Good

Devon Partnership NHS Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Date of inspection visit: 28 July 2015
Date of publication: 18/01/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWV62	Wonford House Hospital	Russell Clinic	EX2 5AF

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / 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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Overall summary

We rated long stay/rehabilitation mental health wards for working age adults as good because:

- The ward was clean, hygienic, with necessary equipment maintained and checked.
- There was sufficient staffing to meet patient need. Patient leave was never cancelled because of lack of staff.
- The care plans were informative and up to date. Staff showed a good understanding of patients' needs and a commitment to meeting them.
- There was good physical health care, with prompt and regular health checks, and good medication practice, with medicines being stored, administered and recorded safely.
- There was a good mix of health professionals who worked together in the best interests of patients.
- Incidents were reported and learned from, with de-briefings and improvements in practice as necessary.
- Rating scales were used to determine individual needs and outcomes, enabling the service to chart the progress of individual patients.
- Mental Health Act and mental capacity documentation was in good order, showing that the organisation was meeting its obligations to patients under the Mental Health Act and the Mental Capacity Act.
- Staff were respectful and responded appropriately to the needs of patients. Staff showed a good understanding of the individual needs of patients.
- The service responded to patient need by taking people from more secure environments and supporting them to move to more independent settings within reasonable time limits.
- Within the confines of a hospital 'institutional' environment, the service provided a pleasant outdoor area and a variety of rooms for activities.
- The ward had been accredited as an 'excellent' inpatient rehabilitation unit by accreditation for inpatient mental health services the previous year.

However:

- Patients' views on their treatment were not always recorded in their care plans.
- Morale amongst the staff team was mixed. However, this did not affect staff's professionalism in responding to patient need, as shown by team responding to patients' need and planning to meet needs during team meeting discussion.

Summary of findings

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

Are services safe?

Good

We rated "safe" as **good** because:

- The ward was clean and well-maintained, with good hygiene practices in place.
- There were separate male and female corridors.
- The clinic room was clean and records showed that equipment was checked regularly.
- There were sufficient staff on the ward to maintain a safe environment. Staffing levels were able to be adjusted to reflect need. There was always a qualified nurse on duty. Patient leave was never cancelled because of staff shortages.
- Staff received mandatory training, with rates of completion of over 90%.
- Medication storage, administration and recording was good.
- Risk assessments took place promptly and care plans were updated as required.
- Regular ligature risk assessments took place.
- Incidents were reported promptly.
- A serious incident the previous month had resulted in a review of safety procedures.

Are services effective?

Good

We rated "effective" as **good** because:

- Care plans were up to date and information was stored securely.
- There was good physical health care, with prompt and regular health checks recorded in individual care plans.
- There was a variety of activity and therapy groups.
- There was good physical health care.
- There were rating scales such as health of the nation outcome scales to record individual needs and outcomes.
- There was a good mix of health professionals. Staff were experienced, suitably qualified, trained and supervised. Handover and review meetings demonstrated professionalism and effective team working.
- Mental Health Act and Mental Capacity Act documentation was in good order.

Are services caring?

Good

We rated "caring" as **good** because:

Summary of findings

- Staff were respectful and responded appropriately to the needs of patients. Staff showed a good understanding of the individual needs of patients.
- An advocate from Rethink visited the ward regularly.
- Relatives were complimentary about the care shown by staff.

However:

- Not all patients and relatives were aware of how to be involved in the care and be involved in feedback.
- Patients' views on their treatment were not always recorded in care plans.

Are services responsive to people's needs?

Good

We rated "responsive" as **good** because:

- The service responded to patient need by taking people from more secure environments and supporting them to successfully move and remain in more independent settings within set time limits.
- Within the confines of a hospital 'institutional' environment, the service provided a pleasant outdoor area and a variety of rooms for activities.

However:

- Trust data showed long waiting times between referral to initial assessment, and from initial assessment to treatment.

Are services well-led?

Good

We rated "well-led" as **good** because:

- Staff showed their commitment to trust values in their interactions with patients and in patient-focussed handovers.
- The manager was able to ensure that staff received regular supervision, appraisal and training.
- The ward had been accredited as an 'excellent' inpatient rehabilitation unit by accreditation for inpatient mental health services.
- Shifts were covered by sufficient numbers of staff. Recent sickness had meant a relatively high use of bank and agency staff. The manager was able to deploy staff to meet needs.

However:

- Morale amongst the staff team was mixed. However, this did not affect staff's professionalism in responding to patient need.

Summary of findings

Information about the service

Russell clinic is a 16-bed rehabilitation ward sited within the main building that is Wonford hospital. It is the only specific rehabilitation service for working age adults operated by the trust. As such, it takes in men and women of working age county wide with the aim of moving them to more independent settings within six months. These settings vary from independent living, supported living with families, other agencies, or other residential settings.

