Good

Tees, Esk and Wear Valleys NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX3AD	Primrose Lodge	Primrose Lodge	DH3 3JX
RX3MM	West Park Hospital	Willow Ward	DL2 2TS
RX3WE	163 Durham Road	Lustrum Vale	TS19 0EA
RX3FL	Roseberry Park	Fulmar Ward	TS4 3BW
RX3FL	Roseberry Park	Kirkdale Ward	TS4 3BW
RX3YK	The Orchards	The Orchards	HG4 1HZ

This report describes our judgement of the quality of care provided within this core service by Tees, Esk and Wear Valleys NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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 Tees, Esk and Wear Valleys NHS Foundation Trust and these are brought together to inform our overall judgement of Tees, Esk and Wear Valleys NHS Foundation 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	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

Mental Health Act responsibilities and Mental Capacity Act / 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

Contents

Summary of findings

Overall summary

We rated long stay rehabilitation mental health wards for working age adults as good because:

- Systems were in place to monitor and manage patient risk. Staff carried out comprehensive risk assessments in a timely manner and regularly reviewed these.
- Assessments of risk from potential ligature points (a ligature point is a place where a patient intent on self-harm might tie something to strangle themselves) were in place, along with policies to support the management of these risks.
- Staff were aware of their responsibilities to report and raise any incidents and safeguarding issues.
- Staff had received mandatory training.
- Managers assessed and reviewed staffing levels to keep patients safe.
- Feedback from patients was positive. We observed staff treating patients in a respectful manner, and with a caring and compassionate approach. Most patients said they were involved in their own care planning.
- Managers evaluated feedback from patients to improve patient care and treatment at the hospital.
- Senior managers were visible and staff felt supported and consulted about their roles.
- There were good governance structures with audits in place to support and deliver safe care and to monitor the performance of the service.

However:

- The Orchards did not have a nurse call system. This meant patients had no means of summoning staff help or support in an emergency. Staff did not routinely carry personal alarms at The Orchard.
- Clinic room temperatures on three of the wards were consistently above acceptable limits. On Lustrum Vale blood collection tubes and blood spill kits had expired. The blood spill kit had also expired on Kirkdale ward.
- On The Orchards, care plans did not always reflect the involvement of patients or include detailed and personalised information. Expired section 17 leave forms were still on file and not scored through to indicate they were no longer current.
- There were trip hazards in the patient's courtyard on Fulmar ward.
- Discharge planning was not clear in care records.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The Orchards did not have a nurse call system for patients and staff did not regularly carry personal alarms.
- Blood collection tubes and blood spill kits had expired on Lustrum Vale and Kirkdale ward.
- Some patients had had activities cancelled due to not enough staff.

However:

- All wards were visibly clean and tidy.
- The wards had sufficient staff on duty with support from regular bank staff. Patients said they felt safe on the wards.
- Patients had up to date risk assessments and management plans.
- Staff had good knowledge of safeguarding procedures and were proactive in raising concerns.
- There were good medicines management practices in place and staff worked closely with pharmacists to ensure prescribing was safe and in line with national guidance.

Are services effective?

Good

We rated effective as good because:

- Care plans were up to date and were personalised, holistic, recovery oriented and included monitoring of physical health problems.
- A range of skilled staff including doctors, nurses, health care assistants and associated disciplines provided input into the care of patients.
- Compliance with mandatory training, supervision and appraisals was on target overall across the service to meet the trusts standards.
- We found good compliance across the service with the requirements of the Mental Health Act and the code of practice.
- Staff had a good understanding in relation to issues regarding capacity and consent.

However:

- On The Orchards, care plans did not always reflect the involvement of patients or include detailed and personalised information.

Summary of findings

Are services caring?

Good

We rated caring as good because:

- Staff engaged with patients in a caring, compassionate and respectful manner throughout our visit to the wards.
- Feedback received from patients was positive in relation to the care and treatment they received.
- Patients had the opportunity to be involved in all aspects of their care including regular reviews.
- The service had systems in place to gain feedback from patients and their carers.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The service provided care and treatment which was underpinned by the principles of the recovery model.
- Wards had facilities available which promoted recovery, comfort, dignity and confidentiality.
- Patients knew how to make a complaint.

However:

- Intervention plans and patient review meetings mentioned discharge planning, however, discharge planning was not clear in care records.

Are services well-led?

Good

We rated well-led as good because:

- Staff worked within the trust values and we saw evidence of kind, compassionate and caring staff.
- Staff felt supported by the management team and the multidisciplinary team.
- Staff told us that they would feel confident to raise concerns if wards were unsafe or there was poor practice.

