Tesito House

Quality Report

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Date of inspection visit: 13 December 2018
Date of publication: 27/02/2019

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

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 Tesito House as Inadequate because:

- In 2018, we placed the service into special measures because the provider did not ensure patient care was being delivered to the highest standard possible, patient assessments were not complete, shortcomings were not promptly identified and rectified. At this re-inspection we found a number of areas of concern raised in our previous inspection had not improved.
- Safety was not a sufficient priority. Measurement and monitoring of safety performance with regards to the use of restrictive practices and the safe proper management of patient medication was poor.
- Systems, processes and standard operating procedures were not robust and regularly reviewed to keep patients safe.
- Staff did not have access to training and development to enable them to meet the needs of patients. The learning needs of staff were not understood. Staff were not supported to participate in training and development or the opportunities that were offered did not meet their learning needs.
- Patients were not supported to understand information they were given about their care and condition. Staff did not consistently provide clear information to patients or give them time to respond.
- Discharge and transition planning was not timely, was not done in partnership with patients and did not consider all of the patient's needs.
- Governance systems and processes were not effective and did not give the service oversight to ensure the standard of care and treatment was maintained. There was no process in place to review key items such as the strategy, values, objectives, plans or the governance framework. The impact of service changes on the quality of care was not understood.
- Notifications were not submitted to external organisations in a timely manner.
- There was no evidence of learning and reflective practice. When concerns were raised or things did go wrong, the approach to reviewing and investigating causes was insufficient or too slow. There was no evidence of learning from events or action taken to improve safety.
- The service operated with a number of blanket restrictions in place which were not individually risk assessed or care planned.

However:

- Patients were regularly being assessed and their individual strengths, problems and needs were being identified and documented.
- The service kept detailed risk assessments and management plans which were updated when patients' presentations changed and actions taken accordingly.
- Comprehensive physical health provision was available to patients to monitor and review their physical health and wellbeing.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Inadequate 	See detailed findings.

Summary of findings

Contents

Inadequate

Tesito House

Services we looked at:
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Tesito House

Tesito House opened in March 2017 in the Ardwick district of Manchester, as a 24-bedded, high dependency, treatment and mental health recovery centre for women from the city. The service aim was to provide treatment and support for adult women with complex mental health problems by supporting and developing their skills, working through their rehabilitation and recovery pathway in a safe and comfortable environment. It was managed by Alternative Futures Group Limited. Tesito House at the time of inspection was registered for the following regulated activities:

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

The service is developed around a patient's prospective rehabilitation journey through the service's three distinct eight-bedded clinical units. These were named after well-known local personalities. The admissions ward, Carol Ann Duffy ward, was the stabilisation ward. The recovery and therapy ward was Erinma Bell ward. The step-down unit, Marie Stopes, was made up of a series of eight self-contained apartments.

The Care Quality Commission last carried out a comprehensive inspection of this service in March 2018. At this inspection, we rated the service as 'inadequate' overall with ratings of inadequate for safe, effective and well led key questions and requires improvement for caring and responsive key questions. Following the inspection, we placed the service into special measures. Since then, the service had not been accepting any further admissions.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

At the March 2018 inspection, it was found that the provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took regulatory action in line with our enforcement powers by issuing warning notices in relation to:

- Regulation 12; safe care and treatment because the service did not have appropriate management plans in place for managing risk to all individual patients.
- Regulation 17; good governance; because the systems and process in place did not ensure the provider could assess, monitor and improve the quality of care and treatment it delivered. Not all patients had an up to date care plan or physical health monitoring, and all patients did not have the correct legal documentation attached to their medication records.

We also issued four requirement notices advising the provider of a number of improvements we required it to make.

During this inspection it was found that some of the regulatory breaches identified during the last inspection had been addressed. However, a number of breaches and areas for improvement which we had also highlighted at the time of that inspection continued to be reviewed and developed by the service.

At the time of the inspection there were eight patients at the service of whom seven were detained under the Mental Health Act and one was an informal patient. Tesito House works in partnership with the local NHS Trust who provide Mental Health Act administrative support, therapy and pharmacy support, the consultant psychiatrist and the out of hours service.

Summary of this inspection

Our inspection team

The team that inspected the service comprised of a lead inspector, two CQC inspectors, two assistant CQC inspectors and a nurse specialist advisor.

Why we carried out this inspection

We inspected this service because of our continued commitment to re-inspect services placed in special measures within six months of the publication of the initial inspection findings. We took enforcement action at that time to protect people and advised the provider that we would re-inspect once the dates of compliance had passed to assess if the required improvements had been made.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we request all providers to send us and information we held about the location from regular meetings with the provider.

During the inspection visit, the inspection team:

- visited all areas of the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with the registered manager
- spoke with eight other staff members; including doctors, nurses, occupational therapist, pharmacist and psychologist
- spoke with an independent advocate
- attended and observed a community meeting
- looked at seven care and treatment records of patients
- carried out a specific check of the medication management by reviewing six medication records and associated policies and procedures
- spoke with three senior managers from the provider, Alternative Futures Group
- observed a presentation by patients for staff
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During the inspection we offered all patients an opportunity to meet with us during drop in sessions and spoke with four patients who told us about their experiences of the service.

Patients spoke positively about the impact the new registered manager had made on the service and said there had been some noticeable changes and improvements since our last inspection. Patients told us that staffing had been more consistent and a number of therapeutic interventions were now offered at the service.

Patients also shared their frustrations about their experiences. All patients spoke of their concerns that the service offered a limited rehabilitation programme and that discharge planning was limited and not consistent.

Summary of this inspection

Patients told us the number of activities available for patients to do at the service were limited. Patients told us that staff were not always available when they required them. One patient said she did not feel safe at the service. Patients felt that staff morale had been low for some time at the service and spoke of their concerns at the number of staff that had left the service.

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?

Inadequate

We rated safe as **Inadequate** because:

- The administration and management of patient medication was not safe. One patient had not received prescribed treatments for 12 consecutive days. Records were not completed accurately, maintained and updated.
- Physical restraint was not monitored or reviewed by the service to ensure they were appropriately used and patients were kept safe. The current incident management system did not have a facility to report or review the use of restraint.
- When concerns were raised or things did go wrong, the approach to reviewing and investigating causes was insufficient or too slow. There was no evidence of learning from events or actions taken to improve safety.
- Mitigations for ligature risks were not identified within the document used to review and evaluate these across the service.
- The service had a number of blanket restrictions in relation to access around the unit, including patients accessing the kitchen and laundry room, which were normally locked. These restrictions were not individually risk assessed.
- Patients were not aware of the details of their personal emergency evacuation plans as these had been written by their named nurses and not shared with them.
- Not all staff were aware of their responsibilities under duty of candour.
- Staff had not completed mandatory training, Only half of the qualified nurses had completed intermediate life support training and a quarter of qualified nurses had completed Mental Health Act training.
- Staffing levels did not ensure that patients had a consistent level of support and access to activities.

