Good

Cumbria Partnership NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNNBJ	The Carleton Clinic	Acorn Centre	CA1 3SX

This report describes our judgement of the quality of care provided within this core service by

Cumbria Partnership 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

Cumbria Partnership NHS Foundation Trust

Summary of findings

and these are brought together to inform our overall judgement of Cumbria Partnership 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.

Overall rating for the service	Good
Are services safe?	Requires improvement
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

Contents

Summary of findings

Overall summary

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

- There were enough staff for people to receive the care and treatment they required
- staff identified ligature points (places where someone intent on self-harm might tie something to strangle themselves) and took action to remove or minimise risks
- the ward was clean and tidy and was maintained to a high standard
- the staff were caring and treated patients in a respectful and dignified manner
- there was good multidisciplinary team working and staff engaged well with community teams as well as outside organisations
- there were no complaints about this service in the last twelve months
- the clinical leadership on the ward was clear and all staff said that they felt supported and listened to
- staff were aware of the trust vision and values and were committed to providing good care in line with this.

However:

Patients' bedrooms were on the first floor of the building except two bedrooms on the ground floor. There was no nurse call system or alarm system in patients' bedrooms. There were blind spots on the first floor, these were mitigated by the use of parabolic mirrors. However, staff did not routinely work on the first floor, the only staff presence was during hourly observations. This meant there patients had no means of summoning staff help or support in an emergency. This is a breach of regulation 12 of the Health and Social Care Act 2008.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Patients' bedrooms were on the first floor of the building except two on the ground floor. There was no nurse call system or alarm system in patients' bedrooms. There were blind spots on the first floor, these were mitigated by the use of parabolic mirrors. However, staff did not routinely work on the first floor, the only staff presence was during hourly observations. This meant there patients had no means of summoning staff help or support in an emergency
- mandatory training levels were 61% at the time of our inspection. This was below the trust standard of 80%, which the trust would want to achieve by December 2015. However, we could see that the ward manager was prioritising staff to attend in order to increase these numbers.

However:

- the ward was clean, tidy, and well maintained. The clinic room was fully equipped and emergency equipment was checked regularly
- the staffing levels were allocated using a recognised tool and staff rotas showed this was adhered to at all times. The ward did not use any agency staff. An average of five shifts per week were filled by bank staff, all of these were regular staff who knew the ward well Vacancies in the team had been advertised and there were two at the time of our inspection. The vacancies were both for nursing assistant posts
- the trust used a recognised risk assessment tool called the Galatean Risk and Safety Tool. This was available in an electronic format so people could access these out of hours should they need to
- there had been no episodes of seclusion in the twelve months leading up to our inspection. Staff always used restraint only as a last resort and debriefs took place for both staff and patients following this
- staff were aware of how to report incidents and did this via the electronic reporting system

Are services effective?

Good

We rated effective as good because:

- Care plans were individualised and completed in collaboration with the patient

Summary of findings

- there was good evidence of physical health examinations both on admission and throughout a patient's stay
- there was good multidisciplinary working both within the ward and with outside agencies
- there was a wide range of recovery focused activities available including psychological interventions
- there was a full multidisciplinary team in place and staff had good levels of experience in their field
- there were regular team meetings and group supervisions to support staff
- staff showed good awareness of the Mental Health Act and Mental Capacity Act and training figures reflected this.

However:

- Information provided to us by the trust demonstrated that only 32% of staff had received a performance appraisal in the last 12 months. During our inspection, we saw evidence that this was being addressed.

Are services caring?

Good

We rated caring as good because;

- We saw positive interactions between staff and patients
- patients felt they were treated with dignity and respect by the staff and that staff were professional at all times
- staff knew the patients in depth and care plans reflected this
- there was an in depth admission process which included orienteering patients to the ward.
- patients were fully involved in their care plans and had a copy of if they wanted one
- patients were encouraged to remain part of their local community and staff assisted them in doing this
- all patients did their own shopping and cooking on the ward with support from staff
- patients had access to an advocacy service
- there was a daily community meeting where patients were encouraged to discuss issues they had with staff and fellow patients
- two patients had been involved in interviewing staff.

Are services responsive to people's needs?

Good

We rated responsive as good because;

- Leave beds were never used when a person went on leave
- discharge of patients was always planned at an appropriate time for that person

Summary of findings

- there was access to a full range of rooms to support treatment and care
- all patients had access to a telephone should they wish to make a call in private
- patients were able to personalise their bedrooms with pictures posters and items from home
- the ward scored 88% in their PLACE assessment (patient led assessment of the care environment) for privacy, dignity and wellbeing which is above the trust and national average
- there was a wide range of activities available seven days a week including evenings and weekends
- the ward had full disabled access
- information leaflets were displayed on the ward and were available in languages other than English
- there were no formal complaints about the service in the 12 months leading up to our inspection
- staff and patients discussed any problems via staff meetings and community meetings.

Are services well-led?

