Good

Affinity Healthcare Limited

Acute wards for adults of working age and psychiatric intensive care units

Quality Report

100 Wilmslow Road
Cheadle
Cheshire
SK8 3DG
Tel: 0161 428 9511
Website: http://www.priorygroup.com

Date of inspection visit: 23-27 February 2015
Date of publication: 03/08/2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Cheadle Royal Hospital	1-127893060	Alder Ward	SK8 3DG
Cheadle Royal Hospital	1-127893060	Maple Ward	SK8 3DG
Cheadle Royal Hospital	1-127893060	Pankhurst Ward	SK8 3DG
Cheadle Royal Hospital	1-127893060	Willows Ward	SK8 3DG

This report describes our judgement of the quality of care provided within this core service by Affinity Healthcare Limited. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Affinity Healthcare Limited and these are brought together to inform our overall judgement of Affinity Healthcare Limited.

Summary of findings

Ratings

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

Overall rating for acute wards for adults of working age and psychiatric intensive care units	Good
Are acute wards for adults of working age and psychiatric intensive care units safe?	Good
Are acute wards for adults of working age and psychiatric intensive care units effective?	Good
Are acute wards for adults of working age and psychiatric intensive care units caring?	Good
Are acute wards for adults of working age and psychiatric intensive care units responsive?	Good
Are acute wards for adults of working age and psychiatric intensive care units well-led?	Good

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

Systems were in place to monitor and manage patient risk. Comprehensive assessments were carried out in a timely manner, regularly reviewed and reflected in care plans. There was a programme of ligature risk assessment in place and policies to support the management of this risk. Safeguarding was embedded within the service and the processes to support safeguarding were robust. Staff displayed a good understanding of their roles and responsibilities in this regard.

There was an open and transparent culture within the service. Staff were aware of the incident reporting procedure as well as the provider's complaints process. Staff received feedback when things had gone wrong and were encouraged to make suggestions for service improvement.

Ward shift establishments were developed using an accredited tool and actual staffing levels matched the identified need. There was access to a regular cohort of bank staff and external agency use was low.

There was a multi-disciplinary and holistic approach to the delivery of care. Care was delivered in a compassionate manner and in line with current best practice guidance. There was an audit programme to provide assurance in this regard and outcome measures were used to monitor treatment effectiveness.

There were effective systems in place to ensure adherence to the Mental Health Act 1983, the Code of Practice, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Patients were informed of their rights under section 132 on admission and capacity to consent to care and treatment was sought in line with legislation.

Feedback from patients on the service was positive. We observed patients being treated in a respectful manner and with a caring and empathetic approach. Patients were involved in their own care and the wider running of the wards. Patient attendance at multi-disciplinary team meetings was facilitated and patients were given space to provide their opinions.

Senior management were a visible presence and had effectively embedded the vision and values of the provider within the service. Staff felt supported in their roles and were confident in approaching their line manager. There were good governance structures in place to support the delivery of care and to monitor quality assurance.

We identified a concern regarding one of the seclusion rooms. Senior managers were being proactive in addressing this issue. It was captured on the risk register and an action plan was in place.Senior manages provided assurance formally supported by the provider's chief executive that planned works to upgrade the seclusion facility would be expedited and completed by the end of June 2015. A recruitment plan was also in place around medical staffing. Recruitment had already begun and appointments had been made.

Summary of findings

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

Are services safe?

Good

We rated the service as 'Good' because;

- Patient risk assessments were carried out in a timely manner.
- Ligature risk assessments had been carried and identified risks were managed. However there was a need to be more robust in removing ligatures as opposed to managing the associated risks.
- Ward shift establishments had been determined using a recognised tool and actual staffing levels matched these.
- Managers had access to a cohort of regular bank staff and agency use was low.
- Restraint and seclusion was being used appropriately although associated facilities needed improving.
- Staff were aware of incident reporting procedures. Staff confirmed they received debriefs and support post incident and feedback on the outcomes.
- Staff had a good awareness of safeguarding and safeguarding processes were robust.
- Concern was raised regarding the level of medical staffing which was not in line with best practice outlined by the National Association of PICUs (NAPICU). However the provider has a plan in place to address this and recruitment had already commenced.

