussed in team meetings and any learning from them is shared in these meetings. We saw evidence of this in staff meeting minutes.
- The staff team had debrief following significant incidents and were supportive of one another.

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

Summers View

Assessment of needs and planning of care

- Care plans were written in the first person but often contained medical and nursing jargon which suggested they had been written by staff. They were not individualised and there was a lack of patients' views being recorded. Patients told us they were involved and their views were listened to so it seems likely to be a recording issue. Care plans were not Recovery oriented despite the ward using the Recovery Star to support Recovery outcomes. However, they were holistic and included issues such as physical health..
- Often care plans and risk assessment were not altered for long periods of time. There was evidence of some review of care plans. Often this was in terms of dates which confirmed they were still relevant. There was little recorded to indicate why they were still relevant.The inspection team questioned the validity of the system and found some examples where issues had changed but care plans had not been changed to reflect this.
- We saw poor evidence of ongoing physical health monitoring for all patients. Care records show patients' weight increasing over time with no care plans in place to attempt to address the issue. NICE guideline CG43 provides evidence based guidance on managing obesity. We saw no evidence of this guideline being put into practice. There was poor evidence of engaging patients in health promoting activities. We saw poor evidence of monitoring patients on clozapine medicine for any physical health impact beyond weight and blood pressure. NICE guideline CG178 provides evidence based guidance for treating and managing psychosis and schizophrenia in adults. We did not see evidence of this guideline being followed with respect to physical health monitoring or clozapine monitoring. There was poor evidence of regular metabolic monitoring for patients on clozapine medicine. We saw evidence of patients' blood being checked when clozapine medicine was started but little evidence of blood being checked regularly after this.
- There was some evidence of moving people on from the service. Two patients were moving forward. One patient has been on the ward since 2007. We did not see any evidence of structured and rigorous discharge planning, goal setting or MDT planning. There was an absence of direction from the MDT plans.
- The psychologist told us they offer cognitive behavioural therapy (CBT) but some patients declined to participate. The inspection team queried whether the admission process included any evaluation of motivation to engage in therapeutic programmes or of moving forward towards discharge. There was no evidence of any assessment of motivation.
- The occupational therapist (OT) said that there was a lack of accommodation locally to discharge patients to. They said patients deteriorate while waiting for accommodation. However, the RC said there are lots of places to move people to. We did not see any evidence of patients taking up beds because they had no accommodation although one patient had been at Summers View since 2007. No patients we spoke with told us their discharge was delayed due to waiting for accommodation.
- The Responsible Clinician (RC) reported difficulties managing issues associated with substance misuse. Care records indicate that patients with these difficulties were those most likely to abscond. Many of the recorded and reported risk incidents involving patients absconding also involved the patient having misused substances. NICE guideline CG120 provides evidence based guidance on psychosis with coexisting substance misuse but we did not see evidence of this guidance influencing care planning or risk management.
- Some patients told us they did not think they were appropriately placed in a rehabilitation setting.
- There was evidence from one patient's care records of a significant risk incident involving a weapon taking place in August 2015 but no evidence of an incident form having been completed in the evidence requested from the trust.

Best practice in treatment and care

- Patients could access psychological therapies such as cognitive behaviour therapy (CBT) as part of their treatment and psychologists are part of the ward team.
- The wards used a system of Modified Early Warning Signs (MEWS) to identify what action was required if there were any physical health concerns. MEWS enabled staff to recognise when a patient's physical health was deteriorating or giving cause for concern and so trigger a

Are services effective?

Requires improvement

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referral to medical staff. MEWS would not be used routinely to monitor physical health. It would only be used if there was a specific reason to monitor a patient's physical health, such as following the administration of rapid tranquillisation medicine. MEWS is not designed to be used for long term physical health issues.

- The ward staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions.
- The ward use the Recovery Star model to support patients towards their personal recovery goals.