Although other parts of Wonford hospital have been previously inspected by CQC, this service had not.

Our inspection team

The comprehensive inspection was led by:

Chair: Caroline Donovon, chief executive, North Staffordshire Combined Healthcare NHS Trust Head of inspection: Pauline Carpenter, Care Quality Commission Team leader: Michelle McLeavy, inspection manager, Care Quality Commission

The team that inspected long stay/rehabilitation mental health wards for working age adults consisted of a CQC inspector, two nurses and a psychologist.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- Visited the rehabilitation ward (Russell clinic) at Wonford House hospital and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with five patients who were using the service. Seven other patients were approached, but did not wish to speak with us.
- Spoke with the manager of the ward.
- Spoke with nine other staff members; including doctors, nurses and therapists.
- Spoke with three relatives of patients.
- Attended and observed a hand-over meeting and two review meetings
- Looked at the treatment records of seven patients.
- Looked at the clinic room and checked the medication management on the ward.

Summary of findings

What people who use the provider's services say

Seven patients did not wish to speak with us. Five patients did and gave mixed responses on such matters as food and activities. They were generally positive about staff, saying they were helpful and explained things to them about their illness and their treatment. Patients were generally happy to be in the ward environment. They saw it as an improvement on where they had previously been, with the prospect of moving on within the foreseeable future. The patients understood the type of activities they undertook on the ward and the purpose of undertaking them.

Relatives we spoke with praised the support, activities and progress patients made at the ward. They felt the ward could do more to make patients and relatives aware of information. This was because they felt many of the patients might not be active in seeking information, even when it concerned them directly. One relative was anxious as to whether the patient they were concerned about would get sufficient support when they were discharged.

Good practice

A new member of staff praised the involvement of previous patients of the service in specific training for staff, to ensure they focussed on the user experience.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that all patients are aware of what facilities are available and how they could use them. Examples of this were out of hours hot drinks and the complaints procedure.
- The trust should ensure all patients and relatives are aware of how to be involved in care and feedback.
- The trust should ensure patients' views on their treatment are recorded in care plans.
- The trust should review data collection concerning waiting times from referral to initial assessment, and from initial assessment to treatment and check whether these have an adverse effect on patients.

Devon Partnership NHS Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Russell Clinic	Wonford Hospital

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.

- Twenty staff from Russell clinic had received Mental Health Act level 1 training. The manager advised us that Mental Health Act training was available for staff to access via both e-learning and face to face, but it was not compulsory in their core training. Following our visit, the manager informed us they had contacted their training lead in respect of this and were waiting further contact on whether level 2 training would be appropriate.
- Mental Health Act documentation was recorded correctly.
- Consent to treatment forms were attached to medication folders. We looked at seven care records. All seven showed evidence of assessment of capacity. Two did not show evidence of informed consent.
- Patients had their rights under the Mental Health Act explained to them on admission and routinely thereafter. This was recorded on the electronic records system. Detained patients we spoke with did not comment on this.
- All nursing staff we spoke with told us they received good support and legal advice on the implementation of the Mental Health Act and the Code of Practice from the trust Mental Health Act team. This team conducted periodic audits and gave feedback to the service. The manager gave us a recent example of feedback where this team had found the rehabilitation service had not always recorded where patients had their rights under

the Mental Health Act explained to them. This had resulted in reminders to staff to ensure this was done. Mental Health Act documentation was correct on all the seven records we looked at. All information was securely stored electronically.

- The 'welcome pack' included information on accessing advocacy services from both an advocacy service, and the independent mental health advocate.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Records showed that over 90% of staff had up to date training in the Mental Capacity Act (MCA). Staff showed in discussion with us a good understanding of mental capacity assessments.
- There was good evidence of assessment of mental capacity in all seven records we looked at.
- People were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history. We saw and discussed with staff and the manager a recent example of this. Staff were consistent in their responses.
- Staff knew where to get advice regarding the MCA, including Deprivation of Liberty Safeguards (DoLS) within the trust.
- There were no outstanding DoLS applications. There was a policy on the MCA including DoLS which staff were aware of and could refer to.
- There were arrangements in place to monitor adherence to the MCA within the trust.

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

Please see summary at the beginning of this report.

