Requires improvement

Leicestershire Partnership NHS Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT5FK	The Willows	Acacia ward Cedars ward Sycamore ward Maple ward	LE5 0LE
RT5KE	Stewart House	Arran & Skye	LE19 4SL

This report describes our judgement of the quality of care provided within this core service by Leicestershire Partnership NHS 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 Leicestershire Partnership NHS Trust and these are brought together to inform our overall judgement of Leicestershire 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:

- The environment in some areas was very poor, particularly at Stewart House. There was a lack of storage at Stewart House, the utility/laundry room was used to store cleaning equipment. Clinic room temperatures were very hot, although one thermometer was above a radiator so would not give an accurate reading. The room used to administer medication on Arran ward at Stewart House was not appropriate; the room was a bedroom and still had a toilet in. There was no fridge to keep medicines cool when required. The old kitchen at the Willows was not fit for purpose and poorly equipped but was being used by occupational therapy. The ovens were old and the dials were not visible and cupboards were broken. There were no vision panels on patient bedrooms. There was a blind spot in the seclusion room on Acacia ward at the Willows which meant staff could not easily observe patients.
- Men using the laundry had to pass women's bathroom and bedrooms. The 30 bed unit at Stewart House was mixed sex and there were no doors to lock between the male and female sections.
- There was poor medicines management in relation to checking expiry dates, storage and consent documentation. Staff who were unclear of the process for rapid tranquillisation did not have a reminder of the process to follow. Wards did not have a list of stock items.
- There had been periods of understaffing. Staffing levels were not consistent across the two sites. There were high vacancy rates.
- Record keeping at Stewart House was disorganised. Staff used a mixture of paper and electronic records which were not easy to follow. We found loose papers in records. There were problems with access to the electronic system owing to ongoing building works. There was no evidence of patient involvement recorded in some of the notes.
- Mental Health Act documentation was not always up to date on the electronic system. The paperwork was difficult to find and not consistent. Staff were confused about Deprivation of Liberty standards and paperwork was incomplete. Capacity assessments were unclear. Detention renewal paperwork had been signed by a doctor prior to them seeing the patient.
- Local audits were not completed regularly. Team managers could not be assured of local performance around record keeping, care planning and patient involvement.
- Acute patients had been sent to rehabilitation wards inappropriately.
- Staff were not aware of the trust's visions or values.
- There was a high staff sickness rate reported and managers did not always follow the managing sickness policy.

However

- Recruitment was in progress for 10 new healthcare support workers. The senior occupational therapist was trying to recruit to vacant occupational therapy posts. Support workers were being trained in phlebotomy to improve timely blood testing. There was a floating qualified unit coordinator to oversee the service requirement at the Willows. Staffing numbers were met but not always the right skill mix.
- Patients felt safe and said they were checked regularly by staff. Patients described being cared for, respected and treated with dignity. Notes reflected caring and compassionate view of patients. Staff were quick to sort out requests and problems for patients. We observed positive interactions between patients and staff
- There were low levels of restraint and staff tried other methods to de-escalate before restraining patients. There was an effective incident reporting system.
- Staff carried out physical health checks on admission.Ongoing physical healthcare was provided by a local GP who visited two days a week and was available in case of an emergency.

Summary of findings

- There was a range of large therapeutic areas and rooms for art therapy plus other interventions.
- Leadership had been strengthened at Stewart House. Staff acknowledged directors' visits.

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:

- Clinic room temperatures were very hot, although one thermometer was above a radiator so would not give an accurate reading. The clinic room on Arran wing at Stewart House was not appropriate; the room had been a bedroom and still had a toilet in. The clinic room on Sycamore ward at the Willows was small and cramped. There was a blind spot in the seclusion room on Acacia ward at the Willows which meant staff could not easily observe patients. There were no vision panels on patient bedrooms.
- There was no safeguarding plan for a vulnerable female patient.
- Men using the laundry had to pass women's bathroom and bedrooms. The 30 bed unit at Stewart House was mixed sex and there were no doors to lock between the male and female sections.
- There was poor medicines management in relation to monitoring high doses of antipsychotic use, lack of storage space, waste disposal at Stewart House clinics and documenting consent for detained patients. Staff who were unclear of the process for rapid tranquillisation did not have a reminder of the process to follow. Wards did not have a list of stock items.
- There had been periods of understaffing. Staffing levels were not consistent across the two sites.