Summary of findings

Information about the service

Tees, Esk and Wear Valleys NHS Foundation Trust has six long stay and rehabilitation mental health wards for adults of working age.

Primrose Lodge is a 15 bed, mixed sex rehabilitation and recovery unit for people with mental health problems, including those who may be detained under the Mental Health Act. This is a standalone service based in Chester-le-Street. It provides a step down support service for people who have spent time in a hospital setting, in order to help them go back into their local community. At the time of our inspection there were 14 patients using the service.

Willow ward is a locked 15 bed, mixed sex rehabilitation ward for people who display behaviours that challenge. The ward is part of West Park Hospital in Darlington and provides care, treatment and rehabilitation for people with mental health problems, including those who may be detained under the Mental Health Act. At the time of our inspection there were 13 patients using the service.

Lustrum Vale is a locked, 20 bed, mixed sex ward offering rehabilitation, habilitation and recovery services to people whose needs cannot be met by less intensive, adult mental health services, some of whom may be detained under the Mental Health Act. At the time of our inspection there were 18 patients using the service.

Fulmar ward is a locked, 12 bed, female ward which is part of Roseberry Park Hospital in Middlesbrough. The service provides rehabilitation services in a secure environment for people who have been detained under the Mental Health Act. At the time of our inspection there were 12 patients using the service.

Kirkdale ward is a locked, 16 bed, male ward which is part of Roseberry Park Hospital in Middlesbrough. The service provides rehabilitation services for people who have been detained under the Mental Health Act. At the time of our inspection there were 16 patients using the service.

The Orchards is a standalone, 10 bed, mixed sex ward based in Ripon. The service is a recovery ward for working age adults who suffer longer term mental health problems and includes those who may be detained under the Mental Health Act. At the time of our inspection there were nine patients using the service.

Our inspection team

Team Leader: Carole Charman, Inspector, Care Quality Commission

The team comprised two CQC inspectors and two specialist advisor nurses who had experience in working in mental health services. Two members of staff from another CQC department spent time shadowing the inspection.

Why we carried out this inspection

We inspected this core service as part of our ongoing inspection programme. When we last inspected the trust in January 2015, we rated long stay rehabilitation wards for working age adults as **good** overall.

We rated the core service as requires improvement for safe and good for effective, caring responsive and well-led.

Following the January 2015 inspection, we told the trust it must take the following actions to improve long stay rehabilitation wards for working age adults:

- The trust must ensure that Earlston House is compliant with the Department of Health guidance regarding Same Sex Accommodation (SSA) to ensure patients privacy and dignity is protected.

Summary of findings

This related to the following regulation under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

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 we held about long stay rehabilitation services for working age adults and requested information from the trust. Earlston House had been closed since our last visit and hence we did not need to focus on the particular breach of regulation at this location.

During the inspection visit, the inspection team:

- visited all six of the trust's long stay rehabilitation wards, looked at the quality of the ward environment and checked all clinic rooms,
- observed how staff were caring for patients in order to maintain their safety,
- spoke with 14 patients individually and 10 patients within a communal lounge,
- spoke with the managers for Lustrum Vale, Willow ward, Fulmar ward, The Orchards and Kirkdale ward and the clinical lead for community rehabilitation services.
- spoke with 36 other staff members; including doctors, nurses, psychologist and occupational therapists,
- attended and observed three report-out meetings, which were short multidisciplinary briefings where staff discussed what was going on with each patient, and two multi-disciplinary team meetings,
- looked at the care records of 27 patients,
- carried out a specific check of the medication management on all five wards and reviewed the prescription charts of all patients on the wards,
- looked at a range of policies, procedures and other documents related to the running of the service.

What people who use the provider's services say

During this inspection, we spoke with 14 patients and engaged with 10 other patients informally in the ward environment. We observed patients during meetings and interactions with staff. Patients told us staff were caring and treated them with dignity and respect. Patients felt safe on the ward and involved in their care planning.

Most patients felt there was always enough staff around but seven patients told us activities were sometimes cancelled because there was not enough staff.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure patients and staff at The Orchards have an alarm call system that can be easily accessed to summon assistance.

Summary of findings

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that clinic room temperatures at Primrose Lodge, Lustrum Vale and Willow ward are within acceptable limits.
- The trust should ensure that monitoring of blood collection tubes and blood spillage kits takes place to ensure out of date equipment is replaced.
- The trust should ensure there are no trip hazards in the courtyard at Fulmar ward.
- The trust should ensure that all patient care plans at The Orchard are personalised.
- The trust should ensure that expired section 17 leave forms on The Orchards are archived.
- The trust should ensure clear plans are in place to support patients discharge planning and these are documented on the electronic patient record.