Good

We rated well led as good because;

- The staff were all aware of the trust vision and values and they were displayed in both staff and patient areas
- staff commented that they felt well supported by the clinical leaders on the ward
- the senior leadership team were visible and staff told us they felt they could approach them if they needed to
- staff were able to tell us the names of the most senior managers in the trust
- managers felt they had autonomy to run the ward and that they could increase staffing levels should they need to
- sickness levels for the ward were 4.2% which is below the trust and the national average of 5%
- every member of staff we spoke to told us they were happy in their role and felt they made a difference to patient care.

Summary of findings

Information about the service

Cumbria Partnership Foundation Trust has one long term and rehabilitation mental health ward for adults of working age.

The Acorn Centre is a 10 bed rehabilitation ward at The Carleton Clinic in Carlisle. It is commissioned by Cumbria Clinical Commissioning Group. The ward is for male patients, some of whom are detained for treatment under the Mental Health Act (1983). It provides care, treatment and rehabilitation for these men following an acute phase of their illness. It offers a socially inclusive approach to recovery and a return to independent or supported living.

We have inspected the Cumbria Partnership Foundation Trust 22 times at 11 locations since registration. We had not previously inspected this ward.

Our inspection team

The team was led by: Chair: Paddy Cooney, Chief Executive (retired)

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team leaders: Brian Cranna, inspection manager (mental health), Care Quality Commission and Sarah Dronsfield, inspection manager (community health), Care Quality Commission

The team that inspected this core service comprised: a CQC inspector, a Mental Health Act reviewer and two specialist advisors a nurse and a psychiatrist who specialises in rehabilitation in mental health.

Why we carried out this inspection

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

How we carried out this inspection

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

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

- Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited the Acorn Centre
- spoke with five patients who were using the service and spoke to a carer
- spoke with the ward manager
- spoke with 12 other staff members; including doctors, nurses, occupational therapist, and psychologist

Summary of findings

- attended a hand-over meeting
- looked at eight treatment records of patients
- looked at nine medication charts
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

All apart from one patient told us that they felt safe on the ward. Patients were given the opportunity to give feedback on the service they receive prior to our inspection via comment cards left at the ward. We did not receive any comment cards back from this service.

Patients told us that they were able to voice any concerns they had to the staff and at daily community meetings. Staff listened to their concerns and changes had been made following the meetings. For example, when patients reported that some of their food had gone missing from their cupboards, the minutes from this meeting reflected that locks had been ordered for all cupboards. These were due to be delivered in the week following our inspection.

Patients told us they enjoyed the activities available to them on the ward. They did not report any leave being cancelled due to shortages of staff and felt they got out of the ward with staff on a regular basis to their local communities.

Good practice

The ward was completely self -catering. All patients had a weekly budget for their food shopping and staff supported them to make a shopping list and go out to buy the ingredients. The patients maintained a vegetable and herb patch in the outside area and this was used in their cooking

The ward staff went out and engaged with the staff teams taking over their patients care on discharge. For example, both the occupational therapist and the psychologist had gone out and provided training with a supported living accommodation provider in order for them to understand the way they work with that particular patient.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- the trust must ensure that the first floor of the building has an alarm call system that can be easily accessed to summon assistance

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- the trust should ensure all staff have an annual performance appraisal
- the trust should ensure that mandatory training is completed by all staff to achieve the trust standard of 80% staff trained.

Cumbria Partnership NHS Foundation 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
Acorn Centre	The Carleton Clinic

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.

The trust provided us with data about Mental Health Act (MHA) training. As of October 2015 73% of staff had received training in the MHA. This was below the trust target of 80%. However, staff working on the ward that we spoke to showed a good understanding of the MHA despite this.

During our inspection, a Mental Health Act reviewer looked specifically at the care records of people who were detained under the MHA. In total we reviewed eight care records. We found good evidence of recording of detention under the MHA including section 132 rights being read monthly for patients detained on a section 3.There were good systems in place for scrutinising and recording receipt of MHA paperwork in the form of a central office that alerted wards when anything to do with MHA was due to be competed.

We saw evidence on the ward of posters to explain information about patients' rights under the MHA and how to contact the Care Quality Commission to make a complaint.

We found that all patients had a T2 (certificate of consent to treatment) or T3 (certificate of second opinion) in place to authorise their medical treatment and these were attached to the medication charts. Capacity and consent to treatment was clearly recorded in all patient records.

Detailed findings

Independent Mental Health Advocates (IMHA) were available. All patients we spoke with confirmed that they knew how to contact the IMHA should they require advocacy support.

Mental Capacity Act and Deprivation of Liberty Safeguards

Eighty two percent of staff had had training in the Mental Capacity Act (MCA) as at October 2015. This was meeting the trust target of 80%.

There were no deprivation of liberty safeguarding applications in the 12months leading up to inspection.

