

**Good** **Nottinghamshire Healthcare NHS Trust**

# Long stay/forensic/secure services

## Quality Report

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Date of inspection visit: 29 April - 2 May 2014

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### Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
BroomHill House	RHAPK	Broomhill House	NG4 3HS
Newark Community Rehabilitation Unit	RHACC	Newark Community Rehabilitation Unit	NG24 4EB
Mansfield Community Hospital	RHABL	Bracken House Heather Close	NG18 5QJ
Thorneywood Unit	RHAPB	145, Thorneywood Mount 106, Thorneywood Mount	NG3 6AA

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire 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 Nottinghamshire Healthcare NHS Trust and these are brought together to inform our overall judgement of Nottinghamshire 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 Long stay services		Good	
Are Long stay services safe?		Requires Improvement	
Are Long stay services caring?		Good	
Are Long stay services effective?		Good	
Are Long stay services responsive?		Good	
Are Long stay services well-led?		Good	

### **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

People who used the long stay services and their carers were happy with the care and treatment they received.

We observed that staff were kind and had a caring, compassionate attitude. They built positive relationships with people using the service and those close to them.

The service proactively sought feedback from people who used the service and their carers, and we found evidence that it had acted on feedback and implemented changes as a result.

We found that some requirements of the Mental Health Act were not adhered to. For example, there was no evidence to show in the care records we looked at that risk assessments had been carried out before people were granted leave under Section 17 Mental Health Act, or on their return.

Some wards at Broomhill House, Newark Community Unit, Mansfield Community Unit and Thorneywood Mount Unit had not completed an annual ligature risk assessment as per trust policy. We found ligature risks on all the wards we visited with the exception of Bracken House.

This meant that people were exposed to unacceptable and avoidable risk on these wards.

The wards had a clear pathway of care that focused on helping people to recover. The care plans we looked at also focused on people's needs and demonstrated knowledge of current, evidence-based practice. Overall, we found that the quality of care plans was very good and some plans were outstanding.

Access to occupational therapy, psychology and consultant psychiatrists varied across the services, and was dependent on which ward people were staying on.

The service had strong governance structures in place, which were fully embedded on most of the wards. We also saw evidence of shared learning across the wards. The service was committed to improving its performance and the quality of care provided. For example, the rehabilitation wards were putting new care pathway and care plan documentation in place.

# Summary of findings

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

### Are services safe?

Staff on the wards understood their responsibilities for reporting safeguarding concerns.

We found there was no evidence to show that risk assessments were carried out before patient's commenced leave under Section 17 Mental Health Act, or on their return from leave. On all the wards we visited, we found that relatives or carers of people detained under the Mental Health Act were not given adequate information prior to escorting patients during Section 17 leave.

Risks were not always identified and managed appropriately because the trust's 'Risk Assessment in Health and Safety Policy' was not implemented consistently across the service. There was high number of ligature points on all the wards we visited with the exception of Bracken ward.

Requires Improvement



### Are services effective?

The wards had a clear pathway of care that focused on helping people to recover. The care plans we looked at also focused on people's needs and demonstrated knowledge of current, evidence-based practice. The quality of the care plans was very good, and some plans were outstanding. On Broomhill House however, there was little or no evidence to show that people were involved in their reviews. Some people had limited or no access to occupational therapy, psychology and consultant psychiatrists.

Good



### Are services caring?

Staff were kind and had a caring, compassionate attitude. They built positive relationships with people using the service and those close to them; spending time talking to them and establishing good relationships. There was a mutual respect between people using the service and staff.

Good



### Are services responsive to people's needs?

The service proactively sought feedback from people and their carers. We found evidence that it had acted on feedback and implemented changes as a result. People were encouraged to be involved in all aspects of their care, from admission to discharge. Each person had a comprehensive assessment as part of the admission process. This included finding out about their social, cultural, physical and psychological needs and preferences. People who used the services were also given verbal and written information, including in accessible formats, to help them understand more about their care. People had access to interpreters and advocacy services if they needed them.

Good



# Summary of findings

## Are services well-led?

Staff told us that they felt well supported by their managers and were proud to work for the service. They also said that they saw managers on the wards.

The service had strong governance structures in place, which were fully embedded on most of the wards. We also saw evidence of shared learning across the wards. The service was committed to improving its performance and the quality of care it provided. For example, the rehabilitation wards were putting new care pathway and care plan documentation in place.

Good



# Summary of findings

## Background to the service

Nottinghamshire Healthcare NHS Trust inpatient Rehabilitation Service provides care and treatment for adults aged 18 to 65 years old who are recovering from enduring mental health conditions but not yet ready to return home. The service aims to work directly with people to assist them in reaching their maximum potential and to prepare them for their return to community living. The different services offer a range of functions, also including prevention of admission to hospital and focused recovery interventions on an individual and group basis.

The service has six rehabilitation wards, based on four sites in the community. There are: Broomhill House, Mansfield Community Rehabilitation Unit (Heather Close and Bracken House), Thorneywood Mount (145 and 106 Thorneywood Mount) and Newark Community Rehabilitation Unit. Newark Community Rehabilitation Unit consists of four self-contained bungalows and Broomhill House has three self-contained flats in addition to single bedrooms.

Bracken House is a locked rehabilitation ward which provides care and treatment to people detained under the Mental Health Act. People on Bracken ward have been assessed as having a level of risk which means they cannot be safely cared for within an open rehabilitation ward. Broomhill House, Newark Community Rehabilitation Unit, Heather Close and Thorneywood Mount are not locked and provide care and treatment to people who may or may not be detained under the Mental Health Act. The service has a clear care pathway to enable people to be transferred from Bracken ward to one of the open rehabilitation wards when they have been assessed as being appropriate to be cared for in an open ward environment.

Some of the wards have previously been inspected by CQC and there have been previous visits to the wards by Mental Health Act commissioners. We considered the reports from these visits for information as part of this inspection.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Paul Lelliott, Deputy Chief Inspector for Hospitals (Mental Health) Care Quality Commission

**Team Leader:** Jenny Wilkes, Head of Hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: two CQC inspectors, a Mental Health Act commissioner, a social worker and a community psychiatric nurse.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health inspection programme.

## How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

We visited the long stay/secure services of Nottinghamshire Healthcare NHS Trust between 29 April

# Summary of findings

and 2 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff, including nurses, doctors and therapists. We talked with people

who used services, their carers and/or family members. We observed how people were being cared for, and reviewed their care or treatment records. We also attended some ward handovers.

## What people who use the provider's services say

Before the inspection, we used focus groups to speak with people who used the service. During the inspection, we spoke with people who were on the wards and their family members. Overall, we found that people were very positive about their experiences of care.

## Good practice

Staff were kind and had a caring, compassionate attitude towards people who used the service. They built positive relationships with people using the service and those close to them.

Staff were supported by managers within the trust and were proud to work for the trust.

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

#### Action the provider **MUST** take to improve:

- The trust must ensure that the trusts 'Risk Assessment in Health and Safety Policy' is implemented consistently across the service and any identified ligature risks must be removed or managed accordingly.
- The trust must ensure that all Mental Health Act documentation is available for scrutiny on Bracken Ward and Broomhill House.
- The trust must ensure that relatives or carers are given adequate information prior to escorting patients during Section 17 leave.

- The trust must ensure that risk assessments are undertaken before patients commence and return from Section 17 leave periods.

#### Action the provider **SHOULD** take to improve:

- The trust should ensure that people at Broomhill House are involved in their care plan reviews.
- The trust should ensure that planned, regular fire drills take place on the wards.
- The trust should ensure that access to occupational therapy and psychology input is consistent across the wards.



## Nottinghamshire Healthcare NHS Trust

# Long stay/forensic/secure services

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Broomhill House	Broomhill House
Newark Community Rehabilitation Unit	Newark Community Rehabilitation Unit
Bracken House Heather Close	Mansfield Community Rehabilitation Unit
145, Thorneywood Mount 106, Thorneywood Mount	Thorneywood Mount Rehabilitation Unit

#### Mental Health Act responsibilities

We found inconsistencies in the application of the Mental Health Act (MHA) across the service. On Bracken House and Broomhill House, we were unable to scrutinise some MHA documentation as it was not available either on the ward or in the patients' care records. This is not in accordance with the Code of Practice (30.11).

We found there was no documented evidence to demonstrate that risk assessments were reviewed or undertaken prior to a patient, detained under the MHA, commencing leave or upon their return to the ward following a period of leave under Section 17 MHA. This is a requirement of the Code of Practice (21.8).

There was no evidence to show that some patients and their carers, where appropriate, had been given a copy of the Section 17 leave authorisation. Or that they understood the legality and conditions of leave or had been informed of who to contact in an emergency.

We found that medication was prescribed within British National Formulary (BNF) limits and in accordance with T2 and T3 forms. Some patients we spoke with were aware of the medication they were prescribed and the reasons why they were prescribed it in keeping with the Code of Practice (23.9). One patient was unable to do so however although we found a T2 form had been completed for the patient which showed they had given their consent to treatment.

# Detailed findings

We found the recording of patients' rights under Section 132 was not always completed at regular intervals.

Some patients had limited understanding in relation to their legal status, rights to appeal and the role of the Independent Mental Health Advocate (IMHA). On one ward two patients had only been referred to an IMHA on the day of our visit despite both patients having being detained for several months.

We identified concerns regarding the treatment monitoring of patients detained under the MHA by their Responsible Clinician (RC) on Broomhill House. We looked into the care records of all patients detained under the MHA on this ward and there was little or no evidence to show that patients were regularly seen and reviewed by their RC.