However:

- Recruitment was in progress for 10 new support workers. The senior occupational therapist was trying to recruit to vacant posts. There was a floating qualified unit coordinator to oversee the service requirement at the Willows and cover if needed. Staffing numbers were met but not always the right skill mix.
- Patients felt safe and said they were checked regularly by staff.
- There were low levels of restraint and staff tried other methods to de-escalate before restraining patients. There was an effective incident reporting system.
- We observed the effective implementation of a safeguarding plan.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Summary of findings

- At Stewart House record keeping was disorganised. Staff used a mixture of paper and electronic records which were not easy to follow. We found loose papers in records. There were problems with access to the electronic system owing to ongoing building works.
- Mental Health Act documentation not always up to date on the electronic system, particularly at Stewart House. The paperwork was difficult to find and not consistent. Staff were confused about Deprivation of Liberty Standards and paperwork was incomplete. Capacity assessments were unclear. Detention renewal paperwork had been signed by the doctor prior to them seeing the patient.
- At Stewart House local audits were not completed regularly. Team managers could not be assured of local performance around record keeping, care planning and patient involvement.

However:

- Staff carried out physical health checks on admission.Ongoing physical healthcare was provided by a local GP who visited two days a week and was available in case of an emergency.
- Support workers were being trained in phlebotomy to improve timely blood testing.

Are services caring?

Good

We rated caring as good because:

- Patients described being cared for, respected and treated with dignity.The care records reflected caring and compassionate view of patients.
- We observed positive interactions between patients and staff and received positive patient feedback.
- Staff actively tried to engage with a patient who was isolating themselves.
- Older people in the service were cared for appropriately.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Some acute patients had been sent to rehabilitation wards inappropriately.
- Not all patients had room keys at Stewart House and there was limited storage space for belongings.
- There was a lack of storage at Stewart House and at the Willows the utility/laundry room was used to store cleaning equipment.

Summary of findings

- The old kitchen was not fit for purpose and staff were using it as an occupational therapy kitchen which was not a therapeutic area. The ovens were old and the dials were not visible. The kitchens at Stewart House had broken cupboards.

However:

- Patients had their own rooms and some had ensuite facilities.
- There were large therapeutic areas/rooms for art therapy plus other interventions.
- Staff were quick to sort out requests and problems for patients.
- Drinks were available 24 hours when requested. The cook knew patients' requirements and tried to accommodate requests.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff were not aware of the trust's visions or values and not aware of how they had been agreed.
- Staff were unclear about the future plans for Stewart House in any detail and could not tell us the timescales for the refurbishment.
- There was a high staff sickness rate reported and managers did not always follow the managing sickness policy.

However:

- A recruitment programme was in place to fill vacancies.
- Leadership had been strengthened at Stewart House.
- Mandatory training and clinical supervision levels were high. The trust had strengthened the governance processes.
- Senior executives visited the services.

Summary of findings

Information about the service

The services are provided from two inpatient units. The Willows, in Leicester, is a 38-bedded unit, comprising four wards. Acacia ward, Cedars and Sycamore have10 beds, Maple has eight beds. Two of the wards are mixed sex and two wards are male only.

Stewart House is a 30-bedded unit which is in Narborough and consists of Arran and Skye wings.

Due to the severity of their mental health needs, patients have been unable to sustain living in residential community settings and need an alternative approach to prolonged stays on acute inpatient wards, with a focus on rehabilitation back into the community. The patients might have high levels of disability owing to their mental illness. The teams aim to help them in enhancing their quality of life and improve their abilities to cope with day-to-day living whilst living with severe and enduring mental ill health. All patients have their own rooms and some have ensuite facilities. Care is provided by multi-disciplinary teams and a range of facilities supports patient rehabilitation, including occupational therapy, activity and sensory rooms.

The whole trust was last inspected in March 2015. The long stay, rehabilitation services were inspected as part of this and were rated as requires improvement for safe and effective and good for caring, responsive and well led. The overall rating for this service was requires improvement.

Requirement notices were issued for the following issues:

- recording and storing of consent to medication documents
- medicines management
- carrying out medical tests as requested by the doctor
- adherence to the Mental Health Act code of practice

There were still issues about medicines management and consent to treatment on this inspection but the other requirements had been met.