Our findings

Safe and clean environment

- The ward consisted of long corridors with rooms along either side. This hospital model was not seen as an issue in terms of observation and safety as patients were there for rehabilitation. However, for patients moving towards recovery and more domestic-scale environments, it was very institutional in appearance.
- There were regular ligature point audits with risk assessments done regularly. Records showed these were checked and updated regularly. The audits we saw did not show any risks that had not been evaluated and managed.
- The ward complied with guidance on same-sex accommodation. There were separate male and female corridors. There was a room on the female corridor for use as a female only lounge, but most patients tended to use the main lounge.
- The clinic, seclusion room and de-escalation room were at one end of the female corridor. The manager told us this had been escalated to the trust risk register. This area was due to be altered and improved. Immediately following our visit, they were meeting with the architect, and plans were in place to make alterations. These involved converting the seclusion room, which was no longer used, into a bedroom, and moving the other rooms to more central positions. There was an external entrance to the de-escalation room, so that males did not have to walk through the female corridor. This external access had been used when there had been a serious incident.
- The clinic room was clean and tidy with anti-bacterial cleaning materials available. There was a suitable examination couch, weighing scales and a locked fridge containing emergency medication with records showing this was checked daily. Resuscitation equipment was kept in the nurse office, as this was more central to the rest of the ward and was therefore more readily accessible for emergency use. Records showed this equipment was checked daily, with additional evidence of a detailed monthly check.
- All ward areas were clean, had reasonable furnishings and were well-maintained. A relative who visited regularly told us they saw only cleanliness and good hygiene.
- There were small bottles of hygienic hand rubs for all staff to carry and use. There were posters promoting good hygiene, most notably in the clinic area.
- Cleaning records for individual rooms and overall household checks were up to date and showed regular cleaning took place. One patient told us “cleaners come in once a week to clean my room” and “staff prompt me to clean my room when it gets messy.”
- There was an alarm system in place and nurses carried alarms. The previous month, an administrative member of staff had been attacked. The manager detailed the circumstances of the attack and the de-escalation process that followed. The patient had voluntarily removed themselves from the area of the incident and then agreed to oral medication and a move to the acute ward. This had prompted a review of safety procedures for all staff, and a review of initial assessment procedures.

Safe staffing

- The ward had 12 nurses and 11 nursing assistants in order to provide cover of four staff on the two day shifts and two staff on the night shift. The manager informed us of a ‘safer staffing’ review that had resulted in the appointment of two more nurses. We saw the details of the reasons for this as presented to the senior management board.
- The number of nurses matched the required number on all shifts. Shortfalls were covered by agency and bank staff. Records showed that 37 of the 120 shifts in April had needed bank or agency staff to cover for sickness. The bank staff were regular staff who were familiar with

Good

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the ward. There were two nurse vacancies. Bank staff had been used more frequently because of the current shortage caused by sickness. There were two staff on long-term sickness and the nature of this sick leave and the subsequent shortfall had a distressing effect on staff and patients. The sickness was not work-related.

- The ward manager was able to adjust staffing levels daily to take account of varying patient needs. The manager said this was very rare and occurred only if a particular patient was unwell or if particular patterns of behaviours or incidents occurred. They gave as an example a period when there were a number of younger patients who were misusing alcohol and required additional supervision and support for a period of time. Staff told us additional staff were drafted in to increase levels of observation if and when required.
- There was a qualified nurse present on the ward at all times. Because of the layout of the ward, the communal area was some distance from the nurse's office. On our visit, the communal area was not well used. Some patients spent time in their rooms and others spent time in the reception area, near the nurse's office.
- The manager told us every patient had a named nurse and that time spent with them was 'flexible'. Staff told us they were named nurses with particular patients. Two patients told us staff spent time talking with them but they were not clear whether these were their named nurses. One patient who had been at the unit for three weeks told us they knew their named nurse.
- There were no instances of escorted leave being cancelled. Comments from patients and other staff confirmed this. One patient told us "I get leave and it's never been cancelled." This patient also told us activities, notably the morning meeting, pottery and 'wild life' group were never cancelled. Weekend activities were more vulnerable to being postponed, as the occupational therapists did not work then.
- There were enough staff to safely carry out physical interventions. Staff were trained in this, but all consistently told us that de-escalation ("talking down") was used, with 'safe holds' being occasionally used. Patients told us they felt safe on the wards. No patient said anything about any restraint being used.
- The ward had not recorded any incident of restraint for the past six months. The response from patients we spoke with indicated they felt safe and secure on the ward, and they compared it very favourably to their experiences on other wards. There was mostly a calm and quiet atmosphere on the ward during our visit. One patient was displaying agitation at their continued stay on the ward. This was responded to calmly by staff who allowed him space to walk off his agitation. We discussed the recent serious incident involving an attack on a member of staff. Restraint had not been used. The manager detailed at length the event and response. The patient had ended the attack when another member of staff arrived and told them to stop. This was followed by de-escalation, voluntary medication and an escorted walk away from the area by the patient to the de-escalation room and a subsequent move to another ward.
- Records showed that physical care checks and responses were good. Medical staff were available promptly from nearby wards if required. A carer told us a psychiatrist was always available when needed.
- Staff had received and were up to date with appropriate mandatory training and the average mandatory training rate for staff was above 90%.