Staff we spoke to understood the principles of the MCA and were able to give us examples of how they had appropriately assessed patients capacity. One example of this was around an individual's capacity to continue to smoke despite a serious health condition. This was assessed using a capacity assessment and then a best interest decision. All patients were presumed to have capacity unless it was proven otherwise and independence was promoted on the ward.

Requires improvement

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

Our findings

Safe and clean environment

The ward provided a clean, well maintained and spacious environment for patients. This included bright pictures of the local area. Cleaning records were up to date and completed regularly. There was access to an outdoor area which was open for patients to use at all times. The outdoor area has a high fence surrounding it and this design would be more suited to a higher security facility. It was also directly facing the main entrance so cars passed by as they entered the hospital. However, the trust were aware of this and had asked patients how they would like to change this. The patients had worked together to grow ivy on the fence to provide more privacy for the patients whilst out in the garden. There were lots of smaller lounges which patients could utilise for activities, 1-1s with staff (where patients meet individually with a named member of staff to discuss their care and treatment) or just generally time alone.

The ward had an up to date ligature risk assessment completed annually by the ward manager. Ligature risks were highlighted and plans were in place to mitigate these risks via observations and patient risk assessments.

The ward layout did not allow staff to observe all parts of the ward. This was mitigated by the use of parabolic mirrors, risk assessments and observations by staff downstairs. However, the upstairs of the ward, which contained all patient bedrooms, had blind spots due to the layout being a zig zag shape. There were parabolic mirrors in this part of the ward but there was no member of staff routinely based upstairs as there was in the downstairs of the building. There was no nurse call or alarm systems in place in the patients' bedrooms for patients to alert staff if they needed them.

The ward had a fully equipped clinic room. This contained emergency resuscitation equipment that was accessible to staff including an automated external defibrillator. The clinic room contained emergency medication that was checked on a regular basis. There was also an examination couch present and an electrocardiogram machine that two staff were trained to use.

There were no seclusion room facilities on the ward and seclusion was not used. If a patient was to become unwell they would be transferred to one of the acute mental health wards within the trust or a psychiatric intensive care facility.

Hand washing facilities were available throughout the ward. Staff were observed to wash their hands at appropriate times for example after giving out medication.

Safe staffing

The trust provided us with the following information about staffing levels on Long stay/rehabilitation mental health wards for working age adults:

Establishment levels: qualified nurses whole time equivalent (WTE) 10 there were no vacancies

Establishment levels: nursing assistants (WTE) 12 there were 2 vacancies

Staff sickness rate in 12 month period 4%

Staff turnover rate in 12 month period 2

In order to establish the number of staff required on each shift the trust commissioned a national expert, to support a review of staffing levels across mental health inpatients. This information had been used to inform staffing levels and skill mix. The agreed staffing establishment was one qualified nurse and three support staff on each shift (early, late and night) with one staff member working nine to five pm. The staffing rota confirmed this and staffing levels were supplemented by the presence of the ward manager and psychologist most days.

The ward did not use any agency staff in the six months leading up to our inspection. There was some use of bank staff equalling in total an average of five shifts per week. These were covered by the ward staff, who knew the patients well and regular bank staff. There were two vacancies for healthcare support staff at the time of our inspection and interviews for these posts were planned for the following month.

Where there were increased levels of risk, additional activity or new staff on the ward, staffing levels were adjusted to take account of this. There was enough staff employed by the ward that this could be done without the

Requires improvement

Are services safe?

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

use of bank staff on most occasions. If patients had planned to go out on leave the manager was able to bring in extra staff to cover this. The ward manager was always supernumerary on the staffing rota. However, this did mean that if there was short notice sickness they were able to work on the ward until a staff member to cover was found.

Staff and patients told us that they spent regular one to one time with each other. During our inspection staff were observed to be sat with patients for most of the day engaging with them. The minimum number of one to ones with patients and their key nurse was four per week and care records demonstrated this to be the case

The average mandatory training rate was 60.% which was below the trust standard of 80% compliance. The trust provided us with data for mandatory training as of October 2015.

Of the 26 courses that the trust lists as mandatory for staff, only six met the trusts target of 80%. Records showed levels of compliance were below 75% in the following areas;

Equality and Diversity,

Informed Consent to Treatment,

Mental Health Legislation Update,

PMVA Level 3,

Safeguarding Children- Working with Children and Their Families,

Safeguarding Adults - Level 1,

Risky Business,

Clinical Waste Management,

Local Induction,

Basic Life Support with Defibrillator,

Immediate Life Support,

Information Governance,

Safeguarding Children - Think Family,

Manual Handling People,

Clinical Records Keeping,

Controlled Drugs,

Infection Prevention and Control Level 2,

Hand Hygiene,

Rapid Tranquilisation.

We asked staff why the figures were so low, they told us there was a shortfall in the time it takes for the system to update that a course had been completed. Therefore, most staff kept their own record of what courses they had completed separately to the electronic system. The staff also reported a problem with access to e- learning. They explained that it would take up to three days to get a password and log on for an e learning course and by the time they received it the course had expired so they would have to re-apply.