There were two Mental Health Act reviewer visits between 22 August 2015 and 23 October 2016 finding 12 issues. Six of these issues were related to 'purpose, respect, participation, least restriction', three related to 'protecting patients' rights' and six to 'care and treatment in hospital'. The format of these reports has since changed with different section titles in use.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett.

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

Inspection Manager: Sarah Duncanson, 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, three specialist professional advisors including a social worker, nurse and doctor and an expert by experience that had experience of using mental health 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 we held about these services, asked a range of other organisations for information and sought feedback from patients.

During the inspection visit, the inspection team:

- visited all four wards at the Willows and the two at Stewart House and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 17 patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 20 other staff members; including doctors, nurses, support workers and social workers
- Interviewed the divisional manager with responsibility for these services.
- collected feedback from 5 patients using comment cards
- looked at 13 care records and carried out a review of medicines management
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients told us staff were caring and respectful and they felt safe on the wards. Patients felt involved in their care and their family when needed. They said staff were quick to sort out requests and problems for patients. Patients felt their possessions were safe.

They told us their physical health was monitored and they received treatment if needed. Some patients said there were not enough activities at the weekends.

Patients said they knew how to complain if needed and had raised things which had been sorted. Staff were always available. They could raise things at the community meetings.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure the environment is safe, clean and well maintained and there is sufficient storage to safely store equipment and patients' belongings.
- The trust must ensure the safe management of medicines, including storage, disposal and patients' consent to treatment is documented clearly and accurately.
- The trust must ensure staffing skill mix meets patient need.
- The trust must ensure records are organised clear and contain the necessary information to provide a safe and effective service.

Summary of findings

Action the provider SHOULD take to improve

- The trust should ensure all patients prescribed high doses of anti-psychotics are identified and appropriate physical health monitoring completed.
- The trust should ensure managers follow the trust's policy on managing attendance.

Leicestershire 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
Acacia ward Cedars ward Sycamore ward Maple ward	The Willows
Arran & Skye wing	Stewart House

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.

The trust monitored the use of the Mental Health Act (MHA) and each ward matron completed a monthly MHA census. This captured relevant information which fed into the MHA dashboard. A comprehensive audit programme was in place, which included an audit of section 17, section 132 and section 58 (treatment requiring consent or a second opinion).

When people were detained under the Mental Health Act, the appropriate legal authorities for medicines to be administered were kept within the clinic rooms, so nurses were able to check medicines had been legally authorised before they administered any medicines. However, we found one patient had been prescribed and administered a higher dose of medication than was authorised on their mental health form and another patient had three different section 62 forms in use which could have led to confusion for staff.

The MHA administration team were available to give advice to staff if needed.

The trust provided MHA training to all eligible staff.

Detailed findings

The detention paperwork we reviewed was correctly completed but not always uploaded to the electronic system.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) is a piece of legislation which enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves.

The trust provided MCA training to staff. However staff seemed confused about capacity assessments, best interest assessments and Deprivation of Liberty Standards and their application. Paperwork and records were not always up to date or complete.

The trust monitored the use of the MCA via the audit programme.