## Mental Capacity Act and Deprivation of Liberty Safeguards

We found that staff were trained in the use of and understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.

# 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

## Summary of findings

There were enough staff on duty to meet people's needs. Staff we spoke with knew about their responsibilities for reporting safeguarding concerns or other incidents.

On all the wards we visited, we found that a lack of evidence to show that risk assessments were not carried out before patients commenced leave under Section 17 Mental Health Act, or on their return from leave. On all the wards we visited, we found that relatives or carers of people detained under the Mental Health Act were not given adequate information prior to escorting patients during Section 17 leave.

There were also a high number of ligature points on the wards we visited with the exception of Bracken ward. Risks were not always identified and managed appropriately because the trust's 'Risk Assessment in Health and Safety Policy' was not implemented consistently across the service.

included recording any immediate action taken in response to the incident. Incidents were analysed by the acting ward manager and senior managers to identify any trends and appropriate action was taken in response to these. We found evidence to demonstrate that safety alerts were received and actioned by the acting ward manager.

The ward held regular ward meetings with staff. The meetings covered set agenda items which included safeguarding, learning from incidents and safety alerts. Minutes were made available to staff unable to attend the meetings.

### **Reliable systems, processes and practices to keep people safe and safeguarded from abuse**

Staff had received appropriate training in safeguarding. The ward had an identified safeguarding lead nurse who attended the directorate safeguarding forum passing on key messages to the rest of the team through ward meetings.

The trust had a 'Whistleblowing' policy in place which staff were aware of. This policy provided staff with guidance on how they could escalate a concern they may have without being identified.

Staff had completed training in infection control and prevention. Staff observed the trust's policy regarding hand hygiene and the use of anti-bacterial hand gel at the point of care delivery. The ward was clean, tidy and clutter free. There were cleaning schedules and infection control audits in place.

The ward had sufficient numbers of staff on duty to provide the care and treatment people required, with two staff on duty during the night. There was an alarm system in place which was connected to another location within the trust. The ward manager told us that if the alarm was activated then staff from the other location would attempt to contact the ward. If they were unable to do so, they would automatically contact the police to attend the ward.

### **Assessing and monitoring safety and risk**

The ward had systems in place for staff to assess and monitor the risks for individual people. Each person had an individualised risk assessment in their care records which

## Our findings

### **Broomhill House**

#### **Track record on safety**

There were clear systems and policies in place for staff to follow regarding the reporting of safeguarding incidents to keep people safe and safeguard people from possible abuse. Staff were aware of their responsibilities in relation to escalating and reporting any safeguarding concerns they had. Staff we spoke with told us they would have no hesitation in escalating concerns to their manager. The ward had made appropriate safeguarding referrals through external reporting systems as appropriate.

#### **Learning from incidents and improving safety standards**

The ward had an electronic incident reporting system in place which any member of staff was able to access and complete following an incidents. This allowed the ward manager to review and grade the severity of incidents. Staff we spoke with were aware of how to use the system and their responsibilities in relation to reporting incidents. This

# Are services safe?

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included risks in relation to safeguarding and risk to self and others. Where a risk had been identified, a care plan had been developed with the person to reduce or manage the risk.

Staff we spoke with told us that people were seen by a member of staff prior to them commencing leave and upon their return to the ward. This was to ensure there was not a change in the person's risk status. However; we found that this was not always documented in people's care records. There was no evidence to demonstrate that people detained under the Mental Health Act (MHA) had their risk assessment reviewed and up-dated prior to them commencing Section 17 leave, or upon their return to the ward, following a period of leave under Section 17 MHA. This is a requirement under the Code of Practice (21.8). Appropriate checks on all people were conducted by staff in line with the trust's, 'Observation and Engagement' policy.

The service had a clear pathway in place for transferring people who deteriorated and required an acute bed. The acting ward manager told us that it was rare that a person had required transferring to an acute bed however; they had not had any problems accessing an acute bed when needed.

The trust undertook an environmental risk assessment audit by the Quality Experience Scrutiny Team (QUEST) annually on the ward. The outcome of this audit was monitored through an action plan. However this audit tool was not a specific ligature risk assessment tool and did not identify all potential ligature risks.

We saw that a specific ligature audit was undertaken in June 2012 by the ward manager. The trust's 'Risk Assessment in Health and Safety' policy states that ligature risk assessments should be completed annually as a minimum standard by at least three people. The audit tool which was used was not the same tool which was documented within the trust's policy. The audit did identify some of the ligature risks within the ward but did not identify them all. There was no evidence to demonstrate that any action had been implemented to reduce the risks identified by this audit.

There were a significant number of ligature risks within the ward environment, both high and low level, including people's bedrooms and bathrooms. Risks we found included two balcony galleries on the first floor overlooking

open communal areas below. People could jump or fall over these balconies. Both also had ligature points which could be accessed by people. These balconies exposed people to unnecessary and avoidable risk. We identified these risks to senior managers and the trust on the day of our visit. At our request, the trust sent us an action plan which identified immediate action they had taken to remove the risks posed by the balconies in addition to actions they intended to take to reduce or manage the other risks we identified. We re-visited the ward within the duration of our inspection. We found that the trust had removed the risk of the balconies by erecting a perplex barrier on each of the balconies. This meant that people were no longer at risk from falling or jumping from the balconies and could no longer access the ligature risks on the balconies. The trust has completed a ligature risk assessment of the ward. They have provided assurance that they will take appropriate action to reduce or manage the other ligature risks identified.

## Understanding and management of foreseeable risks

There were plans in place to respond to potential emergencies which may impact on staff, people who used services and visitors. The ward had emergency first aid and resuscitation equipment on site which staff were trained to use. This equipment was checked on a regular basis to ensure it remained in good working order and expiry dates had not been exceeded.

However; there was no system in place to ensure that regular fire drills took place on the ward.

## Newark Community Rehabilitation Unit Track record on safety

There were clear systems and policies in place for staff to follow regarding the reporting of safeguarding incidents to keep people safe, and safeguard people, from possible abuse. Staff were aware of their responsibilities in relation to escalating and reporting any safeguarding concerns they had. The staff we spoke with told us they would have no hesitation in escalating concerns to their manager. The ward has made appropriate referrals through external reporting systems as appropriate.

## Learning from incidents and improving safety standards

The ward had an electronic incident reporting system in place which was completed by staff following any incidents. This allowed the ward manager to review and

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grade the severity of incidents. Staff were aware of how to use the system and their responsibilities in relation to reporting incidents. Incidents were analysed by the ward manager and senior managers to identify any trends and appropriate action was taken in response to these.

We found evidence to demonstrate that safety alerts were received and actioned by the ward manager.

The ward held regular ward meetings with staff. The meetings covered set agenda items which included safeguarding, learning from incidents and safety alerts. Minutes were made available to staff unable to attend the meetings.

## **Reliable systems, processes and practices to keep people safe and safeguarded from abuse**

People, including a relative, we spoke with all told us they felt safe on the ward and would feel safe discussing any concerns they had with staff.

Staff had received appropriate training in safeguarding. The ward had an identified safeguarding lead nurse who attended the directorate safeguarding forum and passed on key messages to the rest of the team through the ward meetings.

The trust had a 'Whistleblowing' policy in place which staff were aware of. This policy provided staff with guidance on how they could escalate a concern they may have without being identified.

Staff had completed training in infection control and prevention. Staff observed the trust's policy regarding hand hygiene and the use of anti-bacterial hand gel at the point of care delivery. The bungalows were clean, tidy and clutter free. However; we found that a communal bathroom in one bungalow had a malodour which a member of staff told us had been present for some time. Funding had been requested to replace the flooring in this bathroom but staff were unsure as to whether this would be approved. There were cleaning schedules and infection control audits in place.

We were told by the ward manager that, on occasions, people were transferred to a vacant bed on the ward from an acute mental health ward with no prior notice due to acute mental health bed pressures. This meant that people had not always been assessed for suitability for a rehabilitation ward by staff from the ward. On occasions, the manager had been required to stop what they

considered to be an inappropriate transfer taking place. They told us that decisions to transfer people were made by an on call manager who may have little knowledge of the ward. There was no clear protocol in place regarding this practice to guide staff.

Staff had completed the full Managing Violence and Aggression (MVA) training in addition to breakaway techniques training. However staff told us that due to the layout of the four bungalows and the isolation of these from other trust premises, they were unable to safely and effectively use the full MVA training.

Staff told us however; that the service had a clear pathway in place for transferring people who deteriorated and required an acute bed. The ward manager told us that it was very rare that a person had required transferring to an acute bed and they had not had any problems accessing an acute bed when needed. They told us staff were trained to use verbal de-escalation techniques to manage incidents of violence or aggression. They said staff would not hesitate to seek assistance from the police if these techniques were not effective in managing the incident.

## **Assessing and monitoring safety and risk**

The ward had effective systems in place to assess and monitor risks to individual people. Each person had a risk assessment in their care records which included risks in relation to safeguarding and risk to self and others. Appropriate checks on all people were conducted by staff in line with the trust's, 'Observation and Engagement' policy. Where a risk had been identified, a care plan had been developed with the person to reduce or manage the risk.

Staff we spoke with told us that people were seen by a member of staff prior to them commencing leave and upon their return to the bungalows. This was to ensure there was not a change in the person's risk status. However; we found that this was not always documented in people's care records. There was no evidence to demonstrate that people detained under the Mental Health Act (MHA) had their risk assessment reviewed and up-dated prior to them commencing Section 17 leave, or upon their return to the ward, following a period of leave under Section 17 MHA. This is a requirement under the Code of Practice (21.8).