The trust was aware of the lack of compliance with mandatory training and had an action plan in place to improve compliance across the trust. This was ongoing at the time of our inspection.

Assessing and managing risk to patients and staff

In the six months leading up to our inspection, there were no episodes of seclusion. There were six episodes of restraint, of these one was recorded as prone restraint and one resulted in rapid tranquilisation.

The trust uses the GRiST risk assessment tool (Galatean Risk and Safety Tool). This complies with the Department of Health Best Practice in Managing Risk guidance (2007) as it covers all the five key areas to risk management that they recommend to be assessed. These are risk of violence, sexual violence, antisocial or offending behaviour, self-harm/suicide and self-neglect/vulnerability.

We did not see any restrictive practice in place on the ward and informal patients were able to leave at any time. This was documented in a sign that was by the door explaining that although the door was locked they could ask staff to leave at any time.

The trust had policies for observations of patients and searching of patients and staff were able to explain these to us. Searching of patients was not routine, but if this was felt to be necessary due to risk to self or others, this was done in accordance with the trust policy, which complied with the MHA code of practice in relation to searches. We saw evidence in patients' notes of how this was risk assessed and care planned on an individual basis and that support was offered to that patient around the issues for which they were being searched; for example use of illicit substances.

Requires improvement

Are services safe?

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

Staff had a good understanding of safeguarding and were able to explain the safeguarding procedure to us. This was reported via a safeguarding hub and staff were able to tell us the name of the contact person there. They also told us they could ring the hub for advice around safeguarding if they needed it. However, compliance for safeguarding training was 73% below the trust standard 80%.

The trust had a medicines policy and there were effective medication managements practice in place. The pharmacist visited the ward once a week. There was a dedicated NICE (the National Institute for Health and Care Excellence) representative for the ward who attended the monthly network governance meeting to discuss NICE guidance around medication. Two patients were working towards self-medicating and this was being done in line with the trusts self-administration of medicines policy. This included a risk assessment of how suitable the patients were to be able to take their own medication based on their understanding of why they need to take the medication and how it works. There was a staged approach to self-administering whereby patients were heavily supported in the first stage getting less so as they moved through the stages. Due to the fact this was a ward environment, patients medications remained in a locked room if they were self-medicating but they were able to have a key to their individual medicines cupboard in that room to get out their own medications.

Track record on safety

There were no serious incidents reported by the long stay/ rehabilitation mental health wards for working age adults in the 12 months leading up to our inspection.

Reporting incidents and learning from when things go wrong

The trust had an electronic incident reporting system in place. All staff were able to tell us how this worked and how they would access it to create an incident.

There was a daily community meeting on the ward where patients and staff come together to discuss any issues they may have and activities for the day. This was in order to try to resolve any emerging issues at a local level by discussing them as a team. During our inspection we observed a community meeting. Patients were encouraged with support from staff to lead on this meeting and discuss things that they wanted to talk about. Staff told us that during meetings they would discuss any incidents that involve the patients and use this as a type of debrief should this be appropriate. This enabled the patients to discuss incidents in a calm and controlled environment.

Staff told us they learnt outcomes from incidents in a number of ways. This included feedback at staff meetings, in supervision and via email. The ward manager also ensured that debriefs happen following incidents. This involved a discussion of what happened, what could have been done differently and also supporting the staff with their emotions around this. During debriefs the staff also discussed who would be best suited to debrief the patient, this may be their key worker or someone they had a good rapport with. The ward manager also attended the trust quality and safety meetings. This was a meeting for ward managers from the acute and urgent care network to discuss incidents from the all areas and share learning. This was fed back to the team via team meetings.

Staff were aware of duty of candour and the need to be open and transparent when an incident occurred.

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.

Our findings

Assessment of needs and planning of care

We reviewed eight care records during our inspection. Care plans were developed in collaboration with the patients and the care team over a 12 week assessment period following admission onto the ward. The ward had a key worker system and there was evidence in the clinical records that patients were having at least four one to one sessions with a key nurse or other member of staff each week. Care plans showed they were done in collaboration with the patient and were signed and every patient we spoke to had a copy of their care plan. The care plans were holistic and covered a range of things such as mental health, physical health, drug and alcohol issues and social issues. The psychologist and occupational therapist also contributed to the care plans demonstrating a multidisciplinary approach. This allowed the care plans to be truly patient focused and personalised. The care plans were recovery focused with the whole aim being for that patient to recover well.

All care records we reviewed showed the patient had a physical health examination on admission to the ward and ongoing physical health monitoring. This included bloods being reviewed, weights being monitored and electrocardiograms being carried out when required.

Records were in paper format although risk assessments and care plans were also electronic so people could access them out of hours. The trust was in the process of moving towards electronic records although this had not been implemented at the time of our inspection.

