Lea Court

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
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 and Deprivation of Liberty Safeguards

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

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

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

Summary of findings

Overall summary

We rated Lea Court as good because:

- The hospital complied with the Department of Health guidance on same sex accommodation.
- There was enough staff to provide recovery-based care and treatment to patients.
- Patients' risk assessments were well completed and reviewed.
- There were minimal significant incidents but when incidents did occur, staff learnt lessons.
- Staff carried out regular physical health checks with patients.
- Patient recovery plans were well completed and personalised.
- There was good multidisciplinary working with thorough occupational therapy assessment and input.
- Staff were receiving specialist clinical skills training to provide more effective care and treatment to patients with a personality disorder.
- Staff were trained in, and adhering to, the Mental Health Act and Mental Capacity Act.
- Comments from patients on the standards of care and treatment were positive.
- Patients were involved in identifying their own goals to aid meaningful recovery and developing their care plans.
- There were regular weekly patient community meetings occurring for patients to discuss day to day issues.
- Staff had regular contact with community mental health team professionals and the hospital had links with the wider community.
- There were no patient complaints and managers had put in systems so that if informal complaints were made they were managed well.
- Staff morale was good and there was good local leadership.
- Governance arrangement and checks in place were good.

However:

- There was a domestic sink in the clinic room with plug and overflow which did not meet good infection control measures. The provider was taking action to address this.
- Following a recent incident, managers at Lea Court had not been able to fully clarify the pathways into acute mental health inpatient and psychiatric intensive care for deteriorating patients with local partners.
- There was no designated on-site psychologist but patients had access to psychological services.
- Managers were working to improve formal supervision uptake rates.
- Although staff were regularly informing detained patients of their rights, we found a small number of patients' files where staff had not revisited patients' rights at particular intervals such as, in one case, when a patient's detention was renewed.
- While overall adherence to the Mental Capacity Act was good; we did see in one case, nursing staff had applied for a standard Deprivation of Liberty Safeguards application and were still awaiting a decision but had not applied for an urgent authorisation alongside this. This was rectified at the earliest opportunity.
- Written minutes of community meetings did not always clearly record what action was needed or what action had been taken to show that patients' concerns had been fully addressed.

Summary of findings

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Summary of this inspection

Background to Lea Court

Lea Court provides services for male and female patients with mental health needs who required rehabilitation. It is managed by the Alternative Futures Group who also have a number of other mental health hospital and community services within the north west of England.

Lea Court is a 26 bed ward and provides rehabilitation to both patients detained under the Mental Health Act and informal patients.

There is a registered manager, accountable officer and nominated individual for this location.

The service is registered to provide the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983,
- treatment of disease, disorder and injury, and
- diagnostic and screening procedures.

Warrington clinical commissioning group block purchases 15 of the 26 beds; St Helen's clinical commissioning group block purchases eight of the 26 beds. Any referrals from outside the Warrington or St Helens area would be funded by the patient's local clinical commissioning group.

Lea Court has been registered with CQC since 21 December 2010.

There have been five previous inspections at Lea Court, the most recent being 23 March 2016. On that inspection, we found Lea Court was meeting the required standards and were rated good overall and across all five key questions we asked (whether services are safe, effective, caring, responsive and well-led).

The provider has a duty to ensure the ratings we give are displayed appropriately so patients, visitors and the public can easily see the hospital's ratings. On this inspection, we found that the current ratings were displayed on the Alternative Future's website**.**The current ratings were also displayed in the hospital's foyer area. Therefore, staff were ensuring that ratings were displayed in a prominent place as required.

Our inspection team

The team that inspected Lea Court consisted of two CQC inspectors, a specialist adviser occupational therapist who specialised in rehabilitation and an expert by experience. Experts by experience are people who have personal experience of using, or caring for someone who use, health or mental health services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information. This included asking representatives of the local clinical commissioning groups who commission beds at the service and the local Healthwatch.

During the announced inspection visit, the inspection team:

- visited the hospital and looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with 10 patients and one relative
- spoke with the registered manager and nominated individual
- spoke with 10 other staff members; including doctors, nurses, support workers and an occupational therapist
- spoke with one student nurse who was on placement at Lea Court
- attended and observed one patient morning meeting
- looked at nine care and treatment records of patients
- carried out a specific check of the medication management on the unit
- spoke with the lead pharmacist for the company
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with ten patients who used the service and one relative.

- Most patients were positive about the standards of care they received from staff.
- Patients reported that staff were very nice, kind, helpful and friendly.
- Many patients compared their care and treatment at Lea Court to care they had in other establishments and stated that they much preferred Lea Court.
- The reason they gave was varied but included the quality of the environment, the relative calmness of the unit compared to previous placements and the quality of the interactions with staff who were committed to provide patient centred care.

A small number of patients who were less positive about their care were recent admissions to Lea Court and their comments centred around not wishing to be compulsorily detained.

We spoke with one relative who was happy with the quality of care and treatment their relative had received at Lea Court.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The hospital complied with the Department of Health guidance on same sex accommodation.
- There were enough staff to ensure the safety of patients at all times.
- Staff carried out ongoing risk assessments on patients.
- Patients were not subject to blanket restrictive practices and each patient had a very detailed plan in place to ensure that any restrictions were individualised, were kept to a minimum and regularly reviewed.
- Managers had made improvements to ensure that there were enough staff safety alarms available.
- There were a range of well-completed health and safety and medication audits in place.
- Staff understood safeguarding procedures and took action to safeguard vulnerable patients.
- The hospital had minimal incidents but when these occurred they told us about them and took appropriate action to address them and learnt lessons.

However:

- There was a domestic sink in the clinic room with plug and overflow which did not meet good infection control measures. The provider took action to address this.

Are services effective?

Good

We rated effective as good because:

- The hospital was recovery focused.
- Staff and patients worked together to complete care and support plans from a recognised recovery based assessment tool (the mental health recovery star tool).
- Patients received medical and clinical interventions to minimise symptoms of their mental health through both medication and psychosocial interventions.
- Patients received input from a multidisciplinary team which included a consultant psychiatrist, visiting GP, nurses trained in psychosocial approaches and an occupational therapist.
- Staff were receiving specialist clinical skills training to provide effective care and treatment to patients with a personality disorder.

Summary of this inspection

- Staff provided individualised support to patients over daily tasks such as budgeting, planning and shopping for meals and cooking.
- Patients received support to ensure they received appropriate physical health care.
- There were good systems in place to support adherence to the Mental Health Act (MHA).
- Where mental capacity assessments were carried out, these were decision specific and followed the principles and stages set out in the Mental Capacity Act.

However:

- There was no designated on-site psychologist but patients had access to psychological services.
- Managers were working to improve formal supervision uptake rates.
- Although staff were regularly informing detained patients of their rights, we found a small number of patients' files where staff had not revisited patients' rights at particular intervals such as, in one case, when a patient's detention was renewed.
- While overall adherence to the Mental Capacity Act was good; we did see in one case, nursing staff had applied for a standard Deprivation of Liberty Safeguards application and were still awaiting a decision but had not applied for an urgent authorisation alongside this. This was rectified at the earliest opportunity.

Are services caring?

Good

We rated caring as good because:

- Patients were positive about the staff in the hospital stating they provided high quality care and support.
- We observed staff providing support to patients in a calm and caring manner.
- Patients were seen as active partners and were encouraged to be involved in decisions that affected them.
- Patients were involved in identifying their recovery goals and developing their care plans.
- Patients were encouraged to be involved in the running of the hospital.
- Patients had access to independent advocacy input.