Skilled staff to deliver care

- The staff working on Summers View came from a range of professional backgrounds including nursing, medical, occupational therapy and psychology. Other staff from the trust provided support to the ward, such as the pharmacy team.
- Attendance of staff on mandatory training is showing as 93% compliant overall.
- Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training relevant to their role, including safeguarding children and adults, fire safety, life support techniques and the use of physical interventions. Records showed that most staff were up-to-date with statutory and mandatory training apart from clinical risk training which had only been completed by 16% of staff. The ward manager had access to the electronic staff records (ESR) for their team. This allowed them to oversee their progress in completing their training.
- Uptake of clinical risk training is 16% as of August 2015. The trust have been centrally reporting on attendance on clinical risk training since July 2015. The trust training manager has said that clinical risk training places have been priority allocated to staff from wards 1 – 7. This means that staff from Summers View have found it more difficult to access the training .
- Most staff told us they received supervision every month, where they were able to reflect on their practice and incidents that had occurred on the ward. Supervision records for the ward showed this to be the case.
- No staff were being performance managed at the time of our inspection.
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Multi-disciplinary and inter-agency team work

- Assessments on the ward were generally multidisciplinary in approach. People's records showed that there was some multidisciplinary team (MDT) working taking place. Care plans did not always demonstrate input from a variety of professionals and were not regularly reviewed by the MDT. Reviews of care plans were mostly left to nursing staff. People we spoke with told us they were supported by a number of different professionals on the ward.
- We observed an MDT meeting and found it to be rather superficial and lacking in leadership. There was an absence of rigorous enquiry about any risk incidents patients may have been involved in. There was a lack of achievable goal setting towards recovery. There was little impetus towards discharge planning.
- There were regular team meetings and staff felt well supported by their manager and colleagues on the ward. Many staff mentioned good team work as one of the best things about their ward .
- There was little evidence of inter-agency team work. There were no representatives from any community teams or agencies at the MDT meeting. There was little discussion within the MDT meeting involving reference to other agencies such as accommodation providers.

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

- Three patients were being prescribed medicines which were not detailed on their T2 or T3. There was no Section 62 form written up for the patient on the T3.
- We saw that the transfer documentation was missing from two files for patients that had been admitted to the ward. This meant that key information relating to risk, safety or individualised care was not available to staff.
- There was some evidence of patients' Rights under Section 132 being completed. For some patients this was undertaken every two months despite the ward schedule indicating it ought to be done monthly. There was no rationale documented for this departure from the ward schedule.
- Some people we spoke with confirmed that their rights under the MHA had been explained to them. We saw evidence in patients' notes that this had happened but

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.

not always in line with the ward schedule of once a month.This showed that the trust had made some progress towards improving issues identified after the last inspection.
- Section 17 leave authorisations were in place as needed.
- Staff knew how to contact the MHA office for advice when needed.
- Patients' were able to access advocacy services if they wished to do so.
- There was no evidence of risk management plans following a PBS (or something similar) as recommended in the MHA Code of Practice (2015, 26.15). There was no evidence of any imminent changes to this practice.

Good practice in applying the Mental Capacity Act

- The service showed good adherence to the Mental Capacity Act. MCA assessments were completed by the consultant psychiatrist but lacked any fine detail. Most staff were up to date with MCA training and all staff were able to explain the main principles.
- There were no Deprivation of Liberty Safeguards as no patients' in this service were appropriate for this process.

Florence House

Assessment of needs and planning of care

- Care plans were not Recovery oriented despite the ward using the recovery star model to support Recovery goals. However, they were holistic and included other issues such as physical health.
- Some patients' views had been recorded on their care plans but this was inconsistent.
- Some patients' had been given copies of their care plans but this was also variable .
- Care plans were not regularly reviewed by the MDT. Reviews of care plans were mostly left to the nursing staff. People we spoke with told us they were supported by a number of different professionals on the wards.
- We saw limited evidence of MDT discussions of significant risk incidents. Reviews of risk management plans and care plans to reflect this was also missing.
- There was poor evidence of ongoing physical health monitoring for all patients. Care records show patients' weight increasing over time with no care plans in place to attempt to address the issue. NICE guideline CG43 provides evidence based guidance on managing obesity. We saw no evidence of this guideline being put into practice. There was poor evidence of engaging patients in health promoting activities.
- Evidence of monitoring patients on clozapine medicine for any physical health impact beyond weight and blood pressure was also limited as was evidence of regular metabolic monitoring for patients on clozapine medicine. NICE guideline CG178 provides evidence based guidance for treating and managing psychosis and schizophrenia in adults. We did not see evidence of this guideline being followed with respect to physical health monitoring or clozapine monitoring.
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Best practice in treatment and care

