

Requires improvement 

Coventry and Warwickshire Partnership NHS Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

Wayside House
Wilsons Lane
Coventry
CV6 6NY
Tel: 0121 3294900
Website:
www.covwarkpt.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RYG1	Hawkesbury Lodge	Hawkesbury Lodge	CV6 6TD
RYG1	St Michaels Hospital	Hazelwood	CV34 5QW
RYG05	Highfield House	Highfield House	CV11 4PW

This report describes our judgement of the quality of care provided within this core service by Coventry and Warwickshire Partnership NHS. 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.

Summary of findings

Where applicable, we have reported on each core service provided by Coventry and Warwickshire Partnership NHS Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire Partnership NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- Ligature risk assessments across the service did not explain how staff managed these risks. When staff identified ligature risks, there were no clear action plans of how staff mitigate these.
- Hawkesbury Lodge did not comply with the Mental Health Act code of practice on eliminating mixed sex accommodation.
- There was no resuscitation and emergency equipment at Hawkesbury Lodge or Highfield House.
- We found no records of the monitoring of the temperature in the clinic rooms or identified room where medications were stored.
- Staff compliance with the management and prevention of aggression training was low across the service, as was the compliance with MHA training.
- Risk assessments were variable across the service. Staff did not update these or review on a regular basis. Care plans were brief, not person centred, holistic and not recovery focused on two of the three wards. Staff did not review care plans regularly and there was minimal evidence of patient involvement.
- Two of the three wards had a clinical supervision rate of 49%. This was below the trust target. There had been a reported lack of psychology input across the service due to vacancies.
- Patients were transferred from the acute ward to the rehabilitation services for the purpose of a “sleep-over”. This was due to pressure on bed availability as opposed to assessed clinical need.
- There was a low morale among the staff interviewed. The staff felt uncertain regarding the future of the rehabilitation services.

However,

- The wards were visibly clean.
- Ward managers were able to adjust the staffing on a day-to-day basis to ensure that patients’ needs were met.
- Staff regularly met with patients on a one to one basis.
- Patients had risk assessments completed upon admission to the service. Staff carried out regular and thorough physical health assessments for patients.
- Staff understood what constituted an incident and knew how to report them.
- New staff underwent a formal induction, which prepared them for their new role and enabled them to familiarise themselves with designated ward. Most staff had completed their annual appraisal.
- There were effective links with outside agencies, which enabled staff to support patient care on an individual basis.
- Most staff had received awareness training around the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- Patients had the opportunity to attend regular community meetings.
- The service maintained contact with carers, and invited them to review meetings if patients wanted them present.
- Managers carried out audits to monitor the quality of the service.
- Staff felt supported by their immediate line managers.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Hawkesbury Lodge did not comply with the Mental Health Act code of practice on eliminating mixed sex accommodation.
- Ligature risk assessments did not mitigate identified risks and did not include assessment of outdoor spaces.
- There was no resuscitation equipment on two of the three wards.
- Staff compliance with the management and prevention of aggression training was low across the service.
- Staff did not monitor room temperature in clinic rooms to ensure that medications were being stored correctly.
- There was variation in the quality of patient risk assessments. Not all risk assessments were up to date. Staff had not reviewed on a regular basis.
- Bank or agency staff did not always cover nursing shifts and so the wards were short staffed. This meant that patients may not have received the care and treatment they required at the time they needed it.
- There was low staff compliance with MHA training and the prevention and management of violence and aggression.

However,

- The wards were all visibly clean and tidy.
- Equipment was well maintained.
- The wards had a range of staff to deliver care and treatments to patients.
- There were good systems for reporting, recording and reviewing incidents.
- Staff reported their managers were supportive when incidents occurred. Debriefs occurred at the earliest opportunity.
- Ward managers were able to adjust staffing levels on a day-to-day basis, if for example clinical activity had increased.
- Patients received regular one to one time with staff.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

- Care plans were brief, not holistic and not recovery focused on two of the three wards. They did not reflect the full range of patients' problems and needs.

Requires improvement



Summary of findings

- Staff did not review care plans on a regular basis and there was minimal evidence of patient involvement in two of the three wards. Patient signatures were missing and the care plans appeared generic and did not always consider patients' views.
- Two out of three of the wards had a clinical supervision rate of 49%. This is below the trust target. The ward managers and deputy ward managers supervised their junior colleagues. All wards reported difficulties in finding the time to undertake this.
- There was a low compliance with the MHA mandatory training among eligible staff.
- Psychology input across the service has been minimal due to vacancies. The trust has addressed this and has actively recruited.