The trust undertook an environmental risk assessment audit by the Quality Experience Scrutiny Team (QUEST) annually on the ward. The outcome of this audit was

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monitored through an action plan. However this audit tool was not a specific ligature risk assessment tool and did not identify all potential ligature risks. A specific ligature audit was undertaken in February 2014 by the ward manager using the trust's ligature audit tool. Although this identified some of the ligature risks within the ward, it did not identify them all. We saw evidence to demonstrate that action had been taken to reduce the risks identified by this audit.

We found there were a significant number of ligature risks within the ward environment. These included both high and low level ligature risks in all areas, including people's bedrooms and bathrooms. Risks we found included a non-collapsible shower rail and curtain rails. This meant the ward was not adhering to the trusts, 'Risk Assessment in Health and Safety Policy' (16.10 January 2014 p.43) which states that all shower curtain rails must be collapsible.

We raised these risks with the manager and trust at the time of our visit. The trust took immediate action to remove this shower rail. The trust has also completed a ligature risk assessment of the ward and sent us an action plan which identified actions they intended to take to reduce or manage the other risks we identified. They have provided assurance that they will take appropriate action to reduce or manage the other ligature risks identified.

## Understanding and management of foreseeable risks

There were appropriate plans in place to respond to possible emergencies which may impact on staff, people who used services and visitors. The ward had emergency first aid and resuscitation equipment on site which staff were trained to use. However; there was no system in place to ensure that regular fire drills took place on the ward.

## Mansfield Community Rehabilitation Unit - Bracken House and Heather Close

Bracken House provides 18 rehabilitation beds for men and women within a locked ward, whilst Heather Close provides 18 rehabilitation beds for men and women within an open ward environment. The wards are on the same site within a community setting.

## Track record on safety

There were clear systems and policies in place for staff to follow regarding the reporting of safeguarding incidents to keep people safe and safeguard people from possible abuse. Staff were aware of their responsibilities in relation to escalating and reporting any safeguarding concerns they

may have. The staff we spoke with told us they would have no hesitation in escalating concerns to their manager. The wards had made appropriate referrals through external reporting systems as appropriate.

## Learning from incidents and Improving safety standards

The wards had an electronic incident reporting system in place which staff completed following any incidents. This enabled ward managers to review and grade the severity of incidents. Staff were aware of how to use the system and their responsibilities in relation to reporting incidents. Incidents were analysed by the ward, and senior managers to identify any trends and appropriate action was taken in response to these.

We found evidence to demonstrate that safety alerts were received and actioned by the ward managers.

The ward managers held regular ward meetings with staff. The meetings covered set agenda items which included safeguarding, learning from incidents and safety alerts. Minutes of the meetings available to staff who were unable to attend.

## Reliable systems, processes and practices to keep people safe and safeguarded from abuse

People we spoke with all told us they felt safe on the wards and would feel safe discussing any concerns they had with staff. One person told us, "All the staff here are very nice, they help you and it feels safe."

Staff had received appropriate training in safeguarding adults at risk. The wards had an identified safeguarding lead nurse who attended the directorate safeguarding forum and passed on key messages to the rest of the team at ward meetings.

The trust had a 'Whistleblowing' policy in place which staff were aware of. This policy provided staff with guidance on how they could escalate a concern they may have without being identified.

Staff had completed training in infection control and prevention. Staff observed the trust's policy regarding hand hygiene and the use of anti-bacterial hand gel at the point of care delivery. The wards were clean, tidy and clutter free. There were cleaning schedules and infection control audits in place.

The service had a clear pathway in place for transferring people who deteriorated and required an acute bed. The



# Are services safe?

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ward managers told us that it was rare that a person required transferring to an acute bed however they had not had any problems accessing an acute bed for a person who required one.

We were told by the manager that on occasions, people were transferred to a vacant bed on Heather Close ward from an acute ward with no prior notice due to acute bed pressures. This meant people had not always been assessed for suitability for a rehabilitation ward by staff from the ward. On occasions, the ward manager had been required to stop what they considered to be an inappropriate transfer taking place. They told us that decisions to transfer people were made by an on call manager who may have little knowledge of the ward and may have never visited the ward. There was no clear protocol in place regarding this practice to guide staff. Staff informed us that the operational manager was addressing this issue and it had improved recently with less inappropriate transfers taking place due to acute bed pressures. This was not an issue on Bracken ward.

Staff had completed the full Managing Violence and Aggression (MVA) training in addition to breakaway techniques training. Staff told us that if there was an incident on either ward, then staff would be deployed from the other ward to assist. There were alarm systems on each ward which were connected to the other ward.

The service had made appropriate referrals for people to be assessed under the Deprivation of Liberty Safeguarding legislation as needed to make sure their rights were being protected.

## Assessing and monitoring safety and risk

The wards had effective systems in place to assess and monitor risks to individual people. Each person had a risk assessment in their care records which included risks in relation to safeguarding and risk to self and others. Appropriate checks on all people were conducted by staff in line with the trusts, 'Observation and Engagement' policy. Where a risk had been identified, a care plan had been developed with the person to reduce or manage the risk.

The trust undertook an environmental risk assessment audit by the Quality Experience Scrutiny Team (QUEST) annually on the wards. The outcome of the audits was monitored through action plans. However, this audit tool did not identify all potential ligature risks. A ligature risk

assessment had been carried out on both wards in August 2013 however this was general in nature and did not guide the assessor to check particular areas of the building. There were no specific ligature risks identified through the audit or our visit to Bracken Ward however; there were in relation to Heather Close. These included both high and low level ligature risks in all areas of the ward including people's bedrooms and bathrooms. There was no evidence to demonstrate that any action had been implemented to reduce the risks identified by the audit which meant that people were exposed to unnecessary and avoidable risk. We identified these risks to senior managers and the trust on the day of our visit. At our request, the trust sent us an action plan which identified action they had taken. This included completing a ligature risk assessment of the ward. They have provided assurance that they will take appropriate action to reduce or manage the ligature risks identified.

## Understanding and management of foreseeable risks

There were appropriate plans in place to respond to possible emergencies which may impact on staff, people who used services and visitors. The wards had emergency first aid and resuscitation equipment on site which staff were trained to use. However; there was no system in place to ensure that regular fire drills took place on the wards.

## Thorneywood Rehabilitation Units- 145 and 106 Thorneywood Mount

145 Thorneywood Mount provides 12 male rehabilitation inpatient beds. 106 Thorneywood Mount provides six female rehabilitation inpatient beds. The units are located on opposite sides of the road to each other.

## Track record on safety

There were clear systems and policies in place for staff to follow regarding the reporting of safeguarding incidents to keep people safe and safeguard people from possible abuse. Staff were aware of their responsibilities in relation to escalating and reporting any safeguarding concerns they may have. Staff we spoke with told us they would have no hesitation in escalating concerns to their manager. The ward made appropriate referrals through external reporting systems as appropriate.

## Learning from incidents and improving safety standards

The wards had an electronic incident reporting system in place which staff completed following any incidents. This

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allowed ward managers to review and grade the severity of incidents. Staff were aware of how to use the system and their responsibilities in relation to reporting incidents. Incidents were analysed by the ward and senior managers to identify any trends and appropriate action taken in response to these.

We found evidence to demonstrate that safety alerts were received and actioned by the ward managers.

The wards held regular ward meetings with staff. The meetings covered set agenda items which included safeguarding, learning from incidents and safety alerts. Minutes were made available to staff who were unable to attend.

## **Reliable systems, processes and practices to keep people safe and safeguarded from abuse**

People we spoke with all told us they felt safe on the wards and would feel safe discussing any concerns they had with staff.

Staff had received appropriate training in safeguarding. The wards had an identified safeguarding lead nurse who attended the directorate safeguarding forum and passed on key messages to the rest of the team through ward meetings.

The trust had a 'Whistleblowing' policy in place which staff were aware of. This policy provided staff with guidance on how they could escalate a concern they may have without being identified.

Staff had completed training in infection control and prevention. Staff observed the trust's policy regarding hand hygiene and the use of anti-bacterial hand gel at the point of care delivery. The wards were clean, tidy and clutter free. There were cleaning schedules and infection control audits in place.

Staff had completed the full Managing Violence and Aggression (MVA) training in addition to breakaway techniques training. Staff told us that if there was an incident on either ward, then staff would be deployed from the other ward to assist. There were alarm systems on each ward which were connected to the other ward.

The service had made appropriate referrals for people to be assessed under the Deprivation of Liberty Safeguarding legislation as needed to make sure their rights were being protected.

## **Assessing and monitoring safety and risk**

The wards had effective systems in place to assess and monitor risks to individual people. Each person had a risk assessment in their care records which included risks in relation to safeguarding and risk to self and others. Appropriate checks on all people were conducted by staff in line with the trusts, 'Observation and Engagement' policy. Where a risk had been identified, a care plan had been developed with the person to reduce or manage the risk. However we found that risk assessments were not reviewed, or undertaken prior to a patient detained under the Mental Health Act (MHA) commencing Section 17 leave, or upon their return to the ward following a period of leave under Section 17 MHA. This is a requirement under the Code of Practice (21.8).

All ward areas undertake environmental risk assessments which include ligature risks on an annual basis. The outcome of these audits was monitored through action plans. This audit tool however did not identify all potential ligature risks. There were no specific ligature risk assessments in place on the wards which meant they were not completing annual ligature risk assessments as per the trusts, 'Risk Assessment in Health and Safety Policy' (16.10 January 2014 p.41-48).