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

- There were issues with the environment and maintenance. There was a lack of storage at Stewart House and broken window restrictors, shelving, door locks and door handles. Four fire extinguishers were out of date at Stewart House. The utility/laundry room at the Willows was used to store cleaning equipment. There was a blind spot in the seclusion room on Acacia ward at the Willows. A plastic glove was covering the air conditioning sensor in the staff room at Stewart House.
- Blind spots on Sycamore and Acacia, at the Willows, had mirrors and closed circuit television in place to mitigate risk. However, patients could reach the closed circuit television camera on Maple and could change direction of the camera.
- Clinic room temperatures were very hot, with temperatures exceeding 25 degrees regularly, fridge temp monitoring was intermittent and out of range frequently, meaning medicines were not stored at the correct temperature to ensure effectiveness. One room used for administering medication on the male side at Stewart House was not appropriate, the room had been a bedroom and still had a toilet in and it had no fridge. The other clinic room was well kept, clean and tidy and was well laid out. The clinic room on Sycamore ward at the Willows was small and cramped.
- Men using the laundry had to pass women's bathroom and bedrooms. The 30 bed unit at Stewart House was mixed sex and there was no door to lock between the male and female sections (wings). We saw a female patient walk through the male area to ask staff a question. There were separate male and female lounges, bathrooms and toilets.
- At the Willows there were two emergency equipment trolleys, one on maple and a second in the central clinic room for the unlocked wards. There was one at Stewart House for both wings and all were checked regularly.
- There was a recent ligature risk assessment dated 2016 with actions in progress. The organisation had a ligature policy which set out the organisational arrangements for the management of ligature risks through a risk assessment process using a recognised audit tool. All environmental ligature risk assessments were required to be reviewed annually unless there was a change to the environment or patient group within the environment. If this was the case then the risk assessment was modified to reflect those changes as and when they occurred. The annual environmental ligature audit was monitored and reviewed through the patient safety group and health and safety committee. The directorate risk register included a Willows specific ligature risk which was reviewed quarterly. We were provided with copies of environment risk assessments.
- Staff had guidance on the use of ligature cutters. We identified some ligature points at Stewart House which included windows, door closers, wardrobe handles and soap dispensers. Staff pointed out the patient group presented a lower risk and we saw detailed individual risk assessments in records.
- The trust carried out an annual health and safety check on each ward.
- There was an alarm system for staff and visitors and in patient bedrooms. Staff checked alarms were working and signed each shift.
- In relation to cleanliness, the 2016 PLACE score for Leicestershire Partnership NHS Trust average was 94.7% with Stewart House scoring 88% and the Willows scoring 94.84%. However, we found toiletries in the bathrooms which were not labelled with the patient's name and could present an infection control issue. We brought this to the attention of the matron who said they would address. Cleaning materials and substances hazardous to health were locked away so complied with control of substances hazardous to health (COSHH) requirements. Electrical equipment was subject to safety testing.

Safe staffing

- The qualified nurse vacancy rate for this core service was above the trust average as was the percentage of staff leavers in the 12 months prior to the inspection and the staff sickness rate.

Requires improvement

Are services safe?

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

- This core service reported a vacancy rate of 9.6% overall which was below the trust average of 12%. However, the vacancy rate on Sycamore was 12%.
- The staff sickness rate was 7.6%, which is above the trust rate of 4.8%.
- The staff fill rate was above 125% for all staff groups in the period covered, which suggests baseline staff establishment levels are low.
- Total number of substantive staffwas 122

  Total number of substantive staff leavers in the 12 months prior to inspection was nine

  Total turnover of ALL substantive staff leavers was 7.3%

  Establishment levels qualified nurses (WTE) was 70.8

  Establishment levels nursing assistants (WTE) was 78.2

  Number of WTE vacancies qualified nurses was six

  Number of WTE vacancies nursing assistants was six

  Qualified nurse vacancy rate was 9.6%, which is lower than the trust average of 12.9%.

  Nursing assistant vacancy rate was 9.6%

  Shifts filled by bank staff to cover sickness, absence or vacancies was 1496

  Shifts filled by agency staff to cover sickness, absence or vacancies was 30 (2%)

  Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies were 104 (7%).
- There had been periods of understaffing. Staffing levels were not consistent across the two sites. Staff completed daily safer staffing tool which was monitored by senior managers. A safer staffing dashboard was produced each month to provide an overview of staffing during the period in review. Lead nurses provided further qualitative narrative to identify particular 'hot spots', the risks they posed and the mitigating actions and longer term plans which were in place to ensure wards remain safe. Recruitment was in progress for the 10 new support workers. The senior occupational therapist was recruiting to occupational therapy vacancies. Staffing numbers were met but not always the right skill mix.
- Staff spent regular one to one time with patients. There was always a member of staff in communal areas. Leave was not cancelled because of low staffing although it was sometimes rearranged. The ward manager could increase the staffing when needed on a daily basis.
- Compliance with mandatory training was 95% and included fire, moving and handling, life support, safeguarding, medicines management, record keeping and management of violence and aggression.The compliance for the management and prevention of aggression was 92.5%.