However:

- Written minutes of community meetings did not always clearly record what action was needed or what action had been taken to show that patients' concerns had been fully addressed.

Summary of this inspection

Are services responsive?

Good

We rated responsive as good because:

- The hospital started planning for patient discharge from when patients were first admitted.
- Patients being prepared for discharge were able to choose which hospital support work staff would follow with them to provide ongoing community support, where possible.
- The hospital had a homely feel and there were a range of rooms and facilities for patients including an outdoor gym and bikes to loan from the hospital.
- There had been no formal complaints at Lea Court for the last 15 months.
- Managers had made improvements to ensure that there was a system for recording informal concerns on the electronic database.

However:

- Following a recent incident, managers at Lea Court had not been able to fully clarify the pathways into acute mental health inpatient and psychiatric intensive care for deteriorating patients with local partners.

Are services well-led?

Good

We rated well-led as good because:

- Staff morale was good.
- There was good local leadership and staff felt well supported by an experienced and committed registered manager who was very patient-centred.
- Manager and senior nurses felt well supported with ongoing support from staff at the regional office.
- Staff were focused on patients' recovery.
- Governance arrangement and audit checks in place were good.
- There was good adherence to requirements relating to staffing, training and mental health legal requirements.

Detailed findings from this inspection

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.

We carried out a Mental Health Act monitoring visit to Lea Court on the 15 December 2016. This showed overall good adherence to the requirements of the Mental Health Act with a small number of shortfalls including access to independent mental health advocacy service, the outcome of leave not always recorded and individual patient issues. Managers at Lea Court sent a provider action statement stating how they would improve and take action to address the shortfalls we identified.

On this inspection, we found

- Managers ensured that copies of patients' detention papers and associated records (such as section 17 leave forms) were available for all staff and stored systematically.
- Patients had improved access to information about independent mental health advocacy services.
- Section 17 leave was well recorded and usually included the outcome of leave.
- Information was displayed to tell informal patients that they could leave the ward freely.
- Staff from the local mental health NHS trust provided ongoing Mental Health Act administrative support.
- Staff ensured that legal authorisations around consent to treatment (T2 and T3 forms) were routinely attached to medicines charts to aid nurses to check them prior to administering medication for mental disorder.
- Staff undertook monthly checks of adherence to the Mental Health Act.
- All staff had received training in the Mental Health Act.
- Staff had easy access to the Mental Health Act Code of Practice.

Detained patients were informed of their rights under section 132 on admission and frequently through their detention. However, we found two patients' files where staff had not revisited patients' rights at particular intervals such as when a patient's detention was renewed. In these cases, it was clear that patients' had received their rights verbally a short time before the renewal but not at the specific time that their detention was renewed.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of the inspection, 17 out of 23 patients were detained under the Mental Health Act. The rest were informal and had capacity to agree to informal admission.

- All staff had training in the Mental Capacity Act and staff had a good understanding of the Mental Capacity Act.
- Staff knew where to get advice about the Mental Capacity Act, including the Deprivation of Liberty Safeguards.
- There was a policy on the Mental Capacity Act, including the Deprivation of Liberty Safeguards which staff were aware of and could refer to.
- For people who might have impaired capacity, capacity to consent was assessed and recorded appropriately.
- Assessments were decision-specific and people were given assistance to make a decision.
- When patients were deemed to lack capacity, systems were in place to determine patient's best interests decisions in line with the requirements of the Mental Capacity Act.
- There had been no significant recent decisions requiring best interest considerations or meetings.

In one case, nursing staff had applied for a standard Deprivation of Liberty Safeguards application and were still awaiting a decision but had not applied for an urgent authorisation alongside this. This was rectified at the earliest opportunity.

Long stay/rehabilitation mental health wards for working age adults

Good

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

Lea Court was a single-storey building providing community based inpatient rehabilitation care and treatment. Since the last inspection, there had been extensive building work including an increase in beds by two, a new administration block and a new clinic. There was twenty en-suite bedrooms and six self-contained studio apartments.

The unit had recently changed from being for just male patients to now admitting male and female patients. All rooms were individual en-suite so patients had their own washing and toilet facilities. There were two separate areas for male and female bedrooms. Patients did not have to walk through an area occupied by another sex to reach a toilet or bathroom. There was a separate female lounge. Through rota management, managers ensured there was a mix of male and female staff on duty at all times.

Curtain tracks in bedrooms were ligature free. Curtain rails in communal areas were not collapsible but these were in areas where staff could observe patients. These were identified on the ligature risk assessment and were mitigated as they were in communal areas in tandem with initial assessment of patients, ongoing observations and staffing levels alongside a positive risk taking approach as a community rehabilitation unit.

Lea Court had four bedrooms modified for patients who were at higher risk of ligature with anti-ligature bathroom fittings and other adaptions such as no window blinds fitted. There was work ongoing to reduce or remove ligature risks further in these rooms such as removing door closure mechanisms. In the meantime, risks were mitigated by patient admissions, allocating bedrooms where work had been completed and staff carrying out observations, where necessary.

The provider had identified a particular ongoing ligature risk, which was identified on the risk register due to potential self-harm from some fixed window blinds fitted in the other patient bedrooms. These could be used as a ligature fixing due to a significant gap in the blind track system. These did collapse when weight was applied but managers were carrying out proper load bearing tests on the window blind track system to check fully what weight they could hold and what further remedial action was needed. This meant that whilst there were ligature points on the unit, the risks were adequately mitigated. The manager was aware of the need to keep the management of ligature risks under review based on the risks presented by the patient population at any given time.

The ward layout allowed staff to observe all communal areas of the ward. Managers regularly assessed the ward for ligature points. There were ligature cutters available in the clinic area and staff knew where they were kept so staff could respond if an incident occurred. There had been no incidents of patients tying a ligature. Patients told us that they felt the environment was safe.

Lea Court, as part of its model of care, did not have a seclusion facility. The patients at Lea Court at the time of the inspection did not present with significant, ongoing management problems. Staff looked at the potential need

for seclusion on an ongoing or intermittent basis during admission assessment. Staff would not admit patients if seclusion was likely as part of an individual management plan.

Since the last inspection, the clinic room had been improved to include a large room for medicines storage, a private area with a desk for administering and dispensing medication and a private area for patient examination. All rooms in the clinic suite were clean and tidy. The clinic room and refrigerators were checked daily by nursing staff to ensure that medicines were stored at the correct temperature and were safe to use.

The clinic room had a hand washing sink which was a domestic sink with a plug and overflow. This went against national infection control advice which stated that sinks in clinic rooms used for hand hygiene should be of suitable specification without a fitted plug or overflow. There was no current risk management plan in place associated with having a clinic room sink which did not meet the required national standard. As soon as we identified the shortfall, managers removed the plug and planned to take remedial action to cover the overflow.

Lea Court had appropriate emergency and resuscitation equipment, including a defibrillator which was checked regularly to ensure it was working correctly. Qualified staff were trained in using the equipment. Lea Court had a small stock of certain emergency medicines. All bedrooms had fire alarms and nurse call systems. On the last inspection we found that staff did not have personal alarms which we raised as a something the provider should improve. On this inspection, we found staff now had personal alarms.

The service was planning to go smoke free in September 2018.