However:

- The service provided a clean and well maintained environment for patients.
- Patients had access to call buttons if they required assistance and modern bedroom space which they could personalise.
- Clinic rooms were well stocked and clean.
- Patient risk assessments were detailed and these comprehensive risk assessments were regularly reviewed.

Summary of this inspection

Are services effective?

Inadequate 

We rated effective as **inadequate** because:

- Staff did not receive all the training required to perform their roles prior to working with individuals. Staff did not have access to specialist training to work with high risk patients.
- The learning needs of staff were not understood by the service. Staff were not supported to participate in training and development to meet their needs. Clinical supervision records were not maintained and individual staff concerns or needs identified were not escalated by supervisors. This meant that staff did not have the experience or confidence to care for and treat patients with complex mental health needs.
- The service was not proactive in engaging with independent Mental Health Act advocacy service. The service did not invite advocates or carers to patient review meetings.
- Policy documentation did not refer to the current guidance. The managing aggression and violence policy did not reference the current Mental Health Act code of practice or current national guidance. This meant staff training did not use current best practice.
- An informal patient had a T2 consent to treatment form present with their medication administration records, to show they had consented to treatment. These should only be used for patients who were detained under the Mental Health Act.
- The Care Quality Commission were not sent requests for patients to be reviewed by a second opinion approved doctor.
- There were a limited number of activities available for patients each day.

However:

- Care plans and assessments were personalised and specific to individual needs identified during assessments.
- A number of assessments, recovery, psychological or occupational therapy tools were used to assess and monitor patients.
- The service took a positive and proactive approach to monitoring physical health and wellbeing of patients.

Are services caring?

Requires improvement 

We rated caring as **requires improvement** because:

- Patients were not always involved in their own care planning. Patients expressed concern about the lack of progress and rehabilitation since they had arrived at the service, with patients unclear about their rehabilitation journey and discharge plan.

Summary of this inspection

- Patients were not always comforted when patients were unwell or distressed.
- Staff were not always available when patients required support.
- The service did not actively engage with carers or meet them when they attended the service to visit the person they cared for.
- The visitors room was not used when relatives visited with patients meeting relatives in the main foyer away from the clinical area.

However:

- We observed positive and friendly interactions between staff and patients.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- Discharge and transition planning were undertaken but were not timely and did not consider all the person's needs and were not done in partnership with patients.
- The service did not consistently plan or deliver care and treatment taking into account individual needs and preferences. Patient choice was not always recognised by the provider.
- There had been no discharges from the service since our last inspection.
- The service did not have processes in place to share learning from incidents.
- Patients had limited access to activities and organisations within the local community.

However:

- The service had responded positively to patients concerns about food provision and had empowered patients to raise concerns with regular meetings with the catering firm.

Are services well-led?

Inadequate

We rated well-led as **inadequate** because:

- In 2018, we placed the service into special measures because the provider did not ensure patient care and treatment was being delivered to the highest standard with shortcomings not promptly identified and rectified. At this re-inspection we found a number of areas of concern raised in our previous inspection had not improved.

Summary of this inspection

- The provider did not have robust governance systems and processes in place to monitor, review and develop the service. Audits including medicines audits had not identified concerns such as missed dosages and incomplete records.
- Systems, processes and standard operating procedures were not reliable or appropriate to keep people safe. Monitoring of whether safety systems were implemented was not robust.
- Systems for collating and monitoring staff training needs were not co-ordinated. This meant that the training requirements for the service were not understood and addressed. This meant that staff did not develop the knowledge, skills and experience to enable them to deliver good quality care. Data and notifications were not promptly submitted to external organisations as required. There had been no innovation used to develop the service. There was minimal evidence of learning and reflective practice. The impact of service changes on the quality of care was not understood.
- Information relevant to monitoring the Mental Health Act, including Mental Health Act performance and Second Opinion Appointed Doctor activity, were not robustly collected and reviewed appropriately.
- The provider had not consistently supported the service, its staff and patients by making support available and disclosing information relating to the running and development of the service.

However:

- The provider had responded positively to concerns raised by commissioners for the need for greater oversight and evaluation of the service provision and a new service development and governance lead had recently commenced at the service.

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.

Mental Health Act administration was provided by a local NHS Trust. There were systems and process in place to ensure administration and implementation of the Mental Health Act was regularly reviewed. This included monthly audits which reviewed the legal status of each patients' detention. This was an improvement since our last inspection.

The service provider had a policy relating to the Mental Health Act which staff were aware of. However, we did find references to the Mental Health Act in other policy documentation were not up to date, with references to the code of practice referring to the 2008 guidance and not the current 2015 guidance.

Staff routinely explained to patients their rights under the Mental Health Act. Patients had access to section 17 leave and this was documented within individual records. Leave documentation we reviewed detailed any applicable conditions and risks. However, leave paperwork was not always signed in and out with accompanying staff signatures.

Training in the Mental Health Act was mandatory for all qualified nurses. The records we reviewed showed two of the current eight eligible qualified nurses had completed this training over the last twelve months.

Patients who required a consent to treatment form had one in place and mental capacity assessments had been completed in accordance to the Mental Capacity Act 2005. However, one patient who was informal, had a consent to treatment form present with their prescribing records.

Patients detained under the Mental Health Act did have paperwork completed for their treatment to be reviewed by a SOAD when required. However, found over the past twelve months, three patients should have been reviewed by a SOAD had not had their paperwork sent to the Care Quality Commission.

Information about the independent Mental Health Act advocate was displayed across the service. The advocate advised us that the service did not contact the advocacy about individual patients, in accordance to the Mental Health Act code of practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

As part of the corporate induction all staff were required to attend the safeguarding and Mental Capacity Act module. All staff we spoke with understood the Act and could explain what they would do if they were presented with more complex issues.

The provider of the service had a policy regarding the MCA and DoLS. The hospital had not made any DoLS applications since it opened.