Assessing and managing risk to patients and staff

- Records contained detailed risk assessments and management plans, which were updated regularly.
- A member of the medicines management team completed medicines reconciliation on all electronic prescription charts. All prescriptions were clearly written and included information about allergies, weight, Venous Thromboembolism (VTE) assessment, and date of birth. Appropriate codes were used to note medicines refusals and medicines for physical health were prescribed and monitored appropriately. We found clinical pharmacists were involved in patients' individual medicine requirements, through the electronic prescribing system. These had well documented notes annotated with pharmacist interventions. However, there was limited clinical pharmacist presence on the ward, to provide improved communication with staff and patients around intervention notes and there was limited involvement of clinical pharmacists in ward multidisciplinary team meetings. There were three types of medicine out of date in the medicines trolley on Arran ward at Stewart House and there was limited storage space for medicines in the clinic rooms.
- Rapid tranquilisation was prescribed within National Institute for Health and Care Excellence guidelines, although none had been used. Staff did not have something to refer to quickly if rapid tranquillisation was required.
- When people were detained under the Mental Health act, the appropriate legal authorities for medicines-to be administered were kept within the clinic rooms, so nurses were able to check medicines had been legally authorised before they administered any medicines.

Requires improvement

Are services safe?

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

However, we found one patient at the Willows had been prescribed and administered a higher dose of medication than was authorised on their mental health form. The staff were not aware a patient had been prescribed anti-psychotic medication that was higher than the maximum recognised British National Formulary limit. This meant there was a risk the monitoring of the physical health of the patient was not sufficient.

- One patient had three separate section 62 forms in place, with different medication on each form to cover all medication prescribed. Staff may not have been able to know which form(s) to check against the electronic prescribing record when administering medication.
- There were low levels of restraint and staff tried other methods to de-escalate before restraining patients. There was an effective incident reporting system. Long stay / rehabilitation wards for adults of working age had 37 incidents of restraint (4% of all restraints recorded trust wide) involving 14 patients' between1 February 2016 and 31 July 2016. There were no incidents of prone restraint. Staff said any incident of prone restraint would be investigated and outcome shared. There were four uses of seclusion at the Willows during the same period. Stewart House did not have a seclusion room. Compliance with training in managing violence and aggression was 85%.
- There were 17 safeguarding notifications recorded on our internal systems regarding Leicester Partnership NHS Trust from 1 October 2015 to 30 September 2016. All were closed. Three of the 17 notifications related to this core service.
- Staff were trained in safeguarding with an 87% compliance rate for eligible staff. Staff knew how to identify and refer safeguarding concerns. We observed the effective implementation of a safeguarding plan. However, there was no safeguarding plan for a vulnerable female patient.
- There was no designated child visiting room but a room was available off ward if required. Staff said they rarely needed to use it for this.

Track record on safety

- Between 1 July 2015 and 30 June 2016, trust staff reported no serious incidents concerning this core service.

Reporting incidents and learning from when things go wrong

- Staff knew how and when to report incidents onto the electronic system. The trust produced a newsletter with learning from incidents – an example of learning included information on Deprivation of Liberty, mental capacity and record keeping. Managers feedback in team meetings also. Staff were aware of the need to be open and honest when informing patients or relatives of any incidents.
- There were de-briefs following serious incidents for staff to discuss the incident, reflect and receive support if needed.

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

- The doctor carried out a physical examination of a patient on admission and staff carried out ongoing checks. However, this was not always reflected in the records. A local GP visited two days a week to provide ongoing healthcare advice and deal with any urgent matters.
- We looked at 13 records. Staff completed a comprehensive assessment of need for each patient. Care plans were variable in quality with some showing effective planning. However, care plans on Cedar and Acacia were not personalised. Staff used recovery planning tools with patients to identify goals.
- Discharge plans were in records, however not all showed patient involvement and some lacked detail.
- Records were electronic with controlled access. However, some paper records were also kept which meant information could get missed if not all on the electronic system. There were Wi-Fi issues at Stewart House which meant connection was affected. However, staff showed us there was a backup computer.

Best practice in treatment and care

- Staff used nationally recognised recovery planning tools with patients to plan care.
- The trust had a clinical audit programme and some local managers carried out weekly local audits on record keeping using a random sample of five sets of notes.
- Occupational therapists support the patients' rehabilitation program following the recovery model. A structured plan of care was developed this included regular activities on the wards and in the community. Sensory approaches were used support patients to develop coping strategies and help them manage and understand how their illness affects them before being discharged into the community.
- We observed a meal time. Staff recorded what patients ate and provided assistance when required. Records included physical healthcare and ongoing monitoring.
- The trust had an audit programme to monitor compliance against National Institute for Health and Care Excellence guidelines.
- Patients could access psychology but there was limited psychologist time in the team. This meant patients had to wait for psychological interventions.