- The wards used a system of Modified Early Warning Signs (MEWS) to identify what action was required if there were any physical health concerns. MEWS enabled staff to recognise when a patient's physical health was deteriorating or giving cause for concern and so trigger a referral to medical staff. MEWS would not be used routinely to monitor physical health. It would only be used if there was a specific reason to monitor a patient's physical health, such as following the administration of rapid tranquillisation medicine. MEWS is not designed to be used for long term physical health issues.
- The ward staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions.
- The ward use the recovery star model to support patients towards their personal Recovery goals.
- The ward had regular visits from a therapy dog for pet therapy. The ward has adopted a dog with the Dogs' Trust.This was in response to patient requests.

Skilled staff to deliver care

- The staff working at Florence House came from a range of professional backgrounds including nursing, medical, occupational therapy and psychology. Other staff from the trust provided support to the ward, such as the pharmacy team.
- Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training relevant to their role, including safeguarding children and adults, fire safety, life support

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.

techniques and the use of physical interventions. Records showed that most staff were up-to-date with statutory and mandatory training apart from clinical risk training which had only been completed by 18% of staff. The ward manager had access to the electronic staff records (ESR) for their team. This allowed them to oversee their progress in completing their training.

- Staff at Florence House were encouraged to access specialist training in working with patients with particular diagnoses such as PD, ASD and substance misuse.
- No staff were subject to performance management at the time of our inspection.

Multi-disciplinary and inter-agency team work

- Assessments on wards were generally multidisciplinary in approach. People's records showed that there was multidisciplinary team (MDT) working taking place. There was evidence of inter-agency team work. The ward manager told us the ward uses ASIST advocacy services, MIND and Rethink. We saw evidence of this and staff and patients told us about it too.
- Patients were able to move on from the service to appropriate accommodation. The service works with Brighter Futures who provide accommodation for people with mental health issues.

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

- One T2 form that we viewed was not consistent with the patient's prescription chart. Medicine had been prescribed on the prescription chart at a higher dose than was permitted on the T2. The medicine had not been given to the patient at this dose.
- There was evidence of patients' Rights under Section 132 being completed regularly. It was not always clearly documented whether or not the patient understood.
- Some people we spoke with confirmed that their rights under the MHA had been explained to them. This showed that the trust had made some progress towards improving issues identified after the last inspection.
- Section 17 leave authorisations were in place as needed.
- Staff knew how to contact the MHA office for advice when needed.
- Patients' were able to access advocacy services if they wished to do so.
- There was no evidence of risk management plans following a PBS model (or something similar) as recommended in the MHA Code of Practice (2015, 26.15). There was no evidence of any imminent changes to this practice.

Good practice in applying the Mental Capacity Act

- One patient had been given medicine the day after admission. There was no record of assessment of capacity prior to giving the medicine. A persons capacity to make decisions about whether or not to take medicine should always be assessed before they are offered the medicine.
- The service showed some adherence to the MCA. MCA assessments were completed by the consultant psychiatrist. There was often a lack of detail recorded on these assessments. Most staff were up to date with training and all staff were able to explain the main principles.
- There were no Deprivation of Liberty Safeguards (DoLS) as none of the patients' in this service were appropriate for this process at this time. Staff were aware of how to make a DoLS application if it were required.

Good

Are services caring?