Best practice in treatment and care

There is best practice guidance provided by the Royal College of Psychiatrists for rehabilitation services in mental health. The focus of this guidance is around the individual gaining support in recovery with patient involvement and social inclusion in order to successfully transfer back into the wider community. We found during our inspection that there was a wide range of recovery focused activity available on the ward and a wide range of psychological therapies. The national institute for health and care excellence recommends cognitive behavioural therapy for people with a long term diagnosis of a psychotic illness. There was a full time psychologist on the ward who was trained in these techniques and was using these with patients on the ward. This also included other techniques such as motivational interviewing for people who use illicit substances and work around boundary setting with families and carers to maintain effective relationships.

There was access to a range of physical health links at the local acute hospitals if patients required investigations into a physical health problem. However, there was no GP allocated to the ward and the trust was trying to organise a local GP to provide primary care input. Most patients on the ward were outside the catchment area of their own GP. The consultant was able to liaise with secondary physical healthcare services and had access to GP trainees for advice.

The staff on the ward were involved in clinical audits and were able to describe these to us and show us the outcomes. These included medication audits, records audits and an audit of patients' section 17 leave documents. The occupational therapy team used a wide range of scales to measure outcomes of the work they were doing. These included functional capacity assessments which gave them an idea of how much support people needed and could be done on a regular basis to show improvements. Collaborative goal technology was used to inform the care plans of a patient. This looked at their goals and was reviewed monthly and gave a percentage of attainment. These were completed with the patient during sessions with the occupational therapist.

Skilled staff to deliver care

The ward was staffed by a multidisciplinary team. There were registered mental health nurses, healthcare support workers and a dedicated consultant psychiatrist who specialised in mental health rehabilitation. There were four occupational therapists one of which was a senior band six. There was also a full time psychologist. There were student mental health nurses on placement on the ward and plans to start having student occupational therapists in the near future. The pharmacist visited the ward weekly and was available on the telephone during working hours. There were also administrative and domestic staff who solely work on that ward.

The ward manager was proactive in putting out adverts for new staff when jobs became available and there were

Are services effective?

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upcoming interviews for the two vacancies on the ward. There was a robust induction for new starters and new staff we met during inspection spoke highly of this. They described being met at the door by a "buddy" who was allocated to show them how the job is done.

There were monthly team meetings and these were done at a time when the most staff would be able to attend for example handover time. Minutes of team meetings were made available for people who were unable to attend so information was passed on. There was regular supervision in place for staff which was a minimum of monthly. Staff described the team as having a "flattened hierarchy" which created good multi-disciplinary team with a culture of discussions to remedy problems and improve patient care. There was good evidence of peer to peer supervision for example the occupational therapists received their supervision from a senior occupational therapist. There was a clear format used to document supervision and we saw evidence of this during the inspection. Managers were encouraged to take part in leadership training to support their development in the role.

The trust provided us with data of non-medical staff performance appraisals for the twelve months leading up to our inspection. This was currently at 32% for the ward which shows poor compliance. During our inspection we saw evidence that this was being addressed.

There were structures in place for senior staff to manage performance within the team. The manager and senior staff, which included senior nurses and occupational therapists, were confident in the way they would approach this and could give examples of how this had been done. Examples of this were around staff sickness levels and managing these in accordance with the trust policy.

Multi-disciplinary and inter-agency team work

There were a number of multi-disciplinary meetings on the ward. On a Monday and Friday there was a clinical handover. This included the nurses, doctors, occupational therapists and psychologists. This was about planning for the week and ensuring that everyone in the team was aware of what was going on for patients that week. There were also rehab goal setting meetings that happened weekly. The team for that patient would attend and discuss where that person was up to on the recovery pathway. The team described this as a time to focus on the rehabilitation aspect of care in a focused way.

The community mental health teams for the patients on the ward remained involved during their admission. They were involved in planning the care of that patient at multi-disciplinary meetings as well as facilitating leave and discharge for their patients with ongoing support.

During our inspection we observed a handover. This included everyone on duty for that shift. The staff member giving handover referred to the care records to provide all staff with an up to date progress report of that patient. There were some staff present who had been off duty for more than one day. They were given a full handover for the period of time they had been off duty. The handover was observed to be very positive and focused. Details about the patients mental health act status, level of observations, leave status and any changes in risk were handed over.

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

The trust provided us with data of Mental Health Act (MHA) training as of October 2015 73% of staff have had training in the MHA. This is below the trust target of 80%. However, staff working on the ward that we spoke to showed a good understanding of the MHA despite this.

During our inspection a Mental Health Act reviewer looked specifically at the care records of people who were detained under the MHA. In total we reviewed eight care records. We found good evidence of recording of detention under the MHA including section 132 rights being read monthly for people detained on a section 3. There were good systems in place for scrutinising and recording receipt of MHA paperwork in the form of a central office that alerted wards when anything to do with MHA was due to be competed.

We saw evidence on the ward of posters to explain information about peoples rights under the MHA and how to contact the Care Quality Commission to make a complaint.