Skilled staff to deliver care

- The trust had not set a target rate for appraisal compliance. As at 1 September 2016, the overall appraisal rates for non-medical staff within long stay / rehabilitation wards for adults of working age was 74%, below the trust figure of 83%. The lowest rate was on Sycamore at 58%. Supervision rates were at 81% compliance overall.
- New staff completed an induction to the ward using an induction checklist and students received an induction pack.
- Staff could access specialist training. Two support workers were receiving physical healthcare training and two were accessing a university course to train as a nurse. Support workers were being trained in phlebotomy to improve timely blood testing. Staff had received tissue viability training. The trust provided training to healthcare support workers for the care certificate.
- Staff that had made an error giving out medicines were supervised and assessed before administering medicines on their own again.
- One manager we spoke with told us about managing poor staff performance and action taken.

Multi-disciplinary and inter-agency team work

- Staff held weekly multidisciplinary meetings, which included psychiatrists, nurses, occupational therapist, speech and language therapist and dietician. Staff from other services in the community attended when necessary.
- Nursing staff handed over to each shift on changeover. Some staff at Stewart House said communication could be improved and gave an example of not knowing a patient had been sectioned.

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.

- Apart from the issues regarding inappropriate placement of patients in rehabilitation services worked effectively together.

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

- As at 1 September 2016, the trust scored 80% compliance for the number of staff trained in the Mental Health Act. This course is mandatory for staff. Long stay/ rehabilitation mental health wards for working age adults scored 94.5% with 15 out of 16 eligible staff completing this training.
- We looked at ten sets of detention paperwork, all were in order and filed correctly. Approved mental health practitioner reports were included where necessary. However, one Section 19 authority for transfer from one hospital to another under different managers' form was not immediately available for inspection. The MHA administration office contacted the relevant independent hospital who faxed a copy of the form to the trust.
- The Mental Health Act administration office provided reminders to Responsible Clinicians (RCs) for, section renewals and consent to treatment actions. Nursing staff checked and received detention papers. Scrutiny of the papers was undertaken by the Mental Health Act administration office. Managers' hearings and tribunals took place.
- All detained patients were automatically referred to the Independent Mental Health Advocacy (IMHA) service. The IMHA service received a list of detained patients on a weekly basis.
- When people were detained under the Mental Health Act, the appropriate legal authorities for medicines to be administered were kept within the clinic rooms, so nurses were able to check medicines had been legally authorised before they administered any medicines. However, we found one patient had been prescribed and administered a higher dose of medication than was authorised on their mental health form and another patient had three different section 62 forms in use which could have led to confusion for staff.
- The majority of patients had received their rights under the Mental Health Act. However, one patient on Section 37/41 on Skye Ward had not understood their rights and there was no evidence of the rights being re-read. One patient on Section 3 on Skye Ward had "refused to listen/sign" their rights. There was no evidence of the rights being re-read or attempts being made.
- MHA audits were carried out and the last one had been completed in November 2016. Staff could seek advice when needed.

Good practice in applying the Mental Capacity Act

- As at 1 September 2016, the overall compliance rate for this training course across the trust was 84%. The trust target was not provided. Long stay/rehabilitation mental health wards for working age adults scored 98% of eligible staff having completed this training.
- The trust provided information around the Deprivation of Liberty Safeguards (DoLS) applications they had made between 1 March 2016 and 1 September 2016. Between 1 March 2016 and 1 September 2016 the trust made 142 Deprivation of Liberty Safeguards applications. From data provided two DoLS applications were made regarding this core service. From a review of records we found several references to DoLS applications but the paperwork was incomplete and records did not show updates on progress of the applications.
- We looked at nine capacity assessments and all had been reviewed in the two weeks prior to the inspection. Capacity assessments were unclear. Capacity assessments were incomplete and records showed confusion over which decisions required a best interest assessment. Staff were also unsure when asked. Staff could seek advice if needed and regular audits on the use of the Act were in place.

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

- Staff interacted with patients in a caring and respectful way. We observed staff trying to engage positively with a patient who was isolating themselves. They showed concern for the patients' needs and compassion.
- In relation to privacy, dignity and wellbeing, the 2016 PLACE score for Leicestershire Partnership NHS Trust was 80%, which was below the England average of 90.7%. Stewart House scored 70.6% and the Willows 76%.
- Patients told us staff were caring, polite and respectful. They said they could get privacy when needed.