However,

- Patients received regular monitoring of their physical healthcare needs.
- Staff actively completed clinical audits.
- Staff received regular appraisals.
- Hand overs were thorough and effective. Current risks of patients were discussed, for example any safeguarding concerns that had arisen over the past twenty-four hours, or any incidents of concern. Staff relayed what leave each patient had. Tasks needing completion were discussed and staff agreed how these would be facilitated. The current presentation of the patients as well as any changes or concerns around prescribed medications was also discussed.
- The service provided staff from a variety of professional backgrounds to ensure the delivery of effective care.

Are services caring?

We rated caring as good because:

- We observed appropriate and respectful interactions with patients.
- Patients told us that they found the staff respectful and lovely.
- Patients had access to advocacy and actively used this. We saw posters on the walls for advocacy services.
- There was regular contact between the staff and carers. Carers or relatives were invited to care review meetings where appropriate.
- Staff on all wards held regular community meetings, which gave patients the opportunity to input into the service, and express their views and concerns.

However,

Good



Summary of findings

- It was not clear in records if patients had been involved in developing and reviewing their care plans.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- There was evidence of some delayed discharges across the service, although each ward actively pursued discharge. There was a delay due to funding issues or awaiting bed availability.
- There was movement of patients for non-clinical reasons from the acute service. This could cause distress to the patient being moved, and to the patients on the ward to which they were allocated a bed.
- There was an ongoing complaint at one of the services. This was not formally logged as per policy.

However,

- Patients using the service were aware of how to make complaints and felt that staff would support them.
- Staff collected patient feedback and made changes to reflect this.
- There was direct access to outside space.
- There was a wide variety of activities available to patients.

Requires improvement



Are services well-led?

We rated well led as requires improvement because:

- The trust did not have robust governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures. Whilst ligature risk assessments and action plans were in place, they did not address how to manage the risks.
- Some mandatory training rates were low across the wards – in particular the MHA training and the prevention and management of violence and aggression.
- Staff did not receive regular clinical supervision.
- Bank or agency staff could not always cover vacant shifts, which had an impact upon patient care.
- Morale was low across the service. Staff felt uncertain about future service change.

However,

- Staff said they felt supported by their immediate line managers.
- The services were responsive to feedback from patients and made changes at ward level to reflect this.
- Arrangements were in place to monitor quality within the service and managers carried out audits.

Requires improvement



Summary of findings

Information about the service

The long stay/rehabilitation mental health wards for working age adults provided by Coventry and Warwickshire Partnership NHS Trust are located at three different sites. Referrals are received from community mental health teams and inpatient services. Patients are either informal or formally detained under the Mental Health Act 1983 (MHA)

- Hawkesbury Lodge is a 20-bedded, mixed gender, high dependency, inpatient rehabilitation ward in Longford, Coventry. Patients may have a severe and enduring mental disorder with additional physical, social and psychological needs, including substance misuse. The ward has a 'step down' area, which consists of four beds.
- Hazelwood ward is based at St Michael's hospital in Warwick. It has 12 beds and is for men with enduring

mental illness and challenging behaviour. Hazelwood ward provides rehabilitation and recovery services in a high dependency inpatient environment.

- Highfield House is an eight-bedded, open, community-based rehabilitation ward in Nuneaton, for men and women who have mental health difficulties.

All of these wards were inspected in January 2014. Highfield House and Hawkesbury Lodge were found to be meeting all of the essential standards. Two breaches of regulations were identified at St Michael's hospital: a breach of regulation 20 (1)(a)(i)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) regarding the safekeeping of information; and a breach of regulation 17 (1)(a) regarding the dignity, privacy and independence of patients. These requirements were met during this inspection.

Our inspection team

Our inspection team was led by:

Chair: Paul Jenkins, Chief Executive, Tavistock and Portman NHS Foundation Trust.

Team Leader: Julie Meikle, Head of Hospital Inspection, (mental health) CQC.

Inspection Manager: Margaret Henderson, Inspection Manager, mental health hospitals, CQC.

The team that inspected the long stay/rehabilitation mental health wards for working age adults consisted of three CQC inspectors, two specialist advisors (one nurse and one social worker),; one Mental Health Act reviewer and one person with experience of using services.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and fair with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information. We also sought feedback from patients with comment cards that we placed around the wards.

During the inspection visit, the inspection team:

- Visited all three wards looked at the quality of the ward environment and observed how staff were caring for patients.

- Spoke with seven patients who were using the service and received two comment cards from patients using the service.
- Interviewed three ward managers.
- Spoke with 15 other staff members, including doctors, nurses, health care assistants, occupational therapist and psychologists.
- Spoke with two relatives of patients using the service.
- Reviewed 25 patient care and treatment records.
- Carried out a specific check on medication management for 13 patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Observed two hand overs at two different wards.
- Observed two staff meetings on two different wards.
- Observed a patient community meeting.