Are services effective?

Good

We rated the service as 'Good' because;

- Staff assessed patients within 24 hours of admission using a recognised tool.
- Staff reviewed patient's care plans and progress regularly; including in multi-disciplinary ward rounds.
- Clinical staff delivered care and treatment in line with current evidence based guidance. They audited their compliance with this.
- Staff were appropriately skilled to deliver care and there were a range of disciplines that contributed to the ward.
- There was good access to psychology.
- Wards used the Health of the Nation Outcome Scales (HoNoS) to measure outcomes.
- There was a strong multi-disciplinary approach on the wards.
- There were strong systems in place to ensure adherence with the Mental Health Act.
- There was good practice in applying the Mental Capacity Act.

Summary of findings

However:

- There were some inconsistencies in relation to the monitoring and recording of physical health needs.

Are services caring?

Good

We rated the service as 'Good' because;

- Patients were treated with compassion and respect. We saw several positive interactions between patients and staff.
- Feedback from patients about staff and staff attitudes was positive. Patients felt staff were caring and empathetic
- Patients using the service were given the opportunities to be involved in decisions about their care. Staff facilitated patient attendance at MDT meetings and where applicable involved family and carers.
- Regular community meetings were held on the wards and the minutes of the meetings demonstrated that action was taken in response to issues that had been raised.

Are services responsive to people's needs?

Good

We rated the service as 'Good' because;

- Acute wards had a clear pathway to access PICU beds.
- There was good OT input into wards and a range of activities available to patients.
- Wards had a range of rooms available to patients and access to external garden areas.
- There was good management of complaints.
- There was support for spiritual and religious needs in place and access to a chaplaincy service.

Are services well-led?

Good

We rated the service as 'Good' because;

- Staff were engaged with the vision and values of the provider. Senior management were well known and had a visible presence in clinical areas.
- There were strong governance systems in place.
- There was an open and transparent culture evident on the wards. Staff stated they were supported in their roles and that their managers were approachable.
- Staff were able to make suggestions around service improvement and were encouraged to do so.

Summary of findings

Background to the service

Affinity Healthcare Cheadle Royal provides inpatient mental health services for young people and adults. These services are provided for people who are admitted informally and patients compulsorily detained under the Mental Health Act. This report looks at the acute adult inpatient wards and the psychiatric intensive care units (PICU) provided by the organisation.

The two adult acute wards we visited were:

Alder Ward - a 12 bed mixed gender adult acute ward

Maple Ward – a 12 bed mixed gender adult acute ward

The two PICUs that we visited were:

Pankhurst PICU – a 10 bed female only PICU

Willows PICU – a 11 bed male only PICU

Since their registration with the Care Quality Commission Cheadle Royal Hospital has been inspected six times and each of the acute wards and PICUs have received a visit from a Mental Health Act reviewer. Visits by Mental Health Act reviewers have previously highlighted issues with the environment and seclusion facilities on the PICUs.

Our inspection team

Our inspection team was led by:

Team Leader: Sharon Marston, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a consultant psychiatrist, an expert by experience, a pharmacist and a Mental Health Act Reviewer.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of 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 commencing the inspection visit we reviewed the information we held about these services and engaged with other stakeholders to gather further information.

During the inspection the inspection team:

- Visited both of the acute adult wards and both of the psychiatric intensive care units (PICUs)
- Spoke with the managers of each of these wards.
- Spoke with 11 other staff including doctors, nurses, healthcare assistants, OTs and independent mental health advocates.
- Spoke with 15 patients who were using the service.
- Collected comment cards from six patients.
- Reviewed 12 care records and seven prescribing charts.
- Attended and observed two multi-disciplinary ward rounds.
- Looked at a range of policies, procedures and other documentation related to the provision of care.

Summary of findings

What people who use the provider's services say

We spoke with 15 patients and received five comment cards from the acute and PICU wards.