Assessing and managing risk to patients and staff

- Staff undertook a risk assessment of every patient on admission and updated this regularly and after any incident. There had been a serious incident a month prior to our visit, where a patient had attacked a member of staff. This had resulted in a revision of how they evaluated patients, showing a need to probe further into some of the assessment details they were given.
- We looked at seven patient records in detail. We saw risk assessments had been completed and stored on all but the most recent patient record we looked at. These were up to date on all but one patient.
- One patient raised the issue of the kitchen (access to snacks and hot drinks) and garden (access to smoking) being locked after midnight until six the following morning. The manager explained the policy was that staff would open these areas to individual patients at night if requested. One patient we spoke with did not appear aware of this. The night time locking was justified on the grounds of encouraging more 'normal' sleeping patterns as part of rehabilitation, rather than

Good

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on any safety grounds. This was explained in the 'welcome pack'. A member of staff we spoke with later verified this, saying that an explanation of this and the reasons for it were given to residents as part of their induction to the ward. We saw no evidence of other 'blanket' restrictions.

- The ward was not locked, which meant informal patients could come and go as they wished.
- All patients were on level one observation, meaning that staff needed to know where patients were. Searches were carried out on an individual risk basis. The manager was able to give examples of this.
- Staff were trained in restraint, safe holds and breakaway techniques. Staff told us safe holds were used on rare occasions and face down restraint had never been used. Restraint was only used after de-escalation has failed and using correct techniques. Trust data showed no restraints occurring on this ward between November 2014 and May 2015.
- Patients told us they felt safe on the wards. None commented on any restraint being used. The response from patients we spoke with indicated they felt safe and secure on the ward, and they compared it very favourably to their experiences on other wards. There was mostly a calm and quiet atmosphere on the ward during our visit. One patient was displaying agitation at their continued stay on the ward. This was responded to calmly by staff who allowed him space to walk off his agitation. We discussed the recent serious incident involving an attack on a member of staff. Restraint had not been used. The manager detailed at length the event and response. The patient had ended the attack when another member of staff arrived and told them to stop. This was followed by de-escalation, voluntary medication and an escorted walk away from the area by the patient to the de-escalation room and a subsequent move to another ward.
- Staff were trained to use rapid tranquilisation, but staff were consistently clear it had not been used on the ward. We saw no evidence in patient records we examined that rapid tranquilisation had been used.
- There was a seclusion room, but it had not been used for over two years. The manager acknowledged that the seclusion room was not 'fit for purpose' and plans had been drawn up to change the use of the area it currently occupied.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and did this when appropriate. Safeguarding referrals were made to the local authority safeguarding team. Staff were able to discuss a recent example of a safeguarding referral and how and why it had been made.
- We saw that medicines were stored, recorded and administered appropriately. A trust pharmacist visited weekly. Medication was all in date and stocks were checked weekly.

Track record on safety

- There had been one serious incident in the past 12 months. A patient had assaulted a member of the administrative staff. This had resulted to changes in practice, both in the protection of vulnerable staff and in more thorough investigation of risks noted in the previous history of individual patients assessed and admitted to the ward.
- Staff had alerted the local authority safeguarding team and involved the police where one patient had suffered potential harm in the course of taking leave. A nurse we spoke with praised the responsiveness of the safeguarding team. The service had put in extra safeguards to support this person's leave as a result of this incident.

Reporting incidents and learning from when things go wrong

- Incidents were reported as appropriate to the trust. Staff were able to explain how and when incidents were reported. There had been 56 incidents reported in the past year. Individual incidents, such as absences without leave, patients smoking indoors, and medication errors were discussed in team meetings as part of learning and improving practice.
- A serious incident had not been immediately shared with patients as no patients had witnessed it. Staff had

Good

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decided it would cause distress to patients if they were told about the incident immediately. Patients were informed of the outcome of the incident in a sensitive manner, so as to inform them, but not alarm them.

- Staff received debriefing relating to the serious incident that occurred and were able to discuss this incident. The debriefing session was led by a psychologist from a different ward. This had also been discussed in supervision meetings. The incident had been distressing to staff as it was the first such incident for many years. Although lessons had been learned from the incident and changes made, one staff member told us they were not confident that such an incident would not occur again, because they felt the client group would always pose a potential risk.

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

Please see summary at the beginning of this report.