What people who use the provider's services say

We spoke with seven patients:

- All but one patient told us that staff were respectful and easy to approach.
- Patients liked having keys to their bedrooms and felt that they had enough privacy.
- Patients told us that they felt safe on the wards.
- Patients told us that they were able to have visitors or could arrange to go out on leave to see family and friends.

- Patients told us that they knew how to access advocacy and one gave us an example of how they used this service.
- One patient told us they were unhappy staff had to check them every hour throughout the night. It disturbed their sleep and they felt it unnecessary. The patient told us hourly checks had recently been introduced as the service moved into another division.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure adherence to the guidance on mixed sex accommodation.

- The trust must ensure that ligature risk assessments are completed with action plans to show what action will be taken to mitigate risks.

Summary of findings

- The trust must ensure that care plans are person centred, holistic, demonstrate active patient involvement and are recovery focused.
- The trust must ensure that staff receive regular clinical supervision.
- The trust must ensure that staff receive training on the MHA 1983 and in the prevention and management of violence and aggression.

Action the provider **SHOULD** take to improve

- The trust should ensure that there is clear signage telling informal patients that they are able to leave the wards.
- The trust should ensure that each ward has resuscitation and medical emergency equipment available.
- The trust should ensure that clinic room temperatures are monitored daily to ensure medicines are stored correctly.

Coventry and Warwickshire Partnership NHS Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hawkesbury Lodge	Hawkesbury Lodge
Hazelwood ward	St Michaels Hospital
Highfield House	Highfield House

Mental Health Act responsibilities

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

- MHA 1983 training was a mandatory training requirement for qualified staff. Across the service, compliance was low at 43%.
- Staff had completed the MHA 1983 paperwork correctly and detention paperwork was up to date.
- Staff had access to support from a MHA administrator when they needed it and qualified staff knew how to access this.
- Medical staff completed consent to treatment and capacity assessments. Staff attached copies to medication charts to ensure they administered medication in accordance with the MHA1983.
- There was evidence that the staff regularly explained patients' rights to them under the MHA1983.
- Patients had access to generic advocacy, independent mental health advocates and independent mental capacity advocates. Information pertaining to detention under the MHA 1983 was available on all of the wards.
- Patients had access to tribunals and hospital managers meetings to appeal against their legal detention.

Detailed findings

- Patients had access to section 17 leave, which the consultant granted on either an escorted or an unescorted basis. Documentation seen was clear in respect of the frequency and length of leave granted.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) awareness training which was mandatory. The compliance rate with this training was 96%.
- Staff knew how to access the trust's MCA policy and additional information about the act through the staff intranet system.
- Mental capacity was discussed in clinical reviews and recorded in care and treatment records.
- Patients who were subject to a DoLS restriction had appropriate paperwork in place. There was evidence of discussions among the multidisciplinary team and the patients, around least restrictive options

Are services safe?

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

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

Our findings

Safe and clean environment

- Hawkesbury Lodge did not comply with eliminating mixed sex accommodation guidelines. The ward had 20 beds over two floors. Four female bedrooms were downstairs and the first floor was for 12 males. A female patient's privacy and dignity could be affected, as there was a female communal bathroom in the upstairs male corridor. A female patient would have to pass male bedrooms to access the bathroom. The step down area of the ward for patients nearing discharge was in a separate corridor downstairs. One step down bedroom had an ensuite shower room. Staff said the step down beds were single sex. If a woman was admitted to this area, men would not be. However, we observed that men were using the other communal areas.
- Hawkesbury Lodge and Hazelwood wards were locked wards. This meant that informal patients needed staff to unlock the doors for them to go out. At Highfield House, the front door was locked from the outside, but could always be opened from the inside so that patients could freely leave as and when they wanted. This meant that patients and staff were protected from unwanted visitors entering the ward.
- Hawkesbury Lodge had reasonable lines of sight with long corridors. There was closed circuit television (CCTV) covering the external areas. Hazelwood ward had CCTV internally and externally and so all areas could be visible to staff.

Highfield House had numerous blind spots due to the layout and structure of the building. It was originally two houses, which later converted to one. Patients across the service were being cared for under general observations (hourly basis unless they were assessed as requiring more frequent observations).
- We saw multiple high and low ligature risks across the wards. These were identified through the trust ligature audits. Staff had completed ligature risk assessments.

However, these did not contain plans for how staff could manage these risks. These assessments did not cover the garden and outside areas of the wards where there were ligature risks.