We found that all patients had a T2 (certificate of consent to treatment) or T3 (certificate of second opinion) in place

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.

to authorise their medical treatment and these were attached to the medication charts. The recording of capacity and consent to treatment was clearly recorded in all patients records.

Independent Mental Health Advocates (IMHA) were available. All patients we spoke with confirmed that they knew how to contact the IMHA should they require advocacy support.

Good practice in applying the Mental Capacity Act

A total of 82% of staff had had training in the Mental Capacity Act (MCA) as at October 2015. This was meeting the trust target of 80%.

There were no deprivation of liberty safeguarding applications in the twelve months leading up to inspection.

Staff we spoke to understood the principles of the MCA and were able to give us examples of how they had appropriately assessed peoples capacity. One example of this was around a patients capacity to continue to smoke despite a serious health condition. This was assessed using a capacity assessment and then a best interest decision. All patients were presumed to have capacity unless it was proven otherwise and independence was promoted on the ward

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

During our inspection we saw interactions between patients and staff. We observed all of these to be respectful and kind. We observed medication being administered by staff in a discreet manner, allowing the patients' time to ask questions about their medication. During the day we observed patients and staff cooking together and found this to be done in a supportive way. We observed a handover and found the staff to be very positive about the patients during this.

Patients we spoke to told us that staff were professional at all times. Staff were praised by patients for being approachable, caring and always making time to talk. We spoke to nine patients during the inspection and all except one told us that they felt safe on the ward. Patients told us they felt listened to by the staff.

The staff we spoke to during the inspection all knew the patients very well. They were aware of their care plans and their individual needs. We observed staff arranging a debrief following an incident and in depth discussions around who would be the best person to lead this for that particular patient. The staff were aware of who the patient had the best rapport with and how they this would be best approached to suit their needs.

The involvement of people in the care that they receive

There was an in depth pre admission process that ensured patients were orientated to the ward. Patients were assessed prior to being accepted onto the ward and were able to visit to have a look around and meet some of the staff. Once admitted patients were shown around and introduced to the other staff and patients on the ward. There was then a structured 12 week induction/assessment period where certain assessments were completed with the patient at certain points of the period. This was in order for the staff and patients to get to know each other and to work collaboratively to ensure they were working towards the same shared outcome. During the first 48 hours patients were orientated to the ward and basis admission checks such as physical health were carried out. During this time patients were introduced to their key worker.

We reviewed eight care records and all care plans and risk assessments apart from one showed full involvement of the patient. When the patient was not involved it was clearly documented by the staff why this was and clear attempts continued to be made to involve that particular person. Patients were aware of their care plan and had a copy of this. Care plans were all signed by patients.

This included focusing on including the patients in their own local communities (not the local community to the hospital). For some people this meant travelling a long distance to get to a football match or a gardening group in their home town. However, the occupational therapists within the team worked hard in order to ensure that patients were kept up to date with what was going on in their local area by way of a newsletter which identified what was going on in the different parts of Cumbria.

Patients were encouraged to maintain their independence in a number of ways. They all did their own shopping and cooking for example and staff supported them to do this if they required help.

There was access to an advocacy service "your voice" and there was information about this displayed on the ward during our visit. The advocates attend the community meetings on the ward on a regular basis. The trust has an automatic referral system to an independent mental health advocate for people who are detained under the mental health act.

Patients' families and carers were encouraged to engage in their care. This included attending meetings and reviews at the request of the patient. When family and carers attended they were given the chance to explain their views.

There was a daily community meeting where patients could give their feedback on the service. We observed one of these meetings during our inspection and found that patients were actively involved with support from staff.

Two of the patients had been involved in interviewing staff for the ward. The trust had a policy that staff above band five being interviewed would have a patient or carer on the interview panel. One patient was involved in the interviews of staff that would be supporting them on discharge and this had been agreed by the commissioners for that service.

Good

Are services responsive to people's needs?

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

Our findings

Access and discharge

The average bed occupancy over the six months leading up to our inspection was 57%. The ward has 16 beds but is currently commissioned for 10 beds by Cumbria Clinical Commissioning Group. During our inspection nine beds were occupied.

Patients going out on leave have access to a bed on their return. The majority of the admissions to the ward are from the adult acute wards within the trust although there have been referrals from forensic services, psychiatric intensive care units (PICU) and from people currently in the community. At the time of our inspection there were two patients awaiting admission to the ward. The trust did not have a provision for females who require rehabilitation and we were told that females would go to an out of area placement should this be required.

There was a psychiatric intensive care unit available if a patient required more intensive care, this was based on the same site.

The discharge of patients was always planned and done at an appropriate time of day. Since the ward opened 18 months ago there have been two discharges. In the last six months there have not been any delayed discharges or re-admissions.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms and equipment on the ward to support treatment and care. There was a clinic room which had an examination couch for use when required. There was a number of small lounges where patients could go to spend time alone or to meet with staff. There was a large activity room with access to games equipment and the outdoor area which could also be accessed via the main dining area on the ward. There was also a community garden in a different part of the hospital that patients could access and this was maintained by the patients with help from volunteers. All patients at the time of our visit had their own mobile phones and could use these in the privacy of their own room if they wanted to make a private phone call. However, if patients did not have access to their own mobile phone there was also a mobile phone on the ward for patients to use in a private area.