Tees, Esk and Wear Valleys NHS Foundation 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
Primrose Lodge	Primrose Lodge
Willow Ward	West Park Hospital
Lustrum Vale	163 Durham Road
Fulmar Ward	Roseberry Park
Kirkdale Ward	Roseberry Park
The Orchards	The Orchards

Mental Health Act responsibilities

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

Staff had a good understanding of the Mental Health Act and code of practice. The trust had a central Mental Health Act administration team who advised and supported staff in the application of the Act.

Copies of the patients' detention papers and reports by approved mental health professionals were available and stored correctly. Staff regularly explained to patients their rights under section 132 and recorded their understanding in patient records. A system for recording patients' section 17 leave was in place.

Detained patients received treatment authorised by the appropriate certificates. Copies of the certificates were kept with the patients' prescription cards. Staff clearly recorded capacity and consent to treatment in all patient records.

Detailed findings

Staff supported patients to access independent mental health advocates. Notice boards on the wards displayed information about patients' legal status and rights under the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good understanding of the Mental Capacity Act and we saw examples of good practice. Patients' records contained decision specific capacity assessments and showed that staff held best interest meetings where appropriate.

The hospital had a central Mental Health Act office that provided guidance and advice regarding mental capacity, consent, and Deprivation of Liberty Safeguards. At the time of our visit there were no deprivation of liberty safeguards in place.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

The inspection team spent time touring each of the six ward environments. Willow ward, Fulmar ward, Kirkdale ward and Lustrum Vale were all modern and purpose built. Primrose Lodge was a standalone unit in Chester-le-Street and The Orchards was a standalone unit in Ripon. We found each of the wards visited to be clean, with furnishings in a good state of repair. We saw evidence of maintenance work being carried out on wards, when required.

With the exception of Primrose Lodge, all wards had bedrooms with ensuite facilities. At Primrose Lodge we found female patients shared a bathroom and male patients were able to access one of three bathrooms. There were also male and female toilet facilities on the ground floor of the service.

Throughout our inspection we witnessed staff carrying out cleaning duties on each of the wards. Cleaning equipment for each ward was kept in a locked cupboard and staff had a cleaning schedule which staff signed to show they had completed the required tasks. We observed staff on all wards washing their hands or using disinfecting hand rubs to reduce the risk of infection.

All the wards we visited had patient led assessments of the care environment scores. This is a system for assessing the quality of the environment in which patients are treated. The scores for condition, appearance and maintenance and cleanliness in 2016 were as follows:

- Primrose Lodge scored 99% for cleanliness and 94% for condition.
- Willow ward scored 100% for cleanliness and 92% for condition.
- Lustrum Vale scored 97% for cleanliness and 84% for condition.
- Fulmar ward scored 100% for cleanliness and 97% for condition.
- Kirkdale ward scored 100% for cleanliness and 97% for condition.
- The Orchards scored 100% for cleanliness and 98% for condition.

All the wards we visited had ligature points. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points on all wards had been identified on the ward environmental risk assessment. Where a risk had been identified, actions were put in place to mitigate the risk and help keep people safe. At Primrose Lodge there were multiple blind spots. A blind spot is an area where staff may not be able to see someone from their position. Risks to patients were primarily mitigated by use of assessment and observation. Staff we spoke with told us there was no one that was a suicide risk, but hourly care rounds were always carried out.

Other wards we visited used closed circuit television to monitor activity on the ward and to ensure the safety of patients. Staff told us they also used risk assessments to monitor risk and staff were visible on the wards at all times to engage with patients who may need additional support.

Five of the long stay and rehabilitation wards were mixed sex. When we last visited in January 2015, we found one mixed sex ward did not comply with Department of Health guidance. This ward had since closed. When we visited in January 2017 we found that the current wards all complied with the guidance on same sex accommodation. Male and female sleeping and bathroom areas were separated, and patients did not have to walk through areas occupied by the opposite sex to reach toilets or bathrooms. All the wards provided gender specific toilets and bathrooms and female only lounges.

We inspected the clinic room of each ward and found they were all clean and tidy. All clinic rooms contained equipment for physical health monitoring, including blood pressure machines, stethoscopes and scales. With the exception of Primrose Lodge, all clinic rooms contained an examination couch. Staff checked clinic equipment regularly and ensured it was calibrated in line with the manufacturer's recommendations. We saw stickers had been placed on equipment to show when it had last been

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tested. We found some blood collection tubes and blood spillage kits on Lustrum Vale had expired in 2016. The blood spillage kit on Kirkdale ward had also expired. We brought these to the attention of staff.