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

Our findings

Summers View

Kindness, dignity, respect and support

- We observed staff interacting with patients in a caring and compassionate way. Staff responded to people in distress in a calm and respectful manner. They de-escalated situations by listening to and speaking quietly to people who were frustrated or angry about having to be detained in hospital. Staff appeared interested and engaged in providing good quality care to patients.
- When staff spoke to us about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs.
- Staff demonstrated good rapport with complex patients who could present challenges to staff.
- Patients told us staff were kind, caring and compassionate.

The involvement of people in the care they receive

- Details of local advocacy services were displayed in all the wards. Patients told us they were supported to access an advocate if they wished.
- Documented evidence of patients having input to their care plans was inconsistent. However, patients told us they were consulted about their care plans and felt involved in their care.
- Some patients told us they had been offered copies of their care plans. One patient told us they had not been offered any copies of their care plans but they would like a copy.

Florence House

Kindness, dignity, respect and support

- We observed staff interacting with patients in a caring and compassionate way. Staff responded to people in distress in a calm and respectful manner. They de-escalated situations by listening to and speaking quietly to people who were frustrated or angry about having to be detained in hospital. Staff appeared interested and engaged in providing good quality care to patients.
- When staff spoke to us about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs.
- Patients and a carer told us staff were kind, caring and compassionate.
- One patient told us that she had been on leave for five days and a member of staff had telephoned her each day at the same time to support her to stay safe. The member of staff was not on duty but wanted to support the patient.

The involvement of people in the care they receive

- Details of local advocacy services were displayed on the ward. Patients told us they were supported to access an advocate if they wished.
- One carer told us she feels very involved in her relative's care. She feels staff are interested in what she thinks and they listen to her.
- Documented evidence of patients having input to their care plans was inconsistent. However, patients told us they were consulted about their care plans and felt involved in their care.
- Some patients told us they had been offered copies of their care plans.

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

Summers View

Access and discharge

- There is a lack of clarity around admission decisions. Some senior staff say they have little control over who is admitted to the service. We saw evidence of patients being declined admission to the service following assessment. The reason for this decision was the degree of their mental health issue at the time of assessment. It did not mean that the patient could not be re-referred when there was some improvement in their mental health. However, we also saw evidence of a patient being admitted to the ward out of hours because there was no adult acute bed available.
- A number of patients appeared to be acutely mentally unwell but there was a lack of clarity around how such patients might be referred to alternative services. It was also unclear as to how long this process might take.
- In the patients records viewed, we found no pre-admission assessment documentation. This meant that information around risk, safety or individualised care was not available to the staff.
- The inspection team observed that a number of patients appeared to be acutely unwell. One senior member of staff said three of the patients should not have been admitted to the service. Medical staff said the team had no veto, sometimes the team say no to an admission but this is over-ridden by senior managers. The ward manager said he can reject a referral. We saw some evidence of letters sent to reject referrals. The service manager told us that sometimes admissions happen outside the process detailed within the operational policy. The operational policy stipulates that referral to the service should involve completion of an electronic referral form by the referring agency or service in the first instance. The referral form would then be discussed at a weekly multidisciplinary meeting to judge the suitability of the referral for rehabilitation services. For example, one patient had been admitted to the ward at 5pm on an observation level of 1:1. The patient had been admitted to the ward due to a breakdown of their placement and deteriorating mental health. There had been no beds available elsewhere in the service. The patient was admitted due to the lack of an adult acute bed being available at that time. The ward was staffed to care for a group of rehabilitation patients and caring for an acutely unwell patient with risks requiring 1:1 nursing may have impacted the experience of other patients on the ward. A member of medical staff told us he had not supported the admission described above. He believes the admission was inappropriate as it was disruptive to the ward and the patient presented with significant risks to themselves as well as to others. The ward has no link to other colleagues for support after 5pm if there is an incident of any kind.
- Some of the patients said they thought they were not in the right place or not suitable to be on a rehabilitation unit.
- Staff said they do consider whether individuals need an acute service but were unable to say how quickly this happens or whether staff would be supported to take this action.
- Discharge planning was left until late in the admission rather than starting at the point of admission. This is contrary to the ethos of a rehabilitation service.
- The ward manager told us that the average length of stay is 20 months but we observed that one patient has been on the ward since 2007.
- On the day of the inspection one of the patients was visiting his new community accommodation nearby to the ward. The patient kindly allowed one of our inspectors to visit with him. The patient told us he was very satisfied with his new home. Inspectors were impressed with the standard of the accommodation and the support package being proposed.