There were a significant number of ligature risks within the ward environments. These included both high and low level ligature risks in all areas of the wards including people's bedrooms and bathrooms. These ligature risks exposed people to unnecessary and avoidable risk.

We identified these risks to senior managers and the trust on the day of our visit. At our request, the trust sent us an action plan which identified action they had taken. This included completing a ligature risk assessment on the ward. They have provided assurance that they will take appropriate action to reduce or manage the ligature risks identified.

## **Understanding and management of foreseeable risks**

There were appropriate plans in place to respond to possible emergencies which may impact on staff, people who used services and visitors. The ward had emergency first aid and resuscitation equipment on site which staff were trained to use. However there was no system in place to ensure that regular fire drills took place on the ward.



# Are services effective?

Good 

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.

## Summary of findings

The wards had a clear pathway of care that focused on helping people to recover. The care plans we looked at also focused on people's needs and demonstrated knowledge of current, evidence-based practice. The quality of the care plans was very good, and some plans were outstanding. On Broomhill ward however, there was little or no evidence to show that people were involved in their reviews.

Some people did not have access to occupational therapy, psychology and consultant psychiatrists.

## Our findings

### Broomhill House

#### Assessment and delivery of care and treatment

There were processes in place to assess the needs of each person before they were admitted to the ward ensuring that people's needs could be safely met on the ward. We spoke with five people and two relatives on the ward. The people we spoke with said they had been involved in putting together their care plan and were satisfied with their care and treatment. One person said, "Broomhill has been a miracle in my life." Another person said, "I direct my care plan and I feel I am making good progress here."

The care plans we looked at were centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice. Care plans were written and reviewed, where possible, with the involvement of the person.

The consent of the person had been sought in the care plans that we looked at. Each of the people we spoke with told us they had provided consent to their care plan. We saw that signatures had been obtained from people who were able to consent to their care plan.

There was evidence of people's physical health needs being met. For example people had access to an annual health check in addition to access to routine appointments with healthcare professionals such as their General Practitioner (GP) and dentist.

#### Outcomes for people using services

The people we spoke with told us that they were happy with the care and treatment they were provided with. One person said, "I have really settled in quickly and that is down to the staff here." We also received positive feedback from relatives of a person who told us that their relative had achieved a positive outcome.

The ward had implemented a recovery focussed model of care delivery. The ward had a mix of single rooms in addition to three flats, with the flats providing a more independent living experience for people who had made sufficient progress along their care and treatment pathway. The people we spoke with, who were accommodated in a flat, told us they were happy to have achieved their desired outcome to move into one of the flats.

The staff we spoke with told us they felt that they were able to manage their workload. They had a clear understanding of the needs of the people they were involved with and were clearly able to describe the desired outcomes of people and how they were working towards those. People did not have access to time with an occupational therapist on the ward at the time of our visit however there was a programme of activities which staff provided both on and off the ward. People also had access to some self-directed activities such as a pool table, board games and books. We observed people participating in an activity with staff during our visit which was attended by several people and well received. The people we saw looked relaxed and contented during our visit.

#### Staff, equipment and facilities

The training records showed that staff had access to a range of training relevant to their role. The staff we spoke with told us that they felt well supported by their local manager. We were told there had been a recent improvement in the support staff received from management.

The facilities at this location appeared to be bright and well decorated and the communal areas of the building appeared to be clean and hygienic. People had supervised access to a laundry facility and kitchen area to prepare their own food. The door to the laundry room was left unlocked to enable people access to facilities unsupervised. However we found that some detergents, which could be potentially harmful to people, were not kept in a locked cupboard. We spoke with the manager about this and these were removed during our visit. The

# Are services effective?

Good 

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building had several communal areas so that different activities could be facilitated as well as allowing people access to a quieter area if required. There was also a room which people could use for private conversations with visitors.

There was a system in place for reporting any maintenance requirements, which were sent to a central estates team. However we saw that this did not always result in works being carried out in a timely manner. For example one person told us they had been waiting about a month for work to be carried out in their bedroom. We checked the maintenance request book and saw that this was the case. We were told that usually maintenance requests were usually actioned within two weeks. This matter was resolved by staff during our visit.

## Multi-disciplinary working

Each person attended an annual Care Programme Approach (CPA) review with the team assigned to manage their care and treatment. We saw that documentation relating to this was up to date and provided evidence of the person's involvement.

We were concerned about the lack of consultant psychiatrist input into people's care on the ward. People we spoke with told us they did not see their consultant as frequently as they would have liked. We checked the care records of every person on the ward over the previous three months and found little or no evidence to demonstrate that people regularly saw their consultant during, or in between, their care review meetings during this time. There was also little evidence to demonstrate that staff were reviewing care plans with people so their views could be taken into account. In most of the care records we looked at they had copies of, 'Multi-Disciplinary Team (MDT) review' forms. These forms were completed prior to and during the person's MDT review. In one person's record, there were no MDT review forms. The forms had a box titled, 'Discussion with patient (If patient not seen state reason)'. In almost all the forms we looked at, this box recorded, 'Patient not present'. There was no reason provided as to why the person had not attended their review. Where the records confirmed the person had not attended, we did not see any evidence the person had been asked for their views before the meeting. However decisions were being made to either continue with, or

change, a person's treatment during these meetings. This meant that the effectiveness of the care and treatment could not be properly reviewed as the person's views had not always been taken into account.

Most of the forms we saw did not list the attendees and were signed by the senior house officer doctor so it was not possible to determine who had attended the person's care review. There was no evidence to demonstrate that the person's carer, relative or advocate had been invited to attend any people's reviews. One person told us they had not been seen by their consultant for over 10 months. Another person reported they had seen their consultant only three times in 10 months.

The ward had access to an occupational therapist for one day a week. Staff we spoke with told us that this was not sufficient to meet the needs of all the people on the ward. Staff received clinical support and supervision from a psychologist however the psychologist did not provide any direct clinical input with people. Staff told us they struggled to access psychology services for people due to long waiting lists.

## Mental Health Act (MHA)

We identified concerns regarding treatment monitoring of patients detained under the Mental Health Act (MHA) by the Responsible Clinician (RC). We looked in the care records of all the patients detained under the MHA. There was little or no evidence to show that patients were regularly seen and reviewed by their RC. One patient we spoke with was unable to inform us of their formal status and did not understand the role of the Independent Mental Health Advocate (IMHA). They told us that staff had not explained their rights or provided them with written information regarding their detention. The patient had been admitted to the ward in August 2013. A Section 132 'Reading of Rights' form had been completed in April 2014 reporting that the patient understood their rights. There was no evidence in the patient's care records that their rights had been given other than on this one occasion since their admission. The patient was unable to tell us all the medication they were prescribed, or the reason they had been prescribed this, as is required by the Code of Practice (23.9). It was unclear if the patient was therefore able to give informed consent. However a T2 form had been completed for the patient reporting they had given their consent to treatment.

# Are services effective?

Good 

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.

We found that medication was prescribed within BNF limits and in accordance with the T2 form.

We were unable to scrutinise some MHA documentation as it was not available on the ward or in the patient's care records. This is not in accordance with the Code of Practice (30.11). We found a H5 renewal form in a patient's record dated 15/10/13 with the date period ending being 23/04/14. There was no current H5 in the patient's care file to evidence the person was being lawfully detained. Staff told us the form was in the MHA team office. We obtained a copy of the form to assure ourselves that the patient was being lawfully detained. Copies of the medical recommendations were also not available in the patients care records or on the ward.

In one patient's care record we looked in, we found evidence that Care Programme Approach meetings had not taken place prior to Mental Health Tribunals taking place. Two tribunals had been adjourned however we were unable to locate the relevant documentation from the tribunals to inform us of the decision made from these hearings. It was not possible therefore to confirm that any recommendations made by the tribunal had been actioned.

We found that risk assessments were not reviewed or undertaken prior to a patient detained under the MHA commencing Section 17 leave, or upon their return to the ward following a period of leave, under Section 17 MHA. This is a requirement of the Code of Practice (21.8). Some Section 17 leave forms stipulated that leave was to be granted, 'At the discretion of staff'. This is not in keeping with the Code of Practice (21.8). There was no evidence to show that the patient had been given a copy of their Section 17 leave authorisation or understood the legality and conditions of leave.

## **Newark Community Rehabilitation Unit** **Assessment and delivery of care and treatment**

There was a process in place to assess the needs of each person before they were admitted. This was to ensure that the person's needs could be safely met on the ward.

We spoke with three people on the ward. Two of the people we spoke with said they had been involved in putting together their care plan. One person said they felt they had been involved from their arrival on the ward.

Two people we spoke with told us they were satisfied with their care and treatment. One person said, "Staff are friendly and supportive." We were also told by a patient that even when they were having a, "Bad day", that staff continued to be supportive towards them.

The care plans we looked at were centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice. The care plans were very focused on recovery and included the person's aspirations and a recovery wellness plan. The overall standard of the care plans we looked at was outstanding and were written and reviewed, where possible, with the involvement of the person.

The consent of the person had been sought in the care plans that we looked at and each person we spoke with told us they had provided consent to their care plan. We saw that signatures had been obtained from people who were able to consent to their care plan.

People we spoke with told us they were happy with the care and treatment they were provided with. One person said, "This is the best place I have been." Another person told us they had achieved some of their desired outcomes, such as being able to drive again. One relative we spoke with told us, "He has been transformed since he has been here and he has only been here a few weeks. The change in him is amazing. All the staff here are brilliant."

