Humber NHS Foundation Trust

Rehabilitation services

Quality Report

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Date of inspection visit: 22-23 May 2014
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Hawthorne Court	RV941	Hawthorne Court	HU3 3SW
St Andrew's Place	RV980	St Andrew's Place	HU165JQ

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Humber NHS Foundation Trust provides long stay, rehabilitation inpatient mental health services for adults aged 18 to 65 years old.

People who used the services said that they felt safe. Staff understood how to escalate and report any concerns. They also assessed, monitored and managed the risks people posed very well.

The wards were clean and welcoming, and the standard of decoration was generally very good. There were systems in place to assess and monitor the safety of the environment. However, we found ligature risks on some doors within St Andrews Place.

All the people we spoke with told us that they were happy with their care, and felt supported and well-cared for by staff. We found the care staff provided to be outstanding.

The multidisciplinary teams worked well together to plan and deliver care, and there were some excellent examples of how staff engaged and included people, for example in developing their care plans.

We found a care plan for one person who was admitted informally to St Andrews Place stated 'Leave to be agreed with the MDT (multidisciplinary team)'. This practice did not comply with the Mental Health Act Code of Practice because it did not reflect the person's lawful right to leave the ward at any time, and could lead to the person being detained unlawfully.

Staff at St Andrews Place assisted people to prepare meals however; we found they had not received training in basic food hygiene. There were no plans in place for staff to receive this training.

The service had some governance structures in place, which were used on all the wards.

Summary of findings

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

Are services safe?
People who used the services said that they felt safe. Staff understood how to escalate and report any concerns. They also assessed, monitored and managed the risks people posed very well.

There were systems in place to assess and monitor the safety of the environment. However, we found that these had not identified the ligature risks we on some doors which meant these had not been addressed.

Are services effective?
Both the wards had received the Royal College of Psychiatrists' Accreditation for Inpatient Mental Health Services (AIMS). One of the wards were rated 'Excellent'.

A recovery-based model of care was being used across the service to help people get better, and we found that people were involved in developing their care plans. Staff also told us that they had support to provide care and treatment from a range of professionals in the multidisciplinary team.

Are services caring?
People told us that staff treated them with respect and dignity, and they were positive about staff's attitude towards them. All the people we spoke with told us that they were happy with their care, and that they felt supported and well-cared for by staff. We found the care that staff provided on the wards to be outstanding.

We saw some excellent examples of how staff engaged and included people in their care.

Are services responsive to people's needs?
People said they were making progress and were very happy with their care and treatment. We did, however, identify a concern about the use of a restrictive practice on one ward which did not reflect the rights of informal people using services.

Are services well-led?
The service had strong governance structures in place, which were used on all the wards. The wards held regular staff meetings that focused on governance issues. These were linked to the directorate governance meetings, which assured us that concerns or learning could be escalated and shared across the services. Staff achievements were also recognised and celebrated.

Summary of findings

Background to the service

Humber NHS Foundation Trust has two long stay, rehabilitation inpatient wards for adults aged 18 to 65 years old.

The wards are based at St Andrew's Place and Hawthorne Court. They provide care and treatment to people who are admitted informally, as well as those detained under the Mental Health Act.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell CEO Oxford Health NHS Foundation Trust

Team Leaders: Surrinder Kaur and Cathy Winn, Care Quality Commission (CQC) inspection managers

The team included: CQC inspectors, Mental Health Act commissioners, a consultant psychiatrist, a student nurse, an occupational therapist and an Expert by Experience

Why we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

We visited the long stay services of Humber NHS Foundation Trust on 22 and 23 May 2014. During the visit, we held focus groups with a range of staff who worked within the service, including nurses, doctors, and therapists. We talked with people who use services, their carers and/or family members. We also observed how people were being cared for and reviewed their care or treatment records. We used the information we hold about the service, as well as the information we gathered, to inform our inspection of the service and the questions we asked.

How we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health inspection programme.

What people who use the provider's services say

Before the inspection, we spoke with people who used the service at focus groups. Overall, people told us that staff treated them with respect and dignity, and they were positive about staff's attitude towards them.

Every ward held patient meeting forums, and people who attended these meetings said they felt listened to.

Summary of findings

Good practice

- One ward had developed links with Gyroscope which provided support and assistance to people pursuing employment options.
- One ward had built relationships with LINKS (housing association) and Mind to facilitate discharge planning.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider Must take to improve:

- The trust must ensure that the ligature risks on the doors at St Andrew's Place are effectively managed.
- The trust must ensure leave care plans for informal people at St Andrews Place are compliant with the MHA Code of Practice.
- The trust must ensure that staff at St Andrews Place, receive training in basic food hygiene prior to assisting people with the preparation of food.