The ward was completely self-catering. All patients had their own cupboard in order to store their food and a shelf in the fridge. The patients were given support from the staff on the ward around making a shopping list each week and going to the local supermarket to buy the items. Whilst we were on inspection we saw all patients making their own meals and staff supporting people who needed it. The ward provided basic store cupboard items such as rice, pasta and milk. Then patients built on this using their personalised shopping budgets. The kitchen was open at all times and patients could access this whenever they wanted to make a hot drink or snack. In the outdoor area there was a space where patients were growing their own vegetables and herbs which can be used in their cooking.

Patients were able to personalise their bedrooms with photographs of family, items from home and posters etc. Patients all had their own key for their bedroom and could lock this when they were not using it, although patients told us they felt their possessions were safe on the ward. Some patients had laptops that they were happy to leave out in the communal area for other patients to use.

The trust provided us with data of the patient led assessment of the care environment (PLACE). The ward scored 88% which is above the national average for privacy, dignity and wellbeing but also higher than the trust scored as a whole.

There was a wide range of activities available seven days a week during the day and evenings. This was led by the patients and the occupational therapy team. Activities included, walking men's football, social skills group, culinary skills pathway, gym, creative writing, pat dog visits, local church visits to name a few. Patients have an interest checklist given to them on admission and this allows them to highlight areas of activity they may already be interested in or would like to try. This was then matched up, by the occupational therapy team, to what is available in their local area (where they come from – not local to the hospital) and they provided a monthly newsletter detailing what events were taking place. The occupational therapy team were able to take patients to these events with other staff if required. This was a graded approach to the patient doing this alone in order for it to carry on post discharge.

Good

Are services responsive to people's needs?

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

On Sundays, the patients would sit down with the occupational therapist and do their planner for activities for the next week. This would include a budget plan for money and a shopping list for food. On Fridays, the ward did a "fakeaway" night where the patients decide in the community meeting in the morning what theme of takeaway they would like to cook that evening. This is to promote healthy alternatives to take away meals. They then allocate jobs between them for example one to go shopping, one to cook, one to set the table. They also plan other meals as a group including Saturday morning "big breakfast" and Sunday lunch.

Meeting the needs of all people who use the service

The ward was fully accessible for people in a wheelchair; including a lift to upstairs and walk in showers. There were two bedrooms on the ground floor one of which was specifically identified as a disabled access room.

Information leaflets were displayed in the activity lounge and these were available in different languages. There were posters on the ward telling the patients this in different languages and how they can ask for them. There was also access to interpreters and this was booked online via the trust intranet.

As patients all buy their own food they are able to plan for and buy any particular food that meets their own dietary requirements. This includes vegan, vegetarian and coeliac diet as well as kosher or halal if required.

There is a chaplain that comes to the ward on a regular basis. The ward was also able to request different faith representatives such as a rabbi or an imam if this was required. Although the focus of the staff is for people on the ward to be helped to keep contact with their own local religious groups with support from staff as much as possible. There was also an onsite multi faith room called "Oasis". This contained a space for people to pray privately with access to holy books from different religions. On a Sunday there was a small mass held in this room where patients can go to receive Holy Communion if they are not well enough to attend their own local church for mass.

Listening to and learning from concerns and complaints

There were no formal complaints made about this service from 1 November 2013 to 29 October 2015. There was evidence on the wall of the ward to explain to patients and relatives how to complain if they wanted to. There was also a patient experience team who would try to resolve any smaller issues at a local level. The patients we spoke to told us they were given information on admission about how to make a complaint. They also told us they had the telephone number for patient advice and liaison service if they wanted to speak to someone independent from the ward about an issue. However, patients and their carers told us that the staff were approachable on the ward and that they would speak to them directly initially if they had a complaint.

Staff told us that although they have had no formal complaints about the service they still discuss any issues that come up and learn from them. This would be done via the community meetings to discuss things with patients. For example there was a recent problem with some food going missing from patients' cupboards. This was discussed with all the patients and a plan made from this of how to deal with the situation. This was done in an open way allowing patients and staff to learn from the incident. It was decided that locks would be put on the food cupboards and patients would get a key. However, patients were happy to leave their cupboards unlocked until these arrived so they still had access to their food. If there was a complaint/ problem with something not patient related then staff would receive feedback from this in their supervision and team meetings. The ward manager would also send out updates via email in case anyone missed this information.

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.

Our findings

Vision and values

The trust values are "kindness, fairness, ambition and spirit". These were displayed in staff and patient areas of the ward. Staff told us there was lots of publicity about them and they were involved in deciding what they were at engagement meetings with the senior leadership team. Staff commented how they liked the fact they were simple but meaningful as people understood them and thought they reflected the basics needed for good care.