The staff we spoke with told us they felt that they were able to manage their workload. They had a clear understanding of the needs of the people they were involved with and were clearly able to describe the desired outcomes of people and how they were working towards those. Staff told us they felt that generally, people achieved positive outcomes on the ward.

People had limited access to time with an occupational therapist on the ward at the time of our visit. However there was a programme of activities which staff provided both on and off the ward. People also had access to some self-directed activities within the ward, such as board games and books. We observed people participating in an activity with staff during our visit which was attended by several people and well received. The people we saw looked relaxed and contented during our visit.

One person told us they found that the provision of certain activities had helped to increase their self-confidence.

# Are services effective?

Good 

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.

## Staff, equipment and facilities

Staff we spoke with told us they felt that they were provided with opportunities to undertake training and professional development and training records showed staff had access to a range of training relevant to their role. Staff were able to undertake additional qualifications and felt supported to do so by the trust. Staff told us they attended regular supervision meetings, which were productive and they felt well supported by their manager.

We observed the facilities to be bright and well decorated. People we spoke with told us they felt the accommodation was generally of an acceptable standard however one person told us they were not satisfied with the standard of accommodation. There was a maintenance system in place whereby staff could report maintenance requirements to the central estates team. We saw that generally requests were actioned in a timely manner; however tasks that had been assessed as a lower priority had not always been actioned in a timely manner.

## Multi-disciplinary working

Each person attended an annual Care Programme Approach (CPA) review with the team assigned to manage their care and treatment. We saw that documentation relating to this was up to date and provided evidence of the patient's involvement. Staff we spoke with felt they worked well together as a team and said that different designations of staff met regularly to share information about people's treatment.

Staff told us that sometimes it was difficult to access a doctor out of normal working hours. It was felt that because of the geographical location of the ward, that cover from a doctor was more difficult to access.

## Mental Health Act (MHA)

We found that paperwork relating to the MHA was completed and filed appropriately as required by the MHA Code of Practice. There was good evidence to show that patients' had been read their rights under Section 132 at regular intervals and had also given written information regarding their detention. We saw that medication was prescribed within BNF limits and in accordance with the T2 form which was attached to the patients' prescription chart.

We found a lack of evidence to show that risk assessments were reviewed or undertaken prior to a patient, detained under the MHA, commencing Section 17 leave or upon their return to the ward following a period of leave under Section 17 MHA. This is a requirement of the Code of Practice (21.8).

## Mansfield Community Rehabilitation Unit - Bracken House and Heather Close

### Assessment and delivery of care and treatment

There was a process in place to assess the needs of each person before they were admitted ensuring that the person's needs could be safely met at this location. The people we spoke with all told us they were satisfied with their care and treatment. One person told us they were preparing to move on to more independent accommodation. Another person told us, "I am very happy with everything here. I am involved in my care planning and reviews."

The care plans we looked at were centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice. Care plans were written and reviewed where possible, with the involvement of the person.

The consent of the person had been sought in the care plans that we looked at. The people we spoke with told us that they had the opportunity to be involved in their care planning and had provided consent. We saw that signatures had been obtained from people who were able to consent to their care plan.

There was evidence of people's physical health needs being met. For example people had access to an annual health check as well as access to routine appointments with healthcare professionals, such as their GP and dentist.

### Outcomes for people using services

There was clear evidence of each person's progression along their care and treatment pathway. Each person's care plan had a record of the desired outcomes of their care and treatment, for example to access more Section 17 leave or to develop more independent living skills. We saw that each person's progress towards their desired outcomes was periodically reviewed. One person told us, "I now have access to things I couldn't access before I came here." Another person said, "I have Section 17 leave, I enjoy taking part in the walking group."

The staff we spoke with told us they felt able to manage their workload effectively. We were told that shifts were

# Are services effective?

Good 

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.

structured in such a way as to allow staff time to be able to complete paperwork, without detriment to the time they are able to spend with people. Staff described to us examples of where a person had received successful care and treatment which had led to them moving into more independent accommodation.

People had access to time with an occupational therapist at this location. During our visit, we observed people engaged in activities such as a walking group and a newspaper group. The occupational therapist carried out reviews of each person's participation in activities and whether it had achieved their desired outcome. This meant there was an active review of whether the activities being provided were meeting people's needs.

## **Staff, equipment and facilities**

The staff we spoke with felt they were provided with opportunities to undertake training and professional development and training records showed staff had access to range of training relevant to their role. One staff member told us they had been able to undertake an additional qualification through the trust. Staff told us they attended regular supervision meetings, usually once a month. Staff said that the supervision process was productive and they felt well supported by their manager.

We observed the facilities at Bracken House to be bright, modern and well decorated. A programme of redecoration of some internal areas was being carried out during our visit. There was a system in place for staff to report any maintenance requests and we saw that generally requests were actioned in a timely manner. However we saw that a problem with the female shower room floor at Bracken House had been reported one year prior to our visit and had not been resolved. This had led to water infiltrating the wall leading to some damage to the plaster and paint work. The staff we spoke with were unable to explain why this delay had occurred and this meant that the system for dealing with maintenance requests did not always work effectively. We saw that the facilities at Heather Close encouraged greater independence for the people accommodated there. People had access to a greater range of equipment.

## **Multi-disciplinary working**

Each person attended an annual Care Programme Approach review with the team assigned to manage their care and treatment and documentation relating to this was up to date and provided evidence of the person's involvement.

The service had developed relationships with the local social services department to identify suitable accommodation for people before their discharge. This meant that, when a person was ready for discharge, work had already been done to find suitable accommodation in the community.

The staff we spoke with told us that they were able to attend regular staff meetings where discussions about people's progress took place. Staff told us that they found these meetings to be productive and a forum to share ideas. Staff felt that there was a good team working ethos at this location and they felt their views were respected by other members of the team.

## **Mental Health Act (MHA)**

At Bracken House, we found that some Mental Health Act documentation such as medical recommendations were not available in care records or on the ward. Staff told us they believed they were filed in the Mental Health Act office. This is not in accordance with the Code of Practice (30.11).

Patients we spoke with on both wards were aware of the medication they were prescribed and the reasons why they were prescribed it. This is in keeping with the Code of Practice (23.9). However some lacked understanding about their rights and we found that the recording of patients' rights under Section 132 was not completed at regular intervals. In one patient's care records, it recorded that they had their rights read in July 2013 and this was to be repeated in December 2103. There was no evidence in the record that this had been done. Some patients had limited understanding in relation to their rights to appeal and the role of the Independent Mental Health Advocate (IMHA). We found that two patients had only been referred to an IMHA on the day of our visit despite both patients having being detained for several months.

We found a lack of evidence to show that risk assessments were reviewed or undertaken prior to a patient detained under the MHA commencing Section 17 leave or upon their return to the ward following a period of leave under Section 17 MHA. This is a requirement under the Code of Practice



# Are services effective?

Good 

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.

(21.8). Some Section 17 leave forms stipulated a condition that the patient had to be escorted with their relative during the leave period. It was not evident that the patient's relative had been given a copy of the Section 17 leave form or had been made aware of any conditions regarding the leave. There was no evidence to show that the patient's relative had been made aware of any contingency plans or informed of who to contact in an emergency. This is not in keeping with the requirements of the Code of Practice (21.21).

We found that medication was prescribed within BNF limits and in accordance with the T2 form.

## Thorneywood Rehabilitation Units

### Assessment and delivery of care and treatment

There was a process in place to assess the needs of each person before they were admitted ensuring that the person's needs could be safely met at this location. We spoke with three people at this location and two people told us they felt involved in putting together their care plan with the third person saying they had not been able to be involved in their care plan.

The people we spoke with all told us they were satisfied with their care and treatment. One person said, "I have a good trusting relationship with staff." We were also told by one person they felt they had a sense of moving on towards more independent accommodation.

The care plans we looked at were centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice. Care plans were written and reviewed, where possible, with the involvement of the person.

The consent of the person had been sought in the care plans that we looked at. Two of the people we spoke with told us that they had the opportunity to be involved in their care planning and had provided consent to their care plan. We saw that signatures had been obtained from people who were able to consent to their care plan.

There was evidence of people's physical health needs being met. For example people had access to an annual health check as well as access to routine appointments with healthcare professionals, such as their General Practitioner (GP) and dentist.

### Outcomes for people using services

There was clear evidence of each person's progression along their care and treatment pathway. Each person's care plan had a record of the desired outcomes of their care and treatment, for example to develop more independent living skills. We saw that each person's progress towards their desired outcomes was periodically reviewed. One person told us, "I feel my care plan is supporting me towards more independent living."

The staff we spoke with told us they felt that they were able to manage their workload. They had a clear understanding of the needs of the people they were involved with and were clearly able to describe the desired outcomes of people and how they were working towards those.

People did not have access to time with an occupational therapist at this location at the time of our visit. There had been a temporary provision but this had stopped before our visit. During our visit we observed that some people appeared to be disengaged or spending significant amounts of time sleeping. People had access to some self-directed activities within the unit, such as a pool table and books. An activity was provided during our visit by staff however this was not well attended by people and did not appear to be age appropriate or recovery orientated in nature.

### Staff, equipment and facilities

The staff we spoke with told us they felt that they were provided with opportunities to undertake training and professional development. The training records showed that staff had access to a range of training relevant to their role. Staff told us that they had access to regular supervision meetings. Staff said that the supervision process was productive and they felt well supported by their manager. Most of the staff we spoke with told us they felt a part of the overall trust but one member of staff said they did not feel so much a part of the trust.