Humber NHS Foundation Trust

Rehabilitation services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hawthorne Court	Hawthorne Court
St. Andrews Place	St Andrew's Place

Mental Health Act responsibilities

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

We found that paperwork relating to the MHA was completed and filed appropriately as required by the MHA Code of Practice. The statutory detention paperwork was found to be correct and detentions appeared to be lawful. There was good evidence to show that people had been read their rights under Section 132 at monthly intervals and had also been given written information regarding their detention. People we spoke with told us they understood their rights and the legal implications in relation to their detention under the MHA.

We saw that medication was prescribed within British National Formulary (BNF) limits and in accordance with the T2 and T3 forms. However; on Hawthorne Court that not all old T2 and T3 forms had been crossed out which could cause confusion regarding which was the most current form and therefore it was not clear if the person was consenting to treatment or not.

People's capacity to consent to treatment was recorded appropriately.

People we spoke with were aware of the medication they were prescribed and the reasons why they were prescribed it. This is in keeping with the Code of Practice (23.9). We saw evidence which showed that staff had referred people to an Independent Mental Health Advocate appropriately.

We saw evidence that demonstrated people had attended Mental Health Review Tribunals.

People we spoke with, who had been granted Section 17 leave by their consultant, told us that there were enough staff to enable them to take this. On Hawthorne Court we found some Section 17 forms had been signed by the person and their consultant. This is an example of best practice.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

All the wards we visited staff had received training in, and were complaint in their clinical practice with the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguarding legislation.

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

People who used the services said that they felt safe. Staff understood how to escalate and report any concerns. They also assessed, monitored and managed the risks people posed very well.

There were systems in place to assess and monitor the safety of the environment. However, we found ligature risks at St Andrews Place on some doors which had not been identified or addressed.

Staff at St Andrews Place assisted people with the preparation or cooking of food however; they had not received training in basic food hygiene which could pose a risk to people.

Our findings

St Andrew's Place

Track record on safety

There were clear systems and policies in place for staff to follow regarding the reporting of safeguarding incidents to keep people safe and also safeguard people from possible abuse. Staff were aware of their responsibilities in relation to escalating and reporting any safeguarding concerns they might have. Staff said they would have no hesitation in escalating concerns to their manager and we found evidence demonstrating ward staff had made appropriate safeguarding referrals through internal and external reporting systems as appropriate.

All the people we spoke with said they felt safe on the ward and comfortable raising any concerns they may have with staff.

Learning from incidents and improving safety standards

The ward had an electronic incident reporting system in place which was completed following any incidents allowing ward manager to review and grade the severity of incidents. Staff at all levels knew how to use the system and what their responsibilities were when reporting incidents. Incidents were analysed by the ward manager, identifying any trends and taking action in response.

The ward held regular ward meetings with staff. The meetings covered agenda items which included safeguarding and learning from incidents and safety alerts. Minutes were made available for staff who were unable to attend the meetings.

We saw evidence which showed the risk assessments and care plans of people involved in any incidents were updated in a timely manner, following an incident, and appropriate action taken to manage potential future risk.

Handovers took place to ensure that on-coming staff were made aware of any incidents which had taken place on the ward, who had been involved in the incident and the outcome.

There was evidence that safety alerts were received and actioned by the ward manager appropriately. All staff we spoke with told us there was an open culture on the ward and within the trust overall. They said they would not have any hesitations in reporting an incident which occurred.

Assessing and monitoring safety and risk

Staff had received training in safeguarding. The trust had a 'Whistleblowing' policy in place which staff were aware of. The policy provided detailed information to guide staff on how they could raise and escalate concerns within the trust anonymously.

The ward had systems in place to assess and monitor risks to individual people. Each person had an up to date risk assessment completed in their care records.

Staff told us that regular ligature risk assessments were undertaken on the ward. However, we found that these had not identified that several doors had ligature points which posed a potential risk to people who used the service. We raised our concerns with the manager at the time of our visit. We have also asked the trust to address this issue urgently in view of the risk posed.

Staff told us that they assisted people to prepare meals, however we found that staff had not received training in basic food hygiene. This meant that staff were not appropriately trained to assist people in the preparation or cooking of food which could pose a risk to these individuals.

Are services safe?

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

Understanding and management of foreseeable risks

The ward had plans in place to respond to possible emergencies with access to emergency first aid and resuscitation equipment on site which staff were trained to use. This equipment was checked on a regular basis to ensure it remained in good working order and that expiry dates had not been exceeded.

The ward had an effective system in place to assess and monitor risks to individual people. Each person had an up to date risk assessment in their case notes, which was reviewed regularly.

All staff on the ward were provided with personal alarms. Staff told us however, that if they were required to restrain a person during the night, they did not always have a sufficient number of staff to do this, provide care to the other people on the ward and call for assistance. Staff told us they felt on these occasions, that the safety of the ward was compromised.