Managers carried out regular checks on the environment including health, safety and fire arrangements and cleanliness of the communal areas. There were daily cleaning schedule records. The hospital had received ongoing fire safety assessments and had recently had a detailed additional fire safety assessment from the local fire service as part of the assurances required following the tragedy at Grenfell Tower.

The hospital carried out an annual survey of patients with the last results in January 2017 with six patients at Lea Court completing the survey. The results were positive overall. For example, the survey results showed that 83% of patients agreed that the ward environment was clean and comfortable and 83% patients agreed they felt secure on the ward.

Safe staffing

The staffing establishment levels across Lea Court were 10 whole time qualified nurses excluding the ward manager and 20 whole time nursing assistants. At the time of the inspection there was one nursing assistant vacancy.

On each day shift there were two qualified nursing staff and four nursing assistants working at Lea Court. On each night shift there was one qualified nursing staff and two nursing assistants working at Lea Court. These staffing levels were maintained.

Staffing levels were increased in line with patient's needs, whether this was due to additional activities, attendance at other hospitals or increased observational levels.

Alternative Futures Group had recently implemented a new electronic staff rota system. This allowed staffing to be utilised from other areas. This helped reduce the need for bank and agency staff. The system also ensured that staff deployed to work at Lea Court were up to date with mandatory training. The system would not allow people to be rostered on if essential training was out of date. The reporting function of the system also allowed information to be extracted about commissioned versus delivered hours, staffing, sickness and annual leave.

The service had additional cover from a registered manager "on call" system, that provided cover at all times over a 24 hour period, seven days a week. This enabled extra staff to be utilised if required. The clinical lead also met at a monthly forum to discuss additional needs and staffing. Managers could authorise extra staff from the organisation's casual register. The register had nurses and support workers who had completed training with Alternative Futures. This meant that casual staff were familiar with policies and procedures in place. Managers also held a preferred providers list of agencies which they could utilise.

Staff told us that there were rare occasions when they were short staffed, but there was usually enough staff on duty. This meant that patients had continuity of care as the usage of casual and agency staff was kept to a minimum and when they were used, it was usually staff who had

worked at the unit before. There had also been a recent review in the organisation around the salary of staff nurses, which led to an increase in pay to attract nurses to the organisation and avoid nurse staffing shortages.

Throughout the inspection, nursing staff were visible on the ward providing care and treatment to patients. Staff and patients told us leave or activities were never cancelled. Records showed that patients received regular one-to-one time with their named nurse.

Patients were registered with a visiting GP who provided initial baseline physical health assessments and ongoing medical input for physical health conditions. A consultant psychiatrist provided responsible clinician input to Lea Court via a service level agreement with the local NHS mental health trust. The psychiatrist attended weekly and ensured that patients were reviewed at least monthly. During out of hours and when the psychiatrist was on leave or away, psychiatric input came from the doctor on call in the nearby NHS mental health hospital. This arrangement was reported to work well with no recent concerns about delays in the on-call medical input, when required.

All support work staff had completed the care certificate. All staff at Lea Court had completed 'support essentials' training as part of their induction and ongoing refresher training. Some of the main topics included in this training course were: -

- Basic life support
- Equality and diversity
- Safeguarding
- Supporting people to make decisions
- Fire safety
- Health and safety
- Infection control
- Moving and handling

This course was repeated every two years. We found at the time of inspection all staff were up to date with their essential skills training. Staff also additionally to this completed therapeutic management of violence and aggression training. Out of the 30 staff employed at Lea Court, all relevant staff were trained and up to date with their therapeutic management of violence and aggression training. Records showed all qualified staff were up to date and trained in higher level life support and defibrillator training.

Assessing and managing risk to patients and staff

We looked at nine patient's care records. These all contained an up-to-date and detailed risk assessment. Patient risk assessments were completed using a recognised risk assessment tool on admission and reviewed regularly to monitor any changes in patients' risk.

Most patients were detained under the Mental Health Act but many had unescorted leave. The front door to Lea Court was locked but all the patients had ready access to the grounds and gardens with the back door open throughout the day. There were notices by the front door informing informal patients and patients with unlimited unescorted leave of their right to leave and that they just needed to ask staff to open the door.

Restraint was not regularly used on the long stay and rehabilitation wards. In the six months up to March 2018, there had been five recorded incidents of restraint on three different patients; none of these were prone (face down) restraints. Staff told us that most incidents on the wards involved verbal aggression. Staff were skilled at de-escalating patients when they became agitated or distressed and the prevention of management of violence and aggression training included a significant element relating to calming situations and de-escalating patients.

Risk management plan records showed that there were no patients with a current risk of violence and aggression at Lea Court. If patients could not be de-escalated, staff would look to transfer the patient to the nearby local mental health acute wards or psychiatric intensive care unit run by the local NHS mental health trust.

Patients were not subject to blanket restrictive practices. Each patient had a very detailed assessment plan in place to ensure that any restrictions were kept to a minimum, individualised, and regularly reviewed. These assessment plans included assessing restrictions related to restraint, medication, equipment, the environment and any other restrictions in place. The small amount of restrictions in place were justified relating to appropriate clinical or security reasons. For example, in one case the short term restrictions of mobile phone use due to harassment.

At the time of our inspection, four patients were on high doses of anti-psychotic medication (which was where antipsychotics were given above recommended levels either in a single or combined dose). Many patients came to Lea Court on high dose regimes and medical and nursing staff worked with patients over time to reduce the doses to

within or below recommended levels. The reasons for prescribing high dose anti-psychotics treatment were recorded to understand why the patient required medication at higher doses. In each case where high dose anti-psychotics were prescribed, these were covered by the appropriate legal certificates from a second opinion appointed doctor (T3 form). Patients were monitored for appropriate side effects whilst on high-dose antipsychotics including any adverse effects on their physical health.

We looked at medicine charts. The medicine charts were up-to-date and clearly presented to show the treatment people had received. Where treatment for mental disorder was given to detained patients, the relevant legal authority for treatment (T2 or T3 form) was in place. Staff had acted on medicines alerts as appropriate.

Lea Court received regular clinical support from a lead pharmacist employed by the company to review prescription charts and complete medicines related audits. Recent completed medicines management reports showed good overall adherence to safe medicines management practices with a few minor recording shortfalls with staff taking action on shortfalls and making improvements following the audit. For example, the audit identified the need to reorder a doom kit which was equipment used to destroy controlled drugs. We saw this had been actioned.

Medications were stored appropriately in a securely lockable room within a locked cupboard. Stock levels of medication were audited regularly. There were processes for the management of medication, which included prescribing, ordering, storage, administration and disposal. There was one controlled drug on site and we saw that the type and number of controlled drug was properly accounted for in a controlled drug register. Controlled drugs are medicines that require extra checks and special storage because of their potential for misuse. There was a controlled drugs accountable officer at the hospital who could ensure that proper systems were in place when controlled drugs were prescribed.

As a rehabilitation hospital. Lea Court had assessments and procedures for the staged process for patients self-administrating their own medication, with decreasing levels of supervision from nursing staff. This was risk assessed based on patients' level of insight and responsibility around taking medication. Some patients at Lea Court were at different stages of self- administration such as where they attended the clinic room to take their medication unprompted or where they stored medication in locked cabinets in their room.