- Staff told us that patients from the acute wards were transferred over to Hawkesbury Lodge if an urgent acute bed was required. This meant that if a female bed was urgently required and there was no female bed available, an upstairs male bedroom would be used on Hawkesbury for "sleep over" purposes. That is, a patient would be transferred to the ward in the evening and return to the acute service in the morning. Staff told us that these patients would be on close observations. The trust confirmed that between January and March 2016, 14 patients were transferred to Hawkesbury Lodge for the purpose of a sleep over. There could be issues around maintaining the privacy and dignity of these patients, as they were placed on close observations because they were in an inappropriate bedroom, as opposed to being closely observed because of clinical need. Between January and March 2016, two patients slept over on Hazelwood ward. During the same period, no patients were reported to have been sent to "sleep over" at Highfield House. However, staff at Highfield House told us this had happened in the past, and there had been times when staff had received minimal or incorrect information about the patient. During the staff meeting at Highfield House the manager informed the staff they had introduced a "sleep-over" checklist, which staff needed to complete to ensure that information relating to patients, being transferred for a sleep over was adequate. Patients staying at Highfield House solely for the purpose of sleeping there, would arrive as late in the evening as possible, and return early the following morning to minimise disruption to the ward. Transferring of patient for non-clinical reasons could cause the patient unnecessary distress and disruption. This was in breach of the Department of Health guidance and the Mental Health Act code of practice.
- Hazelwood ward was fully compliant with the Department of Health guidance on mixed sex accommodation. Highfield House had one bedroom located on the ground floor, and a further seven bedrooms on the first floor. Upstairs there was a

Are services safe?

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

separate corridor for female and male patients. Both areas had identified separate shower facilities. There was one bathroom, which could be used by all patients. The bathroom was located at the beginning of the male corridor. Staff told us that if a woman wanted to use this, a staff member would be outside of the room. There was a women's only lounge located on the ground floor. There were no concerns expressed by patients around this during the inspection.

- Resuscitation and emergency equipment was not available at Hawkesbury Lodge or Highfield House. Both wards told us that they would call the emergency services in the event of a medical emergency. This could delay the process of commencing effective lifesaving treatment in the event of an emergency. However, staff received training in basic life support as part of their mandatory training. The service was 88% compliant.
- There were no seclusion facilities across the service.
- The ward areas were visibly clean. Cleaning schedules were fully completed and audited. The Patient Led Assessment of the Care Environment (PLACE) 2015 scores for cleanliness was 99% across St Michael's hospital and Hawkesbury Lodge. This is higher than the England average of 98%. Patients told us that the wards were cleaned regularly and were well kept. The patients took some responsibility for cleaning their own personal areas and were encouraged to keep communal areas clean and tidy. For example, Highfield House had a chores rota identifying specific chores for individual patients on specific days. This was to help with rehabilitation and preparation for independent living.
- Staff followed infection control policies and had access to protective personal equipment such as gloves and aprons and hand gels. There were hand-washing facilities across the service. Equipment was well maintained and clean. We looked at the wards' cleaning schedules and saw that the housekeeping staff undertook regular audits for cleanliness. Staff confirmed this.
- Staff completed environmental risk assessments regularly, which considered structural aspects of the buildings. Between audits, staff could report any concerns needing attention.

- Staff carried personal alarms on Hawkesbury Lodge and on Hazelwood ward. There were additional alarms available for visitors to both wards. Staff kept a record of additional alarms and staff checked these regularly to ensure that they were working.

Safe staffing

- Ward managers told us that staffing levels were calculated by the trust. In November 2015 the service had agreed an establishment of 26 whole time equivalent nurses (WTE) and 37 WTE health care assistants. There was one nurse vacancy and eight health care assistant vacancies across the service.
- The ward managers were able to adjust staffing levels on a day-to-day basis in order to meet the needs of the patients and felt supported by the matrons in doing this. However, not all shifts were filled. Bank and agency staff had covered 459 shifts between September and November 2015 but the trust was unable to cover a further 33 shifts. When nursing shifts were not filled, there was a risk that not all patients will get the care they require at the time they need it.
- Sickness rates across the service varied between 5% on Hawkesbury Lodge, to 13% at Hazelwood ward and Highfield House between December 2014 and November 2015. There were two nurses across the service that had been off on long-term sickness.
- The total number of substantive staff leavers across the service between December 2014 and November 2015 was 10, with eight of these being on Hazelwood ward. This represented a 17% turnover in a 12-month period. Staff told us that people had left to take up different opportunities within the trust, with many having gone to work in community teams.
- Each service aimed to have a familiar member of staff present in communal areas of the service at all times, dependent upon where the patients were and what activities they were engaged in. It was not always possible for a qualified member of staff to be present because of overall staffing numbers and activity on the wards.
- Most staff told us that they would try to meet regularly with individual patients on a one to one basis. Patients confirmed they spent regular one to one time with members of the nursing team and we had evidence of this in care records.

Are services safe?