Staff on all sites routinely checked the temperature of the clinic room and the clinic fridge. Temperatures for both were recorded twice daily. We looked at the record of temperatures for each of the clinic rooms and found that the temperature at Primrose Lodge, Lustrum Vale and Willow ward was high. At Lustrum Vale the temperature in the clinic room had exceeded 25°C on 28 days in September 2016, 15 days in October, 22 days in November and 16 days in December. On five days in September we found the temperature exceeded 30°C. It is important for medicines to be stored at temperatures below 25°C as higher temperatures can result in reduced efficacy. We spoke with staff about clinic room temperatures. Staff at Primrose Lodge and Willow ward told us they had a fan, but often the only way to reduce the temperature was to open the clinic room door. Staff at Lustrum Vale told us they too had a fan and they often opened the clinic room window but this caused concerns in relation to patient privacy and also security of the room.

Staff carried out checks of emergency drugs and resuscitation equipment on all the wards we visited. We found all the emergency drugs and equipment was clean, in date and in good working order.

None of the wards had seclusion rooms. With the exception of The Orchards all wards had a functioning staff call system which allowed patients and staff to summon help if it was required. These staff also carried personal alarms which they could activate if assistance was needed. Staff at The Orchards had personal alarms but did not always carry them, they based it on clinical risk whether to carry them. We were concerned about this and brought it to the manager's attention.

Safe staffing

The trust did not use a standard tool to establish staffing levels on the wards. Staffing levels varied due to the number of patients and the acuity of their illness. However, all wards we visited, had a minimum of two registered nurses and between two and three healthcare assistants on day shift and one registered nurse and two healthcare assistants at night. All of the ward managers we spoke with told us they were able to adjust staffing levels if the needs of the patients required it. At Lustrum Vale we saw this in practice as there were patients on enhanced observations. Staff we spoke with told us they felt safe on the wards and felt that staffing levels were appropriate to the needs of the patients. Activities were only occasionally postponed or cancelled. There were episodes when wards were short staffed due to sickness and no cover was found. During these times ward managers supported the staffing establishment.

Nursing staff worked 12 hours shifts. Four staff we spoke to felt the 12 hours shifts were tiring and difficult.

None of the wards we visited used agency staff but all the ward managers we spoke with told us they used bank staff and overtime to respond to unplanned staff absence. Staff told us bank staff allowed consistency on the wards and were able to get to know patients. Staff who had not worked for the trust before were required to undertake a trust induction to ensure they were familiar with the relevant policies and processes. None of the staff we spoke with expressed any concerns with bank staff who had worked on wards.

An analysis of the staffing levels for the three-month period ending December 2016 showed that qualified nurse vacancies was low across all wards with Lustrum Vale having the highest of 1.4 whole time equivalent staff. Willow ward had the highest number of health care assistant vacancies with 3.3 whole time equivalent staff.

All wards used bank staff to cover any vacancies, leave or sickness on the wards. Fulmar ward had the largest use of bank staff over the three month period using bank staff to cover 90 of the required 793 shifts. The lowest use of bank staff was The Orchards who covered three shifts over the three month period.

The average sickness rate for the service over the previous 12 months was 7.5% which was above the trust's average. Willow ward had the highest sickness rate at 14% and Fulmar ward the lowest at 3%. Overall staff turnover was 9.5%.

Staff on all of the wards we visited told us there was little use of restraint and if this was used it was usually low level. However, all wards had sufficient staff to enable them to manage if a patient needed to be restrained. Staff on all but The Orchards were able to summon help with the use of a personal alarm. At The Orchards, staff told us they would

Requires improvement

Are services safe?

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shout to colleagues if they required assistance. This was not safe practice as there was a risk that staff may not be heard by colleagues or that patients may not be heard by staff if they required assistance.

Patients we spoke with told us they felt safe on the wards. They told us they were supported fully by staff and said they were able to get extra support throughout the day if it was needed. Seven patients told us that they had had activities re-arranged or cancelled. We spoke with staff and patients about the ability to access leave. Occasionally leave had been cancelled due to staffing levels but there were usually enough staff available to go on leave with patients, and we were told patient leave was made a priority.

The trust had a supportive engagement and observations policy in place and staff working on the wards followed the policy. Throughout our inspection we saw patients asking staff if they were able to have one to one time with staff, who facilitated the requests in a timely manner.