Alternative Futures had its own safeguarding policy and procedure. The policy guided staff to follow the local safeguarding procedures. There were posters displayed for patients to inform them of safeguarding, their right not to be subject to abuse and how to raise a safeguarding alert. Staff could describe the safeguarding reporting process in the hospital. Staff described that they reported any incidents to the clinical lead nurse or registered manager.

Managers of the hospital had notified us appropriately of any safeguarding allegations. We received six safeguarding notifications relating to allegations which had been made between April 2017 and March 2018. For example, staff had raised an alert relating to suspected financial abuse of a patient by someone outside the hospital. Where staff were implicated in any allegation, we saw managers took prompt action to protect patients. There were no ongoing safeguarding investigations at the time of the inspection. Managers and staff reported active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.

Care records were held mostly on paper records which were kept in a locked staff office. Staff were aware of their responsibilities to keep patient information confidential.

Track record on safety

We looked at the incidents that had occurred recently at Lea Court. All independent hospitals were required to submit notifications of incidents to the CQC. The hospital had notified us of appropriate relevant events including safeguarding incidents and incidents which involved the police where, for example, detained patients had failed to return from authorised leave. Managers had taken appropriate action to ensure these incidents were looked at fully.

In the period April 2017 to March 2018, there was one serious incident recorded which required investigation within the service. This related to one patient secreting medication over a prolonged period. The provider investigation identified staff failings during administration and audit. To ensure that there was no repeat of this

Long stay/rehabilitation mental health wards for working age adults

Good

incident, managers took a number of actions including staff training, assessments of staff competence and improvements in the robustness of audits and the audit schedule.

Reporting incidents and learning from when things go wrong

All incidents were recorded on the electronic incident recording system. Managers reviewed them regularly and at least weekly and in the case of serious incidents also reviewed by the nominated individual as well as the registered manager and clinical nurse specialist. At hospital level, incidents were overseen by the compliance assurance meeting which occurred monthly. Depending on the severity of the incident, incidents could also be reviewed at the incident management review meeting which as a sub group of the quality and safety governance committee reviewed all significant incidents and team incident reviews.

Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Staff were aware of the process for reporting incidents using the electronic reporting system. Any lessons learnt were discussed at staff meetings.

We saw that improvements had been made following a past serious incident. This included action to ensure that managers held individual discussions in supervision with staff, assessments of staff competence and improvements in the robustness of audits. The provider had put measures in place to reduce medication errors by refusing certain agency staff who had made significant or consistent errors. The provider also had systems in place for the management of medication errors by their staff including reflective accounts, competency assessment and suspension from managing medicines, depending on the seriousness of the error.

Duty of Candour

There had been no notifiable events which met the threshold of moderate or severe harm under duty of candour at Lea Court.

Managers reported a culture of openness in the organisation and people were encouraged to raise concerns if needed. Staff had been given a duty of candour leaflet to explain what the regulation meant to them. Mandatory safeguarding training also covered duty of candour requirements to ensure that staff had a working understanding of their responsibilities.

The provider had a policy and systems in place around duty of candour. The provider's standards of business conduct policy gave staff guidance around what action to take following a notifiable event including being open and honest and what duty of candour arrangements were in place.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We looked at nine care records. Staff used a recovery model to support patients' recovery from mental ill health. Staff and patients worked together on care and support plans through using a recognised recovery based assessment tool (the mental health recovery star). The mental health recovery star helped patients to set goals which were meaningful to them and map their own progress against these goals. This was developed into a collaborative action plan that enabled recovery and social inclusion. The care plan clearly identified service user goals and was reviewed regularly.

Care plans provided clear information for patients and staff (including new staff) to fully understand what patient's strengths and needs were and how their needs were being met. The action plans that staff produced from the recovery star assessment were detailed and helped to meaningfully maximise recovery from mental health problems, independence, functional ability, achievement of self-care and patient goals.

Patients received medical and clinical interventions to minimise symptoms of their mental ill health through both medication and psychosocial interventions. Staff also provided practical assistance to patients to aid their recovery. For example, access to appropriate welfare benefits support, help with budgeting, assistance with

activities of daily living, such as shopping, cooking and cleaning. Patients were supported to access social, leisure, educational and vocational activities to help aid their recovery.

Staff ensured that patients received appropriate physical and dental health care including attending primary and secondary medical care appointments. All patients had regular physical health checks. Patients were encouraged to attend their GP for annual physical health checks. Patients had a comprehensive health improvement plan which was a comprehensive physical health tool which included physical health screening and promotion such as supporting male patients to check for testicular cancers. Staff supported patients who were admitted who were clinically obese to lose weight and eat more healthily, supported by dieticians where appropriate.

Lea Court was within walking distance of a large local leisure centre and a large local college so many patients accessed leisure, education and vocational courses to help aid their recovery. Staff also supported patients with a variety of social, cultural and leisure activities.

Best practice in treatment and care

Staff spoke confidently about providing care and treatment underpinned by effective rehabilitation approaches to patients. These approaches included collaborative recovery care planning, optimising medication, psychosocial interventions and developing skills for more independent living. This was in line with the characteristics of an effective rehabilitation service as detailed in recent best practice guidance for commissioners of rehabilitation services for people with complex mental health needs. This report was produced by the Joint Commissioning Panel for Mental Health and the Royal College of Psychiatrists. The focus of this guidance is around the individual gaining support in recovery with patient involvement and social inclusion in order to successfully transfer back into the wider community. Patient's recovery progress was regularly monitored and updated, through looking at the recovery star scores to show patients' working towards their goals.

Staff at Lea Court followed the National Institute for Health and Care Excellence guidelines in the care and treatment of schizophrenia and psychosis and when prescribing anti-psychotic medication. Patients were routinely supported to use a recognised formal side-effect rating tools for reporting and monitoring side effects in order that the efficacy of medication was monitored and side effects could be managed effectively. Patients could discuss their medication with either their consultant psychiatrist or the visiting pharmacist. Nurses and the consultant psychiatrist had easy access to the company visiting pharmacist who visited weekly for specialist advice on prescribing and administering medication.

National Institute for Health and Care Excellence guidance recommended cognitive behavioural therapy for people with a long-term diagnosis of a psychotic illness. While the hospital did not have a designated clinical psychologist on site, there were different pathways for patients to access clinical psychology. The provider had a complex case panel where they could receive or continue with ongoing treatment with a clinical psychologist where identified; some patients were assessed or continued with treatment through the local NHS trust's community or specialist services such as the trust's forensic or personality disorder hub team. At the time of the inspection, eight patients at Lea Court had received clinical psychology assessment, formulation or input with five patients completing clinical psychology work prior to admission, two receiving ongoing formulation or treatment and one patient offered but refusing clinical psychology top up.

Staff told us that they would refer patients to the appropriate psychology on an individual assessed basis. We saw in one case, staff had recognised that a patient may benefit from formal psychology input and the patient was referred and seen by a psychologist from the local forensic service. The psychologist advised on continuing psychosocial interventions.

In addition, there were five staff trained to deliver psychosocial interventions using cognitive behavioural approaches to degree or Masters level and were using it with patients on the ward. Some staff were undergoing training so that patients could also access eye movement desensitization and reprocessing treatment which was a recognised psychotherapeutic approach in the treatment of post-traumatic stress disorder. Staff were also undergoing clinical skills training to work with patients with personality disorder using dialectical behavior approaches. Patients therefore had access to nurse led psychosocial approaches, clinical psychology from the provider's complex case panel or through arrangements with the local NHS community or specialist services. Patients could also

access art therapists from centralised services at the provider's head office. This meant that patients had access to talking therapies and other treatments to aid their recovery in line with best practice.