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

- Each ward identified the importance of patient leave and activities. Staff at Hawkesbury Lodge and Highfield House told us that cancelling patient leave or activities because of short staffing would rarely happen. However, on Hazelwood ward, 50% of staff we spoke with told us that leave would often need to be postponed, or activities cancelled due to staffing shortages.
 - There was medical cover available during the hours of nine to five Monday to Friday at Hawkesbury Lodge and Hazelwood ward. Out of hours, there was an on call rota system. If the psychiatrist was not on site they would be at the Caludon Centre, which is, around twenty minutes' drive away. In an event of an emergency, if the on call psychiatrist was unable to attend quickly, staff would call for an ambulance. At Highfield House patients saw their own GP, and would use the local general hospital for routine medical tests, such as having blood tests.
 - Trust data showed that 92% of staff across the service were up to date with their mandatory training.
 - To promote the safe use of physical interventions (restraint), permanent staff were expected to complete training in the management of violence and aggression. However, staff compliance with management and prevention of aggression (disengagement foundation refresher) was only 39%, which was low. The holding and disengagement foundation advanced level training was completed by 60% of staff; with 75% having completed the refresher. Staff and patients could be at risk if there is not enough trained staff attending incidents where physical interventions and de-escalation may be required. Between June and November 2015 there were three uses of restraint on Hazelwood ward, one of these resulted in the use of prone restraint (face down). Since this time, there was a further two incidents of restraint on Hazelwood ward, involving two patients. None of which resulted in the prone position. The service had a low use of restraint. Physical restraint was used as a last resort by staff after other attempts to calm a distressed patient failed. Staff were aware of the guidance contained in the Department of Health document, Positive and Proactive Care (2014) relating to reducing the use of prone restraint.
- Assessing and managing risk to patients and staff**
- We reviewed 25 care records. Staff undertook a risk assessment of every patient upon admission. Some risk assessments viewed were more detailed than others were. Risk assessments were variable across the service. At Highfield House all care records we examined had up to date and contained thorough risk assessments. At Hawkesbury Lodge 17% of the risk assessments examined had an incomplete assessment, which had not been updated in line with the trust policy. On Hazelwood ward 43% of records examined did not have up to date risk assessments and one patient's assessment did not include a risk, which had been identified by staff. This meant that the staff could not be sure that they were aware of the risks associated to the patients and be able to tailor care plans around these to maintain the safety of the patient and others. Staff told us that one patient was transferred from another ward within the trust recently. Shortly after admission, the patient approached staff to inform them that another patient who was on the ward had previously assaulted them. Care records for both patients did not reflect this. The patient had to be transferred back in order to maintain their safety.
 - Due to the security arrangements at Hawkesbury Lodge and Hazelwood ward, informal patients could find it difficult to leave if they wanted to. One informal patient on Hawkesbury Lodge did not have a care plan relating to their informal status.
 - The trust had a policy on the management of patient observations. There was a planned system for ensuring that all patients were allocated individual staff members to observe them on an hour-by-hour rotation as a minimum.
 - When it was necessary to search patients, staff adhered to the search policy. Staff told us that they only searched patients if there was an increased risk, for example if patients were suspected of taking illicit drugs whilst on leave, or there were concerns about their safety, or the safety of others. Each ward took an individual approach to the use of searching. Staff undertook this on a risk-assessed basis.
 - Medical staff told us they prescribed rapid tranquilisation in accordance with National Institute for Health and Care Excellence (NICE) guidelines. There had been no uses of rapid tranquillisation across the service between June and November 2015.

Are services safe?

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

- All staff undertook basic safeguarding training as part of their mandatory training. All staff (100%) across the service had been trained in the safeguarding of vulnerable adults and children (level 1), with 95% of staff having completed level two. Staff were clear about their safeguarding responsibilities and knew how to identify and make a safeguarding referral. Between November 2014 and January 2016, the service made five safeguarding adult referrals and one safeguarding children referral. However, one patient on Hazelwood ward did not have a protection plan in place for a safeguarding issue although a safeguarding meeting had been held. The patient's care record did not encompass all risks and there was no care plan showing how to manage the risks. We pointed this out to the ward manager who told us the record would be updated.
- The service had processes for the storage, recording and administering of medication. Medicines were stored securely. Staff recorded fridge temperatures daily and these were within required range. However, staff did not record daily clinic room temperature checks to ensure that medicines were stored appropriately to ensure their quality. Highfield House did not have a separate clinic room; the nursing office was also the store for medicines.
- Rooms were identified for privacy and visits. Managers told us that staff completed appropriate risk assessments prior to any children visiting. There were safe procedures in place for children visiting.

Track record on safety

- There was one serious incident reported across the service between February 2015 and February 2016. Staff told us that this incident had been discussed across the service. A learning point was that staff must ensure that they check patients regularly and document where they are. Staff could describe the system to report incidents and their role in the reporting process.