The facilities at 145 Thorneywood Mount looked tired and dated. There was little opportunity for people to personalise their own bedrooms, which were small. People had access to a large outdoor area. The staff and manager we spoke with acknowledged the building was dated and in need of refurbishment. They were not able to confirm if the ward was due to be refurbished.

# Are services effective?

Good 

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.

The facilities at 106 Thorneywood Mount were generally more brightly decorated. People had larger bedrooms and had been provided with more furniture and a fridge to keep in their bedroom.

## **Multi-disciplinary working**

Each person attended an annual Care Programme Approach (CPA) review with the team assigned to manage their care and treatment. We saw that documentation relating to this was up to date and provided evidence of the person's involvement. There was evidence to show that people attended their MDT reviews. The opportunities, for multi-disciplinary team working, were reduced at this location as people did not have access to an occupational therapist. Staff received clinical support and supervision from a psychologist however the psychologist did not provide any direct clinical input with people. Staff told us they struggled to access psychology services for people due to long waiting lists. People also had limited access to a consultant psychiatrist. This meant that there was limited or no input into each person's care and treatment from these professionals.

## **Mental Health Act (MHA)**

We saw evidence which showed that staff had referred patients to an Independent Mental Health Advocate (IMHA) appropriately. We found that medication was prescribed within BNF limits and in accordance with patients T3 forms.

There was written documentation to show that patients' rights under Section 132 had been read on a regular basis.

Some Section 17 leave forms stipulated a condition that the patient had to be escorted with their relative during the leave period. It was not evident that the patient's relative had been given a copy of the Section 17 leave form or had been made aware of any conditions regarding the leave. There was no evidence to show that the patient's relative had been made aware of any contingency plans or informed of who to contact in an emergency. This is not in keeping with the requirements of the Code of Practice (21.21).

We found a lack of evidence to show that risk assessments were reviewed or undertaken prior to a patient detained under the MHA commencing Section 17 leave or upon their return to the ward following a period of leave under Section 17 MHA. This is a requirement of the Code of Practice (21.8).

One Section 17 leave form was dated to cover a two month period. It documented two time scales for escorted leave which was confusing.

All relevant Mental Health Act documentation was available for scrutiny on the wards.

# Are services caring?

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

## Summary of findings

Staff were kind and had a caring, compassionate attitude. They built positive relationships with people using the service and those close to them. Staff spent time talking to people and those close to them, and had good relationships with people, which were valued. There was a mutual respect between staff and people who used the service.

## Our findings

### Broomhill House

#### Kindness, dignity and respect

People who use the service and those close to them were treated with respect. The people we spoke with at this location told us they were treated with respect by staff. One person said, "The staff are so understanding." Another person told us, "The staff are really nice, I am treated well." We observed that staff interacted positively with people during our visit.

Staff in all roles put significant effort into treating people with dignity. People felt supported and well-cared for. Staff responded compassionately to people experiencing emotional distress in a timely and appropriate way. One person told us that staff had supported them to reduce the likelihood of them wanting to self-harm.

Staff were kind and had a caring, compassionate attitude and built positive relationships with people using the service and those close to them. Staff spent time talking with people, or those close to them. People valued their relationships with staff and experienced effective interactions with them. There was a mutual respect between staff and people who used the service.

Confidentiality was respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication.

#### People using services involvement

People were not always fully involved in planning their care and making decisions. We looked at the care plans for every person at this ward. We found little or no evidence in care plans of people being involved in reviews of their care. It was not clear from the records how staff tried to obtain the views of people about their care.

People had opportunities to discuss their health, beliefs, concerns and preferences to inform their individualised care. People were able to decide who to involve in their care and decisions about their care, and to what extent. Family, friends and advocates were involved as appropriate and according to the person's wishes.

Staff had effective communication skills. They communicated in a way that people understood and which was appropriate and respectful. During our visit, it was apparent that staff were aware of the preferred communication methods of different people. Verbal and written information, that enabled people who used the service to understand their care, was available to meet people's communication needs. This included ensuring individuals had access to information in different accessible formats, and interpreting and advocacy services if necessary.

Staff took all practicable steps to enable people to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to what was proposed, in accordance with the Mental Capacity Act.

#### Emotional support for care and treatment

Staff supported people to cope emotionally with their care and treatment. The people we spoke with told us that they valued the support provided to them by staff. One person told us that staff's understanding of their needs had led to a reduction in them self-harming.

People were supported to manage their own health and care when they were able and to maintain independence. People were supported to participate in social and community activities and to maintain and develop their networks to support recovery or long term care.

Where appropriate people were supported to stay connected to their family, friends and community, (including education) so that they did not become isolated and disconnected. Visitors were encouraged and supported with visiting times that suited them, with staff available for discussions in a private space if necessary.



# Are services caring?

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

## Newark Community Rehabilitation Unit

### Kindness, dignity and respect

People who used the service and those close to them were treated with respect. People we spoke with at this location told us they were treated with respect by staff. One person said, “The staff are warm and friendly.” We observed that staff interacted positively with people during our visit.

Staff in all roles put significant effort into treating people with dignity. People felt supported and well-cared for. Staff responded compassionately to people experiencing emotional distress in a timely and appropriate way. One person told us how they built trusting relationships with staff, which had previously been difficult for them to do.

Staff were kind and had a caring, compassionate attitude and built positive relationships with people using the service and those close to them. Staff spent time talking with people, or those close to them. People valued their relationships with staff and experienced effective interactions with them. There was a mutual respect between staff and the people who used the service.

Confidentiality was respected at all times when delivering care, including in staff discussions with people and those close to them and in any written records or communication.

### People using services involvement

All staff involved people as partners in their own care and in making decisions, with support where needed. People told us they felt involved in planning their care, making choices and informed decisions about their care and treatment. The staff we spoke with told us it was important for people to be involved in planning their care and treatment.

People had opportunities to discuss their health, beliefs, concerns and preferences to inform their individualised care. People were able to decide who to involve in decisions about their care, and to what extent. Family, friends and advocates were involved as appropriate according to the person’s wishes. One person told us that staff were very accommodating of their partner when they visited the unit.

Staff had effective communication skills and communicated in a way that people understood and which was appropriate and respectful. During our visit, it was apparent that staff were aware of the preferred communication methods of different people. Verbal and written information that enabled people using the service

to understand their care was available to meet people’s communication needs. This included ensuring individuals had access to information in different accessible formats, and interpreting and advocacy services if necessary.

Staff took all practicable steps to enable people to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to what is proposed, in accordance with the Mental Capacity Act.

### Emotional support for care and treatment

Staff supported people to cope emotionally with their care and treatment. The people we spoke with told us that they valued the support provided to them by staff.

People were supported to manage their own health and care when they were able and to maintain independence. During our visit; some people visited the local community independently or with staff support. People were supported to participate in social and community activities and to maintain and develop their networks to support recovery or long term care.

Where appropriate people were supported to stay connected to their family, friends and community, (including education) so that they do not become isolated and disconnected. Visitors to the ward were encouraged and supported with visiting times that suited them with staff available for discussions in a private area if necessary.

## Mansfield Community Rehabilitation Unit - Bracken House and Heather Close

### Kindness, dignity and respect

People and those close to them were treated with respect. The people we spoke with at this location told us they were treated with respect by staff. One person said, “The staff are really good.” We observed that staff interacted positively with people during our visit.

Staff in all roles put significant effort into treating people with dignity. People felt supported and well-cared for. Staff responded compassionately to people experiencing emotional distress in a timely and appropriate way. One person told us how they had been supported by staff during a period of distress.

Staff were kind and had a caring, compassionate attitude building positive relationships with people using the service and those close to them. Staff spent time talking

# Are services caring?

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

with people, or those close to them. People valued their relationships with staff and experienced effective interactions with them. There was a mutual respect between staff and people who used the service.

Confidentiality was respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication.

## People using services involvement

All staff involved people as partners in their own care and in making decisions with support where needed. People told us they felt involved in planning their care, making choices and informed decisions about their care and treatment. The staff we spoke with told us it was important for people to be involved in planning their care and treatment.

People had opportunities to discuss their health, beliefs, concerns and preferences to inform their individualised care. People were able to decide who to involve in their care and decisions about their care, and to what extent. Family, friends and advocates were involved as appropriate and according to the person's wishes.

Staff had effective communication skills. They communicated in a way that people understood and which was appropriate and respectful. During our visit, it was apparent that staff were aware of the preferred communication methods of different people. Verbal and written information that enabled people who used the service to understand their care was available to meet people's communication needs. This included ensuring individuals had access to information in different accessible formats, and interpreting and advocacy services if necessary.

Staff took all practicable steps to enable people to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to what is proposed, in accordance with the Mental Capacity Act.

## Emotional support for care and treatment

Staff supported people to cope emotionally with their care and treatment. The people we spoke with told us that they valued the support provided to them by staff.

People were supported to manage their own health and care when they were able and to maintain independence. During our visit some people visited shops in the local

community independently or with staff support. People were supported to participate in social and community activities and to maintain and develop their networks to support recovery or long term care. Staff told us how some people had become actively involved in a gardening group. There was also a walking group which was well attended on the day of our visit.

Where appropriate, people were supported to stay connected to their family, friends and community, (including education) so that they do not become isolated and disconnected. Visitors to the wards were encouraged and supported with visiting times that suited them and staff were available for discussions in a private area if needed.