Overall the feedback from patients on their experience was positive. Staff were praised for their caring attitude and were considered approachable and friendly.

The majority of patients we spoke to felt involved in their care. Patient feedback also included positive comments on the OT and psychology services as well as the medical and nursing staff.

Patients compared their experience at Cheadle Royal positively in relation to their previous expereinces.

Our observations of patient staff interaction were positive. Staff engaged with patients in a caring and empathetic manner and treated them with respect.

Good practice

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider should ensure that they successfully deliver the project to upgrade the seclusion facilities.
- The provider should ensure that their recruitment plans for medical staffing on the psychiatric intensive care units (PICUs) are delivered.
- The provider should ensure identified ligatures are removed where possible.
- The provider should ensure that care plans are person centred and reflective of patient goals.
- The provider should ensure that assessment and management of physical health care issues is consistent.

Affinity Healthcare Limited

Acute wards for adults of working age and psychiatric intensive care units

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Alder ward	Cheadle Royal Hospital
Maple ward	Cheadle Royal Hospital
Pankhurst ward	Cheadle Royal Hospital
Willows ward	Cheadle Royal Hospital

Mental Health Act responsibilities

The acute and PICU wards had effective systems in place to ensure adherence to the Mental Health Act 1983 (MHA) and the Code of Practice (CoP).

Staff were trained in the MHA, the CoP and the guiding principles and were able to seek administrative support and legal advice from a central team.

Documentation in respect of the MHA was generally good. Patient files were in good order with each containing relevant detention documents including a full approved mental health professional report. There was evidence that documents relating to the detention of patients were scrutinised and correctable errors were amended within the specified period and in accordance with the MHA and CoP.

Patients were informed of their rights in accordance with section 132 on admission. Where patients lacked capacity to understand, we found evidence that repeated attempts were made to ensure that patients continued to be given this information until they could understand it.

Patients were being treated under the appropriate authority in line with section 58.

Detailed findings

We found one patient who was being treated under 62 emergency provisions where the responsible clinician had not requested a second opinion appointed doctor to review the assessment.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were part of the provider's mandatory training programme. On Maple ward and Pankhurst and Willow PICUs all nurses and health care assistants had attended training. On Alder ward 11% of nurses were identified as not having attended training.

The provider had policies available covering MCA and DoLS and staff reported they were aware of the documents.

Assessments of mental capacity were completed at key milestones in the patient's treatment although we found one example of a patient who had not had an assessment of his mental capacity documented prior to the first administration of medication.

With the exception of one patient we found that the responsible clinician had recorded patients' capacity to consent to medication.

Good

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean ward environment

The four wards were housed within an old building that was not designed for purpose. As a result there were several environmental issues that were present.

There were some blind spots within the ward layouts which meant that staff could not observe all parts of the ward. On Pankhurst PICU there was a bedroom which could not be directly observed or viewed by cameras. Where these issues were present staff were able to tell us how they were managed by risk assessment and the use of observation. We saw evidence of patients having been risk assessed in relation to the bedroom they were allocated.

There were ligature points on each of the wards. These had been identified through a ligature risk assessment and risks were managed by staff through risk assessment and the use of observation. However removal of these ligature points would further reduce the risks.

Anti-ligature knifes were available to staff. Staff knew where this equipment was and how to use it.

The presence of ligatures has meant the imposition of some restrictive practices. For example ligature risks in the bedrooms on Pankhurst meant patients were risk assessed for keys to their bedrooms and did not always have free access.

In general the wards were clean and well maintained. In response to reports from past CQC Mental Health Act visits, Pankhurst PICU had recently been repainted and patients were involved in choosing the colours used. Pankhurst PICU was located in the basement of the building and damp had been identified in one of the bedrooms. The provider had taken action to address this problem although it had not been fully resolved. Staff had closed the bedroom off and further remedial action was scheduled to take place.

On Alder ward it was not possible to fully open the toilet door on the female corridor due to the sink being located behind it. In a bedroom on Alder ward there is an old fire escape door which allowed a draft and rain in through the base. Staff confirmed that this had been reported and the door was going to be replaced.