Reporting incidents and learning from when things go wrong

- Care records showed that incidents were reported as they occurred. Managers reviewed reports and conducted investigations at both local and senior management level.
- Ward managers attended monthly meetings where incidents and lessons learnt were discussed. They passed on outcomes of investigations to the staff during team meetings. Permanent staff received regular bulletins and a trust wide learning log electronically, as a way to share learning around incidents.
- Staff reported their managers and senior managers were supportive when incidents occurred and debriefs were held for the benefit of staff and patients following incidents. Staff were aware of the need to be open and transparent with patients and relevant others following an incident.

Are services effective?

Requires improvement 

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

Our findings

Assessment of needs and planning of care

- We looked at 25 care records and 24 of these had an assessment of the patients following admission to the wards.
- A physical health examination had been undertaken for patients upon, or shortly following admission. Staff monitored patients' physical observations and physical health problems. Staff discussed physical health needs at multidisciplinary team meetings and we saw evidence of this in the care records.
- Care plans across the service were variable. We found there were detailed and thorough care plans that supported patients at Highfield House. The care plans were recovery focused, personalised and holistic. However, at Hawkesbury Lodge 83% of the care records we examined had brief care plans, which were not holistic and were not recovery orientated. On Hazelwood ward 40% of records examined showed that there were brief care plans and staff had not reviewed these in line with trust policy.
- Individual patient records were stored in paper files. They were stored securely and were available to transfer if, for example a patient moved between wards. Some information was also held electronically.
- On Hazelwood ward, the patients were observed frequently entering the nursing office, the door of which was open throughout our visit. We observed patients entering the office to access the fridge, or to sit and chat with staff. This meant that patients might see or overhear private and confidential information.
- Hazelwood ward had just transferred paper records to a new filing system. This meant that it was difficult to access information required, with staff having to access both the new and archived files.

Best practice in treatment and care

- A review of the prescription cards showed medical staff prescribed in accordance with National Institute for Health and Care Excellence (NICE) guidelines.
- There was some access to psychological therapy – the trust had just recruited two psychologists who were employed to work across the service.

- Specialist staff were available for advice relating to specific physical health issues, to include smoking cessation, diabetes and weight management. This included the doctors, dietician and speech and language therapist (accessible via the GP). There was good access to physical health care.
- Staff assessed patients' nutritional and hydration needs using a recognised tool – the malnutrition universal screening tool (MUST).
- Each ward used the 'recover star', which is designed for adults to manage their mental health and recovery.
- Ward managers and ward staff participated in audits, examples included mattress condition, medication audits, cleaning audits, food safety and hand hygiene.

Skilled staff to deliver care

- Ward staff consisted of nurses, consultants, doctors and health care assistants. There was one occupational therapy vacancy across the service. Two of the three wards had an occupational therapist in post. Two psychologists had just been recruited. The psychologists were going to cover each ward as required. The teams also had support from pharmacists and dieticians. Other healthcare professionals could be accessed via the GP, for example the speech and language therapist. This meant that patients had access to a variety of skilled staff for care and treatment.
- New staff underwent a formal induction period to teach them about the ward and trust policies. Newly qualified nurses engaged in a well structured and in depth preceptorship programme. Healthcare assistants undertook the care certificate. The care certificate is a set of standards aimed to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care. This programme was implemented in April 2015.
- Two of the three wards had an appraisal rate of 100%. Appraisal is a method by which the job performance of an employee is documented and evaluated. Highfield House had two outstanding appraisals, which had been scheduled taking the appraisal rate to 89%. This meant that staff had the opportunity to discuss their roles, performance and training requirements.

Are services effective?

Requires improvement 

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

- Managers said they were able to address poor staff performance with support from senior staff and the human resources (HR) department.
- Three staff out of 18 told us that they did not receive regular clinical supervision. Staff told us that supervision was usually planned by their line managers, but was often postponed due to ward activity or staffing levels. Highfield House had 100% clinical supervision rate. Hazelwood ward and Hawkesbury Lodge had a rate of 49%, which was below the trust target.

Multi-disciplinary and inter-agency team work

- Staff attended weekly multidisciplinary meetings across the service. Different professionals worked together to assess and plan patients' care and treatment.
- Staff held hand-overs between each shift. We observed two hand-overs. Both were thorough in nature, highlighting patient risk, physical healthcare, planned leave and activities for the day. There were effective staff interactions and discussions. This meant that staff had an overview of the patients' needs and planned the shift to accommodate these where possible.
- Managers reported effective links with outside agencies to support patient care. For example, local authority representatives attended strategy meetings related to safeguarding referrals and local housing officers attended the hospital sites to assist with housing needs for patients prior to discharge. There was evidence of this during the staff meeting and at the hand-over at Highfield House.

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

- Only 43% of eligible staff had received Mental Health Act 1983 training across the service.
- Medical staff completed consent to treatment and capacity assessments. Staff attached copies to medication charts to ensure medication was administered in accordance with the MHA.