In most records we reviewed we found evidence that patients mental capacity had been assessed. However, in one record this had not been documented.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate

Notes

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Inadequate
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Inadequate

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

Inadequate

Safe and clean environment

During our visit to the service we reviewed the environment to ensure it was safe, clean, well maintained and appropriate for the patients that were there. We did this by both observing the environment and reviewing records the service kept and then asking patients and staff about their experiences.

The service provided a bright, modern and spacious environment for the care and treatment of patients. The unit was split into three separate clinical areas which were intended to accommodate patients based on their presentation and level of risk. Each patient had access to an ensuite bathroom. The layout of the stabilisation ward and recovery ward allowed staff to observe both through a centrally positioned nursing office. There were blind spots which were mitigated by convex mirrors which allowed staff to observe these areas. Each morning staff reviewed patient risk management and observations during handover meetings and adjusted these accordingly. We found evidence the environment was reviewed to ensure it was safe which included an assessment of risks from ligature points, which are items or areas patients can use to cause self-harm by strangulation. Ligature risk assessments were detailed with risks identified and graded. However, there was limited information documented about how risks should be mitigated with phrases such as 'consider remedial action' used instead of plans for actions with accompanying dates. There was also no evidence to show how ligature risks were linked to individual care planning for those patients residing in higher risk areas.

Security and access were controlled throughout the hospital. Access throughout the site was through locked doors and many rooms and areas required the use of a swipe card to gain access. These were given to staff and to patients who were well enough to be staying in the apartments. However, this meant access for patients within the stabilisation or recovery wards was restrictive without being individually risk assessed and care planned, including access to the kitchen, laundry room and outside enclosed courtyard which were all locked during our visit. The service advised these could be accessed by patients upon asking staff for access.

There were call buttons in each bedroom and staff working in clinical areas all carried portable alarms. Patient bedrooms were personalised and all contained a lockable safe.

We found the service had systems and processes in place for daily cleaning. Most areas appeared generally clean. Records we reviewed showed this was being done regularly.

The service did not have a seclusion room. The de-escalation room was being replaced by a low stimulation room which was intended to be used for short term use by patients when they required a space to help them de-escalate or relax. Staff and patients told us both these rooms had not been used for seclusion purposes.

Clinic and treatment rooms were safe and appropriately stocked. The hospital had a single clinic room, which was clean and stocked with equipment required to treat

patients which included emergency equipment and a secure storage area for medication. The clinic was locked with a set of keys held by the nurse and a spare set stored in the office. Cleaning logs and safety check documentation showed regular checks were being completed to ensure equipment and medication were safe to use.

Safe staffing

As part of our inspection we looked at staffing arrangements at the service to ensure arrangements were appropriate to deliver safe care and treatment. We did this by speaking to staff and patients in addition to reviewing information provided by the service.

The provider had defined the staffing establishment for the service, which it felt was required to deliver safe care and treatment to include 13.97 whole time equivalent (WTE) qualified nurses and 30.98 support workers. At the time of our inspection there were 6.67 WTE qualified nurses and 23.77 WTE support workers in post. Information about vacancies showed that there were 7.3 WTE qualified nurses and 7.21 WTE support staff vacancies at the time of our visit. The provider had identified that the daily staffing requirement was for two qualified nurses and six support workers to be on shift during the day and one qualified nurse and four support workers during nights. Where managers had identified that there were increased demands or pressures they had responded by increasing staffing levels. This was done by utilising agency staff or using the staff bank which consisted of staff who were employed by the provider in any of its other services. Staff told us the use of agency staff had decreased since our last inspection. There were also two senior nurse practitioners employed by the service, who along with the registered manager were available to cover shifts if needed. There was an induction process for temporary staff when they first started at the service, which included receiving a tour of the unit, an overview of local processes, policies and to be assigned a buddy to support them.

Records showed that patient activities had been cancelled due to unavailability of staff. From the period 1 August to 30 November, 28 patient activities had been cancelled due to a number of reasons including staffing related concerns.

Records showed that to the year ending 31 July 2018, the total percentage sickness at the service had been 8.3%. Information about patient leave suggested that no leave had been cancelled due to staff unavailability.

Mandatory training had not been completed by all eligible staff. The training which all staff irrespective of role were required to complete had been completed by all permanent staff. This training consisted of all staff attending a two-day corporate induction. This offered, those attending, training in person centred care approaches, equality and diversity, proactive working, basic life support, safeguarding, the Mental Capacity Act and awareness of mental health, dementia and learning disabilities. All the sessions covered during the training linked to modules in the care certificate qualification which support staff were required to work towards during their probationary period. The training covered in the corporate induction needed to be refreshed every two years and information about this was held centrally by the provider. If staff had not completed these modules or their accompanying refresher courses, the electronic staffing system would not allow them to be added to a shift. However, this did not apply to the additional mandatory training that qualified nurses were required to complete. Mental Health Act training had only been completed by two out of the eight eligible staff and intermediate life support training had only been completed by four out of the eight qualified nurses. Information provided by the service did show two of the eight eligible members of staff had only been present at the service a month at the time of our inspection.

There were delays in staff receiving training required to do their roles. Therapeutic management of violence and aggression training which the service required the nursing team to complete each year was not undertaken by new staff before they started working with patients. The service advised that all staff would under normal circumstances receive this training within a month of commencing their roles. Records we reviewed showed that some staff received this training up to six months into their roles, with most receiving this training within four months of starting work. The service advised that if a member of staff had not completed this or the accompanying annual refresher training, they would only work on shifts with others that had completed the training.

Assessing and managing risk to patients and staff

Patient medication was not managed safely and appropriately across the service. We found the service failed to ensure the needs of one patient. Medication was not available for the patient over 12 days which resulted in

the patient not receiving the prescribed treatments. For another patient prescribed a nutritional drink, this was marked out of stock, which meant it was not available for the patient on nine occasions. However, the process for ordering medication had recently changed with all medications and support for managing medication now acquired from a local NHS trust.

The service did not ensure staff kept accurate and complete records. The service had processes in place for enabling patients who were well enough to self-medicate to develop greater autonomy and responsibility. This involved specific monitoring forms for those patients being completed and monitored to ensure they were self-medicating appropriately and their recovery was progressing as planned. We found for one of the patient's self-medicating the record was not fully completed. For another patient who was going on home leave, the name of the medication given had not been recorded. We found for a further three patients, administration records had either not been filled or had been signed for more days than medication had been prescribed.