The facilties promote recovery, comfort, dignity and confidentiality

- The environment does not optimise recovery. The ward is small with limited space with no quiet areas for patients to retreat to.
- It is a mixed sex ward but there are no separate areas for male and female patients. Male and female bedrooms are all on the same corridor.
- The mix of patients and their level of illness makes the ward environment noisy and unsettled much of the time.
- One patient said they were scared when others became loud or aggressive.
- Patients had keys to their bedrooms and were able to personalise their bedrooms.

Are services responsive to people's needs?

Requires improvement

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

- There was little in the way of structured activities. This was particularly the case in the evenings and at weekends. There was no designated ward activities coordinator.
- There was no designated child visiting area.

Meeting the needs of all people who use the service

- Summers View met the needs of all those using the service in terms of disability,culture and faith. The ward was accessible for people with a disability. It is on the ground floor and has toilets suitable for use by people with disabilities and wheelchair users. Patients can order meals to meet any cultural requirements they may have. Patients can receive spiritual support from a variety of religious denominations in the local area if they wish to do so.

Listening to and learning from concerns and complaints

- Patients told us they know how to make any complaints. Staff told us they take patients complaints very seriously.
- There are no formal complaints logged with the trust. Staff told us that complaints are usually resolved at ward level.
- Information regarding the Patient Advice and Liaison Service (PALS) is freely available.
- Patients can access advocacy services. There are posters on the ward to inform patients how to contact advocacy services.
- Patient community meetings are held weekly. We saw the minutes from these meetings. The meeting minutes showed updates being given about issues raised in previous meetings.
- Staff are made aware of any learning from complaints at staff meetings.
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Florence House

Access and discharge

- The ward manager at Florence House told us the rehabilitation team meets weekly to discuss referrals to the service. Two senior members of staff are allocated to meet the person referred to the service to discuss their needs and their goals. The team at Florence House said they prefer that the operational policy does not have any exclusions to the service apart from pre-senile dementia and acquired head injury.

Pre-admission assessment documentation was missing from each of the 5 sets of patient records that we viewed.There was no evidence of discharges being delayed due to accommodation in the community not being available..

- Staff told us that the rehabilitation team were getting better at applying admission criteria and focusing on the purpose of admission.

The facilties promote recovery, comfort, dignity and confidentiality

- The environment optimises recovery despite being small and cramped. Effort has been made to make the most of the environment. It is bright and airy in appearance and has been made as homely as possible.
- There is a quiet room at Florence House for patients to use whenever they wish to do so.
- It is a mixed sex ward but there are no separate areas for male and female patient. One patient told us that patients can see in to each other's bedrooms. The environment would not accommodate separating male and female bedrooms as there is only one bedroom corrodor available.
- Patients had keys to their bedrooms and were able to personalise their bedrooms.
- There was no designated child visiting area.

Meeting the needs of all people who use the service

- Florence House met the needs of all those using the service in terms of disability,culture and faith. The ward was accessible for people with a disability. It is on the ground floor and has toilets suitable for use by people with disabilities and wheelchair users. One of the bedrooms is an assisted room.Patients can order meals to meet any cultural requirements they may have. Patients can receive spiritual support from a variety of religious denominations in the local area if they wish to do so.
- The team gave examples of when Florence House had been able to work with individuals who had a diagnosis of personality disorder by focusing on specific goals and positive risk taking

Are services responsive to people's needs?

