Good

Cheshire and Wirral Partnership NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

Trust Board Offices
Upton Lea
Countess of Chester Health Park
Liverpool Road
Chester
Cheshire
CH2 1BQ
Tel: 01244364186
Website: www.cwp.nhs.uk

Date of inspection visit: 23 June – 24 June 2015
Date of publication: 03/12/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXA72	Soss Moss Site	Complex assessment and recovery service	SK10 4SZ
RXAAE	Jocelyn Solly (Millbrook)	Lime Walk House	SK10 3JF
RXA19	Redesmere, Countess of Chester Health Park	Rosewood Ward	CH2 1BQ

Summary of findings

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

Contents

Summary of findings

Overall summary

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

The wards had systems in place to manage patient safety. The ligature risk management plan identified ligature points and how they might be used by patients who were suicidal. This made sure that staff were fully aware of the risk presented. The suicide prevention environmental risk assessment clearly documented where the risks were, the level of risk and how they were to be mitigated

The service generally had sufficient numbers and the appropriate skill mix of staff on duty to meet patients' needs. Ward managers could increase staffing levels when appropriate. There was access to a regular cohort of bank staff.

There were clear processes in place for reporting safeguarding concerns. Staff had a good understanding of procedures and were confident in applying trust policy. Safeguarding was a standing item on the team meeting agenda.

Staff delivered care and treatment that was underpinned by best practice and a recovery focused theme was evident across the service.

Supervision and appraisals took place in line with trust policy. This meant that staff were supported by managers and colleagues and received the professional development needed to carry out their duties effectively. Managers were able to assess the quality of staff performance.

Peer support workers helped support patients, carers and staff. A peer support worker is a person with direct experience of mental illness.

The admission process informed and oriented patients to the wards. Each patient received an information pack before admission. Staff organised a series of pre-admission visits that gradually introduced the patient to the ward environment. Both patient and carer were included in these visits. On the day of admission patients were met by a member of staff who was familiar to them.

There was effective management of complaints. Patients discussed informal concerns during community meetings and nursing staff discussed any actions arising from these discussions during hand over. The ward manager investigated formal complaints in line with trust policy.

The service captured the ethos of the trust's vision and values and this was evident in the care and treatment provided by the staff. Senior management had a visible presence on the wards and supported ward managers and staff.

There were good governance systems at a local level. Ward managers routinely monitored key performance information. Team meetings included governance issues as standing items on the agenda.

However, the service was struggling to enforce the nicotine management policy relating to the restriction of tobacco related products. Staff were aware that patients were bringing tobacco and lighters on to the ward and had been reminded about the trust's search policy. In spite of this, we found little documented evidence relating to the searching of patients or their rooms for contraband items.

We were concerned about the confidentiality of patient and carers information due to the location of the office whiteboard on Rosewood. Information contained on the board, which included home contact numbers for patients and their relatives/carers was visible to anyone who passed by the office on their way to the dining area.

There was not enough emphasis on adhering to the Mental Health code of practice in respect of section 132 rights and access to an independent mental health advocate (IMHA).

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 wards had systems in place to manage patient safety. The ligature risk management plan illustrated ligature points and how they could be used. This made sure staff were fully aware of the risk presented.
- Risk assessments for individual patients were completed in a timely manner and updated regularly or when the need arose.
- The service generally had sufficient numbers and the appropriate skill mix of staff on duty to meet patients' needs.
- There was access to a regular cohort of bank staff.
- There were clear processes in place for reporting safeguarding concerns. Staff had a good understanding of procedures and were confident in applying trust policy.

However:

- The service was struggling to enforce the nicotine management policy relating to the restrictions of tobacco related products. Staff were aware that patients were bringing tobacco and lighters on to the wards. Despite this, there were few documented incidents relating to searching patients or their rooms for contraband items.

Are services effective?

Good

We rated effective as **good** because:

- Staff delivered care and treatment that was underpinned by best practice. A recovery focused theme was evident across the service.
- Patients' physical health needs were monitored and addressed.
- The ward used the health of nation outcome scales to measure outcomes.
- Staff supervision and appraisals took place in line with trust policy.
- Peer support workers helped support patients and carers. A peer support worker is a person with direct experience of mental illness.
- The service developed good links with external agencies, for example, GP surgeries, housing organisations and the recovery college.

However:

Summary of findings

- There was not enough emphasis on adhering to the Mental Health code of practice in respect of section132 rights and access to independent mental health advocates.

Are services caring?

Good

We rated caring as **good** because:

- We observed positive and caring interactions between staff and patients. Patients told us staff were approachable, empathetic, and responsive to their needs.
- Patients and their carers were actively involved in the recovery process.
- The admission process informed and oriented patients to the wards. Pre-admission visits took place and both patients and carers were involved.