Our findings

Assessment of needs and planning of care

- We looked at the care records of seven patients. These showed that a physical examination had been undertaken in all cases, and that there was on-going monitoring of physical health problems. Patients told us they had regular physical health checks.
- Care plans were present and up to date. All but the most recent admission (admitted ten days previously) had up to date risk assessments recorded. Only two of the seven had patients' views recorded. Five had holistic and recovery-focused care plans in place. All seven showed evidence of capacity assessments. Five showed clear evidence of informed consent. Two did not show clear evidence of informed consent. Only one recorded that the patient had been given a copy of their care plan.
- All information was recorded electronically in a secure manner and available to staff.

Best practice in treatment and care

- We looked at the prescription cards for eleven patients in the clinic. These were all filled in appropriately and were signed and dated. The consultant liaised with the trust pharmacist on medication issues. Practice was consistent with NICE guidelines. There were medication reviews on admission and on-going reviews.
- Patients had access to psychologists two days a week, and referrals to separate psychology services. There was an art therapist and an environmental therapist who led activities. A timetable showed activities and therapy groups taking place throughout the week, with activities taking place each day. The occupational therapists who led activities worked Monday to Friday, so there were few activities at weekends.
- There was good access to physical healthcare, including access to specialists when needed. Details of physical health checks were in personal folders in the clinic.
- Health of the nation outcome scales were used to rate the severity of need and outcomes. The 'wheel of life' was used as a self-rating tool for patients. The manager and a senior health professional we spoke with were enthusiastic about the wheel of life as a model of recovery and rehabilitation. Although this is not specifically approved by NICE (National Institute for Health and Care Excellence), the manager advised that it was a self-management tool, the use of which is recommended by NICE. The tool shows involvement of the patient, with equal weighting being given to the patient and professional's views, as recommended by NICE. The tool was comprehensive and detailed and allowed for extensive patient input. One patient told us the consultant-led groups were "really good - helps me understand about illness".
- The consultant was not aware of any clinical audits, other than reviewing care plans at monthly review meetings. We were not made aware of any audit of the 'wheel of life' by the service in order to try to gauge its effectiveness. The manager felt that the service was effective, and that this was evidenced by the success of placing patients in more independent settings within six months of their admission to the service. The manager was able to provide details of a report to senior management board in September 2014 which evidenced this. The manager also provided information showing the reasons for patients being discharged and for referrals not being accepted. With one exception, the patients at the time of our visit had been on the ward for less than six months. The manager acknowledged the effectiveness of all aspects of the service could be better shown by a wider range of audits and evaluations.

Skilled staff to deliver care

- The work of the ward was supported by a psychologist, consultant psychiatrist, and occupational therapists. The psychologist was available Monday and Friday. There was an art therapist on the ward on Thursday mornings. The consultant was on the ward four days a week. A duty doctor was available at other times. There was a full time occupational therapist and two part-time occupational therapists. There were weekly visits by a pharmacist from the trust. A nurse we spoke with

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praised the pharmacist support. They said the pharmacist visited at least once a week, were accessible by phone and were supporting the ward in measuring compliance with patients who were self-medicating.

- Staff were experienced and qualified. There was always a qualified nurse on duty. We spoke with one staff member who was a relatively new starter. They had received a full induction from the trust. All other staff we spoke with had been there for a number of years.
- Records showed regular supervision taking place at six weekly intervals. There were annual appraisals and regular team meetings.
- Staff received the necessary specialist training for their role. There was forthcoming training on the principles of mental health recovery which was being used on the ward to enhance recovery. One staff member praised the recovery training they had received which had been delivered by a previous patient. They told us they had found this very helpful. A member of staff explained how ex-patients had always been involved in training. They saw it as a very positive aspect of the ward that ex-patients who still visited were happy to provide support for patients and to pass on their experience and knowledge.
- Staff performance was addressed through supervision and was seen as 'development'. There were no examples of disciplinary measures being taken.

Multi-disciplinary and inter-agency team work

- There were two full MDT (multi-disciplinary team) meetings every week which were made up of appropriate professionals. We did not observe these, but attended a pathway meeting and a handover. The pathway meeting was a consultant-led review of each patient, updating their current status, and included a review of new referrals. A member of a housing panel would attend at least once a fortnight to discuss housing requirements and availability as part of patient discharge plans.
- The handover meeting took place daily between the morning and afternoon shift. This was well run and showed that team members worked well together, had a good knowledge of current patients and shared that knowledge effectively. The meeting ran for less than an hour and all the patients and their immediate needs and any risks were discussed. Discussions and information sharing included current medication needs, therapies and leave, and progress towards discharge. The staff showed a good holistic knowledge of patients' needs and how to meet them.
- The rehabilitation team worked closely with care coordinators working across community mental health teams. A new member of staff commented positively on the links with community teams. The service worked with social service funded accommodation officers and with a social care panel that met monthly. The service would prepare for this in advance to try to ensure discharges happened smoothly and in accordance with patients' wishes and needs.