All wards we visited had good access to medical cover. They had at least one consultant psychiatrist and one junior doctor, although some wards had more than this. Staff on all wards told us doctors worked closely with them and other members of the multi-disciplinary team. Out of hours cover was provided with the use of a rota system to ensure help was available on all wards within 30 minutes.

Staff were required to complete the trust's mandatory training. The training modules included, infection control, health and safety, fire and equality and diversity. Overall compliance with mandatory training was: Primrose 80%, The Orchards 87%, Lustrum Vale 93%, Fulmar 97%, Willow ward 85% and Kirkdale ward 89%. The trusts target for mandatory training was set as 95% and ward managers felt they were on target to achieve this.

Assessing and managing risk to patients and staff

We looked at 27 patient records during the inspection and found staff regularly conducted risk assessments. The service used a 'safety management plan' to record risks, triggers and actions to reduce harm. Risk was reviewed at key events such as medication changes, before and after leave and following incidents. We observed risk being discussed during report out meetings and multidisciplinary team meetings.

There were no incidents of seclusion and 34 incidents of restraint over the previous six months. Lustrum Vale had the highest number of restraint incidents with 11, followed by Fulmar ward with 10. These had involved four different patients on each ward. There was one use of the prone position during incidents of restraint on Fulmar ward. This is when the patient is restrained in a face down position.

None of the restraint incidents in the previous six months had resulted in rapid tranquilisation. Staff told us that rapid tranquilisation was rarely used on the wards. When it was administered to patients, staff said they followed the trust policy and monitored and recorded patients' physical observations.

The trust had a policy in place for searching patients. Patients and patients' bedrooms were only searched if staff had reason to suspect there was an increased risk to patient safety. Any patients deemed as requiring searching had care plans in place for this.

Staff we spoke to had received training in safeguarding adults and children. Staff explained the safeguarding procedures and gave examples of referrals made to the local safeguarding teams. Safeguarding concerns were discussed in daily and weekly report out meetings.

We reviewed 78 prescription charts across the service. We found the wards had good systems in place for the management of medication including the appropriate storage, dispensing and recording of medication. Some patients managed their own medications and care plans were in place for this.

Track record on safety

The long stay rehabilitation wards had not reported any serious incidents for the period July 2016 to December 2016. We saw an example of a more recent serious incident included a root cause analysis investigation. Lessons learnt were communicated to staff via email and meetings.

Reporting incidents and learning from when things go wrong

All staff could tell us about the processes to follow for incident reporting. The trust used an electronic reporting system which all staff had access to. Examples of incidents reported included assaults, smoking, staffing shortfalls and patients absent without leave.

Requires improvement

Are services safe?

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Ward managers cascaded any learning from incidents through team meetings, handovers, emails and during supervision sessions. Staff told us debriefing from serious incidents took place and we heard past examples relating to staff assaults by patients.

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.

Our findings

Assessment of needs and planning of care

We looked at 27 patient care records across the service. Records contained comprehensive and timely patient assessments following admission on to the ward. We found all of the records we looked at showed a physical examination had been undertaken and there was ongoing monitoring of physical health problems.

On The Orchards, some of the care plans did not always reflect the involvement of patients or include detailed and personalised information. Otherwise, care plans were up to date and were personalised, holistic and recovery oriented. They addressed a full range of needs including personal, social, physical and mental health needs. We saw the team reviewed care plans with the patient and we observed patients discussing their care and treatment plans with staff in multidisciplinary team meetings. The patients' views were taken into account during these meetings.

All information was stored securely on the electronic records system, which ensured that confidentiality of patient information was maintained. Although staff told us patient information was accessible when needed, we found some records were difficult to navigate even with the support of staff members, who at times, struggled to find information. Occasionally the electronic records system was very slow and crashed.

Best practice in treatment and care

The service delivered care and treatment which was underpinned by the principles of the rehabilitation and recovery model and best practice guidance. Patients were able to access psychological therapies including cognitive behavioural therapy, group therapy and family therapy. This is treatment recommended by the National Institute for Health and Care Excellence for the treatment of psychosis and schizophrenia.

Prescription charts showed that staff followed National Institute for Health and Care Excellence guidance when prescribing medication and following the use of rapid tranquilisation.

Patients received a full physical assessment on admission. All patient records we reviewed showed ongoing physical health monitoring and referrals to specialists when needed. Care plans for specific physical conditions were in place, for example diabetes.

The service used health of the nation outcome scales and the recovery star outcome measures. A variety of evidence-based tools to assess and record severity were also used. These included national early warning scores, hospital anxiety and depression scale and Lester tool.

Staff engaged in clinical audits on the ward and we saw examples of infection control, medication and care record audits.