Maple and Alder wards were mixed gender wards. There were separate male and female corridors and some of the bedrooms were en-suite. There were separate designated bathrooms on each corridor on Maple ward. On Alder ward, although female patients had access to designated shower facilities on their corridor, the only bath available was on the male corridor. However the provider had a protocol in place to manage this and escort female patients whose preference was to use the bath.

Each of the mixed sex wards had separate female only lounges.

Clinic rooms on the wards were well maintained and tidy. Emergency equipment, including defibrillators, oxygen and first aid kits were in place and in working order. Regular checks were carried out to ensure equipment was fit for purpose.

Emergency drugs such as Epipen were available and staff were aware of their location and how to use them. The temperature of medication fridges was regularly monitored and weekly medication audits were carried out.

The de-escalation room on Pankhurst PICU did not provide a suitable environment. The room did not have suitable furniture including settees so it would not be possible to sit with someone in holds following an incident of restraint.

The seclusion room on Pankhurst did not contain toilet and bathroom facilities. The ward manager was aware of these issues and they were captured on the provider's risk register. There was an intercom and a clock visible to patients and the air conditioning and heating could be controlled. The seclusion room on Willows ward had been refurbished. There was a full length observation window that looked directly onto the attached toilet facilities. This gave an unrestricted view of any patient using the toilet which impacted upon privacy and dignity. The ward manager acknowledged this issue and privacy film was placed on this window that day.

Good

Are services safe?

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

Concern over the suitability of the seclusion rooms in both PICUs had been raised previously by Mental Health Act reviewers. The provider had made progress in this regard and the seclusion room on Willows had been refurbished. We raised the issue of the seclusion room on Pankhurst with the provider at the time of the inspection. During the course of the inspection we received written confirmation from the provider that planned works to upgrade the seclusion room would be expedited from the end of the year to the end of June 2015.

Each of the wards had access to a garden area but these were largely bare. Ward managers did discuss plans to improve the external environment through planting and new furniture.

All the wards were secure and operated a signing in process for visitors. Personal alarms were in use and made available to the inspectors.

Safe staffing

All four wards used the Staffing Ladder to identify the number and grade of nurses required on shift. Completed staff rotas showed that actual staffing levels were in line with the levels and skill mix determined as safe.

Ward managers reported that they had the authority to adjust staffing levels as required. Each ward had a regular cohort of bank staff that they could access if required. Agency staff were used but as a last resort. An orientation process was in place for agency staff along with a competency checklist.

Staff reported that it was rare for 1:1 time or escorted leave to be cancelled due to staffing levels although there were instances when it had been delayed. This was confirmed by the patients that we spoke to.

Concern was raised over the level of medical staffing across the two PICUs. There was one locum consultant and one substantive staff grade covering both units. The National Association of Psychiatric Intensive Care Units (NAPICU) issued staffing guidance in 2014 stating that medical staffing levels would be dependent upon a variety of factors but that there should be a 'dedicated consultant psychiatrist input, and at least one single dedicated sub consultant grade doctor for the unit.' The provider had recognised the need to increase medical staffing levels and this was escalated on their risk register. We raised this issue as part of the inspection and an action plan was in place to increase medical staffing to meet the guidance by May 2015.

Assessing and managing the risk to patients and staff

Every patient had a risk assessment completed within 24 hours of their admission using the STAR risk assessment tool. On Alder Ward staff were developing a new risk screening tool to pilot. Risk assessments were comprehensive, regularly reviewed and reflected in care plans. However physical health care issues were not always captured.

Staff reported that restraint was only used if de-escalation failed. There had been two incidents of restraint on Alder acute ward and 12 incidents of restraint on Maple acute ward in the last six months. None of these involved face down restraint or resulted in the use of rapid tranquilisation. Staff told us that when restraint was used it was often within 24 hours of admission and prompted consideration for transfer to a PICU service.