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

- 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.
- Twenty staff from Russell clinic had received Mental Health Act level 1 training. The manager advised us that Mental Health Act training was available for staff to access, both via e-learning and face to face, but it was not compulsory in their core training. Following our visit, the manager informed us they had contacted their training lead in respect of this and were waiting further contact on whether level 2 training would be appropriate. Mental Health Act documentation was recorded correctly. All staff we spoke with mentioned the good support they got from the trust's Mental Health Act team.
- Consent to treatment forms were attached to medication folders. We looked at seven care records. All seven showed good evidence of assessment of capacity. Two did not show clear evidence of informed consent.
- Patients had their rights under the Mental Health Act explained to them on admission and routinely thereafter. This was recorded on the electronic records system. Detained patients we spoke with did not comment on this.
- All nursing staff we spoke with told us they received good support and legal advice on the implementation of the Mental Health Act and the Code of Practice from the trust Mental Health Act team. This team conducted periodic audits and gave feedback to the service. The

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.

manager gave us a recent example of feedback where this team had found the rehabilitation service had not always recorded where patients had their rights under the Mental Health Act explained to them. This had resulted in reminders to staff to ensure this was done. Mental Health Act documentation was correct on all the seven records we looked at. All information was securely stored electronically.

- The 'welcome pack' included information on accessing advocacy services from both an advocacy service, and the independent mental health advocate.

Good practice in applying the Mental Capacity Act

- Records showed that over 90% of staff had up to date training in the Mental Capacity Act (MCA). Staff showed a good understanding of mental capacity assessments.
- There was evidence of assessment of mental capacity in all seven records we looked at.
- People were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history. We saw and discussed with staff and the manager a recent example of this, where a patient's wish for a contact had a negative impact on their well-being. Staff were consistent in their responses.
- Staff knew where to get advice regarding the MCA, including Deprivation of Liberty Safeguards (DoLS) within the trust.
- There were no outstanding DoLS applications. This was in keeping with the service being a rehabilitation ward. There was a policy on the MCA including DoLS which staff were aware of and could refer to.
- There were arrangements in place to monitor adherence to the MCA within the trust.

Good

Are services caring?

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Kindness, dignity, respect and support

- We saw staff responding appropriately to the needs of patients. Staff took time to listen to patients' concerns and queries. Where these were confidential, staff ensured patients could have privacy. In the handover, staff spoke of individual patients in a respectful, sympathetic manner.
- We received five 'comment cards' back from patients and carers. Two of these were positive and two were a mix of positive and negative. Comments noted were a patient writing "staff are nice" and a patient asking about a smoking shelter and a drinking fountain.
- A relative of a patient told us that staff were respectful and helpful and they were accessible. However, they also noted that while the named nurse system was good, there could be a lack of communication if the named nurse was off sick. A staff member explained the named nurse system. Each person had a named nurse, and a registered nurse as a second named nurse. This nurse said they were a named nurse for three patients and a second nurse for two patients.
- Patients told us staff were polite and helpful. One patient said; "staff are really helpful, they explain things to me.".
- One patient said that staff did not always knock on entering the room, but acknowledged this only occurred when the patient was found smoking in their room. Smoking in rooms were recorded as incidents.
- Staff showed a good understanding of the individual needs of patients, and of how to meet these needs. This was particularly evident during a handover meeting. Relatives we spoke with were complimentary about the care and understanding shown by staff. One relative told us they hoped that the patient they were concerned with "received the same level of support in their placement after Russell clinic as they did there."

The involvement of people in the care that they receive

- Welcome packs were provided for patients. These gave details of the ward and the service, what was expected of patients and what patients could expect. The wheel of life recovery model used by the service gave patients an extensive role in their recovery plans. Patients were involved in care reviews.
- A patient who was willing to talk with us at length showed us their copy of their care plan. They showed it to us because they could not remember what was in it, although they knew it was 'a plan to get better'. The plan was robust and detailed. They were aware they had a discharge plan, although they felt this was 'a long way off' at present as they felt they were still in the early stages of recovery.
- There was an advocate from Rethink who visited the ward regularly. Some patients appeared unaware of his role as an advocate, but one patient told us they had found him really useful. A staff member told us that patients were informed they could also access the services of an independent mental health advocate.
- One relative told us they were kept informed and up to date via email and kept informed of clinical progress. They had been to regular meetings and met clinicians as well as nurses involved in the patient's care. They felt included in the care planning process, although they had not been asked for feedback. Another carer told us that there had been a carers' meeting advertised on the noticeboard, but not all carers were aware of it, and they were the only ones to attend.
- We saw limited evidence of people being involved in decisions about the service, other than involvement in patients' meetings. One patient told us "I would like to be involved in recruitment but I'm not." The manager was surprised when we relayed this information, as they said they offered patients the opportunity to be involved in recruitment. They acknowledged that with the turnover of patients and the nature of some patients' illnesses, staff may have to work harder to get particular messages across.