## Thorneywood Rehabilitation Units

### Kindness, dignity and respect

People and those close to them were treated with respect. The people we spoke with at this location told us they were treated with respect by staff. One person said, "The staff are friendly and helpful." We observed that staff interacted positively with people during our visit.

Staff in all roles put significant effort into treating people with dignity. People felt supported and well-cared for. Staff responded compassionately to people experiencing emotional distress in a timely and appropriate way. One person told us that staff recognised when they were becoming unwell and supported them through this.

Staff were kind and had a caring, compassionate attitude and built positive relationships with people who used the service and those close to them. Staff spent time talking with people, or those close to them. The people we spoke with told us there was always a staff member available who they could talk to. People valued their relationships with staff and experienced effective interactions with them. There was a mutual respect between staff and people who used the service.

Confidentiality was respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication.

## People using services involvement

All staff involved people as partners in their own care and in making decisions, with support where needed. Two out of the three people we spoke with told us they felt involved in planning their care, making choices and informed

# Are services caring?

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

decisions about their care and treatment. One person told us they had not felt involved initially in the planning of their care. The staff we spoke with told us it was important for people to be involved in planning their care and treatment.

People had opportunities to discuss their health, beliefs, concerns and preferences to inform their individualised care. People were able to decide who to involve in their care and decisions about their care, and to what extent. Family, friends and advocates were involved as appropriate and according to the person's wishes.

Staff had effective communication skills. They communicated in a way that people understood and which was appropriate and respectful. During our visit, it was apparent that staff were aware of the preferred communication methods of different people.

## **Emotional support for care and treatment**

Staff supported people to cope emotionally with their care and treatment. The people we spoke with told us that they valued the support provided to them by staff.

People were supported to manage their own health and care when they were able and to maintain independence. People were supported to participate in social and community activities and to maintain and develop their networks to support recovery or long term care. We saw that there was a programme of activities available off site, including some day trips. However; it was apparent that some people did not actively engage with the activities provided.

Where appropriate people were supported to stay connected to their family, friends and community, (including education) so that they do not become isolated and disconnected. Visitors to the wards were encouraged and supported with visiting times that suited them and staff were available for discussions in a private area if needed.

# Are services responsive to people's needs?

Good 

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

## Summary of findings

The service proactively sought feedback from people and their carers. We found evidence that it had acted on feedback and implemented changes as a result.

People were encouraged to be involved in all aspects of their care, from admission to discharge. Each person had a comprehensive assessment as part of the admission process. This included finding out about their social, cultural, physical and psychological needs and preferences. People who used the services were also given verbal and written information, including in accessible formats, to help them understand more about their care. People had access to interpreters and advocacy services if they needed them.

## Our findings

### Broomhill House

#### Planning and delivering services

The ward provided care and treatment which was underpinned by a recovery focussed model to promote people's independence. Each person had a comprehensive assessment completed as part of the admission process which included people's social, cultural, physical and psychological needs and preferences.

Verbal and written information that enabled people who used the service to understand their care was available on the ward. This included ensuring people had access to information in different accessible formats. People had access to interpreting and advocacy services if necessary.

Staff took all practicable steps to enable people to make decisions about their care and treatment wherever possible and they understood the process to follow should they have to make a decision about or on behalf of a patient lacking mental capacity to consent to what was proposed, in accordance with the Mental Capacity Act.

#### Right care at the right time

The ward did not have a current waiting list. Staff told us that any new referrals were discussed at a weekly multi-disciplinary team (MDT) meeting. Staff from the ward would then arrange to assess the person to make sure that the ward was able to meet their needs' and that it was the right service for them to be transferred to.

### Care Pathway

The ward accepted transfers from a range of services including the acute wards and community settings. The ward had some self-contained flats which were used to enable people to gain more independence prior to their discharge. We saw that plans were being put into place for some people to move into more independent accommodation within the community. Staff told us that Care Programme Approach (CPA) meetings took place before a person was discharged to ensure they were supported during and after their discharge from the ward. The ward provided an outreach service for some people who had been discharged from the ward and people receiving this service remained under the care of the consultant and ward staff until their care was transferred to a community mental health team. This service was provided to ease the transition for people who had been an in-patient for several months or years to reduce the risk of them experiencing a relapse during their transition into the community.

### Learning from concerns and complaints

People were provided with information about how they could raise complaints or concerns about the ward. The ward actively sought feedback from people through the use of a suggestion box and regular patient meetings took place. These meetings were minuted and available for people to look at on the ward. Staff were able to show us changes the ward had made in response to feedback from people through the Patient Advice and Liaison Service (PALS).

The ward held a monthly carers' support meeting which was also used as a forum for gaining feedback from carers'.

The ward meetings had a set agenda which included complaints and feedback from people who used the service. Complaints were also discussed in the service's clinical governance meeting which took place monthly which meant that the wards ensured that learning from complaints, comments and compliments were embedded in their governance processes.

### Newark Community Rehabilitation Unit

#### Planning and delivering services

The ward provided care and treatment which was underpinned by a recovery focussed model to promote people's independence. Each person had a comprehensive assessment completed as part of the admission process

# Are services responsive to people's needs?

Good 

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

which included people's social, cultural, physical and psychological needs and preferences. One person told us they had been transferred to the ward so they could be nearer to their family.

People had access to an occupational therapist and psychologist on the ward. One person said they had found this to be vital part of assisting their recovery.

There was evidence that people's physical health needs being met. For example; patients had access to an annual health check and routine appointments with healthcare professionals such as their General Practitioner (GP) and dentist.

We saw that people's care plans were being reviewed for their effectiveness at regular intervals with the person to make sure the service continued to meet their needs.

One bungalow did not provide gender specific accommodation, however we were satisfied from the information were given during our visit, that the clinical reasons' for this decision met the criteria for 'exceptional' exemption as defined in the Department of Health (DH) Single Sex Accommodation (SSA) requirements and therefore was not in breach of this guidance.

## Right care at the right time

The ward did not have a current waiting list. Staff told us that any new referrals were discussed at a weekly multi-disciplinary team meeting and they would then arrange to assess the person to make sure that the ward was able to meet their needs' and that it was the right service for them to be transferred to.

## Care Pathway

The ward accepted transfers from a range of services including the acute wards and community settings. This location was split into four sets of bungalows. Staff told us that people would gradually progress through the bungalows as they become more settled and independent. We saw that plans were being put into place for some people to move into more independent accommodation within the community. Staff told us that Care Programme Approach (CPA) meetings took place before a person was discharged to make sure that they were supported during and after their discharge from the ward.

## Learning from concerns and complaints

People were provided with information about how they could raise complaints or concerns about the ward. The

ward actively sought feedback from people through the use of a suggestion box and regular patient meetings took place. Staff we spoke with were able to tell us how the ward had responded to feedback from people which included the use of a, 'You said-We did' board displaying and recording action the ward had taken in response to feedback.

The ward meetings had a set agenda which included complaints and feedback from people who used the service. Complaints were also discussed in the service's clinical governance meeting which took place monthly. This meant that the wards ensured that learning from complaints, comments and compliments were embedded in their governance processes.

## Mansfield Community Rehabilitation Unit - Bracken House and Heather Close

### Planning and delivering services

The wards provided care and treatment which was underpinned by a recovery focussed model to promote people's independence. Each person had a comprehensive assessment completed as part of the admission process which included their social, cultural, physical and psychological needs and preferences. Staff told us that any new referrals were assessed by two members of the multi-disciplinary team to assess their suitability for the ward which they were referred to.

The wards were supported to meet people's needs by a range of professionals including a psychologist, occupational therapist, pharmacist, activity support workers, nursing and medical staff.

The wards were accessible to people with mobility needs.

### Right care at the right time

Staff told us that Bracken House tended to be full to capacity which meant there was seldom a vacant bed available. They said that they would only place a person's name on the waiting list if there was likely to be a bed available within three months of the referral. If a bed was not likely to be available in this time, then the referrer would be advised to seek alternative accommodation for the person. On Heather Close this was not an issue. Staff told us that if a person relapsed in community they could directly access a bed on either ward dependent upon their needs.

As Bracken House was a locked ward, all of the people on the ward were subject to detention under the Mental



# Are services responsive to people's needs?

Good 

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

Health Act. It was not clear what the protocol was regarding people who may have their detention status revoked following a tribunal review. There were inconsistencies from staff with regards to how they would manage this situation.

## Care Pathway

The wards accepted transfers from a range of services including the acute wards and community settings. Bracken House also accepted referrals from forensic services.

Staff at Bracken House told us that as soon as people were ready to be transferred to a less restricted environment, they would be transferred to one of the open rehabilitation wards within the trust. On both wards, staff told us they had no issues obtaining an acute bed for a person if this was required.

Staff told us that Care Programme Approach (CPA) meetings took place before a person was discharged to make sure that they were supported during and after their discharge from the ward.

Staff could provide follow up support to people for up to six months after they had been discharged from the wards before they were transferred to a community mental health team. This was to reduce the risk of the person relapsing post discharge.

## Learning from concerns and complaints

People were provided with information about how they could raise complaints or concerns about the wards.

The wards actively sought feedback from people through regular patient meetings and staff were able to tell us how the wards had responded to feedback from people. This included developing a smoking cessation lead nurse following requests for assistance and support to stop smoking. The lead worked closely with a physical health nurse who people could be referred to. Staff told us that the programme had successfully helped some people to stop smoking.

The ward meetings had a set agenda which included complaints and feedback from people who used the service. Complaints were also discussed in the service's clinical governance meeting which took place monthly. This meant that the wards ensured learning from complaints, comments and compliments was embedded in their governance processes.