Clinical staff at Lea Court carried out a number of routine audits including weekly and monthly medication audits, Mental Health Act, records checks, patient involvement, risk management and infection control. Staff were able tell us about how changes had been made following the results of audits. For example, routine medication audits identified common errors and staff were informed that they should be vigilant in those areas. Where errors arose, the audits identified many related to agency staff.

Lea Court was accredited to take student nurses on placement. This gave students an insight into the work that was carried out at the hospital and also allowed existing staff to embrace new innovative ways of working.

Skilled staff to deliver care

We spoke with a number of staff including the registered manager, clinical nurse specialist, registered and unregistered nursing staff and other professionals including the consultant psychiatrist and occupational therapist. Staff were positive about working at Lea Court and were highly motivated to provide quality recovery based care and treatment. Staff were able to show they had expertise to support patient's recovery and address patients' complex and individualised needs including mental health and physical health promotion, supervising patient medication regimes (including assessing and overseeing patient self-management), psychosocial approaches, self-care, everyday living skills and support with meaningful activities and occupation.

Staff confirmed that they had received additional training and this was confirmed by training records seen. This included training on recovery, psychosocial interventions, suicide and self-harm, personality disorder awareness, support planning and positive behaviour support. We found that staff had access to regular formal supervision at least three times a year and had received annual appraisals with all staff having had an appraisal in the last year. In addition, staff had regular team meetings which included reflective practice. The service was relatively small with a good retention of staff and approachable clinical leaders, there were informal supervision occurring on a regular basis.

The provider had supported staff to enrol on the degree and masters level training on psychosocial mental health care and psychosocial interventions for psychosis to help staff deliver person-centred interventions.

Where staff had identified competency or capability issues, managers took action to ensure staff were supported and/or their performance was addressed.

Multidisciplinary and inter-agency team work

Patients at Lea Court were supported in their rehabilitation and recovery from a multidisciplinary team which included a consultant psychiatrist, registered nursing and unregistered nursing staff and an occupational therapist. Nursing staff had a strong psychosocial ethos and could offer care and treatment informed by cognitive behavioural, solution focused therapy and other approaches. Clinical psychological therapies were available through patient's community mental health team, through the provider's complex care or psychology link team or through more specialist services such as the local community personality disorder hub. At the time of the inspection, staff were receiving clinical skills training provided by staff from this hub to help provide a consistent approach to patients with personality disorder.

The consultant psychiatrist was designated just to work at Lea Court. They provided eight sessions to Lea Court which included attending for four clinical sessions at Lea Court with the rest of the time spent on administrative and professional development time (which equated to working four days a week). Patients at Lea Court were registered with their local GP for medical prescribing, physical health assessment and ongoing checks. Staff could access other professionals for patients via referral through the GP, for example tissue viability nurse, dietician or speech and language therapy. There was full time domestic support and staff working in food preparation via a centralised contract between Alternative Futures and a private company.

Multidisciplinary team meetings occurred every week with each patient discussed monthly.

All patients received support from a care coordinator from the local mental health trust's community mental health teams. The records showed they were routinely invited and attended multidisciplinary and care programme approach meetings. The manager met with the responsible clinician

on a regular weekly basis to ensure that their ongoing clinical tasks were undertaken. The manager also met with representatives of the local mental health NHS trust to review the service level agreement providing medical input.

Managers met regularly with local commissioners funding patients' care as part of the block purchasing agreement. Staff from the clinical commissioning groups told us that they were satisfied overall with the quality of the services patients received. They also confirmed that staff at Lea Court provided effective services and that they were increasingly working with patients with more complex clinical and rehabilitation needs. One local commissioner had been working with Lea Court and NHS mental health trust staff on pathways for deteriorating patients.

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

We carried out a Mental Health Act monitoring visit to Lea Court on the 15 December 2016. This showed overall good adherence to the requirements of the Mental Health Act with a small number of shortfalls including access to independent mental health advocacy service, the outcome of leave not always recorded and individual patient issues. Managers at Lea Court sent a provider action statement stating how they would improve. On this inspection, we saw that patients had improved access to information about independent mental health advocacy services.

Managers ensured that copies of patients' detention papers and associated records (such as section 17 leave forms) were available for all staff and stored systematically. Section 17 leave was well recorded and included the outcome of leave.

Staff ensured that legal authorisations around consent to treatment (T2 and T3 forms) were routinely attached to medicines charts to aid nurses to check them prior to administering medication for mental disorder. When consent was discussed with patients, the responsible clinician completed an assessment of capacity and consent for treatment for mental disorder. The hospital had one lead responsible clinician which helped with adherence to the Mental Health Act and Code of Practice requirements around consent.

Patients had access to an independent mental health advocacy service as a representative from the local advocacy visited regularly. Information was displayed to tell informal patients that they could leave the ward freely.

Staff from the local mental health NHS trust provided ongoing Mental Health Act administrative support.

Detained patients were informed of their rights under section 132 on admission and frequently through their detention. However, we found two patients' files where staff had not revisited patients' rights at particular intervals such as when a patient's detention was renewed. In these cases, it was clearly recorded that patients' had received their rights verbally a short time before the renewal but not at the specific time that their detention was renewed.

Staff undertook monthly audits of adherence to the Mental Health Act. The themes covered within the audits included section 17 leave; consent to treatment; second opinion; information provided to detained and informal patients. The main findings within recent audits were around shortfalls regarding outcomes of section 17 leave. However; through staff efforts on this issue, recording had improved.

All staff had received training in the Mental Health Act which was provided through the arrangements with the local mental health NHS trust. Staff we spoke to had a good understanding of the Mental Health Act. The provider had relevant policies and procedures that had been developed in line with the most recent guidance and staff knew how to access them. Staff had easy access to the Mental Health Act Code of Practice.

Good practice in applying the Mental Capacity Act

At the time of the inspection, 17 out of the 23 current patients were detained under the Mental Health Act. One patient was awaiting a standard authorisation Deprivation of Liberty Safeguards assessment. Five patients had accepted informal admission to hospital and had capacity to agree to informal admission.

All staff had training in the Mental Capacity Act. Staff had a good understanding of the Mental Capacity Act, and how to apply this.

There was a policy on Mental Capacity Act, including the Deprivation of Liberty Safeguards which staff were aware of and could refer to. For people who might have impaired capacity, capacity to consent was assessed and recorded appropriately. Assessments were decision-specific and people were given assistance to make a decision.

When patients were deemed to lack capacity, systems were in place to determine patient's best interests and ensure they were made recognising the importance of the person's

Long stay/rehabilitation mental health wards for working age adults

Good

wishes, feelings, culture and history. There had been no significant recent decisions requiring best interest considerations or meetings. However, the consultant psychiatrist was considering arranging a best interest meeting for the management and treatment for diabetes for an incapacitated patient.

Staff knew where to get advice about the Mental Capacity Act, including the Deprivation of Liberty Safeguards, including internally and through a named lead within the clinical commissioning group.