The service did use restraint but did not report, monitor or review its use. Information the provider had made available before our inspection noted there were no incidents in which restraint was used. However, information about complaints noted a complaint being raised about the use of restraint. The manager and senior staff informed us that restraint was used at the service, but information about restraint usage was captured within the details of individual incidents and reviewed as per those incidents. We were told this had been identified as potential service risk and had been escalated to identify a work around, but this was not evidenced in the services risk register.

The service had processes in place to assess patient risk. All records we reviewed had risk assessments present which were comprehensive and updated regularly which included following significant changes in patient presentation. The Short-Term Assessment of Risk and Treatability tool (START) was used for assessing and documenting risk.

Individualised patient risk management plans were present for each patient. The service utilised different tools and aides to manage patient risks, from individualised wellness tools which advised staff about patient wellbeing to personal emergency evacuation plans outlining what needed to be done in an emergency. We found Individual records contained detailed risk formulation, which outlined patient risk triggers, how a patient may react in certain situations and proactive and mitigating actions staff could take to help the individual. There was evidence these were regularly updated including after an incident. Patients also could alert staff about how they felt, using a traffic light or mood board display outside their rooms. Collectively these helped staff to understand patient needs and respond accordingly when needed.

Staff we spoke with were aware of de-escalation strategies and received training about how to manage violence and aggression. Staff we spoke with were aware of what to do when patients mental health deteriorated. This included use of verbal de-escalation in which staff members would use a change in tone of voice, physical posture, facial expressions and asking patients if they wanted to go to elsewhere such as the courtyard or the de-stimulation room.

The service had systems and processes in place to ensure staff and patients remained safe from fire risk. There were regular fire alarm tests and the service had an up to date fire risk assessment. Before the inspection, the service told us it had three staff trained to be fire wardens, to help and co-ordinate the service in the event of a fire based emergency. During the inspection we queried this and it was confirmed they had eight staff who had undertaken fire warden training and all staff received basic fire awareness training. For patients requiring a personal emergency evacuation plan, these were in place. However, these were written by individual named nurses and not written in partnership with the patients concerned. Patients had not received copies of these.

Staff had an awareness of how to safeguard patients from abuse. All staff received basic safeguarding training as part of their induction and qualified nurses attended an enhanced safeguarding training seminar. Staff were aware who to raise concerns with and the process associated with this.

The service had a policy of not secluding patients, not using long term segregation and not using rapid tranquilisation.

Track record on safety

We found there were no systems or process in place to investigate individual incidents. From the period 1 August 2018 to 30 November 2018 there had been three serious incidents recorded by the service. These all involved

Long stay/rehabilitation mental health wards for working age adults

Inadequate

patients failing to return to the service from leave and harming themselves. The service told us they did not have a process to investigate incidents separately, with all incidents only discussed and reviewed at a monthly governance meeting. However, the service had recently brought in a specialist to review and update this shortcoming and it was planned that the service would commence a programme of reviewing incidents within 72 hours and then a separate mechanism to investigate these where required.

Reporting incidents and learning from when things go wrong

The provider, across all its services, used an electronic incident reporting system to record all incidents that occurred at the service. All permanent staff had access to the system and could report incidents and concerns directly. This was an improvement since our last inspection. The service defined the types of incidents that needed to be reported and staff we spoke with were aware of these. The manager would review completed forms and investigate where required. All incidents were reviewed during monthly governance meetings.

Staff were updated about incidents during meetings and staff handover. Staff and patients were debriefed following incidents. Patients were informed about incidents during morning meetings. Individual patient records and risk assessments were updated following incidents.

Sharing lessons learned from incidents could not be evidenced. Lessons learned from incidents were not always being shared with staff at the service. This had been recognised by the service and had been added to the service risk register.

Duty of candour

The duty of candour is a legal duty on registered persons to act in an open and transparent way in independent and NHS services to notify the relevant person the incident occurred and give reasonable support to the relevant person and apologise if mistakes have been made in their care that led to a level of harm. The purpose of duty of candour is to help patients receive accurate and truthful information from health providers. The provider stated that there had been no notifiable events which met this threshold. The provider did have guidance on duty of candour. However, the support staff we spoke with were not clear about what duty of candour is.

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

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

We reviewed how patient care and treatment was assessed and planned to ensure it met the needs of individual patients. At our last inspection of this service, we told the care provider that care plans were not person centred, did not look at the physical health needs of individual and were not recovery focused. During this inspection we found that some improvements had been made.

Patient care and treatment records were paper based. They were stored separately in different files based on the type of information, with physical health records for all patients kept together and Mental Health information kept in separate Mental Health files.

Care plans and assessments were personalised, specific to each patient's presentation and needs. Patients had individualised care plans present in their care records which had all been developed and/or reviewed within the last four months. The care plans met the needs of the patient identified during assessments.

The service used dedicated plans and recognised tools to support planning and assessment of care. The service utilised a recognised tool for assessing risk, the short-term assessment of risk and treatability (START). To measure the health of individual patients, the service used the malnutrition universal screening tool and the Lester tool to assess physical health. We found evidence that other specific tools and assessments had been used including the model of human occupation screen tool (MOHOST) to assess an individual's occupational functioning, wellness recovery action plans (WRAP) to help monitor and support a patient emotion wellbeing and recovery. These included details about individual triggers and strengths.

Ongoing patient needs were being monitored and reviewed. Patients who had experienced depression had a tool, the becks depression inventory, present to measure

the intensity and severity of episodes. Modified early warning scores were done routinely and when patients presentations changed, to monitor their health and wellbeing.

There was a positive and proactive approach to physical health care and monitoring. Patients were having their physical health needs routinely reviewed and monitored.

Care plans included patients' wishes. Crisis plans are advance decisions which are a summary of the patient's wishes and preferences during a deterioration in their mental health. These were documented in the care plans we reviewed. These were intended to guide staff on how best to respond to the patient, their wishes and what the patient preferred in a variety of situations including during episodes of distress. Crisis plans had been developed outlining patients' individual preferences and how to avoid certain situations.

Best practice in treatment and care

We found individual patient care and treatment records referred to appropriate national guidance and best practice standards. This included within discharge planning references to the relevant National Institute for Clinical Excellence guidance and standards.

The service offered a range of therapeutic interventions including psychological and occupational support for its patients. Group and individual therapy sessions were available for patients if this had been approved by the multi-disciplinary team. This included dialectical behaviour therapy, relaxation, art and dance therapy sessions.