- Staff regularly explained and recorded patient's rights under Section 132 of the MHA we saw this in records reviewed.
- Staff completed MHA paperwork correctly and this was up to date. There was administrative support for staff if they needed help with any issues pertaining to the Mental Health Act (MHA) or Mental Capacity Act (MCA). Staff stored information securely.
- Patients had access to independent mental health advocates. Information relating to this service was displayed on each ward notice board.
- Ward managers undertook a weekly audit. This included the monitoring of MHA documentation. There was also a MHA administrator who was available for additional support and guidance.

Good practice in applying the Mental Capacity Act

- Staff completed MCA and Deprivation of Liberty (DoLS) awareness training which was mandatory. The compliance rate for this training was 96%.
- Between July and December 2015 there had been three DoLS applications made across the service. Two of which had been granted and one was awaiting assessment. These patients had appropriate care plans in place, with evidence that staff held discussions around least restrictive practice.
- Staff showed some understanding around the MCA and DoLS. There was some evidence in clinical notes that the multidisciplinary team had considered mental capacity during care reviews. The psychiatrists used capacity forms when considering consent to treatment reviews.
- Capacity assessments were completed on an individual basis. We saw evidence of this in relation to the management of finances. We saw that patients were encouraged and supported to make decisions for themselves. We saw evidence of a best interests meeting in relation to a patient and future accommodation.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

- We observed some staff interactions with patients. Interactions were respectful, supportive and encouraged independence.
- We spoke with seven patients receiving care and treatment across the service. Patients told us that they found the staff respectful. They said that staff always knocked before entering their rooms.
- The latest Patient Led Assessment of the Care Environment audit (PLACE) for Hawkesbury Lodge showed 87% satisfaction for privacy, dignity and wellbeing. This was slightly higher than the England average of 86%.

The involvement of people in the care that they receive

- All wards had a patient admission and welcome pack, which was being revised across the service.

- Patients had access to advocacy services. Posters were visible on each ward with details about how to contact an advocate. The staff actively assisted patients to make a referral if needed. One patient explained that staff had recently helped them contact the advocacy around assistance with making a complaint.
- All wards had regular contact with carers and where appropriate, invited them to reviews. Carers we spoke with confirmed this, and there was evidence of communications in the patient's records.
- Patients were involved in the running of the wards through regular community meetings where they could raise ideas or concerns. We saw evidence of this in recent meeting minutes, in a community meeting and a staff meeting.
- However, staff did not review care plans on a regular basis and there was minimal evidence of patient involvement in two of the three wards. Patient signatures were missing and the care plans appeared generic and did not always consider patients' views. It was not evident that patients were offered a copy of their care plans across the service.

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Access and discharge

- Average bed occupancy across the service between June and November 2015 was 93%. All three wards had a bed occupancy rate of more than 86% with Hazelwood reaching 100%.
- The trust data stated that there were no out of area placements between April and December 2015. Ward managers told us that there was not any out of area placements identified at the time of inspection.
- Bed management was co-ordinated from the Caludon centre. Hawkesbury Lodge had two patients on the waiting list, with two patients awaiting a transfer to Highfield House. Highfield House also had three patients awaiting assessment for admission. There were no patients on the waiting list for Hazelwood ward, although there were four patients awaiting assessment for admission.
- Patients were moved between the services for non-clinical reasons. This was due to the pressure on beds in the acute division. Between January and March 2016, 16 patients were moved to relieve bed pressures in the acute division.
- The discharge of five patients was delayed between April and November 2015. Four of these were on Hazelwood ward and one at Highfield House. Ward managers told us that there would often be a delay in discharge due locating an appropriate placement, awaiting the appropriate funding approval, or to wait for a vacant bed in the identified service.
- There had been no re-admissions to hospital within 30 days of discharge throughout the service between April and November 2015.
- Each ward had direct access to outside space. All wards had a garden area. Two had identified vegetable patches, and one had an outside gym.
- The Patient Led Assessments of the Care environment (PLACE) scored 89.75% for food at Hawkesbury Lodge, which is slightly above the England average of 88.69%. At St Michael's hospital the score for food was 85% which is under the England average.
- Patients were able to access hot drinks and snacks throughout the twenty-four hour period across the service.
- Patients were able to personalise their bedrooms. We saw patients had photographs and artwork displayed in their rooms.
- Each ward had activity programmes. These programmes included a range of activities such as community meetings, cooking, current affairs discussions and trips out.
- Staff at Highfield House had contact with the volunteer bureaux in the hope of securing work for some of the patients.
- There was a lack of facilities for doctors to complete a physical examination at Hawkesbury Lodge and there was no examination couch. This could happen in the patient's bedroom if they gave consent. We observed a patient having their blood pressure taken in an activity room, when there was another patient engaging in an activity.