On the first day of the inspection, we were told there was one patient who was subject to a Deprivation of Liberty Safeguards application. Nursing staff had applied for a standard Deprivation of Liberty Safeguards application and were still awaiting a decision but had not applied for an urgent authorisation alongside this. This meant that the patient was deprived of their liberty without procedural safeguard because staff did not complete the form correctly. We received immediate assurances that staff would rectify this. On the second day of the inspection, we saw that the urgent authorisation was completed and the form resubmitted so that the procedural safeguards were met.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

We spoke with ten patients who used the service and one relative. Most patients were positive about the standards of care they received from staff. Patients told us that staff were always available to talk to. Patients reported that staff were very nice, kind, helpful and friendly. Many patients compared their care and treatment at Lea Court to care they had in other establishments and stated that they much preferred Lea Court. The reason they gave was varied but included the quality of the environment, the relative calmness of the unit compared to previous placements and the quality of the interactions with staff who were committed to provide patient centred care.

A small number of patients who were less positive about their care were recent admissions to Lea Court and their comments centred on not wishing to be compulsorily detained.

We spoke with one relative who was happy with the quality of care and treatment their relative had received at Lea Court. Patients told us that there was a good variety of activities available to them which met their needs. Patients found the morning meeting helpful to ensure that activities were arranged which interested the majority of the patients. Activities liked by patients included arts, music sessions, board games, the media group, trips out and cooking. Patients also received ongoing support and encouragement to help them reach their rehabilitation goals, for example, staged support to self-manage medication and support to cook independently.

We observed very positive and warm interactions between patients and staff. It was clear staff knew patients' needs well and could identify quickly if patients' mental health was relapsing. Staff used humour appropriately to engage patients and to help develop rapport between patients and staff.

Healthwatch told us that they did not have any public feedback data about Lea Court. Healthwatch was the independent consumer champion created to gather and represent the views of the public inhealth and social care. Representatives from Healthwatch attended a service open day held at Lea Court in April 2017. The informal feedback that they received from staff and service users was generally positive. For example, patients continued to visit Lea Court as volunteers due to their positive experiences.

The involvement of people in the care they receive

Where patients were well enough to engage in their treatment, patients told us they felt involved in their own care and were encouraged to identify their own recovery goals through staff working with them on the recovery star. The recovery star clearly evidenced patient involvement and patients identifying their own needs and goals. The recovery star work then was incorporated into a recovery action plan which was individualised and written in the first person.

Patients were not routinely directly involved in the recruitment of staff working in the hospital, but had contributed to the interview questions candidates were asked.

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Good

Staff completed an "all about me" document that contained details of patients' family, life history, and things that they did and did not like. This was useful for any new staff coming as a quick reference guide to get to know a little about each patient. Patients had been involved in completing these with staff.

Patients told us that they were offered their care plans and could choose to have a copy if they wished. We saw in care files that patients were offered their recovery star care plan relating to their mental health and their physical health care plans. Patients had signed to say they understood and agreed with the content of their care plans.

Patients were involved in the running of Lea Court. Patients had daily morning meetings where they could suggest activities for that day and monthly regular community meetings where they could comment on the running of the hospital including activities, any maintenance repairs required as identified by patients, patient concerns, and any changes in the running of the hospital.

The minutes showed that staff had mostly addressed matters brought up at the community meetings. Staff had acted upon suggestions from community meetings which included different activities, day trips and meal choices provided. However, on some issues raised by patients at community meetings, the minutes did not always clearly record what action was needed or what action had been taken at the next meeting to show that issues had been fully addressed. We spoke with the registered manager who provided other evidence to show that the specific concerns raised had been addressed. The registered manager accepted that the minutes of the community meeting could clearly identify how matters were resolved.

The registered manager had a regular presence in the unit which allowed patients, families and carers to approach as and when they needed assistance or need to give feedback.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

Lea Court had specific admission criteria which included that any patient coming to Lea Court should have a primary diagnosis of mental illness, be aged over 18, have commitment and motivation to engage in treatment and the potential to move to less dependent accommodation within a two year period.

Lea Court had 26 beds and, at the time of the inspection, there were 23 patients. This gave a bed occupancy rate of 88% at the time of the inspection. Over the six months prior to the inspection, Lea Court had a mean bed occupancy of 85%. This was just at the optimal maximum bed occupancy level of 85% to support quality and safety of adult in-patient care as suggested by the Royal College of Psychiatrists. Most of the beds at Lea Court were block purchased and paid for by two local clinical commissioning groups for patients who were resident in their area. Only one patient was not from either of these localities but was originally from a nearby local authority area. This meant that all the patients were being cared for close to home.

Most of the referral requests came from treating teams of patients from local NHS acute mental health wards and nearby low and medium secure care services, including transferring patients who were already detained under the Mental Health Act. Staff worked with other providers' staff to coordinate the transfer of patients including communicating with the Ministry of Justice to receive approval for transferring restricted patients.

Staff carried out timely assessments of patients to consider the appropriateness of admission for rehabilitation to Lea Court. Lea Court was set, by commissioners, and were meeting a two week time limit to see patients who were assessed. Once patients were accepted for admission, there were occasional delays which were beyond the control of staff from the hospital. For example, one recent delay was regarding a patient who was on a restriction order where there were delays in getting permission from the Ministry of Justice for a transfer from another hospital. During the waiting period, the patient visited the hospital regularly on section 17 leave to aid the transition.

If patients deteriorated while at Lea Court and could not be de-escalated, staff would look to transfer the patient to the nearby local mental health acute wards or psychiatric intensive care unit run by the local NHS mental health trust. Following a recent incident involving a significantly deteriorating patient, staff at Lea Court had met with representatives from the local NHS mental health trust and from the clinical commissioning group, to discuss pathways into acute mental health care. At the time of the inspection, these pathways had not yet been clarified fully.

The average length of stay of patients at Lea Court in the 12 months up until March 2018 was 536 days which amounted to approximately one year and a half years. This was within lengths of stay we would expect for patients with rehabilitation needs within a community rehabilitation unit as many of the patients at Lea Court had significant habilitation (learning new skills for daily living) or rehabilitation needs, co-morbid physical health needs and some had stepped down from forensic settings.

Records showed that Lea Court had discharged eleven patients in the twelve months prior to the inspection. There were three patients likely to be discharged in the next three months (up to September 2018) with well advanced plans for support, wellness recovery and aftercare for these patients.

There were six episodes of patients being considered delayed discharges from Lea Court at the time for the ten months up to 31 October 2017. The principal reasons for delays included shortage of suitable accommodation to move on to, difficulties in allocating community mental health team input, and a lack of local specialist services for people who require more complex packages of care. All of these were beyond the full control of the hospital but the hospital had taken action with local providers and commissioners to try and remove these delays. The provider employed an integrated pathway lead who worked at Lea Court and two other hospitals to assist patients to be discharged without undue delay. Managers met regularly with commissioners to discuss delayed transfers of care and looked at what could be done to reduce these delays.

Where possible and based on patients' need, the provider continued to support individuals in the community through its registered community support service. One patient was due to be discharged and they were able to choose a named healthcare assistant from the hospital to continue to work with them as a community support worker to help ensure they had a successful transition and was supported by staff who knew them well.

Staff recorded regular, ongoing contact and communication with community mental health team professionals, including invitations to attend regular six monthly care programme approach meetings. Patients' discharge progress was routinely considered at care programme approach meetings.

Each patient's recovery star care plan had information on goals towards discharge. Where patients were closer towards discharge, these plans were more detailed. For example, we saw one patient was due to be discharged to their own accommodation with community support work input. There were detailed discharge goals for this patient.