Hawthorne Court

Track record on safety

There were clear systems and policies in place for staff to follow regarding the reporting of safeguarding incidents to keep people safe and safeguard people from possible abuse. Staff we spoke with were aware of their responsibilities in relation to escalating and reporting any safeguarding concerns they may have. Staff told us they would have no hesitation in escalating concerns to their manager. We found evidence which demonstrated that ward staff had made appropriate safeguarding referrals through internal and external reporting systems as appropriate.

All the people we spoke with said that they felt safe on the ward and comfortable raising any concerns they may have with staff.

Learning from incidents and improving safety standards

The ward had an electronic incident reporting system in place which was completed following any incidents which allowed the ward manager to review and grade the severity of incidents. Staff at all levels were aware of how to use the system and their responsibilities in relation to reporting incidents. Incidents were analysed by the ward manager to identify any trends and appropriate action was taken in response to these.

The ward held regular ward meetings with staff. The meetings covered agenda items which included safeguarding and learning from incidents and safety alerts with minutes made available for staff who were unable to attend the meetings.

We saw evidence which showed the risk assessments and care plans of people involved in any incidents were updated in a timely manner following an incident and appropriate action taken to manage potential future risk.

Handovers took place to ensure that on-coming staff were made aware of any incidents which had taken place on the ward, who had been involved in the incident and the outcome of the incident.

Some staff told us that learning and recommendations from Serious Untoward Incidents (SUI's), which may have occurred on the ward they were working or on another ward, could sometimes seem to take a long time to be disseminated to them. Staff told us this was due to the time it could take for the reports to be completed.

There was evidence that safety alerts were received and actioned by the ward manager appropriately.

All staff we spoke with told us there was an open culture on the ward and within the trust overall. They said they would not have any hesitations in reporting an incident which occurred.

Assessing and monitoring safety and risk

Staff had received appropriate training in safeguarding and the ward had an identified safeguarding lead within the team. The trust had a 'Whistleblowing' policy in place which staff were aware of. The policy provided detailed information to guide staff on how they could raise and escalate concerns within the trust anonymously if they wished to do so.

We were told by staff that the ward had regular ligature audits completed. The ward environment was clean, tidy and free from hazards.

The ward provided accommodation for both male and female people. We saw there was a locked door separating male and female bedroom areas and separate bathing and toileting facilities. The ward had a separate lounge available for female people who used the service. This meant the ward was compliant with Same Sex Accommodation (SSA) requirements.

Are services safe?

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

Understanding and management of foreseeable risks

The ward had appropriate plans in place to respond to possible emergencies, with access to emergency first aid and resuscitation equipment on site which staff were trained to use. This equipment was checked on a regular basis to ensure it remained in good working order and that expiry dates had not been exceeded.

All staff on the ward were provided with personal alarms. People we spoke with told us that staff were quick to respond to alarms and any problems on the ward.

The ward had effective systems in place to assess and monitor risks to individual people. Each person had an up to date risk assessment in their case notes which was reviewed regularly.

The unit was kept locked to prevent entry by anyone not authorised to enter the ward and also to keep vulnerable people safe from exiting the unit. All visitors were required to sign in and out at reception.

Are services effective?

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

Both the wards had received the Royal College of Psychiatrists' Accreditation for Inpatient Mental Health Services (AIMS). One of the wards was rated as, 'Excellent'.

A recovery-based model of care was being used across the service to help people get better, and we found that people were involved in developing their care plans. The overall standard of the care plans we looked at on the wards was very good.

Staff also told us that they had support to provide care and treatment from a range of professionals in the multidisciplinary team.

Our findings

St Andrew's Place

Assessment and delivery of care and treatment

The ward had processes in place to assess the needs of each person before they were admitted to the ward. The assessment included the person's social, cultural, psychological, occupational and physical needs. Each person had a detailed comprehensive risk assessment in their care records which identified the person's risk to self and others. Where a risk had been identified, there were clear risk formulations which had been completed. This was to ensure that people's needs could be safely met on the ward.

A care plan was then developed to meet their identified needs' under the framework of the Care Programme Approach (CPA). However; some people told us they either did not have a care plan or were not sure if they had one. In the care records we looked at, we found evidence that people did have up-to-date case notes and there was evidence of people's views documented in the records.The person's carer or family were fully involved in people's care planning with the consent of the person. The care plans we looked at were centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice. In all the care records we looked at, we found signed evidence to demonstrate that people had consented to their care plans. The care plans were very focussed on recovery and included the person's aspirations and a recovery wellness plan. The overall standard of the care plans we looked at on this ward was very good.

People who used the service had access to a range of evidenced based psychological interventions which included relapse prevention work, family work and Cognitive Behavioural Therapy. Each person had an individualised programme which included a range on activities and therapeutic interventions which were delivered both on the ward and within the community. The ward offered a number of activities for people including various groups such as; anxiety management, confidence building, trips and leisure activities. Activities had also been planned for weekends.