There had been 44 incidents of restraint on Pankhurst PICU in the last six months. None of these involved face down restraint and rapid tranquilisation was not used. There had been 11 cases of restraint on Willows PICU. None of these involved face down restraint and rapid tranquilisation was not used.

Rapid tranquilisation had not been used in the previous six months but a policy was in place in line with NICE guidance.

Seclusion was being used properly and there was an up to date seclusion log in place. We examined the seclusion records for one patient and found that seclusion was undertaken and documented in line with the Mental Health Act (MHA) and Code of Practice (CoP). However we found that the multi-disciplinary review had not taken place in a timely manner as specified by the CoP.

Staff on Alder and Maple acute wards used the seclusion facilities on the PICU when they were required. There had been three incidents of seclusion from Alder ward and eight from Maple ward in the last six months.There had been 30 incidents of seclusion on Pankhurst PICU and 18 incidents of seclusion on Willows PICU in the last six months.

Good

Are services safe?

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

All staff that we spoke to had received safeguarding training. Training records supplied by the provider demonstrated a high level of compliance with both vulnerable adult and child safeguarding training.

Staff were aware of safeguarding processes, what kind of issues should be reported and how this should be done. Staff could discuss concerns with their line manager and stated they could access advice from the Priory Safeguarding Lead.

Safeguarding was discussed at handovers and in MDT ward rounds. It was also discussed as part of supervision.

There was good medicine management practices on the wards we visited. An external pharmacist attended each ward weekly to carry out audits and the findings were discussed with staff. This included highlighting any prescribing outside of British National Formulary (BNF) guidance and discussing the rationale for it. A controlled drugs book was in place on each ward and appropriate locked cabinets were used for storage. Fridge temperatures were monitored regularly.

Track Record on Safety

In the period between the beginning of December 2013 and the end of November 2014 the PICUs reported 24 serious incidents requiring investigation (SIRI). Pankhurst PICU reported 17 of these and Willows PICU reported 7. These included the reporting of abuse that occurred outside of the service and that resulted in safeguarding referrals.

In the period between the beginning of December 2013 and the end of November 2014 the acute wards reported 6 SIRI incidents. Maple ward reported 4 of these and Alder ward reported 2.

Information about adverse incidents and lessons learnt was available to team managers and cascaded to staff through team meetings. We saw an example on Willows ward where the hospital director had attended a team meeting to report back on the findings of an investigation into a serious incident.

Reporting incidents and learning from when things go wrong

Staff knew how to recognise and report incidents using the provider's electronic system. They discussed a variety of ways in which they received feedback from incidents. These included team discussion in handovers, the use of a clinical risk bulletin and a copy of incident recommendations being available to staff.

Staff reported that they received debrief sessions after incidents and that they could access additional support from the psychologists on the ward either on a 1:1 basis or in a group setting.

Are services effective?

Good

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

Summary of findings

Our findings

Assessment of needs and planning of care

During the course of the inspection we reviewed 12 care records and seven prescription charts.

Initial assessment occurred within 24 hours of admission. Assessments were mainly comprehensive and findings were reflected in care plans. However physical health needs were not always being effectively monitored or documented. We reviewed three care plans on Maple ward where the majority of information under the physical health section was recorded as 'unknown'. However there was effective monitoring and management of a patient with diabetes on the same ward.

Records we reviewed on Alder, Pankhurst and Willows ward also had variable levels of physical health assessment and limited evidence of on-going physical health care.

Care records were up to date and had been regularly reviewed. However not all of the care plans we reviewed clearly captured patient views and some were not patient centred. Alder ward was developing a wellness and recovery care programme to facilitate a greater focus on patient goals and needs.

Best practice in treatment and care

Policies were in place to ensure medication was prescribed in line with NICE guidance. A regular weekly audit was conducted by an external pharmacist and highlighted any prescribing outside of recommended levels. In such cases the prescribing doctor provided a rationale for the decision.

Patients could access psychological therapies as part of their treatment and psychologists were part of the ward team. Psychologists attended the MDT ward rounds.

The ward staff assessed patients using the Health of the Nation Outcome Scales.