Staff were able to tell us the names of the most senior people in the organisation. The staff felt that their immediate managers were approachable and easily contactable should they need to speak to them. The most senior managers in the organisation have twitter accounts and staff and patients can follow them to see what they do in their daily roles. Staff told us that the majority of the senior leadership team had worked their way up from frontline mental health services provided by the trust, staff told us this made them feel they understood the problems they faced and could give them support around their clinical work.

At ward level all staff we spoke to told us that they felt supported by the clinical leadership team on the ward. They told us that they would never feel worried to approach them and voice any concerns. They told us they felt listened to and their opinions were all important. They felt they were encouraged to give their opinions in meetings and handovers about patient care and that these opinions were taken into account.

Good governance

Staff received monthly emails regarding the status of their mandatory training compliance. This is held centrally at trust level and allows managers to see what staff are compliant with and when training is due. However all staff we spoke to told us that system was slow to update when they had completed training. Some staff told us they kept their own log of what training they had completed as this was more up to date.

Appraisals were undertaken annually. At the time of our inspection the trust provided us with data which showed only 32% of staff on the ward had received an appraisal in the last year. Staff supervision was ongoing every four weeks for staff at all levels and records showed this was up to date. All staff we spoke to told us they had regular supervision with some group supervision and informal supervision happening monthly.

The trust commissioned a national expert, to support a review of staffing levels across mental health inpatients. This information had been used to inform staffing levels and skill mix.

When we spoke to patients they told us they spent one to one time with staff on a regular basis. We reviewed eight sets of records during our inspection and all of these evidenced staff spending therapeutic time with patients on a daily basis.

There were two ongoing clinical audits for the ward. One of these was around record keeping and the other around mental health act paperwork. The ward manager was also introducing another clinical audit around the prescription charts which was going to be a monthly audit.

Staff knew how to report incidents and records showed they did this in accordance with policy. There were no formal complaints about this service. However, staff and patients told us they were aware of the process they needed to complete should they wish to complain. Staff learnt from incidents via staff meetings and one to one supervision. Information was also sent out via emails to people who were not on duty at the time to receive the feedback.

The ward manager had sufficient authority to run the ward and was able to increase staffing numbers should this be required. There was a monthly meeting for acute and urgent care where ward managers could attend and discuss items they felt needed to be added to the risk register. There are currently five items from the ward on the risk register and staff were able to tell us what these were.

Leadership, morale and staff engagement

The sickness level for the ward at the time of our inspection was 4.2%. This is below the trusts average of 4.8% and below the national average of 5%.

There were no ongoing bullying and harassment cases at the time leading up to our inspection. However, staff told us they were aware of the whistleblowing policy and how

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to report this should they need to. All staff we spoke to told us they felt confident to raise concerns to their managers if they had a problem. They felt they were listened to and that they would not fear victimisation if they spoke up.

Every staff member we spoke to told us they were happy in their job role. They reported that morale in the team was high and that they all supported each other. Staff told us they love what they do and felt they were empowered in their role to make decisions and this was supported by the clinical leadership team. There were lots of staff meetings and peer support, which often included the team psychologist to guide the sessions. All staff told us that they felt they made a difference in what they do and that they enjoy going to work. The senior team had all been encouraged to attend some form of leadership training and reported this had helped them in carrying out their job. Staff felt they could give their opinion on changes that may improve the service through team meetings and supervision.

Commitment to quality improvement and innovation

The ward opened 18 months ago and was just starting to go through the process of applying for Accreditation for Inpatient Mental Health Services (AIMS). They reported they were hoping to start this early 2016.

The ward is a placement provider for student nurses and student occupational therapists. They have also formed links with Dumfries University for people who want to choose rehabilitation wards as an elective placement.

The occupational therapy team featured in the local press during national occupational therapy week. This gave an outline of what the ward provides and how the occupational therapy team support this.

The ward had a twitter account, which was solely managed by the ward manager for governance reasons. However, this was used in order for the ward to show good practice and events that they were involved in. The trust senior management team followed the ward on twitter and therefore can see what good practice they were achieving. This had also been a way for the ward to make links with national mental health groups. One in particular being the positive practice in mental health, which was a scheme for recognising excellence in mental health services. In doing this the ward had access to conferences and training which specialise in rehabilitation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found a breach of regulation 12 (1) and (2) (b) as the provider was not doing all that was reasonably practicable to mitigate the risks to health and safety of patients. This was because: Patients' bedrooms were on the first floor of the building except two bedrooms on the ground floor. Staff did not have clear lines of sight throughout the first floor, this was mitigated by parabolic mirrors. However, staff did not routinely work on the first floor, the only staff presence was during hourly observations. There was no nurse call system or alarm system in patient bedrooms. This meant patients had no means of summoning staff help or support in an emergency.