## Thorneywood Rehabilitation Units

### Planning and delivering services

The location had two wards which were on opposite sides of the road to each other. The wards were gender specific for males and females. They both provided care and treatment which was underpinned by a recovery focussed model to promote people's independence. Each person had a comprehensive assessment completed as part of the admission process which included their social, cultural, physical and psychological needs and preferences.

There was evidence that people's physical health needs were being met. For example people had access to an annual health check and routine appointments with healthcare professionals such as their General Practitioner and dentist.

We saw that people's care plans were being reviewed for their effectiveness at regular intervals with the person to make sure the service continued to meet their needs.

There was no dedicated input on the wards from an occupational therapist (OT). We were told by the manager that a bid had been submitted to commissioners to secure an OT for the wards and they were awaiting the outcome. Staff received supervision from a psychologist however no clinical input was provided for people on the wards. Staff told us they were required to refer people as needed to access a psychologist however due to waiting list times, this was not always accessible in a timely manner.

### Right care at the right time

The wards did not have a current waiting list. Staff told us that any new referrals were discussed at a weekly multi-disciplinary team meeting. Staff from the wards would then arrange to assess the person to make sure the ward was able to meet their needs and that it was the right service for them to be transferred to.

### Care Pathway

The wards accepted transfers from a range of services including the acute wards and community settings. We saw that plans were being put into place for some people to move into more independent accommodation within the community. Staff told us that Care Programme Approach (CPA) meetings took place before a person was discharged to make sure that they were supported during and after their discharge from the ward.

# Are services responsive to people's needs?

Good 

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

## Learning from concerns and complaints

People were provided with information about how they could raise complaints or concerns about the ward. The ward actively sought feedback from people through the use of a suggestion box, patient feedback questionnaires and regular patient meetings. Staff we spoke with were able to tell us how the ward had responded to feedback from people which included the use of a, 'You said-We did' board which displayed and recorded action taken in response to feedback from people.

The wards held monthly carer meetings which were also used to gain feedback from carers and relatives. One relative we spoke with told us they had made a complaint about the care their relative was receiving. This was being dealt with in line with the trust's complaint policy.

The ward meetings had a set agenda which included complaints and feedback from people who used the service. Complaints were also discussed in the service's clinical governance meeting which took place monthly. This meant that the wards ensured that learning from complaints, comments and compliments was embedded in their governance processes.

# Are services well-led?

Good 

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.

## Summary of findings

Staff told us that they felt well supported by their managers and were proud to work for the service. They also said that they saw managers on the wards.

The service had strong governance structures in place, which were fully embedded on most of the wards. We also saw evidence of shared learning across the wards. The service was committed to improving its performance and the quality of care it provided. For example, the rehabilitation wards were putting new care pathway and care plan documentation in place.

## Our findings

### Broomhill House

#### Vision and strategy

All of the staff we spoke with told us that they felt proud working for the ward. However some staff said they felt detached from the trust at times due to the isolated location of the ward. They did say that there were systems in place to address this, such as the intranet and team meetings, which were used to keep them up to date with developments within the trust. They told us that they felt supported by their managers and felt they could approach them if needed. Some staff were aware of the chief executive and board level leadership through the trust and were able to identify the trust values.

#### Responsible governance

The ward manager told us they had only been in post for a few weeks however during this time, they had identified a number of issues which they were addressing with the operational manager and matron to strengthen governance arrangements on the ward. This included implementing a number of audits on the ward and using the same care pathway and care plan documentation across all the rehabilitation wards.

The ward held regular staff meetings that had an agenda which was focussed on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services.

#### Leadership and culture

The ward manager, operational manager, matron and staff on the ward were all very open and transparent when speaking with us about some of the challenges they faced on the ward and how these were being addressed.

Staff told us that their manager was very available and supportive and they supported each other within the team very well. The acting ward manager told us they received the support they needed from managers to act up into the position of manager.

#### Engagement

Staff we spoke with were aware of internal and external whistleblowing policies, where to find them and would feel comfortable raising concerns with their managers.

The ward was proactive in its approach to gaining feedback from people who used the service through patient meetings, a suggestion box, PALS and a carers' meeting. We saw evidence of positive changes that had been made in response to feedback from people.

#### Performance improvement

Staff we spoke with had annual appraisals and were aware of their own personal development goals. The acting ward manager was implementing a range of audits to identify areas which required improvement in addition to the external audits which took place on the ward. This showed that the service was committed to improving its performance.

### Newark Community Rehabilitation Unit

#### Responsible governance

The ward held regular staff meetings with an agenda which was focussed on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services.

#### Leadership and culture

Staff told us that their manager was very available and supportive and they supported each other within the team very well.

#### Engagement

Staff we spoke with were aware of internal and external whistleblowing policies, where to find them and they would feel comfortable raising concerns with their managers. The ward was proactive in its approach to



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gaining feedback from people who used the service through patient meetings, a suggestion box, PALS and a carers' meeting. We saw evidence of positive changes that had been made in response to feedback from people.

## Performance improvement

Staff we spoke with had annual appraisals and were aware of their own personal development goals. Both internal and external audits took place on the ward. We saw evidence which showed that action had been taken in response to the outcome of some of these.

The wards were in the process of implementing the new care pathway and care plan documentation which was being rolled out across all the rehabilitation wards to improve the quality of the service provided.

This showed that the service was committed to improving its performance.

## Mansfield Community Rehabilitation Unit - Bracken House and Heather Close

### Responsible governance

The wards held regular staff meetings that had an agenda which was focussed on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services.

### Leadership and culture

Both Bracken House and Heather Close had acting ward managers in place. Interviews of potential applicants had taken place but an appointment had yet to be made. The manager told us that the position was in the process of being re-advertised. The acting managers told us they received the support they needed from managers to enable them to act up into the manager's position.

Staff told us that their manager was very available and supportive when required. They told us that they supported each other within the team very well.

### Engagement

Staff we spoke with were aware of internal and external whistleblowing policies, where to find them would feel comfortable raising concerns with their managers.

The ward was proactive in its approach to gaining feedback from people who used the service through patient meetings, a suggestion box, PALS and a carers' meeting. We saw evidence of positive changes that had been made in response to feedback from people.

## Performance improvement

Staff we spoke with had annual appraisals and were aware of their own personal development goals. Both internal and external audits took place on the ward. We saw evidence which showed that action had been taken in response to the outcome of some of these.

The wards had fully implemented the new care pathway and care plan documentation which was being rolled out across all the rehabilitation wards, improving the quality of the service provided.

Bracken Ward had attained the Accreditation for Inpatient Mental Health Wards (AIMS) from the Royal College of Psychiatrists. This showed that the service was committed to improving its performance.

## Thorneywood Rehabilitation Units Responsible governance

All of the staff we spoke with told us that they felt proud working for the wards and that there were systems in place, such as the intranet and team meetings, which were used to keep them up to date with developments within the trust. They told us that they felt supported by their managers and could approach them if needed. Some staff were aware of the chief executive and board level leadership through the trust and were able to identify the trust values.

The ward held regular staff meetings with an agenda which was focussed on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services.

### Leadership and culture

Staff told us that their manager was very available and supportive. They told us that they supported each other within the team very well and felt the wards had a positive culture.

### Engagement

Staff we spoke with were aware of internal and external whistleblowing policies and where to find them and told us that they would feel comfortable raising concerns with their managers. The ward was proactive in its approach to gaining feedback from people using the service through patient meetings, a suggestion box, PALS and a carers' meeting. We saw evidence of positive changes made in response to feedback from people.

# Are services well-led?

Good 

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.

## Performance improvement

Staff we spoke with had annual appraisals and were aware of their own personal development goals. The acting ward manager was implementing a range of audits to identify areas for improvement, in addition to the external audits

which took place at trust level. This showed that the service was committed to improving its performance. We saw evidence that action had been taken in response to the outcome of audits to improve performance.

# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>The registered person did not ensure that service users were protected against the risks associated with unsafe or unsuitable premises by means of:</p> <p>Suitable design and layout and adequate maintenance and the proper operation of the premises.</p> <p><b>The way the Regulation was not being met:</b></p> <p>The trust's 'Risk Assessment in Health and Safety Policy' stated that ligature risk assessments should be undertaken in each in-patient ward on an annual basis. Some wards at Broomhill House, Newark Community Unit, Mansfield Community Unit and Thorneywood Mount Unit had not completed an annual ligature risk assessment in line with the trust policy. We found ligature risks on all the wards we visited with the exception of Bracken House. These risks were not always identified and managed appropriately across the service.</p> <p>Regulation 15 (1)(a)(c)</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of:</p> <p>The planning and delivery of care and where appropriate, treatment in such a way as to:</p> <p>Ensure the welfare and safety of the service user.</p> <p><b>The way the Regulation was not being met:</b></p> <p>Mental Health Act documentation was not available for scrutiny on Bracken Ward and Broomhill House. This is not in accordance with the Code of Practice (30.11) and could result in patients' rights not been protected.</p>

## Compliance actions

On all the wards we visited, we found that relatives or carers of people detained under the Mental Health Act were not given adequate information prior to escorting patients during Section 17 leave. This meant that the patient's relative or carer had been made aware of any contingency plans or informed of who to contact in an emergency. This is not in keeping with the requirements of the Code of Practice (21.21).

There was no evidence to show that patients risk assessments had been reviewed before they commenced and returned from Section 17 leave periods on the wards we visited. This is a requirement of the Code of Practice (21.8).

Regulation 9 (1) (b) (ii)