Ward staff were aware of the service's audit programme and stated that findings and recommendations were discussed in team meetings and handovers. During the inspection we saw examples of completed audits covering areas such as medication management, care planning and infection control.

Skilled staff to deliver care

The staff group on each ward represented a range of professional backgrounds including nursing, medical, OT and psychology. Staff such as gym instructors also contributed where applicable. Staff were appropriately qualified and had the skill set required for their role. The staff we spoke to were highly motivated and focused on providing good quality care.

Staff received appropriate training and supervision and stated they felt supported in their role. Staff undergo annual appraisal and received supervision carried out in both 1:1 and group formats. On Alder ward, supervision for health care assistants needed to be held more regularly and there was an action plan in place to achieve this.

Staff training covered both mandatory and specialist training. Managers had access to training compliance figures. Attendance at mandatory training ranged from 81% to 95% and was discussed in supervision.

Staff told us of additional training that was available. Staff on Willows ward referred to teaching sessions put on by the psychologist. A nurse we spoke to on Pankhurst referred to training in the use of gym equipment which enabled them to support patients to use the facility.

Managers were able to explain the process for addressing poor staff performance and the use of performance improvement plans. Staff we spoke to stated they felt supported by their managers and ward colleagues.

Multi-disciplinary and inter-agency work

MDT meetings were held weekly on each ward. We observed three MDT meetings. There was strong multi-disciplinary attendance by staff covering a range of roles who worked together well. Effective reviews of patient care and progress were carried out and patient involvement was promoted.

We observed one handover. The handover covered all key issues including changes in patient presentation, risk and safeguarding.

Many patients resided outside the local area and communication with care coordinators was often via telephone. Pankhurst ward explained that they also sent minutes of MDT reviews to care coordinators to ensure effective sharing of information.

Are services effective?

Good

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

Adherence to the MHA and MHA Code of Practice

Staff had received training on the Mental Health Act and the Code of Practice. This was included as part of the mandatory training requirements. Compliance across the teams was good. On Alder ward 89% of nurses and 100% of health care assistants had attended training. On Maple ward 100% of nurses and 80% of health care assistants had attended training. On Pankhurst PICU 89% of nurses and 94% of health care assistants had attended training. On Willows PICU 100% of nurses and 90% of health care assistants had attended training.

All four wards had strong systems in place to ensure adherence to the Mental Health Act and the Code of Practice.

We reviewed a sample of patient records and found treatment was being given under the appropriate authority in accordance with section 58 of the MHA.

Patients were informed of their rights in accordance with section 132 on admission. Where patients lacked capacity to understand repeated attempts were made to ensure patients were given this information until they could understand it. Patients confirmed that they had regular discussions about their rights with staff and were aware of their legal status.

Staff were able to access advice from the Mental Health Act office.

Monthly audits against the MHA were carried out on each ward and discussed in team meetings and supervision sessions.

We checked the records of eight detained patients and found evidence that effective systems and processes were in place for the administration of the Act. Patient care records were in good order with each containing relevant detention documents including a full approved mental health professional report. Detention documents were scrutinised and correctable errors were amended within the specified period and in accordance with the Act and Code of Practice.

Good practice in applying the MCA

Training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was included as part of the provider's mandatory training requirements. Compliance across the teams was good. On Maple ward and Pankhurst and Willow PICUs all nurses and health care assistants had attended training. On Alder ward 11% of nurses were identified as not having attended training.

The provider had relevant policies in place on the MCA including DoLS. Staff were aware there were policies in place.

Assessment of mental capacity was completed upon admission and at key milestones within treatment. Capacity to consent was recorded appropriately in the records we reviewed. Copies of the mental capacity assessment were attached to the medicine card. However we found one example of a detained patient who had not had an assessment of his mental capacity documented prior to the first administration of medication.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

Throughout our inspection we witnessed patients being treated with dignity and respect and in a caring and compassionate manner.

Feedback from patients was positive and complimentary towards staff. Patients reported that they were treated with empathy and that staff took the time to listen to them.