The ward had developed links with Gyroscope which provided support and assistance to people pursuing employment options.

People had access to a range of health promotion advice such as smoking cessation and healthy eating. People received annual health checks and told us they had no problems accessing a doctor if they had a physical health need.

People we spoke with told us that they received their medication as prescribed. The medication administration record (MAR) charts we looked at confirmed this. All the people we spoke with told us that they were satisfied with their care and treatment and were very complimentary about the care they received from staff.

Outcomes for people using services

The staff we spoke with told us they felt that they were able to manage their workload. They had a clear understanding of the needs of the people they were involved with and were clearly able to describe the desired outcomes of people and how they were working towards those. The ward had embedded the principles of the recovery model within clinical practice to assist people in their recovery.

Staff we spoke with explained how they took great care to ensure that people were discharged to appropriate accommodation which could meet their needs. The discharge process included staff supporting people during the transitional period from the ward to community based accommodation to reduce the risk of relapse.

Are services effective?

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.

People we spoke with told us that they had built good relationships with staff and felt staff supported them well. People were very clear about what they wanted to achieve and could describe how staff were assisting them to meet their goals.

The team had been awarded the, Accreditation for In-Patient Mental Health Services (AIMS) award from the Royal College of Psychiatrists (RCP) with excellence. The award is given to services which have been assessed as meeting set standards which cover area's such as; staffing, service provision, care plans, transfer between services and interventions people receive.

Staff, equipment and facilities

The ward had sufficient numbers of staff on duty to meet people's needs. The staff we spoke with told us they felt that they were able to manage their workload. Staff told us that the manager would use bank staff if there was any shortfall in staffing numbers due to unforeseen circumstances such as staff sickness.

The training records showed that staff had access to range of training relevant to their role. Staff we spoke with told us that they felt well supported by their local manager in relation to training.

Staff received regular clinical supervision and annual appraisals in line with trust policy. The ward had an established; 'Reflective Practice Group' which staff attended to discuss clinical issues. Staff told us they valued these sessions and found them very beneficial.

The ward was clean, tidy and well decorated. People we spoke with told us they were happy with the standard of their bedroom and the ward environment.

The ward had sufficient equipment and facilities to meet people's needs'. These included an assessment kitchen, laundry room, access to a garden area and private meeting rooms. There were a range of activities available for people on the ward.

There was a system in place to report any maintenance issues which needed attention. Staff told us that any issues they reported were dealt with in a timely manner.

Multi-disciplinary working

All the staff we spoke with told us that they were supported by a range of professionals within a multi-disciplinary team (MDT) framework to provide care and treatment to people. This included ward based professionals such as psychologists, occupational therapists, occupational therapy assistants, nursing and medical staff and health care support workers. In addition; the wards were supported by social workers, pharmacists, Independent Mental Health Advocates, faith leaders, General Practitioners, dieticians and Care Co-ordinators for example. We saw evidence that ward rounds and Care Programme Approach (CPA) meetings had input from the professionals involved in peoples' care and that decisions were made using the MDT approach. People's carers' or relatives were also involved in line with the person's wishes.

People we spoke with told us they had the opportunity to attend reviews about their care and CPA meetings. We saw evidence in people's records which confirmed this.

Mental Health Act (MHA)

The statutory detention paperwork was found to be correct and detentions lawful. We found that paperwork relating to the MHA was completed and filed appropriately as required by the MHA Code of Practice. There was good evidence to show that people had been read their rights under Section 132 at regular intervals and had also given written information regarding their detention.

We saw that medication was prescribed within British National Formulary (BNF) limits and in accordance with the certificates of treatment for consenting and non consenting detained people. We found that people had been appropriately referred to be assessed by a Second Opinion Appointed Doctor (SOAD) in line with the requirements of the MHA.

People we spoke with were aware of the medication they were prescribed and the reasons why they were prescribed it. This is in keeping with the Code of Practice (23.9). We saw evidence which showed that staff had referred people to an Independent Mental Health Advocate appropriately.

People we spoke with told us that if they had Section 17 leave granted; that there were enough staff to enable them to take this. People were aware and understood any conditions which were stipulated within their Section 17 leave forms.

Hawthorne Court

Assessment and delivery of care and treatment

The ward had processes in place to assess the needs of each person before they were admitted to the ward. The assessment included the person's social, cultural, psychological, occupational and physical needs. Each

Are services effective?

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.

person had a detailed comprehensive risk assessment in their care records which identified the person's risk to self and others. Where a risk had been identified, there were clear risk formulations which had been completed. This was to ensure that people's needs could be safely met on the ward.