The involvement of people in the care that they receive

- Patients received a welcome pack on admission which contained a "tell matron" card for any queries they might have, information about their named nurse, the care programme approach, physical health, advocacy, their rights and information about the recovery college. There was also a pre-admission and admission checklist. Patients were shown around the ward on admission or soon after.
- Advocacy visited the wards twice a week and leaflets were displayed about this service.
- Records did not always evidence the patient's involvement in care planning or decisions about their care. However, patients told us they felt involved and could have a copy of their care plan if they wished. Patients attended multidisciplinary meetings on a two weekly basis.
- The Willows produced a newsletter called "The Voice" which contained information and feedback for patients about services and activities.
- Stewart House displayed information for carers, including carer assessment information.
- There were no records of any advance decisions by patients.

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

- Skye wing (Stewart House) reported a bed occupancy rate of 100% or above between August 2015 and July 2016. These bed occupancy rates include leave days. The average length of stay for Skye was 1210 days.
- Between August 2015 and July 2016, 'long stay rehab mental health wards for working age adults' reported 12 delayed discharges during the period covered.
- Staff held a discharge planning meeting weekly and minutes were recorded. The discharge co-ordinator attended these meetings. Delayed discharges were discussed at this meeting. Reasons for a delay included, waiting for a home assessments by an occupational therapist, lack of appropriate placement, lack of funding or physical health needs.
- There was effective communication with other services such as the assertive outreach team and community teams.
- We saw evidence of three occasions in September 2016 when patients had been transferred into the service from acute and staff felt it was inappropriate. They had reported these as incidents. There had been no further incidents reported.
- There was no issue about patients having a bed when they returned from leave.
- There were no female psychiatric intensive care beds commissioned in the trust, male psychiatric intensive care beds were on Belvoir ward, at the Bradgate unit. Patients needing an acute bed were transferred to the Bradgate unit.

The facilities promote recovery, comfort, dignity and confidentiality

- All service users had their own rooms and some had ensuite facilities. However, not all patients had their own key and there was no record of individual risk assessment.
- However, there was a lack of storage for personal possessions. Bedrooms at Stewart House were being used for storage when no patients needed them. Patient had use of a pay phone or could use personal mobiles.
- PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness and food. The trust scored slightly lower than the national average of 85.5% for food with 85%. Stewart House scored 83% and the Willows 78.7%.
- Kitchens were locked and some of the cupboards were broken which did not promote independence or comfort. The old kitchen was not fit for purpose and staff were using it as an occupational therapy kitchen which was not a therapeutic area. The ovens were old and the dials were not visible.
- There were no vision panels on bedroom doors which meant staff had to enter the room to check on patients which might disturb the patient if they were resting.
- Rooms were available for therapies and one to one sessions. There was a sensory room for patients to use to relax. Patients had the use of a hair salon. There was no multi faith room for patients to use.
- One patient had no toiletries, apart from shower gel and had been admitted for one week. Staff told us they would make sure they received some toiletries when this was pointed out to them; they had already obtained some clothing for them.
- Drinks and snacks were available on request.
- A refurbishment was underway at Stewart House but staff did not know the timescales for this.
- There was an activity programme for during the week. However patients told us there were no activities at weekends. Patients can request specific activities if they wish. Occupational therapy staff told us they work some weekends to increase activities.

Meeting the needs of all people who use 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.

- There was a choice of menus for patients which met different personal, religious or spiritual needs. There was information on display about sugar in food and drink to encourage healthy eating.
- Other information was available about services in leaflet form and there was a carer board with information on for carers. Staff could access interpretation services when required.
- There were no signs for patients to know how they could leave the building if informal and all patients were escorted to leave the building because the reception staff did not know who could leave or not. However, at the time of our inspection there was building work underway so the doors were locked for safety reasons.
- There were no regular visits from religious leaders, however, staff said they had requested when needed.
- Stewart House was on the ground floor and was accessible from someone in a wheelchair. There were assisted bathrooms and shower rooms and assistive equipment for patients in the kitchen.

Listening to and learning from concerns and complaints

- Eighteen complaints were made against this core service, 16 of these were upheld. None were referred to the ombudsman.
- Long stay / rehabilitation wards for adults of working age received four compliments during the last 12 months (1 August 2015 to 31 July 2016).
- Information on how to complain was displayed, including the patient advice and liaison service information. Patients told us they knew how to complain and felt their concerns would be addressed.
- Feedback from complaints was included in team meetings. Staff said they tried to resolve most complaints locally. Staff knew how to report complaints.