If a patient relapsed and required more intensive treatment, they would usually be admitted to one of the acute wards psychiatric intensive care unit at the local NHS mental trust. Following a recent incident, the hospital met with representatives from the local NHS mental health trust and the clinical commissioning group to look at pathways to admission for patients who relapsed significantly who required acute or intensive care.

The facilities promote recovery, comfort, dignity and confidentiality

Lea Court was a single-storey building. Lea Court was located just outside Warrington town centre, close to local shops, a large leisure centre and local further education college. It provided twenty en-suite bedrooms, six self-contained studio apartments, a kitchen, two laundry rooms and a games room. In addition, there were three communal lounges and a multi-purpose room, a large dining area, two rehabilitation kitchens and a large activities area. There was a computer room where patients could access computers and the internet. Lea Court also had Wi-Fi available for patients to use so they could connect devices to the internet.

Lea Court had pleasant gardens with a summerhouse, flowerbeds and polytunnel containing home grown fruit and vegetables. Patients had direct and unlimited access to a garden area. The gardens were well maintained and provided seating as well as a smoking shelter for patients to use. The garden had exercise equipment suitable for outdoor activities. Lea Court also had a large bike shed

with both hospital-supplied and patients' bikes to help promote patients to cycle in the local area. There were, therefore, a number of indoor and outdoor areas that could be used for activities, visiting and quiet time for patients.

There was a payphone in a private booth for patients to make private phone calls. Patients could also have mobile phones. The only exception was where this had been risk assessed for individual patients on clinical or security grounds. Patients had personalised their bedroom areas.

Patients had access to a kitchen to make hot drinks and in addition they could get hot drinks through a vending machine. Patients were provided with a fob which gave four free drinks per day that they could use in the drinks machine without paying. Once used, patients could pay 20 pence for further hot drinks from the vending machine. Patients in the self- contained studio apartments had a kitchenette where they could make meals and hot drinks. Staff ensured that there was fresh fruit, water and juice available throughout the day.

Patients were given their own key for their bedroom. Patients had a lockable drawer and a variety of other storage in their room area. The hospital also had a secure safe and patients were encouraged to store sums of money or items of value in the hospital safe.

Activities were available with a detailed activities programme which was led by the occupational therapist. The activities available varied and were discussed at morning meetings to ensure patients maintained interest in the activities available; they included unit-based activities such as cooking, art groups, crafts, relaxation, bingo and games; and outdoor activities identified on an individual basis such as college, walking groups, cinema, swimming and shopping trips. Activities occurred during the day supported by the occupational therapist; during evenings and at weekends, this was led by nursing staff and nursing assistants. The hospital had an event to mark the recent royal wedding and was planning events for patients around the forthcoming World Cup.

Most patients had unescorted leave. The occupational therapist worked with the patients to look at their individual interests to draw up individual activity planners and develop recovery goals in line with their individual recovery star. The occupational therapist also carried out a road awareness assessment to identify support needs for patients accessing the community. One patient had been supported to complete their Masters degree and was now going on to do a PhD.

Meeting the needs of all people who use the service

Lea Court was a single storey building with wide access at the front to enable people who use a wheel chair easy access. There was a bathroom with a hoist for those patients with limited mobility. Staff told us that if additional aids or support were required, these would be sourced on an individual basis. For example, as some patients were morbidly obese, the hospital had bariatric weighing scales.

There were information leaflets available on the unit on a number of topics, including recovery, patient rights, safeguarding, and complaints. There were no patients at the time of inspection whose first language was not English. Leaflets in other languages could be arranged and staff could access an interpreter on an individual patient's needs basis.

Since the last inspection, the provider had changed from cooking food on-site to a centralised catering service. While this helped to ensure consistent quality of food, healthy options and controlled portion size, we heard that this change had resulted in slightly less flexibility around patients' choice. However we did not receive any significant concerns from patients about the current quality of the food. There was always both a meat and vegetarian option available. Patients made daily choices regarding their food choice. In addition to the pre-prepared meals, kitchen staff were able to offer sandwiches, salads and cheese on toast on request.

Staff also told us how patients' cultural and religious requirements could be supported. Patients with religious needs were encouraged to attend community religious facilities as part of their integration back into the community in line with recovery principles.

Listening to and learning from concerns and complaints

The provider had a comments and complaints policy within the organisation. The policy expected staff to ensure that all complaints were acknowledged within three working days and a full investigation was carried out within 28 days. All comments and complaints were logged on to an electronic management system. An annual report was

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Good

produced analysing information from the database. A complaints leaflet had been developed for patients, families and carers which allowed complainants to send their complaint using free postage to alert the provider's central complaints co-ordinator.

There were no formal complaints made about this service in the previous fifteen months up to end of May 2018. At the last inspection we found that the provider needed to improve how informal complaints were logged to ensure that these were captured and handled appropriately. This was because we found that there were a small number of informal complaints (such as complaints about portion size of the food) but these were not recorded. We told the provider that it should consider how informal complaints were logged to ensure that these were captured and handled appropriately. On this inspection, we found managers had a system in place where they were now able to record informal concerns and complaints on the electronic database system.

A comments book was located in the reception area of the unit, where people were encouraged to leave feedback.

We observed a morning meeting. Staff were open and encouraged patients to speak about any general concerns they had at the community meeting. This meant that staff could often deal with a problem quickly and reduce the need to formally complain.

Information about how to make a complaint was clearly displayed on the noticeboards at Lea Court for patients to read. As well as the morning meeting which occurred each day, patients had monthly community meetings where they could raise issues and concerns informally. Patients told us that they felt well supported by staff and would speak to the registered manager if they needed to raise issues. Patients felt confident that staff would take their complaint seriously and agreed when asked if staff would look to address and resolve issues.

Staff were aware of their responsibilities to offer an apology where appropriate.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

Vision and values

Alternative Futures had the following vision and mission:

'A world where people control their lives. Together with our people and partners we will unlock skills, gifts and talents to support everyone's right to choose and achieve their aspirations.'

They had the following values:

- We are one.

We succeed together with a shared purpose and vision. We inspire others, take pride in what we do and trust each other. We all have a part to play.

- Every person matters.

We are people focused and value skills, gifts and potential. We listen. How people think and feel matters; everyone has a voice.

- We make a positive difference.

We change lives. Our 'can do' attitude and passion enables people to be the best they can be.

- We raise the bar.

We learn from the past, are adaptive and excited by our future. We innovate and lead the way. We strive for best quality with least waste. Better never stops.

- We take ownership.

We do the right thing, are solution focused and get results. We are responsible for our behaviour and hold each other to account.

Alternative Futures Group had recently launched their new values. Managers collaborated with a consultancy firm who helped facilitate a number of listening sessions for staff. From these sessions, the new values were developed. The provider also had an over-arching recovery strategy that set out what its' services needed to do to promote patients' meaningful recovery from mental ill health.

The team had local objectives which included reducing the length of stay of patients and to improve clinical to community pathways and reduce staff sickness levels.

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Staff we spoke with at all levels were committed and passionate about providing high quality, recovery based care in line with the vision, strategy and team objectives.

Good governance

Alternative Futures had a range of quality assurance and governance meetings set up across their organisation. Alternative Futures had recently introduced a new governance structure, with the aim to develop and improve systems and outcomes across the organisation. A new quality and improvement committee had been established to enhance policy and systems and further improve communication from ward to board and back by enabling assurance to be evidenced and success congratulated.