Skilled staff to deliver care

The service had a range of mental health disciplines and workers including psychology, occupational therapy and pharmacy. This meant there was a sufficient skills mix among staff to meet patients' needs. Willow ward had an occupational therapy vacancy but were recruiting into the post. Occupational therapy support on Fulmar ward and Kirkdale ward was highlighted by staff as being very good due to the level of support they received. The other wards felt more occupational therapy input would be beneficial to support patient's rehabilitation.

All staff had received regular supervision including clinical supervision for qualified staff. The percentage of non-medical staff that had had an appraisal in the last 12 months was: Primrose Lodge 62%, Orchard 86%, Kirkdale 88%, Willow 74%, Fulmar 79%, Lustrum: 60%

Staff were supported to undertake specialist training that would enhance the skills within the team and lead to professional development. Staff had access to a range of training and qualifications that were rehabilitation and recovery oriented. For example, cognitive behavioural interventions, mindfulness, autism and venepuncture. Staff on Fulmar ward were trained in dialectical behaviour therapy.

Staff received both a corporate induction and local induction on the ward. Each ward held regular staff team meetings.

Multi-disciplinary and inter-agency team work

Multidisciplinary formulation meetings took place within 28 days of a patient's admission. These meetings identified a

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framework to develop the most suitable treatment for the patient. Ongoing multidisciplinary team meetings continued at four and six weekly intervals. Patient's relatives or carers were invited to attend in line with the patient's wishes.

Regular daily and weekly report out meetings took place where the team discussed patients' current presentation, risks, incidents and actions for that day.

Nursing handovers occurred before each shift change. Staff discussed issues such as physical health, incidents, safeguarding and patient's risk.

Staff reported effective relationships with the community mental health teams including good handovers amongst care co-ordinators.

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

Mental Health Act training was not mandatory in the trust. The trust planned to introduce a mandatory programme from April 2017. A number of sessions were available for staff which included renewal, challenges to detention and discharge and the revised Mental Health Act code of practice. A number of staff we spoke to told us they had attended Mental Health Act training or were booked to attend shortly. Overall staff had a good understanding of the Mental Health Act, the code of practice and the guiding principles.

Twenty eight patients were detained under the Mental Health Act during our visit. Detention paperwork was filled in correctly, was up to date and stored appropriately. Consent to treatment and capacity requirements were adhered to and copies of consent to treatment forms were attached to medication charts where applicable. On prescription charts we looked at, there were no discrepancies between medications being administered and medication listed on the T2 (certificate of consent to treatment) and T3 (certificate of second opinion) forms. All authorised medication was within the British National Formulary limits.

Staff informed patients of their rights on admission and on a regular basis thereafter. Clear records for granting detained patients leave under section 17 were maintained. We saw on The Orchards that several old section 17 leave forms were still on file and not scored through to indicate they were no longer current. This has the potential to cause confusion for staff and lead to a risk of patients taking unauthorised leave.

Patients had access to the independent mental health advocate service and staff were clear on how to access this support.

Administration support and legal advice on implementation of the Mental Health Act and its code of practice was available from a central team. Staff on the wards knew how to contact the team. They felt supported by the team and we saw efficient systems and processes to support nursing and medical staff in meeting the responsibilities of the Act including regular audits to ensure the Act was being applied correctly.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was not mandatory in the trust. The trust planned to introduce a mandatory programme from April 2017. A number of training sessions were available for staff which included Mental Health Act and Mental Capacity Act interface. Staff we talked to were trained in and had a good understanding of the Mental Capacity Act and the five statutory principles. Staff were aware of the policy on Mental Capacity Act including Deprivation of Liberty Safeguards and could refer to it.

Although it was difficult to locate some capacity assessments in the electronic system, overall we saw that for patients who might have impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis with regards to significant decisions, for example, financial decisions. People were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, culture and history. Wards used visual display boards to ensure consent to treatment and capacity requirements were adhered to.

The hospital had a central Mental Health Act office that provided guidance and advice regarding mental capacity, consent, and Deprivation of Liberty Safeguards. A Deprivation of Liberty Safeguard application becomes necessary when a patient, who lacks capacity to consent to

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.

their care and treatment, has to be deprived of their liberty in order to care for them safely. At the time of our visit, there had been no Deprivation of Liberty Safeguards applications in the previous six months.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Patients told us staff were caring and supportive. They were complimentary about staff attitude and engagement. Staff were described as “good” and “very good”. There were positive and warm interactions across the service between staff and patients. We saw staff being discreet and respectful towards patients. During multidisciplinary team meetings we observed patients being treated with kindness, dignity, respect and compassion by all team members. This was the case both when patients were present and in ‘report out’ meetings when patients were not present.