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

Please see summary at the beginning of this report.

Our findings

Access and discharge

- Average bed occupancy over the last 12 months was 91%.
- Beds were available when needed by people living in the 'catchment area'. As patients were generally discharged within the six months, this freed beds for local need, as well as allowing the service to take patients from further away. A nurse on Russell clinic detailed the referral process. A referral was received by the ward and discussed within seven days at an initial planning meeting. A plan was made and contacts were made for an assessment within two weeks, or within four weeks if the referral was from outside the county. This could take longer depending on all parties being able to agree suitable dates and times. This was the case sometimes with referrals from, for example, London. Assessment to treatment time could take up to ten weeks, and bed availability could be a factor. Data provided by the trust showed there were 104 days from referral to initial assessment, and 83 days from initial assessment to treatment. The nurse was surprised at this, and thought the figures could be affected by one or two cases taking a lot longer. She also advised that referrals were sometimes made well in advance, so the process could take place in a calm, evenly-paced manner. While we gained no impression of patients experiencing long delays in being treated at Russell clinic, there appeared to be a mismatch between trust data for ward waiting times and the experience of the ward.
- The manager showed us a report made to the senior management team detailing the success of the unit in placing patients who remained in placements after six months. This had increased from 80% in 2013 to 100% in 2014. This showed that placements from the service were successful.
- There was access to a bed on return from leave. We discussed recent examples where patients were on weekend leave, and sometimes longer, with their beds awaiting their return.
- As there was only one rehabilitation ward, patients were only moved for clinical reasons or if they were being discharged. We discussed on isolated example where a patient required more intensive care after an incident and moved to the acute ward. This was done within the same day.
- Discharges were planned and prepared for to ensure they happened positively with minimal delays other than for clinical reasons.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had long corridors with generally bare walls. It was part of a large, nineteenth century building. There were brief splashes of colour on notice boards. One patient told us they felt safe there because it was a "strong building". Two staff used the word "institutional" to describe the physical environment. Staff and patients had done some good work in the garden in planting and nurturing some plants and making the outdoor area more attractive. There were three therapy rooms and a resource room. One patient told us they "tried to attend as many groups as possible." They added, "I get prompted by staff if I need it."
- There were quiet areas available on the ward and a room where patients could meet visitors. One patient told us there was a place to meet family but they tended to meet outside in good weather. One carer we spoke with told us they found the environment calm and peaceful.
- The overwhelming impression from patients, relatives and staff we had contact with was that the environment and atmosphere on the ward compared very favourably with their experience in other environments. One relative, knowing their family member was soon to move on to further independence, hoped the next place would have "the same levels of support as here".
- People had access to outside space. There was a pleasant garden area. There were also extensive grounds outside the ward which informal patients and those with agreed leave could use.

Are services responsive to people's needs?

Good

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

- There were opportunities for patients to make their own food, as well as provided meals. We had limited feedback about the food from patients. There were mixed views, with one saying it was poor, another saying it was "much of a muchness" and a third saying it was "prepared to a pretty high standard."
- Patients were able to personalise their bedrooms and were encouraged to do so. One patient told us their room was "nice".
- Patients were able to store their possessions securely. Patients told us they had access to their own rooms and did not feel concerned that other people might enter their rooms without permission.
- There was access to activities; this was limited at weekends. Occupational therapists did not work at weekends, and nursing staff had limited opportunities to engage in activities. Patients we spoke with did not see this as a concern. Patients gave a variety of examples of the various activities they did during the week. These included activities on and off the ward, in accord with the activities schedule prominently displayed.