The continued monitoring of patients' physical health needs had significantly improved since our last inspection. The service employed a full time general nurse and a specialty locum doctor. There was evidence of regular one to one physical health sessions for patients. There were also specific health plans for patients relating to physical health conditions including diabetic and oral health care plans. The service had been responsive when patients care needs changed and developed care plans specifically for individual concerns such as physical ailments.

The service carried out a number of monthly clinical audits to review the provision of the service. Each qualified nurse led on a different area and was responsible for completing audits and associated actions. This was an improvement since our last inspection and meant there was a system in place to review and ensure service provision was being delivered to a certain standard.

The service had a process in place to monitor patients taking antipsychotic medication in accordance to national guidance. Staff ensured patients had regular electrocardiograms to monitor their heart function and blood tests to monitor the impact of their treatments.

Tesito House did not participate in any care or treatment benchmarking programmes or Royal College of Psychiatrists' peer review networks.

Skilled staff to deliver care

The specialists that worked at the service who inputted into the care and treatment of patients included a consultant psychiatrist, specialty doctor, clinical psychologist, occupational therapist, pharmacist, art therapist, dance therapist, support workers and nurses. Additional expertise such as from primary medical services, were available if required by liaising with the local GP practice. Many of the non-nursing team worked part time at the service. The pharmacist was present at the service two days a week. The consultant psychiatrist worked at the service two days a week. The specialty doctor was based at the service and worked there five days a week. The occupational therapist had only recently joined the service on a short-term contract and was due to work there four days a week. The clinical psychologist, who had started working at the service the week before our inspection, was contracted to work at the service for up to four and a half days a week. The art and dance therapists both worked at the service four days a week. The service had, had some permanent staff leavers from their psychology and occupational therapy teams in recent weeks. This had meant there had been a period when some therapies, including Dialectical behaviour therapy were not available for patients due to staffing changes. However, the service had reached agreement for these specialisms to be provided by a local NHS trust and those staff had started working at the service on a part time basis.

Staff had access to regular supervision and appraisals. Staff appraisal and supervision are a means of assessing staff performance to ensure an individuals practice is appropriate and effective and that they have appropriate support available. They are intended to be used to help

create and facilitate plans for rectifying any areas for improvement whilst developing an individual's potential and identifying training. Staff told us they had access to regular supervision and appraisals. The providers policy for supervision stated it was expected that staff received regular supervision every six to eight weeks. The service kept detailed records of the management supervision staff received, which was monthly. However, records relating to clinical supervision were held by each individual supervisor including when each supervision session occurred and this was not co-ordinated by the management team. This meant the provider did not have oversight of clinical supervision and details could not be confirmed on the day of our visit. This information was subsequently provided after staff had been contacted to confirm the details and showed clinical supervision was being offered regularly to all staff in accordance to the providers policy. This included therapy staff who received regular supervision from professionals outside the service.

Staff training needs were not co-ordinated and staff did not have access to continual development opportunities. The training needs of individuals was discussed within supervision meetings. However, because these meetings were confidential, the information about training needs were not shared with the management team to ensure needs could be met. For example, we spoke to two members of staff who had discussed their desire for further training on the Mental Health Act and Mental Capacity Act but the management team were not aware of this.

There was limited ongoing training and development for staff. The training required by the provider to be undertaken by all staff did not include specialist training to allow staff to gather the expertise and proficiency to work with the patients in their care including working with patients with personality disorders and those that self-harmed. We found no evidence of continued staff development. However, the service was in the process of rolling out training in recovery star, the services planned new approach for monitoring individuals progress, which was due to commence in April 2019. To help staff better understand their conditions, the patients had developed a presentation about emotionally unstable personality disorder through their work with the art and dance therapists.

Team meetings were not structured and co-ordinated. Team meetings to discuss the service and professional development were held each month, but did not have a structure and as such no agenda was produced prior to each meeting. The service had held an away day for staff which was well attended and subsequently had attempted to hold individual engagement drop in sessions for staff to come and discuss any concerns they may have but these had been poorly attended.

Care and treatment of patients involved a multi-disciplinary team**.** The service had an agreement with a local NHS Trust for the provision of some professionals and services as well as employing some directly. An occupational therapist, psychologist, a specialty doctor, an art therapist, a music therapist, a consultant psychiatrist, mental health and general nurses, support workers and a pharmacist made up the multidisciplinary team. There was a close working relationship with the local GP practice and the service had a nurse led out of hours provision which provided by the local NHS trust, which staff knew how to contact. This included provision for on call doctor cover if it was required.

Multi-disciplinary and inter-agency team work

There was a range of professional disciplines that made up the team caring for and treating patients. Staff received a handover before each shift, in which each patients' clinical presentations, care plan and activities were discussed.

Patients were reviewed by a range of specialists once a week. The service held meetings with the multidisciplinary team which were chaired by the consultant psychiatrist twice a week in which the care and treatment of four patients would be discussed. Weekly meetings reviewed care plans, risk assessments, patient clinical presentations and assessments. Separate progress meetings or Care Programme Approach meetings were also held throughout the year for each patient. Patients and care co-ordinators would attend these. We were also told other relevant parties were invited including carers and the independent Mental Health Act advocate if patients had agreed. However, a carer and an independent Mental Health Advocate told us, they were only invited by patients and that they were not provided with any information beforehand including schedules, agendas and notes from previous meetings.

Adherence to the MHA and the MHA Code of Practice

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Inadequate

We carried out a routine Mental Health Act monitoring visit in September 2018. At that visit there were actions identified in relation to consent to treatment documentation, care planning, section 17 leave authorisations, records of discussions of patients' rights and discharge planning.

Following the visit, the provider submitted plans that showed it would address all these issues by October 2018. During this visit we found that some improvements had been made.

A Mental Health Act administrator was provided by a local NHS Trust. There were systems and processes in place to ensure administration and implementation of the Mental Health Act was regularly reviewed. Monthly audits looked at the legal status of each patients' detention, consent to treatment, administration of patient leave and the rights of patients. This had been introduced since our last inspection.

The service provider had a policy relating to the Mental Health Act which staff had an awareness about. However, references to the Mental Health Act code of practice in other policy documentation including the Managing Violence and Aggression policy, referred to the older 2008 Code of Practice and the 2005 NICE guidelines for management of violence and aggression, both of which were updated in 2015. This meant staff were not following the most recent guidance.