Patients made positive comments about the quality of the care and treatment provided. Staff understood the individual needs of patients and had a clear vision of the patient’s pathway. This was reflected in the multidisciplinary team meetings and in staff interviews.

We saw that patients had personalised their bedrooms and they told us they could access them during the day.

The involvement of people in the care they receive

On admission to the ward patients were oriented to the ward and given information in a welcome pack.

Care records showed that most patients were actively involved in care panning. Not all patients said they had a care plan but they told us they discussed their care with staff. During a multidisciplinary team meeting on Primrose Lodge we saw a patient being given time and encouragement to share their views and wishes. The patient’s family member was also given time to describe her concerns. Discussion in the meeting was recovery focused and held in a respectful manner.

We saw evidence of appropriate involvement of families in care records. Patients could access advocacy services and a number of patients told us they had an advocate. Patients that were detained under the Mental Health Act had access to independent mental health advocates. Staff informed patients about the availability of the independent mental health advocates and enabled them to understand what assistance the independent mental health advocate could provide.

Patients were able to give feedback on the service they received through questionnaires, ideas forms, suggestion boxes and community meetings.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The average bed occupancy across the service for the six month period ending December 2016 was 93%. All wards apart from Primrose Lodge had a bed occupancy of more than 85%.

There had been 20 out of area placements from acute wards in the past six months because there were no available beds in the trust's rehabilitation service within the York and Selby locality.

There had been a total of 33 discharges in the six month period July 2016 to December 2016. Primrose Lodge had had 4 discharges, The Orchards 2, Lustrum Vale 12, Willow ward 6, Fulmar ward 4 and Kirkdale ward 5. We saw discussions relating to discharge in some care records. Staff told us discharge planning was part of the patient intervention plans. We did not see this clearly when reviewing some of the records.

Discharge planning across all wards was in conjunction with the patient, carers, care coordinator and any other services involved in the care. Patient discharge considerations began at the 28 day formulation review on Lustrum Vale. When it was determined that there were no barriers to discharge the patient moved to a green pathway of care and discharge took place within 10 weeks. The Orchards and Willow ward had an anticipated length of stay of between two and three years with regular reviews to ensure a timely discharge occurred.

Primrose lodge had an expected length of stay in the service of up to a maximum of nine months. Discharge planning which included relapse prevention techniques and management took place with full liaison with care co-ordinators, carers and other providers.

Kirkdale ward is a truswide adult mental health locked rehabilitation ward. Fulmar ward catered for patients stepping down from forensic services or who had significant risks. Patients anticipated length of stay on these wards was 12 months.

In the previous six months there had been four delayed discharges. These were due to lack of community options and placements.

The facilities promote recovery, comfort, dignity and confidentiality

Across the service, there was a range of rooms and equipment to support the rehabilitation and recovery of patients. For example, there were laundry rooms, games rooms, computer rooms and art rooms. The Orchards, Lustrum Vale and Primrose Lodge had fully equipped kitchens for patients to practice or learn cooking skills. Quiet areas or rooms were available for 1:1 time with staff or where patients could spend time away from others.

There was a range of daily activities for patients to engage in. These included arts and crafts, women's group, men's group and gym. Activities in the community included swimming, voluntary work and dog walking. Activities were available seven days a week; however some patients said they would like more activities to be available.

Primrose Lodge, Lustrum Vale, Willow ward and The Orchard had a female only lounge that complied with the Department of Health's guidance on mixed sex accommodation. All wards had either a carers room or rooms identified where families and carers could visit.

Every ward had access to outside space for patients 24 hours a day. Primrose Lodge had a garden room and a garden. Patients were encouraged to grow flowers or vegetables as well as using the garden to relax in. Fulmar ward had a small courtyard which appeared neglected, with dying plants in sunken earth areas which created a potential risk of trips and falls. Some paving slabs had also sunk making the paving uneven. Kirkdale ward had a rectangular outside space which appeared to have dirty paving, with stains from standing water. There was also a small area under cover which had been used as a smoking area. There were lots of cigarette stub marks on the wall and paving which created an unpleasant environment visually.

Patients were able to access hot drinks and snacks 24 hours a day. We saw that patients had somewhere secure to store their possessions in either locked cupboards or their locked bedrooms.

Meeting the needs of all people who use the service

All wards had facilities for disabled access including disabled toilet and bathroom. Specific bedrooms could accommodate wheelchair users.

Are services responsive to people's needs?