Meeting the needs of all people who use the service

- There was ramped access for people with impaired mobility. This was away from the main entrance to the ward and led into the far end of one of the corridors. The manager said that no wheelchair users had used the service since they had been manager. A nurse detailed the arrangements in place for a doctor who had been a wheelchair user and worked for the service four years ago. Their time on the ward ensured it was compliant with disability needs and accessibility. The nurse also detailed how the ward was able to access equipment for an older patient two years ago. They were now able to obtain equipment such as hoists from the trust within twelve hours if required.
- There were no information leaflets other than in English. This reflected the demographics of the area served by the trust. Translators and interpreters could be made available if required. The manager said there had been no referrals to date for patients who required such a service.
- There were welcome packs which gave information on such things as treatments, local services, patients' rights, and how to complain.
- A choice of food could be made available to meet dietary requirements of religious and ethnic groups.
- There was a chaplaincy service available. However, one patient told us they would "like a priest but they don't see one". The manager acknowledged the service may need to work harder to get messages across to patients.
- One patient told us they would like to make a complaint about the food but did not know how to. Another patient was able to make complaints and did so. There had been four formal complaints made in the past twelve months, of which three had been upheld.
- Staff were aware that the function of patient advice and liaison services (PALS) was to deal with formal complaints. The manager expressed their concern that when complaints were made to PALs they may not get to know about them for many months and therefore could not act upon them or learn from them. There were weekly residents' meetings where issues, including complaints, could be raised and responded to locally or escalated to PALs if the complainant wished. There was a 'you said, we did' board in the communal lounge.

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

Please see summary at the beginning of this report.

Our findings

Vision and values

- Staff showed in their interactions with patients and in handovers that they were committed to patient welfare and well-being, in line with trust values. One member of staff told us they felt "proud" to work for the trust and of the work they had done at the clinic.
- The manager told us the senior managers visited the ward. Some staff were aware of senior figures visiting the ward; others were not so aware. One member of staff told us they felt the service manager had recently become more visible on the ward and offered support and encouragement. Some staff felt they were remote from the trust, whilst others felt they were involved and supported by the trust. All staff said they were well supported by the trust in respect of the Mental Health Act team. Nurses said they were well supported by the pharmacist.

Good governance

- Mandatory training, supervision and appraisals were in place and monitored to ensure they took place. Staff received mandatory training and were appraised and supervised.
- The manager and senior staff ensured shifts were covered by a sufficient number of staff of the right grades and experience. Recent ill-health had resulted in more bank staff being used to ensure shifts were staffed to agreed numbers. Rotas showed this was so.
- In the daily handovers, staff knowledge of patient needs and activities indicated they spent much of their time on direct patient-focused work. Handovers were led by the senior nurse on duty. Patients were positive in comments about staff, saying they spent time talking with them. Patients told us of the activities they did and support they had, indicating that staff were spending their time with patients.
- Incidents were reported. There were 56 incidents reported in the previous year. The most recent, serious incident was followed by debriefings and learning for the whole staff team.
- The manager showed us the report sent to the senior management team in September 2014. This showed the manager working with other professionals to present an update on the effectiveness of the unit.
- The ward manager felt they had sufficient authority and administrative support to do their role.
- Items were submitted to the trust risk register by the ward manager. These currently concerned the need for the environment to be upgraded.

Leadership, morale and staff engagement

- Sickness rates in the twelve months up to March 2015 were under 5%. Sickness and absence rates since then had been adversely affected by two staff on long term sickness which was not work related.
- Staff told us they were aware of the whistle blowing process. While staff told us they were able to raise concerns, not all staff felt comfortable doing so. Most of the concerns expressed by staff related to views on aspects of clinical care that could usefully be discussed openly and constructively in team meetings.
- The manager acknowledged that they had brought in new ideas, such as the wheel of life assessment tool, and plans to remove the seclusion room that was no longer used. Some staff were not yet fully behind the changes. The manager had arranged a team building day, and more of these were planned. A large poster had been put up recently to gain views from patients and staff. We saw on a comment on it that spoke of staff being divided. It was not clear if this comment had come from a patient or staff.
- Staff felt their jobs gave them satisfaction, but morale was mixed, with some staff feeling unable to fully raise issues or concerns while others felt they could. This indicated the staff group was divided. There had been a team building day to help the team bond. One staff member we spoke with about this said it was useful, principally as a training day. They said further days were

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planned. Morale and engagement in groups and patient interaction was positive, showing that whatever concerns staff had personally, they did not let it interfere with patient care and support.

- Our observations of handovers showed team members working positively together for the benefit of supporting patients and each other. Staff picked up responsibilities from each other and shared tasks in order to facilitate effective working and patient care. For example, staff arranged, at short notice between themselves, cover and support to maximise patient's activities and appointments.

Commitment to quality improvement and innovation

- The ward had been accredited as an 'excellent' inpatient rehabilitation unit by AIMS (accreditation for inpatient mental health services) in April 2014. This accreditation would last until 2016 when it would be due to be re-assessed. We saw details of the accreditation report whose findings in areas such as involving ex-users of the service, having a wide range of flexibly used rooms and a well-tended outdoor space were reflected in our own findings.