Senior managers had introduced annual safety walk arounds where members of the executive team and the board visited to introduce themselves to staff and patients, get feedback and benchmark services relating to the five key questions we ask on inspection. Lea Court had a safety walk around in April 2018. The registered manager was still awaiting formal feedback but had been informed verbally that it was a positive visit with no significant shortfalls.

The provider had an audit calendar which showed which audits needed to be completed. There was identified oversight of the audits and results through quarterly local quality assurance meetings systems to flag up any delays in completing the audits as identified on the audit cycle. Staff completed clinical audits and knew how to report incidents. Local governance processes at Lea Court were largely good with evidence of audits and action to address any shortfalls identified. Managers held quarterly quality assurance meetings to receive feedback from audits, learning from any incidents/concerns and to implement improvements and disseminated information as required.

Staff attended mandatory training and were supported by their managers to do so. The new e-rostering system ensured that only trained staff could work at Lea Court. Most staff at Lea Court had received supervision on a quarterly basis (72%) and the provider had an action plan to improve this further. All relevant staff had received an appraisal within the last 12 months. The new e-rostering system ensured that appropriately qualified staff covered shifts and additional staff were brought in to cover patient observations where needed.

The provider had a medicine management and physical health forum. Lea Court's registered manager was joint chair and responsible for the physical health sub forums for the review of policy and documentation and to advise on matters arising within the organisation.

At Lea Court, comprehensive medicines management audits were completed monthly by the medication management lead. The most common theme at Lea Court identified in the medicines audit was missing signatures from administered medications. However, stock checks often confirmed that medication had been administered. The majority of these errors had been identified as arising mainly from agency staff. The provider had put measures in place to reduce these errors.

The provider has systems in place to survey patients and carers. The last patient survey was completed in January 2017 with analysis and a report produced by a local university. The results were positive overall but only six patients at Lea Court completed it. Where there were slightly mixed results for Lea Court, it appeared to be comments from one patient expressing discontent about their stay across a number of questions. There was no action identified for Lea Court due to the positive results overall and patients were unable to identify how Lea Court could improve. The local university had made recommendations about how the survey may be completed differently next time. There had not yet been a patient survey in 2018. The carers' survey was completed in October 2017, all relatives and friends of patients were given the opportunity to take part. The results were very positive across most questions. For example, 90% of carers felt that staff caring for their relative were kind and caring. The one less positive result was a question relating to whether their relative was involved in choosing their own staff with 52% disagreeing. The provider was working on an action plan and managers at Lea Court were still waiting on this.

Leadership, morale and staff engagement

Staff told us they felt well supported personally and professionally from the clinical lead nurses and registered manager. Staff received regular training and appraisal, and attended team meetings to ensure they were confident and competent in working with recovery based approaches with patients. We saw that changes had occurred following staff meetings.

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Good

Alternative Futures, as a provider, surveyed staff on an annual basis. The most recent staff survey identified that across the independent hospitals that Alternative Futures run across Cheshire and Wirral that most staff were positive in their work with scores of 77% for staff feeling proud to work for Alternative Futures, 75% for staff understanding the strategic goals and 81% of staff feeling motivated in their work. The highest scoring positive questions in the staff survey for the independent hospitals that Alternative Futures run across Cheshire and Wirral were:

- As a service we are always looking at ways to improve.
- I know what is expected of me at work.
- I feel comfortable in approaching managers.

The lowest scoring questions were:

- I think I am paid fairly in comparison with people who work in similar organisations.
- I know who is who in the company.
- I know what the employee partnership forum discuss with management.

In response to the less positive scores managers had carried out a recent review around the salary of staff nurses which led to an increase in pay to attract nurses to the organisation, produced an employee partnership forum e-Newsletter, and developed management biographies and photos uploaded to the intranet.

Staff were committed to working as an effective multidisciplinary team to ensure that patients received good recovery outcomes, patient centred care and effective and safe discharge. There were high levels of staff satisfaction. Staff told us they liked working at Lea Court and were proud to work for Alternative Futures. Staff spoke highly of the positive recovery focused culture. Staff were actively encouraged to raise concerns and changes had been made to address any concerns. Staff also had the opportunity to feed their ideas to the wider organisation through the employee partnership forum which ensured staff could contribute towards key decisions.

Morale was reported to be very good with a real commitment to teamwork to ensure patients were at the centre of decisions and discussions about both day-to-day running and more strategic decisions.

Sickness and absence rates across the hospital were 11%. At the time of the inspection, there was one member of staff on longer term sickness, with two other staff returned from long term sick – none of these were work related sickness.

The registered manager was an experienced clinical nurse leader who had very good managerial and clinical oversight of the hospital while also being approachable to patients. Staff were very complementary about the registered manager in terms of their approachability, recovery focus, clinical leadership skills, commitment to staff development and management approach.

The registered manager had an excellent understanding of the legal frameworks in which Lea Court operated including understanding the regulations we inspect against, the mental health and mental capacity legislation. Both representatives from the clinical commissioning group were complimentary about the skills of the registered manager. The registered manager was supported by two experienced and committed clinical lead nurses.

The provider had developed a whistleblowing leaflet which explained how staff could raise concerns and how to escalate concerns if they were still concerned, or were unhappy with the response. The leaflet also included details of who to contact externally including the CQC. Staff we spoke to were aware of how to whistle blow if they had concerns.

Commitment to quality improvement and innovation

Local commissioners who block booked the beds carried out regular quality assurance visits – there were no significant quality issues reported arising from these. One commissioner reported that they worked well with the service and felt they had a good working relationship with the senior managers and staff. Managers at Lea Court were ensuring that staff were meeting key national targets (the national commissioning for quality and innovation targets) around physical health, smoking and the safety thermometer. Lea Court were working towards being a smoke free environment by September 2018 and staff were being supported in smoking cessation work with patients.

Alternative Futures had recently commissioned an experienced healthcare consultancy organisation to

Long stay/rehabilitation mental health wards for working age adults

Good

improve recovery based outward-facing services as part of an integrated and integral part of local community mental health services and identify future opportunities and challenges.

There were no immediate plans for the hospital to be accredited with the Royal College of Psychiatry quality network. However, the manager was interested in progressing this in the next 12 months. The consultant psychiatrist sat on the Royal College of Psychiatry rehabilitation special interest group and had published articles in relation to care and treatment approaches to patients with schizophrenia.

Outstanding practice and areas for improvement

Outstanding practice

Where practicable, patients due to be discharged were able to choose a named healthcare assistant from Lea Court to continue to work with them as a community support worker. This meant that patients continued to be supported during the transition into the community by staff who knew them well.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should develop a detailed and specific plan to provide designated regular clinical psychology input to patients at Lea Court.
- Managers at Lea Court should continue to work with the local NHS mental health trust and local commissioners to fully clarify the pathways into acute mental health inpatient and psychiatric intensive care for deteriorating patients.
- The provider should ensure that staff provide detained patients with their rights at particular intervals such as when a patient's detention was renewed.
- The provider should make sure that nursing staff are reminded to fully complete Deprivation of Liberty Safeguards applications for urgent authorisation alongside standard authorisation so that patients were deprived of their liberty with the full procedural safeguards.
- The provider should make sure that written minutes of community meetings clearly record what action was needed or what action had been taken to show clearly that patients' concerns had been fully addressed.
- The provide should continue with efforts to improve the uptake of staff supervision.