Care records we reviewed showed staff routinely explained to patients their rights under the Mental Health Act. Patients had access to section 17 leave as this was granted by the responsible clinician and documented within individual records. Leave documentation we reviewed detailed any applicable conditions and risks. However, patients who went on leave were not always signed in and out with accompanying staff signatures.

Training in the Mental Health Act was mandatory for all qualified nurses. The records we reviewed showed two of the current eight eligible qualified nurses had completed this training over the last twelve months. As part of the corporate induction which all staff attended some aspects of the Mental Health Act were covered in the Mental Health awareness module.

We reviewed consent to treatment documentation and prescribing records. All patients who required a T2 consent to treatment form had one in place and the responsible clinician had completed capacity assessments relating to treatment where appropriate.

Two patients had treatment authorised by a second opinion approved doctor (SOAD) with the appropriate T3 certificate completed. (A T3 form is a certificate completed by a second opinion appointed doctor if a patient detained under the Mental Health Act lacks capacity to consent or refuses to consent to medication).

One certificate did not include all prescribed treatments and the accompanying section 62 form, authorising urgent treatment for two of the three medicines was completed but a request for a review by a SOAD had not been made. This meant that one of the patients prescribed treatments had been administered without the appropriate accompanying legal authority to do so. The other T3 certificate noted a patient should have a review form sent to CQC to review the patient's treatments within a timescale but this form had not been sent for action. Following inspection, we found a review form had been completed by the responsible clinician but not sent to CQC. It also emerged that over the past twelve months, there had been two other occasions when individual patients required treatment review, with the appropriate section 61 forms completed by the responsible clinician. However, the forms had not been sent to the Care Quality Commission for review and action. We raised this with the service who confirmed there was no process for sending these or for verifying the resulting outcome. This meant the service had not ensured patients were appropriately safeguarded when detained under a treatment order to ensure their treatment under the order could continue. The service immediately introduced a process to rectify this.

Four patients had T2 certificates stored with their prescription charts. T2 certificates are completed when patients who are detained consent to the treatment being administered. One of these patients was not detained at the time of inspection and the T2 form related to their previous detention under the Act. Because a copy of the certificate was still stored with the current prescription, staff may not be aware of the patient's current legal status.

All four T2 certificates we reviewed listed additional medication which was not prescribed and which were not documented on the capacity assessments. This included

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Inadequate

intramuscular medication and two patients had T2 certificates authorising high dose antipsychotic medication despite neither being currently prescribed this. It was unclear how patients may have consented to medication that they were not prescribed and none of the capacity assessments included detail about these specific issues.

Information about the independent Mental Health Act advocate was displayed across the service. The advocate advised us that the service did not contact the advocacy about individual patients, with individuals contacting the advocacy service directly to arrange support or ask for an advocate to attend and support them during review meetings.

Patients were not involved in conversations about discharge planning and those that we spoke with were not aware about their discharge plans.

Good practice in applying the MCA

All staff we spoke with understood the Act and could explain what they would do if they were presented with more complex issues.

The provider of the service had a policy regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. The hospital had not made any Deprivation of Liberty safeguard applications since it opened.

In most the records we reviewed we found evidence that patients mental capacity had been assessed. However, in one record this had not been documented.

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

Requires improvement

Kindness, dignity, respect and support

We observed positive and friendly interactions between staff and patients. Staff including senior staff and managers appeared to know the patient group well.

We spoke with four patients who use the service, a carer and an independent Mental Health Act advocate. Patients reported permanent staff generally treated them with kindness and respect and how some staff were very supportive.

Patients spoke of an improvement since the new manager started and felt there had been a reduction in the use of agency staff. However, patients spoke about how when they were unwell and required greater staff observations, agency staff were used, who patients were not familiar with, which made some patients feel unsettled. Patients also spoke of their concerns that staff did not always interact with them during observations, even when they were distressed, with one patient mentioning an occasion when she had been crying and though she was on enhanced observations staff did not ask her what was wrong.

Patients informed us there had been occasions when staff were not available when they needed them. This included when they requested to see staff because they were busy.

Some patients shared their concerns that they were not involved in their care planning, including one patient for whom a personal emergency evacuation plan had been written without the patients' involvement. This included information about how the patient would be evacuated from the building if needed in an emergency, which the patient had expressed concerns to us about had been developed without her agreement.

Patients told us that their preferences were not always respected. We observed during a morning meeting, patients being allocated a nurse for the day. The nurses were not allocated in terms of familiarity and need. In one case a patient who could only work with female staff was allocated a male nurse.

The involvement of people in the care they receive

Since our last inspection there had been no new admissions at the service. The admissions process was clear and identified key roles and responsibilities. Information for patients and carers was available and given to them on admission which introduced the ward and outlined the facilities offered and expectations of the service. Information was also available in reception including that for carers.

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Inadequate

Information about how to contact an advocacy service was displayed in a few areas and patients were aware about the service. The service did not contact the advocacy service themselves and told us patients could ask named nurses to contact the advocate on their behalf or would be expected to contact the advocate themselves. However, the advocate advised that the only contact from the service was received from patients directly.

The service had a daily meeting in the morning between staff and patients, in which plans for the day were discussed including what support patients required. This was an opportunity for patients to raise any concerns they may have. It was also an opportunity for patients to be allocated a named nurse for that day, which changed each day.

At our last inspection we found that patients were not involved in their care and that care plans were not written with the patient's voice. We found that the patient voice was reflected in the care plans we reviewed, but, the phrases and language used were technical and not consistent with what would be expected from a patient. Patients told us their care plans were read to them and some did have discussions with staff about their care. Staff did not write care plans in conjunction with patients but, patients were asked if they agreed with the plans. Patients had limited involvement in the care they received.

Patients were not aware of their discharge plans. Records we reviewed showed discharge plans were present in records, which included individual goals and targets to work towards. However, patients we spoke with were not aware of their discharge plans.

A carer told us the service did not give the family updates about the care of the person they cared for. Carers were invited to patient review meetings by patients and when they attended they did not observe engagement with the patient only professionals giving their opinions. Staff did not meet with carers during visits, which were done in the foyer of the hospital and not the visitors room, because it was perceived to be the only available space to meet. Children were allowed to visit the unit by prior arrangement with the service to ensure appropriate arrangements could be made.

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

Requires improvement

Access and discharge

The service aimed to care for female patients from the Manchester locality closer to home, who may otherwise have been cared for out of their local area. All the patents present were from the Manchester area.