Requires improvement

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

Listening to and learning from concerns and complaints

- Patients know how to make any complaints. They told us how they would make a complaint.
- There was a complaints box on the ward for patients to put written complaints in. They could remain anonymous if they wished to do so.
- There were no formal complaints logged with the trust. Staff told us complaints are usually resolved at ward level.
- Information regarding the Patient Advice and Liaison Service (PALS) is freely available.
- Patients can access advocacy services. There are posters to inform patients about advocacy services and how to contact them.
- Patient community meetings are held weekly. We saw minutes from these meetings.
- Staff are made aware of any learning from complaints at staff meetings.
- The ward has a "you said, we did" section on the ward notice board to inform staff, patients and visitors what has been done about complaints, comments or suggestions from patients or carers.

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

Summers view

Vision and values

- Most staff knew of and understood the trust's vision and values. We saw staff treating people as individuals. Staff could explain the SPAR quality objectives (Safe, Personalised, Access, Recovery). There was no evidence from staff meeting minutes of trust values being discussed in team meetings.

Good governance

- Patients' care records were poorly organised. We found documents to be out of place and often incomplete or wrongly filed in the wrong section of the care records. This made it difficult to readily find key information about the patient.
- The service is currently transitioning from paper records to the CHIP electronic record system. There is a lack of coordination between the two systems. It is difficult to readily find key information about an individual patient as it is unclear whether the information is on the CHIP system or in the paper care records. There is no information on either system to direct you to the relevant information.This meant we had to look through both record systems to try to find information.
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Leadership, morale and staff engagement

- Most staff that we spoke with described their morale as being good.
- All staff said they could approach the ward manager with any concerns.
- Some staff said they did not feel well supported by the service manager and that he was not a visible presence.
- All staff said they knew who the senior managers in the trust were and that they see them when they come to the ward.

Commitment to quality improvement and innovation

- Summers View has AIMS accreditation.

Florence House

Vision and values

- Most staff knew of and understood the trust's vision and values. Staff could explain the SPAR quality objectives (Safe, Personalised, Access, Recovery). We saw staff treating people as individuals. The trust's vision and values are not specifically recorded as being discussed at staff meetings.

Good governance

- Patients' care records were poor. They were disorganised and often incomplete or wrongly filed.
- The service is currently transitioning from paper records to the CHIP electronic record system. There is a lack of coordination between the two systems. It is difficult to readily find key information about an individual patient as it is unclear whether the information is on the CHIP system or in the paper care records. There is no information on either system to direct you to the relevant information.This meant we had to look through both record systems to try to find information.
- Most staff told us they received supervision every month where they were able to reflect on their practice and incidents that had occurred on the ward. Supervision records for the ward showed this to be the case .
- There were regular team meetings and staff felt well supported by their manager and colleagues on the ward. Many staff mentioned good team work as one of the best things about their ward.

Leadership, morale and staff engagement

- All staff we spoke with described their morale as being good.
- All staff said they could approach the ward manager with any concerns.
- Most staff said they felt supported by the service manager and that he was a visible presence.
- All staff said they knew who the senior managers in the trust were and that they see them when they come to the ward.
- No staff were being performance managed at the time of our inspection

Commitment to quality improvement and innovation

- There were staff with specialist training in ASD, personality disorder (PD) and substance misuse. Staff are supported to access specialist training in these areas.
- Florence House has AIMS accreditation.

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	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated activities) Regulations 2014 – Staffing The provider must ensure that staffing is reflected in the appropriate levels, skill mix and gender mix for the services being provided This is a breach of regulation 18.—(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated activities) Regulations 2014 – Safe care and treatment Risk management plans must reflect changes in levels of risk Incidents must be recorded on the Trust incident reporting system This is a breach of Regulation 12 – (1)(2)(a)(b)(c)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated activities) Regulations 2014 - Need for consent. Where applicable, the Trust must ensure that capacity to consent has been assessed prior to treatment being given This is a breach of Regulation 11- (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated activities) Regulations 2014 Good governance The Trust must ensure that patients' care records are organised and that risk management plans and care plans are regularly reviewed and updated. Consent to treatment certificates must be accurate and complete This is a breach of Regulation 17 – (1)(2)(a)(b)(c)