In handovers staff displayed a good understanding of individual patient need and discussed care in a respectful manner.

Staff we spoke too felt that patients received good care on the ward and that privacy and dignity were respected. We observed staff ensuring that patient's privacy and dignity were protected where possible. For example staff closed bedroom doors when delivering care and removing distressed patients to private areas to talk.

The involvement of people in the care they receive

All four wards had an orientation process for new admissions. There were also information leaflets available that had been developed with patients. The admission process included an explanation of patients' rights under the Mental Health Act.

Staff encouraged and facilitated patient involvement in multi-disciplinary ward rounds. On Pankhurst Ward patients completed a questionnaire detailing their objectives and desired outcomes. Maple Ward utilised a prompt sheet for patients to help them participate.

Patients told us that care plans were discussed with them and they were asked for their views. However the care plans we looked at did not clearly demonstrate this.

All four wards provided access to advocacy. However some of the wards were more proactive in their approach to promoting this than others. Posters advertising advocacy were clearly displayed on Willows, Alder and Maple ward but not on Pankhurst. Wards held regular drop in sessions and patients told us they were supported to access advocacy if they wished too.

Staff and patients told us that families and carers were involved in care planning where appropriate. On Maple and Alder wards we saw evidence of family members having attended ward rounds.

All four wards held weekly community meetings and displayed the minutes of these in communal areas. Wards had suggestion / comments boxes for patients to utilise if they wished to. Staff told us that they also received feedback informally from patients. On Pankhurst Ward staff told us how feedback had led to an extension of the occupational therapy room opening hours.

Patients were given the opportunity to be involved in decisions about the service. On Pankhurst ward patients had decided on the paint colours for the walls as part of a redecoration process.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access, discharge and bed management

Staff reported that patients going on leave from Alder or Maple ward always had access to a bed upon their return. None of the patients we spoke to had experienced any difficulties in this regard.

Patients were only moved between wards during an admission if it was justified on clinical grounds. This occurred when a patient had been admitted to either Alder or Maple acute wards but were then deemed to require a PICU service.

Staff on Alder and Maple wards did not report any difficulties being able to access beds in the PICU service.

There were some issues with discharge planning. Staff told us that discharge planning starts from admission but we did not always see evidence within patient notes that this happened routinely. However in part this was because some patients are admitted from outside of the region and could be returned to their home area at short notice. Staff maintain contact with patients home care coordinators through phone, email and letter. We saw evidence of this within patients notes.However staff did state that the quality of this communication varied depending upon the home care team.

There had been 11 delayed discharges in the last six months from Willows PICU and four in the same time period from Pankhurst PICU. The primary cause for this was the lack of a step down placement in the patient's home area.

The ward optimises recovery, comfort and dignity

The wards offered a range of rooms and facilities to support treatment and care. These included the provision of clinic rooms, OT facilities, group rooms and gym space.

Each ward had rooms that could be used for visiting. However on Pankhurst PICU the room identified for this purpose had small windows which were high on the wall and provided only limited air flow. Staff confirmed that the door was often left open when visiting was taking place to provide a flow of air. However this could impact upon the privacy of the visit.

Facilities were in place to allow patients to make phone calls in private. Managers we spoke to told us they were reviewing the possibility of utilising Skype.

All wards provided access to an external garden space. However not all of these were welcoming spaces and some contained additional ligature risks. These were managed through the use of observations and CCTV. Smoking shelters were available for patients.

Patients told us that food was OK and there was a choice. Menus were displayed in the ward. Staff assisted patients in making a choice were required.

On Alder and Maple acute wards patients had access to a kitchen and drink making facilities on a 24/7 basis. On Pankhurst and Willow PICUs such access was restricted due to safety reasons. However patients told us that they were able to access hot drinks and snacks through staff.

There was access to a wide and varied occupational therapy (OT) programme on each ward. An OT activity programme was clearly displayed on each ward and staff supported patients to attend. OT staff were present Monday to Friday and nursing and ward staff provided activities over the weekend such as DVD nights and games tournaments. However the OT care plans did not always accurately capture the level of occupational therapy activity that had been delivered. The OTs were flexible in response to patient feedback and OT programmes were adjusted in response.