Meeting the needs of all people who use the service

- Hawkesbury Lodge and Hazelwood ward had access for people with restricted mobility. The wards had wide corridors and en-suite shower rooms. Highfield House had one ground floor bedroom, which would be accessible for a person with a physical disability. This had en-suite facilities.
- Information leaflets were visible on all wards and covered a range of subjects including local services, advocacy and how to complain. Staff could access information in other languages when needed.

The facilities promote recovery, comfort, dignity and confidentiality

- The services had multiple rooms for care and treatment, which included activity rooms, meeting rooms, and rooms where patients could meet visitors or staff in private. Some of these were multiple purposes owing to a lack of space, for example a lounge used for activities. The staff on the wards utilised what space was available which they deemed appropriate for the purpose.

Are services responsive to people's needs?

Requires improvement 

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

- Staff told us that interpreters were available using a local interpreting service. Staff could access these services to assist in assessing patients' needs and explaining their care and treatment.
- Patients across the service were encouraged to cook for themselves, and prepared their own breakfast. At Hawkesbury Lodge and Hazelwood, ward staff assisted with providing a light lunch where necessary. The evening meal was provided where required. Patients at Highfield House were given assistance with meal planning, budgeting, shopping and cooking. There was a range of choices on the menu that catered for patients' dietary, religious and cultural needs.
- Patients were encouraged to use the local chaplain who visited the wards, or to attend local churches in order to meet their spiritual needs and gain support if they wanted to. Patients of different denominations were encouraged to attend a place of worship. If this was not possible staff would contact relevant persons to arrange a visit on the ward.

Listening to and learning from concerns and complaints

- The trust reported that there were no formal complaints received across the service in the previous twelve months. However, staff at Hawkesbury Lodge reported that there was a formal complaint ongoing.
- Information about the complaints process was available on notice boards. Patients we spoke with knew how to make a complaint and had asked staff to assist, or had spoken with an advocate. Staff confirmed they knew how to support patients to make a complaint. At Highfield House, staff assisted a patient who asked for help to make a complaint.
- The ward managers told us that they would give staff feedback about complaints in staff meetings so that outcomes and actions could be discussed.

Are services well-led?

Requires improvement 

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

Our findings

Vision and values

- The trust's vision and values were visible for all to see on notice boards in the wards. Staff we spoke with were aware of these.
- Managers visited the wards and demonstrated the skill and experience to lead their services effectively.
- Managers said they had both the support and autonomy to do their jobs effectively and were able to raise concerns with senior staff.
- Staff were able to tell us who the most senior managers in the trust were.

Good governance

- The trust had governance processes in place to manage quality and safety within the service. Managers attended regular clinical governance meetings, which gave them an opportunity to review the service and discuss incidents. However, the governance arrangements did not always operate effectively. The ligature assessments had not contained details of how to manage the risks and this had not been identified in any audit. The service was not meeting mixed sex accommodation guidelines.
- There were audits in place to monitor service quality.
- Managers had access to performance reports that tracked incidents and other relevant data for each individual ward and the hospital as a whole.
- Managers had access to sickness rates for each ward. Ward managers completed the staffing rota in advance so that appropriate staff could cover shifts where possible.

- Safeguarding, MHA and MCA procedures were adhered to and followed.

Leadership, morale and staff engagement

- The managers leading the service used an open and transparent culture. Staff were actively encouraged to raise concerns and said that they felt able too.
- There were no reported incidents of bullying or harassment across the service at the time of inspection.
- Staff we spoke with confirmed they understood the whistleblowing process and would feel confident to use it. Staff said that they felt able to raise concerns without fear of victimisation.
- Staff felt well supported by their immediate managers and felt they valued their work.
- Staff told us that they felt part of a team at ward level and received support from each other.
- However, morale appeared low. There was uncertainty about the future of the rehabilitation services, and anxiety amongst the staff as they anticipated changes to services. Staff were awaiting further information from the senior managers within the trust. Patients we spoke with at Highfield House were aware of this and we saw that staff tried to minimise concerns expressed.

Commitment to quality improvement and innovation

- The team at Highfield house spoke proudly about how they were nominated for the Quality awards (Q award) within the trust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <ul style="list-style-type: none">• Staff did not create comprehensive risk assessments and did not update them regularly.• Wards and outside areas had potential ligature points that were not fully managed or mitigated. This was a breach of Regulation 12 (1)(2)(a)(b)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care <ul style="list-style-type: none">• Care plans were not always personalised and did not include patients' views, nor were they recovery orientated. This was a breach of Regulation: 9(1)(a)(b)(c), 9(3)(a)(b)(c)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing <ul style="list-style-type: none">• Staff were not receiving regular clinical supervision.• Staff were not receiving all required mandatory training This was a breach of Regulation 18(2)(a).