All the people we spoke with said they had been involved in developing their care plans with staff. The person's carer or family were fully involved in people's care planning with the consent of the person. The care plans we looked at were centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice. Care plans were written and reviewed with the involvement of the person. In all the care records we looked at, we found signed evidence to demonstrate that people had consented to their care plans. The care plans were very focussed on recovery and included the person's aspirations and a recovery wellness plan. The overall standard of the care plans we looked at on this ward was very good.

People who used the service had access to a range of evidenced based psychological interventions which included relapse prevention work, Cognitive Behavioural Therapy and mindfulness therapy.

Each person had an individualised programme which included a range of activities and therapeutic interventions which were delivered both on the ward and within the community.

People had access to a range of health promotion advice such as smoking cessation and healthy eating. People received annual health checks and told us they had no problems accessing a doctor if they had a physical health need. We saw evidence in the documentation of discharge planning which people had been involved in developing.

People we spoke with told us that they received their medication as prescribed. The medication administration record (MAR) charts we looked at confirmed this. All the people we spoke with told us that they were satisfied with their care and treatment and were very complimentary about the care they received from staff.

Outcomes for people using services

The staff we spoke with told us they felt that they were able to manage their workload. They had a clear understanding of the needs of the people they were involved with and were clearly able to describe the desired outcomes of people and how they were working towards those. The ward had embedded the principles of the recovery model within clinical practice to assist people in their recovery.

The ward had an assessment flat on-site which was used to support people to become more independent before being discharged from the ward. Staff we spoke with explained how they took great care to ensure that people were discharged to appropriate accommodation which could meet their needs. The discharge process included staff supporting people during the transitional period from the ward to community based accommodation to reduce the risk of relapse.

People we spoke with told us that they had built good relationships with staff and felt staff supported them well. People were very clear about what they wanted to achieve and could describe how staff were assisting them to meet their goals.

The team had been awarded the, Accreditation for In-Patient Mental Health Services (AIMS) award from the Royal College of Psychiatrists (RCP) with excellence. The award is given to services which have been assessed as meeting set standards which cover areas such as staffing, service provision, care plans, transfer between services and interventions people receive.

Staff, equipment and facilities

The ward had sufficient numbers of staff on duty to meet people's needs. Staff told us that the manager would use bank staff if there was any shortfall in staffing numbers due to unforeseen circumstances such as staff sickness. The staff we spoke with told us they felt that they were able to manage their workload. One person we spoke with told us, "There is always plenty of staff around."

The training records showed that staff had access to range of training relevant to their role. Staff we spoke with told us that they felt well supported by their local manager in relation to training.

Staff received regular clinical supervision and annual appraisals in line with trust policy. The ward had an established; 'Reflective Practice Group' which staff attended to discuss clinical issues. Staff told us they valued these sessions and found them very beneficial.

Are services effective?

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.

The ward was clean, tidy and well decorated. People we spoke with told us they were happy with the standard of their bedroom and the ward environment.

The ward had sufficient equipment and facilities to meet people's needs'. These included an assessment kitchen, laundry room, access to a garden area and private meeting rooms. There were a range of activities available for people on the ward.

There was a system in place to report any maintenance issues which needed attention. Staff told us that any issues they reported were dealt with in a timely manner.

Multi-disciplinary working

All the staff we spoke with told us that they were supported by a range of professionals within a multi-disciplinary team (MDT) framework to provide care and treatment to people. This included ward based professionals such as psychologists, occupational therapists, occupational therapy assistants, nursing and medical staff and health care support workers. In addition; the wards were supported by social workers, pharmacists, Independent Mental Health Advocates, faith leaders, General Practitioners, dieticians and Care Co-ordinators. We saw evidence that ward rounds and Care Programme Approach (CPA) meetings had input from the professionals involved in peoples' care and that decisions were made using the MDT approach. People's carers' or relatives were also involved in line with the person's wishes.

People we spoke with told us they had the opportunity to attend reviews about their care and CPA meetings. We saw evidence in people's records which confirmed this.

Staff held regular handovers for on-coming staff. One person we spoke with told us they "Could tell that information was shared with the team at handovers" as on coming staff where aware and informed about issues which had occurred before they started their shift. This demonstrates there were effective channels of communication between staff on the ward.

Mental Health Act (MHA)

We found that paperwork relating to the MHA was completed and filed appropriately as required by the MHA Code of Practice. The statutory detention paperwork was found to be correct and detentions lawful. There was good evidence to show that people had been read their rights under Section 132 at regular intervals and had also given written information regarding their detention.

We saw that medication was prescribed within British National Formulary limits and in accordance with the T2 and T3 forms. The T2 and T3 forms are used to record if the person consents to treatment or not. We found that not all old T2 and T3 forms had been crossed out however; which could cause confusion regarding which was the most current form and therefore it was not clear if the person was consenting to treatment or not.