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

- Not all staff were aware of the trust's vision and values and how these were agreed.
- Executives had visited in the last year and staff told us about these executive "Board walks".
- Staff said they could raise any concerns and they would be heard.

Good governance

- The average rate of clinical supervision across the service was 68% between 01 August 2015 – 31 July 2016 against the trust's average compliance rate of 60% and a trust target of 85%. Some staff were confused between what was clinical and what was managerial supervision. Senior management monitored appraisal and training rates. There was a clear audit programme and staff could identify and escalate risks when needed.
- Staff demonstrated safeguarding knowledge and there was a clear process for staff to follow.
- Managers received performance reports to check whether they were meeting targets. For example, mandatory training, supervision and appraisals. Some managers carried out local audits also.

Leadership, morale and staff engagement

- Managers monitored sickness but did not always follow the trust's policy. Although some staff had been referred to occupational health for support.
- Staff reported morale was good and managers were supportive. They said they felt they could raise any concerns with their manager and would be heard. However, staff at Stewart House felt unsure about their future as they had been told several times the unit might be closing.
- The trust carried out an annual staff survey. The 2015 results showed an improvement on 2014, however, the overall score was below the England average. In the friends and family test we received data at trust level which showed 55% would recommend the trust as a place to work, the England average was 62% and 71% would recommend the trust as a place to be treated, the England average was 70%.
- Staff said they felt they could raise issues without fear of repercussions. They were aware of the trust's whistleblowing policy.
- The trust was committed to open and transparent communication, however some staff said they did not feel they were kept informed about changes and service development plans.
- Leadership development training was available.
- There were no cases of bullying at the time of the inspection.

Commitment to quality improvement and innovation

- In 2016 the occupational therapists had made two successful bids to a local charity to buy equipment and provide activities and outings for patients.
- The service had been considering going for a national accreditation but the process had not started.

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 11 HSCA (RA) Regulations 2014 Need for consent • Staff had received training in Mental Capacity Act. However, capacity assessments were unclear and staff were confused about implementing Deprivation of Liberty standards. From a review of records we found several references to DoLS applications but the paperwork was incomplete and records did not show updates on progress of the applications. • In one record we looked at, the record said the patient had capacity but a T2 (consent to treatment) form had been completed which indicates no capacity. Capacity assessments were incomplete and records showed confusion over which decisions required a best interest assessment. Staff were also unsure when asked. This is a breach of regulation 11

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 • The environment in some areas was very poor, particularly at Stewart House. There was a lack of storage at Stewart House; the utility/laundry room was used to store cleaning equipment. Clinic room temperatures were very hot, although one thermometer was above a radiator so would not give an accurate reading. The clinic room on Arran at Stewart House was not appropriate; the room was a bedroom and still had a toilet in. There was no fridge to keep medicines cool when required. The occupational therapy kitchen at the Willows was not fit for purpose and poorly equipped. The ovens were old and the dials were not visible and cupboards were

This section is primarily information for the provider

Requirement notices

broken. There were no vision panels on patient bedrooms. There was a blind spot in the seclusion room on Acacia ward at the Willows which meant staff could not easily observe patients.

- Men using the laundry had to pass women's bathroom and bedrooms. The 30 bed unit at Stewart House was mixed sex and there were no doors to lock between the male and female sections.
- There was poor medicines management in relation to monitoring high doses of antipsychotic use, lack of storage space, checking expiry dates, waste disposal at Stewart House clinics and documenting consent for detained patients. Staff who were unclear of the process for rapid tranquillisation did not have a reminder of the process to follow. Wards did not have a list of stock items.

This is a breach of regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Record keeping was disorganised. Staff used a mixture of paper and electronic records which were not easy to follow. We found loose papers in records. There were problems with access to the electronic system owing to ongoing building works. There was no evidence of patient involvement recorded in some of the notes. • Local audits were not completed regularly. Team managers could not be assured of local performance around record keeping, care planning and patient involvement. This was a breach of regulation 17

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Staffing levels were not consistent across the two sites. There were high vacancy rates. Staffing numbers were met but not always the right skill mix.

This was a breach of regulation 18