At the time of our inspection, the hospital was not admitting new patients. Following the publication of our last report the clinical commissioning groups had decided that the service should not admit new patients until there had been assurances about how care and treatment were being delivered. All patients present were referred to the service through NHS funded placements.

The 24-bed unit at the time of our visit had eight patients which meant it had a bed occupancy rate of 33%. Patients were split across the service, with two patients living in the step-down ward, and remaining patients living in the stabilisation ward or the recovery ward.

The care pathway used by the service intended to have a length of stay at the hospital for up to twelve months. However, there had been no discharges at the service since our last inspection. There were three patients present who had been at the service for over 12 months, with the longest length of stay 16 months. The average length of stay across all patients was just over 13 months. This was not in keeping with the service aim to have 12 month length of stays.

The care records that we reviewed contained some mention of discharge planning but the patients that we spoke with were not aware of their discharge plans or how to achieve these. We found evidence of discharge planning in all records. This included, in some records, patients' individual motivations towards self-care and discharge. However, the amount of detail contained varied considerably from record to record. Some records were very detailed and utilised known discharge processes including 'signs, medications, appointments, results and

talk to me (SMART)' to develop goals and interventions to help patient work towards discharge, to those that contained limited discharge planning. Some of the patients that spoke to us told us they believed their care was not recovery focused and they were unsure how to progress through their rehabilitation pathway or how to work towards discharge.

Patients spoke of their concern at the lack of rehabilitation and progress they had made since they arrived at the service. This included not being able to access psycho-social supportive therapies as initially planned, because this was no longer deemed the most appropriate course of treatment for them. Records showed that no complaints had been made to the service about these concerns, though patients had informally voiced their concerns to staff.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a lounge on the stabilisation and recovery wards. Each lounge had seating and a television present. A low stimulation room was being developed away from the main ward corridors, in response to patients concerns that there was lack of quiet space available to them.

A therapy room was available for patients to use under supervision and was normally used for art therapy. We saw patient artwork that patients had developed during their therapy sessions.

There was a separate visitors room away from the ward area. A carer was not aware of this room and said they met their loved one took place in the main foyer away from the patient area. The service could not confirm how often the room was used by carers visiting the service.

Patients could use their own mobile phones depending on their associated clinical risks and patients had access to a payphone away from the main corridors.

There was outdoor space available for patients to access at the service, including an enclosed courtyard at the centre of the building. Staff told us that doors leading to the enclosed courtyard were normally left open during the day. There were separate outdoor spaces with seating but, at the time of our inspection, these doors were closed and locked. This meant that patients had to ask staff to get access to the courtyard and fresh air.

Patients had raised concerns about food provision and the service had responded by working with patients and the catering firm to regularly review food provision, which now included a one-week menu chosen by patients with several choices including sandwiches or jacket potatoes in the evening. Patients could cook their own food once a week which four of the patient group did regularly. The service had empowered patients to raise these concerns and now met with the catering provider on a regular basis to give feedback about catering provisions.

Patients on the step down ward had their own individual kitchens which could be used by patients throughout the day. Patients on the stabilisation and recovery wards were accompanied by a staff member as part of their rehabilitation and therapy.

Patients could access their bedrooms when they wanted, morning or night. Rooms were secure. We saw that patients had personalised their own bedrooms to their own preferences and tastes. However, patients on two of the wards could only access the kitchen by asking staff to unlock the door.

Patients told us there was only a limited choice of activities with very little available in the evenings and activities were often cancelled. We reviewed information about activities and found there had been some cancellations, on average about six activities had been cancelled each month since 1 August 2018. The activity provision had been reviewed and a new activity calendar was due to start in the new year which will offer more evening activities.

Meeting the needs of all people who use the service

We looked at how the service met the needs of its patients, who at the time of the inspection included patients with complex mental health needs.

The service met the needs of patients who may experience mobility difficulties. Tesito House was housed in a modern newly constructed building which met accessibility standards. Access into the building and around the ward corridors were wide enough to accommodate patients' using wheelchairs or other mobility aids.

Information was available by request in different formats which could be understood by patients. At the time of our inspection all patients present understood English and did

Long stay/rehabilitation mental health wards for working age adults

Inadequate

not have any identified communication needs. Though the number of posters and leaflets on display were limited, the service advised that other information was available and in different formats by request.

Information displays with information about patient rights and the Mental Health Act were present.

The service did facilitate individual spiritual preferences. This included some patients going to the local church when they wanted to.

Individual preferences were documented in care plans. Patients preferences, likes and dislikes were noted in care plans. The service had responded to facilitate patients' choices including with one patient who had struggled with the suction pads used for the electrocardiogram machine and the service were in the process of ordering a new machine. In the meantime, the patient only had ECGs done when necessary and these were done at the local GP practice. However, we did witness a patient who had specified a preference to work with same gender staff, not have this facilitated.

Listening to and learning from concerns and complaints

The service had systems and process in place to gather feedback, complaints and concerns. Information on how to make a complaint was displayed in the main receptions area and could also be found in the information packs carers and patients were given on admission.

Staff had a clear awareness of how patients and carers could complain. Complaints, concerns and feedback would be discussed at handover.

Patients had options as to how they could raise concerns, including in morning meetings, with their named nurse or speaking to the manager directly who had an open-door policy which meant patients could drop in at any time. However, Patients told us they felt concerns were not always actioned promptly. We found no evidence of systems in place to review and investigate concerns and these being reviewed and shared with staff.

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

Inadequate

Vision and values

The service shared the provider organisations vision and value statements. Alternative Futures Group Limited 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.

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.

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 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.

The providers vision statement was "A world where people control their lives."

These were understood by managers and senior managers and some of the staff we spoke with. The provider offered staff opportunities to partake in work reviewing its values and visions.

Good governance

Alternative Futures Group used a number of processes to review and monitor service provision. At Tesito House these included monthly governance meetings, audits and assurance visits by the providers board of trustees.

We found audits were not robust at identifying short comings and the service did not review these regularly to ensure the information captured was complete and accurate. The service used a model of a three-monthly cycle of audits, which were each done by designated audit leads and then would be reviewed and information collated and presented to the provider at the end of the

three months. We found audits which reviewed individual Mental Health Act records, noted a patient who was informal had consent documentation which we would expect for detained patients. This had not been noted as an error or that it needed escalating. Medication audits had not identified concerns about medication record keeping. We were told recent medication audits had not been completed because the member of staff leading and deputising had been off work due to sickness. However, there was evidence to suggest audits had identified concerns which were subsequently mitigated and addressed.