People we spoke with were aware of the medication they were prescribed and the reasons why they were prescribed it. This is in keeping with the Code of Practice (23.9). We saw evidence which showed that staff had referred people to an Independent Mental Health Advocate appropriately.

People we spoke with told us that if they had Section 17 leave granted; that there were enough staff to enable them to take this. People were aware and understood any conditions which were stipulated within their Section 17 leave form. We found some Section 17 forms had been signed by the person and their consultant. This is an example of best practice.

Are services caring?

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

Summary of findings

People told us that staff treated them with respect and dignity, and they were positive about staff's attitude towards them. People also told us that they were happy with their care, and that they felt supported and well-cared for by staff. On both wards, we found that staff provided outstanding care.

We saw some excellent examples of how staff engaged and included people and their family in their care.

Our findings

St Andrew's Place

Kindness, dignity and respect

People we spoke with told us that staff were friendly and treated them with respect. One person said they felt supported for the first time that staff really listened to them and cared about what they are doing. We observed that staff interacted positively with people during our visit. People appeared comfortable in the presence of staff. All the feedback we received from people was outstanding.

Staff in all roles put significant effort into treating people with dignity and had built positive relationships with people using the service and those close to them. People valued their relationships with staff and experienced effective interactions with them. There was a mutual respect.

Confidentiality was respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication.

People using services involvement

All staff involved people as partners in their own care and in making decisions, with support where needed. People told us they felt involved in planning their care, making choices and informed decisions about their care and treatment.

People had opportunities to discuss their health, beliefs, concerns and preferences to inform their individualised care. People were able to decide who to involve in their care and decisions about their care, and to what extent. Family, friends and advocates were involved as appropriate and according to the person's wishes.

Staff took all practicable steps to enable people to make decisions about their care and treatment wherever possible.

The ward had an established morning meeting with people who used the service. The meetings focussed on providing people with an opportunity to provide feedback about the ward and to plan each day with people.

The ward had a range of leaflets and information displayed throughout the ward to provide people with information about services available, health promotion and activities on offer. Information was available in a range of different formats. People had access to advocacy, translation services and the Patient Liaison Advice Service (PALS).

Emotional support for care and treatment

Staff supported people to cope emotionally with their care and treatment. The people we spoke with told us that they valued the support provided to them by staff. The recovery model which was used on the ward focussed on assisting people to manage their symptoms and to recognise signs which may indicate they required additional support from staff to prevent deterioration or relapse. Staff used a range of psychological techniques with people to help them to develop effective coping mechanisms which they could learn to use independently.

People were supported to participate in social and community activities and to maintain and develop their networks to support recovery or long term care.

Where appropriate people were supported to stay connected with their family, friends and community, (including education) so that they did not become isolated and disconnected. Visitors were encouraged and supported with visiting times that suited them, staff were available for discussions and there was a private space for visits.

Staff provided support and family therapy sessions which were run by the occupational therapists and psychologist. Some sessions took place in the families' home settings.

Hawthorne Court

Kindness, dignity and respect

Staff in all roles put significant effort into treating people with dignity and respect. People felt supported and well-cared for. People appeared comfortable in the presence of staff.

People told us that staff were kind and had a caring, compassionate attitude and built positive relationships

Are services caring?

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

with them and those close to them. Staff spent time talking to people, or those close to them. People valued their relationships with staff and experienced effective interactions with them. There was a mutual respect. All the feedback we received from people was outstanding.

Confidentiality was respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication. Each person had a single room and their own key to promote their privacy.

People told us that they were happy with the care they were receiving. They said there were always enough staff around to talk with. A person who had recently been admitted to the ward described to us how staff helped them to easily settle on to the ward. We were told that staff provided a caring environment, for example on the day of the FA cup final, when the local team was playing, by setting up bunting and having a BBQ to help people to celebrate the event. Staff told us that they were making improvements to the ward environment by moving the clinic room from its central position to one end of the main corridor, to promote people's privacy and dignity.

People using services involvement

All staff involved people as partners in their own care and in making decisions with support where needed. People told us they felt involved in planning their care, making choices and informed decisions about their care and treatment. The staff we spoke with told us it was important for people to be involved in planning their care and treatment.

People had opportunities to discuss their health, beliefs, concerns and preferences to inform their individualised care. People were able to decide who to involve in their care and decisions about their care, and to what extent. Family, friends and advocates were involved as appropriate and according to the person's wishes.

We saw that the ward had daily morning meetings for people which were used to gain feedback from people about the ward and to share information with people. Similarly there is a service user group on Thursday afternoons where more detailed discussions took place.

Staff took all practicable steps to enable people to make decisions about their care and treatment wherever possible.

The ward had a range of leaflets and information displayed throughout the ward to provide people with information about services available, health promotion and activities on offer. Information was available in a range of different formats.