Meeting the needs of all people who use the service

There was a lift in place to facilitate disabled access to Pankhurst PICU and Alder acute ward which were located in the basement of the building. Assisted bathrooms were available.

There was good provision of information on treatment, services and patient rights on Willows PICU and Alder and Maple acute wards. However this was not the case on Pankhurst PICU where there was limited information on display about advocacy services and what was available was obscured by other leaflets.

Are services responsive to people's needs?

Good

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

Staff told us that they had good access to interpreting services and always sought to use face to face translators. A policy was in place to support use.

Staff told us that leaflets and information could be translated into other languages. We saw evidence of this having taken place. However we also spoke to three service users whose first language was not English. They told us they had not been offered information translated into their own language.

There was access to chaplaincy services and spiritual support available to patients. We saw evidence of services responding to patients' religious and spiritual needs. For example on Alder ward a woman who had been admitted recently was supported to practice her druid faith during a full moon period.

Listening to and learning from concerns and complaints

All the patients that we spoke to said they would be willing to raise any issue they had with staff although they were not all aware of the formal complaints process. Information on how to make a complaint was available however and on display on the wards.

Staff we spoke to were aware of the complaints process and were able to explain how they are managed.

Data on complaints was available. In the past 12 months Alder acute ward received nine complaints. Two of these were withdrawn and six were upheld. Maple acute ward received three complaints. Two of these were withdrawn and the third was not upheld. Pankhurst PICU received 14 complaints. Five of these were withdrawn and five were upheld. Willows PICU received eight complaints of which six were upheld. There was no common theme amongst the complaints. None of the complaints were referred to the Ombudsmen.

We saw evidence of an open and honest culture in the management of complaints. We saw examples of complaints which managers had proactively escalated to the complaints department for a senior manager to independently review.

Are services well-led?

Good

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

Summary of findings

Our findings

Vision and values

The provider's vision and values were evident and on display on the wards. Staff were aware of these and reported they understood and agreed with them.

Ward managers were aware of the provider's objectives and these informed team and individual staff objectives.

Staff were aware of senior managers and stated that they were a regular presence on the ward. Ward managers told us that senior managers were approachable and operated open door policies. Senior managers conducted regular 'quality walk arounds' of the wards.

Good governance

There were systems in place on the wards to monitor staff compliance with mandatory training, appraisal and supervision. Staff told us they felt supported in their roles.

Shift establishments were set using a recognised tool and actual staffing matched requirements.

There were good governance systems in place. Quarterly performance reports were available and included Health of the Nation Outcome Scales scores, patient satisfaction surveys and audit results. Staff were aware of how to access the provider's policies and procedures. There were good processes in place to monitor adherence with mental health legislation for detained patients.

Ward managers told us they had autonomy to manage the ward and felt supported by senior managers. There was a pathway for staff to submit items to the hospital risk register through line management and governance forums. Risk registers were reviewed through governance forums attended by managers.

Leadership, morale and staff engagement

There was no significant staff sickness on the wards.

Staff we spoke to were aware of the provider's whistle-blowing process. All of the staff we spoke to stated they would be confident raising an issue and did not fear that they would be victimised if they did.

We found the wards to be well-led. The culture on the wards was open and staff reported that morale was good. Staff felt supported by their manager and ward colleagues and praised the team environment and collaborative approach.

Staff told us they could make suggestions regarding service development and that managers were open to feedback. On Willows PICU we saw work being led by nursing staff to redesign the referral process and documentation to create a more efficient pathway.

Staff we spoke to were aware of the provider's Listening in Action project.

Commitment to quality improvement and innovation

At the time of the inspection the wards were not participating in national quality improvement programmes. Staff told us this was due to the physical environments of the wards and once scheduled work was completed to up-grade and improve the ward environments, they intended to participate in the Accreditation of Inpatient Mental Health Services initiative. Maple and Alder wards were adopting the Star Wards initiative.