Good

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

A range of information and leaflets were available for patients, these included information relating to treatments, local services, patient's rights and how to complain.

Interpreter services were available to access and care documentation could be translated into a range of different languages and accessible styles to meet patient's needs.

Most patients were working towards being able to self-cater and could budget and shop for their own food. Patients at Primrose lodge had a weekly allowance of £23 to cater for food. Those that did not cook for themselves received trust catering services. Patient's assessments identified individual dietary requirements which the service ensured where met.

Access to faith rooms was available on most wards or staff would enable patients to be able to use their own bedrooms. Patients at Primrose lodge were encouraged to use local facilities in the community.

Listening to and learning from concerns and complaints

The service received three formal complaints in the 12 months ending December 2016. None had been referred to the Ombudsman. At the time of our visit two of the complaints were still under investigation. The third complaint related to clinical care and had not been upheld.

Patients told us they knew how to complain and would talk to staff, the patient advice and liaison service or their advocate. Patients felt confident to raise any complaints. Staff knew how to handle a complaint appropriately and received individual feedback during supervision sessions.

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.

Our findings

Vision and values

The trust's vision was to be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations. The values were: Commitment to quality; Respect; Involvement; Wellbeing and Teamwork.

Staff displayed a good understand of the vision and values and we observed these in the behaviours of staff during our visit. Each ward had an operational policy. The Orchard and Lustrum Vale policies reflected the values of the organisation.

Staff knew who the senior managers in the organisation were and we heard they had visited the ward.

Good governance

We found that overall staff were receiving mandatory training, supervision and annual appraisals. Managers felt their wards would be compliant against the trust's target for training and appraisals by the end of the year.

Despite pressures at times with staffing levels, staff were able to maximise shift-time on direct care activities. We observed staff spending time with patients and responding quickly to patients' requests to be seen. Patients felt there was enough staff but said sometimes staff were stretched and leave or activities were cancelled.

The wards participated in a number of clinical audits such as infection control, care records, environmental audits and medication. Staff reported incidents appropriately and received feedback and lessons learned at team meetings or during individual supervision. There was a good knowledge and understanding of safeguarding procedures, reporting procedures and how to identify abuse.

Ward managers felt they had sufficient authority to do their job and had good administration support. Willow ward had highlighted they did not have enough administration support and was looking to convert some nursing establishment hours to administration hours.

The service had locality risk registers in place. Risk issues identified at ward level were added to an issues log and discussed at locality clinical governance groups or escalated to the 'quality assurance group'. Actions to mitigate risks were taken into consideration to determine if the issues required adding to the risk register.

Fulmar ward was part of the forensic governance structure and directorate whilst the other wards were part of the acute mental health directorate. Some staff commented that being part of the forensic services was beneficial in terms of occupational therapy support.

Leadership, morale and staff engagement

We were provided with information from the staff friends and family tests for all wards apart from Lustrum Vale. We looked at the quarter two period of 2016. Scoring varied across the service with all wards scoring good or excellent for recommending the organisation to friends and family if they needed care or treatment. Three wards – Primrose Lodge, The Orchards and Kirkdale ward scored very poor or fair for recommending the organisation to friends and family as a place to work. Kirkdale ward also scored very poor for 'worth my while making suggestions' and overall job satisfaction.

Despite some of the feedback in the friends and family test we found morale amongst staff was good. Staff were positive about their jobs and working for the trust. They felt there were opportunities for development and felt supported by their manager and the wider multi-disciplinary team.

Staff were encouraged to provide feedback and ideas to improve the quality of care and treatment. Managers told us they felt supported by senior managers. They received leadership and management training

There had been no bullying and harassment cases recorded for the service during the last 12 months. Staff were aware of the whistleblowing process and felt able to raise concerns without fear of victimisation.

Commitment to quality improvement and innovation

The service had used improvement methodologies for several years to improve services, for example, Willow ward had had a rapid improvement workshop which examined the ward layout and had resulted in improvements. A recent project to redesign some rehabilitation and recovery services was currently taking place.

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.

Fulmar ward was working on introducing 'safe wards'. This was a model of care which aimed to reduce levels of potentially harmful events on inpatient wards, for example; restraint, aggression and self harm. Three ward managers had been trained in the boundary see saw model which works on relational boundaries.

Willow ward and Primrose Lodge had achieved the Royal College of Psychiatrists' accreditation for inpatient mental health rehabilitation services.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was no nurse call system or alarm system in place on the unit. This meant patients had no means of summoning staff help or support in an emergency. This was a breach of regulation 12 (1) and (2) (b)