People had access to advocacy, translation services and the Patient Liaison Advice Service (PALS).

Emotional support for care and treatment

Staff supported people to cope emotionally with their care and treatment. The recovery model which was used on the ward focussed on assisting people to manage their symptoms and to recognise signs which may indicate they required additional support from staff to prevent deterioration or relapse. Staff used a range of psychological techniques with people to help them to develop effective coping mechanisms which they could learn to use independently. People told us that they were able to discuss alternative strategies with staff rather than relying on obtaining extra medication.

People were supported to participate in social and community activities and to maintain and develop their networks to support recovery or long term care.

Where appropriate people were supported to stay connected with their family, friends and community, (including education) so that they did not become isolated and disconnected. Visitors were encouraged and supported with visiting times that suited them, staff were available for discussions and there was a private space for visits.

People had access to Skype to keep in touch with their family and friends.

Are services responsive to people's needs?

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

Summary of findings

People we spoke with felt they were making progress in their recovery and were happy with their care and treatment.

However; We also found leave care plans for informal people at St Andrew's Place which were not in accordance with the MHA Code of Practice.

Our findings

St Andrew's Place

Planning and delivering services

The ward accepted transfers from a range of services including the acute wards and community settings. We were told by staff that on arrival people were given a welcome pack however; we found that this was in need of updating.

The ward provided care and treatment which was underpinned by a recovery focussed model to promote peoples' independence. Each person had a comprehensive assessment completed as part of the admission process which included peoples' social, cultural, physical and psychological needs and preferences. All care was delivered under the Care Programme Approach (CPA) framework.

Verbal and written information that enabled people who used the service to understand their care was available on the ward. This included ensuring people had access to information in different accessible formats. People had access to interpreting and advocacy services if necessary.

The ward had a weekly multi-disciplinary team meeting to discuss people's recovery progress.

Right care at the right time

Staff told us that any new referrals were discussed at a weekly multi-disciplinary team meeting. Staff from the ward would then arrange to assess the person to make sure that the ward was able to meet their needs' and that it was the right service for them to be transferred to.

We had concerns about some of the leave care plans on the ward. We found some leave care plans which did not demonstrate collaboration with the person and were generic in nature. We also found a, 'leave care plan' for an informal person which specified that, 'Leave to be recorded on a Section 17 leave form' and that, 'All leave to be agreed by MDT'. The goal of the care plan was documented as being for the person not to abscond from the ward. The person was informal therefore was free to leave the ward without permission whenever as they chose to do so. The care plan was not compliant with the Code of Practice as it did not reflect the person's lawful right to leave the ward at any time. This could result in the de facto detention of the person. We discussed this with the trust during the inspection and were told that this practice would cease with immediate effect.

People were aware of the Independent Mental Health Advocate service, but for informal people, we were told by staff there was a long waiting list for this service.

Care Pathway

The ward accepted transfers from a range of services including the acute wards and community settings. We saw that plans were being put into place for some people to move into more independent accommodation within the community. Staff told us that Care Programme Approach (CPA) meetings took place before a person was discharged to make sure that they were supported during and after their discharge from the ward. People tended to have periods of leave before being discharged to ease the transition and reduce the risk of them experiencing a relapse during their transition into the community.

Staff we spoke with explained how they took great care to ensure that people were discharged to appropriate accommodation which could meet their needs. The discharge process included staff supporting people during the transitional period from the ward to community based accommodation to reduce the risk of relapse.

Learning from concerns and complaints

People were provided with information about how they could raise complaints or concerns about the ward. The ward actively sought feedback from people through regular patient meetings which took place.

The ward meetings had a set agenda which included looking at complaints and feedback from people who used the service. Complaints were also discussed in the service's clinical governance meeting which took place monthly. This meant that the wards ensured that learning from complaints, comments and compliments were embedded in their governance processes.

Are services responsive to people's needs?

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

People we spoke with did not express any complaints or concerns about this ward to us and told us they had not previously raised any concerns or complaints. However; people we spoke with told us they were confident that staff would listen to any concerns they may raise and take appropriate action.

Hawthorne Court

Planning and delivering services

The ward accepted transfers from a range of services including the acute wards and community settings. The ward provided care and treatment which was underpinned by a recovery focussed model to promote people's independence. Each person had a comprehensive assessment completed as part of the admission process which included peoples' social, cultural, physical and psychological needs and preferences.

Verbal and written information that enabled people who used the service to understand their care was available on the ward. This included ensuring people had access to information in different accessible formats. People had access to interpreting and advocacy services if necessary.

Each person had a comprehensive assessment completed as part of the admission process which included peoples' social, cultural, physical and psychological needs and preferences. All care was delivered under the Care Programme Approach (CPA) framework. The ward had a weekly multi-disciplinary team meeting to discuss people's recovery progress.