The service did not have processes in place to ensure incident management and review were robust. Incidents were reviewed in monthly governance meetings and were not individually investigated. Copies of incidents would only be sent to the management team if the member of staff reporting the concern or incident had ticked an option on the form asking for it to be sent. Otherwise information was only seen when reports were run. However, the service did advise us they were in the process of introducing a process to review each incident and then investigate further as required.

The service did not promptly send notifications about concerns or incidents. It was found that the service did not inform the Care Quality Commission in a timely manner when notifiable incidents occurred as stipulated in the registration regulations. This included an incident that occurred during our inspection, where a patient had not returned from authorised leave and could not be reached, for which the police had been contacted. This notification was sent four days after the incident. In reviewing information about other incidents, it was noted that where incidents had been notified these were not done promptly.

Information identified as key quality measures for review each month, was not collected or reviewed. Restraint information was documented as a quality measure which should be reviewed each week. However, this information was only captured in the detail of incidents and could not be easily reviewed. The service did not have a process to review and report this and we were advised this had been recognised as a risk, but our review of the services risk register found this had not been captured as a service risk.

The systems in place to monitor the compliance to the Mental Health Act and review prescribing were not effective. Consent to treatment for planned medication did not look at whether all treatments were prescribed. Consent to treatment forms had medications listed which were not prescribed including intramuscular medication to be given when a patient would refuse normal oral medication or when they were distressed. Patients who had required a review by a SOAD had a form for the review completed, but this was not processed and sent to the Care Quality Commission so that it could be actioned. This had not been identified by the service, both during the audit process and review of individual patients at ward round.

The service provider did not consistently ensure the service was supported and assisted appropriately. The provider had not taken actions when concerns had been raised to it to support the service and staff. This included concerns raised about the frequency and quality of clinical supervision which were not acted upon. The service had a month prior to our inspection had an assurance visit from the commissioners. The findings from this visit were shared with the provider, but at the time of our inspection, these had not been shared with the registered manager.

Systems in place for monitoring staff training and development needs were not co-ordinated. Individual staff training requirements discussed by individuals during clinical supervision were not shared with the management team and collectively reviewed and monitored. Systems for monitoring staff training relied on information being requested from indiviuals, gathered and typed into spreadsheets, meaning these records were not up to date.

Leadership, morale and staff engagement

At the time of our inspection the service had a registered manager who had been in post just over six months. The management team consisted of a registered manager and two senior nurse practitioners. The service manager reported to the providers head of quality and operations for the locality and both were acco untable to the providers regional director. The regional director had been based at the service to oversee improvements for two months.

Following a review of the service, the provider had developed a temporary post for a service development and governance lead , who had started work some weeks prior to our inspection. Although new in post, the service development and governance lead had gained good understanding of areas for improvement and development.

The service had held an away day for staff, which was co-ordinated by the providers staff engagement lead. This

had identified some concerns staff had about the service and their roles. It had identified staff morale had been low and that staff did not feel supported. As a result, the provider organised drop in sessions facilitated by the provider which were led by a manager from one of the providers different services. These had not been widely attended.

The service had not reported any incidents of bullying at the service, but patients we spoke to had told us staff had left because they felt bullied and not supported. We were aware of at least one member of staff that had raised similar concerns to the care quality commission over the last three months which we had at the time raised with the service provider.

Staff and patients told us the recent changes at the service had a negative impact on staff morale. Staff and patients felt there was a shortage of staff and that the current staffing numbers did not enable staff to best react when there was an incident.

Commitment to quality improvement and innovation

The service was not involved with any accreditation or peer review programme. There was no innovation used to develop the service with a lack of learning and reflective practice. However, the provider had recently taken steps to embed a dedicated service development role into the management team.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are appropriate systems in place to review the use of restraint to ensure it is appropriately used and patients are safeguarded.
- The provider must ensure individual incidents are reviewed and where required investigated.
- The provider must ensure medication is managed and administered appropriately and that patient safety is maintained.
- The provider must ensure governance systems are robust and accurately reviewed.
- The provider must ensure patients medications and treatments are appropriately planned and available.
- The provider must ensure records relating to the administration of medication are complete, up to date and regularly reviewed.
- The provider must ensure processes relating to Mental Health Act are robust, regularly reviewed and checked.
- The provider must ensure that it notifies concerned parties including the care quality commission of all notifiable incidents in a prompt and timely manner.
- The provider must ensure restrictions in place are reviewed, monitored, individually risk assessed and mitigated.
- The provider must ensure all staff complete the mandatory training which is specific to their role.

Action the provider SHOULD take to improve

- The provider should ensure patients are aware of how to progress through their rehabilitation pathway including how to work towards discharge.
- The provider should ensure decisions about treatments are fully documented including the potential use of intramuscular medication and consent to treatment records reflect current treatments.
- The provider should ensure that it has oversight of staff skills and their clinical training requirements.
- The provider should ensure that there are adequate staff on duty to ensure that patients are safe, able to access activities and support when required.
- The provider should work to increase appropriate opportunities for patients in the local community as part of their planned care.
- The provider should ensure it engages with local community teams in discussions about and planning for discharge.
- The provider should ensure it better engages with carers and that they are able to meet patients in the visitors room when they visit.
- The provider should ensure all policies and procedures are based on current national guidance and best practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Failed to ensure patients who were required to be reviewed by a second opinion approved doctor had been by ensuring forms were submitted to the CQC. Failed to ensure patients Mental Health Act status was appropriately updated across all records. Did not ensure the latest guidance including Mental Health Act were referenced in policies by the provider.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Failed to investigate all incidents that affect patient health or safety when these occurred.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 CQC (Registration) Regulations 2009 Financial position There were blanket restrictions in place in terms of access around the service which had not been individually risk assessed and documented.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Role specific mandatory training had not been completed by all qualified nursing staff.**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Failed to promptly notify the commission of a notifiable incident.**

This section is primarily information for the provider

Enforcement actions

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment For 12 days failed ensure a patient received the planned prescribed treatments. Did not ensure records relating to the administration of medication were up to date and complete.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance Did not have systems and processes in place to ensure restraint was used appropriately. The processes for monitoring compliance to the Mental Health Act and consent to treatment were not effective There was no provision of specialist training and continued professional development for staff.