The ward had a self-contained flat which was used to enable people to gain more independence prior to their discharge.

Right care at the right time

Staff told us that any new referrals were discussed at a weekly multi-disciplinary team meeting. Staff from the ward would then arrange to assess the person to make sure that the ward was able to meet their needs' and that it was the right service for them to be transferred to.

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People we spoke with did not express any complaints or concerns about this ward to us and told us they had not previously raised any concerns or complaints.

Are services well-led?

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

The service had strong governance structures in place, which were used on both wards. The wards held regular staff meetings that focused on governance issues. These were linked to the directorate governance meetings, which assured us that issues could be escalated and shared across the services. Staff achievements were also recognised and celebrated.

Our findings

St Andrew's Place

Vision and strategy

All of the staff we spoke with told us that they felt positive and proud of the work they undertook on the ward. Staff we spoke with told us that they felt supported by their manager and could approach them if needed. Some staff were aware of the chief executive and board level leadership through the trust. Staff told us that the Chief Executive Officer and Chair of the trust visited the wards regularly. The trust values were embedded within the Performance and Development Reviews (PADR) annual appraisal process for staff.

Responsible governance

The service had robust governance structures in place which were fully embedded on the ward. The ward held regular staff meetings that had an agenda which was focussed on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services.

The service had an established, 'Clinical network forum' which met bi-monthly where staff could raise clinical issues which may impact on their work.

Leadership and culture

Staff told us that their manager was very available and supportive when required. Managers told us they have good relationships with their senior managers. Staff told us they supported each other within the team very well and felt the ward had a collective, positive culture. However; some occupational therapists we spoke with told us that their profession felt undervalued by the trust due to the cuts to OT provision.

We found that staff were engaged in clinical supervision. Staff received annual appraisals through the PADR process. Staff received mandatory training in addition to specific training relevant to their role for example; National Vocational Qualification (NVQ) Level 3 training for healthcare assistants. The trust had also introduced an, 'Unsung hero' award which any member of staff could nominate another member of staff for in recognition of their work.

Engagement

All the staff we spoke with told us that they would feel comfortable raising concerns with their managers.

Staff pro-actively engaged with and supported people's carers and family members.

We found good examples of how the ward had built relationships with statutory and non-statutory agencies outside of the trust.

Performance Improvement

Staff we spoke with had annual appraisals and were aware of their own personal development goals. Both internal and external audits took place on the ward. We saw evidence which showed that action had been taken in response to the outcome of some of these.

The ward had been awarded the Accreditation for Inpatient Mental Health Wards (AIMS) accreditation from the Royal College of Psychiatrist. This showed that the service was committed to improving its performance.

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Leadership and culture

The ward manager was very visible and accessible to both staff and people using services. Staff spoke to us of the good team spirit and how supported they felt within the staff team. Staff were involved in training specific to their role. Health care assistants were embracing new apprenticeships at NVQ level 3 for example. The ward was full of information for people who used the service which staff had produced.

Staff received annual appraisals through the PADR process and accessed clinical supervision.

Engagement

The ward was proactive in its approach to gaining feedback from people who used the service through Quality Circle meetings with people who used the service, patient meetings and PALS. We saw evidence of positive changes that had been made in response to feedback from people.

The ward engaged with and provided support to people's carers and family members.

We found good examples of how the ward had built relationships with statutory and non-statutory agencies outside of the trust. The ward manager was involved in service development and was part of a panel with clinical commissioning groups and local authorities to look at funding issues. In addition they had built relationships with LINKS (housing association) and Mind to facilitate discharge planning.

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Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	The registered person must ensure that service users are protected against the risks associated with unsafe or unsuitable premises by means of: (a) suitable design and layout **The way the Regulation was not being met:** There were ligature risks on some doors at St Andrew's Place which were not identified or managed effectively.

Regulated activity	Regulation
Treatment of disease, disorder or injury	The registered must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by: (a) receiving appropriate training professional development, supervision and appraisal. **The way the Regulation was not being met:** Staff at St Andrews Place assisted people to prepare meals however; they had not received training in basic food hygiene. Regulation 23 (1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of:

Compliance actions

(b) the planning and delivery of care and, where appropriate, treatment in such a way as to-

(i) meet the service users' individual needs and

(iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment.

The way the Regulation was not being met:

At St. Andrews Place, we found a, 'leave care plan' for an informal person which specified that, 'Leave to be recorded on a section 17 leave form' and that, 'All leave to be agreed by MDT'. The goal of the care plan was documented as being for the person not to abscond from the ward. The person was informal therefore was free to leave the ward without permission whenever as they chose to do so. The care plan was not compliant with the Code of Practice as it did not reflect the person's lawful right to leave the ward at any time. This could result in the de facto detention of the person.

Regulation 23 (1a) HSCA 2008 (Regulated Activities) Regulations 2010