However:

- We were concerned about the confidentiality of patient and carers information due to the location of the whiteboard used for the daily multi-disciplinary handover on Rosewood.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- There was a clear pathway in place to support patient recovery. The discharge plan was constructed as part of the admission process and was a central part of the care plan.
- There was effective management of complaints and concerns. Patients discussed Informal concerns during community meetings and nursing staff discussed any actions arising from these discussions during hand over.
- The facilities available were comprehensive and appropriate and patients had access to a wide range of therapeutic and recreational activities.

However:

- We reviewed patient activity plans and found that some patients' plans included activities that did not actually take place.

Are services well-led?

Good

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

- The service captured the ethos of the trust's vision and values and this was evident in the care and treatment provided by the staff.

Summary of findings

- Senior management had a visible presence on the wards and supported ward managers and staff.
- There were good governance systems to monitor key performance information.
- Morale was generally good. Teams felt supported by their colleagues and there were effective working relationships between the multi-disciplinary teams.

Summary of findings

Information about the service

Cheshire and Wirral Partnership NHS Foundation Trust provides inpatient long stay rehabilitation mental health wards for working age adults. These services are provided for patients who are detained under the Mental Health Act and patients who are admitted informally. The three wards we visited were:

The complex assessment and recovery service (CARS) – a 15 bed male long stay/rehabilitation ward. This ward was relocated in March to a low secure facility whilst works were undertaken to the dementia ward at Millbrook Unit, Macclesfield. The CARS ward should have returned two weeks before the inspection but the decision to refurbish the nurses' office delayed the move by two to three weeks.

Lime Walk House, which is based at the Jocelyn Solly (Millbrook Unit) site is a 20 bed mixed gender long stay/ rehabilitation ward.

Rosewood ward, which is on the Bowmere Hospital site, is a 16 bed mixed gender long stay/rehabilitation ward. Rosewood also had two single person self-contained flats on the ward for on-going assessment of independent living skills.

The Care Quality Commission (CQC) had previously inspected the Soss Moss site and the Bowmere Hospital where two of the wards were located. There was no current enforcement or compliance action being taken by the CQC in relation to any of the rehabilitation wards at the time of this inspection.

We have carried out regular Mental Health Act (MHA) monitoring visits. Where there were issues relating to the MHA, the trust had provided an action statement detailing steps to improve adherence to the Mental Health Act 1983 and its code of practice.

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director of Mental Health, Department of Health (retired)

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leaders: Sharon Marston, Inspection Manager (mental health), Care Quality Commission,

Simon Regan, Inspection Manager (community health services), Care Quality Commission.

The team that inspected this core service comprised three CQC inspectors and the following specialists:

- a Mental Health Act reviewer,
- a psychologist,
- a senior social worker
- a ward manager (registered mental nurse)

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?

Summary of findings

Before the inspection visit, we reviewed information that we held about these services and engaged with other stakeholders to gather further information.

During the inspection the inspection team:

- visited all three of the wards at the three hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 13 patients who were using the service
- spoke with three carers
- spoke with the managers for each of the wards
- spoke with 28 other staff members; including doctors, health care assistants, nurses, occupational therapists, peer support workers, psychologists and social workers
- attended and observed a handover, a care pathway approach review, a community meeting and a multi-disciplinary meeting.

We also:

- reviewed 19 care records, 13 patient activity plans, 10 clinical records and 11 prescription charts
- carried out a specific check of the medication management on the three wards.
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke with 13 patients who were using the service. Patients' views and experiences of the care and treatment they experienced were mainly positive. Patients praised staff for being approachable and empathetic to their needs.

Most of the patients we spoke to said they were involved in their care as much as they wanted to be.

Areas for improvement

Action the provider SHOULD take to improve
The provider should:

- review how the nicotine management policy is implemented within the rehabilitation wards as both staff and patients were struggling to comply with the policy.
- ensure that confidential information displayed on office whiteboards cannot be viewed by anyone other than ward staff. Confidential information included contact numbers for patients and their relative/carers.
- ensure that access and referrals to independent mental health advocates are embedded in practice. The reading of section 132 rights should follow the MHA code of practice.

Cheshire and Wirral 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
The Complex Assessment and Recovery Service	Soss Moss Site
Lime Walk House	Jocelyn Solly (Millbrook)
Rosewood Ward	Bowmere 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.

Staff were trained in the use of the Mental Health Act (MHA) and could seek advice and support from the trust's Mental Health Act office. There was varied compliance with the MHA documentation. We found good compliance with section17 leave. Paperwork authorising leave was given individually according to need and stage of recovery

There was not sufficient emphasis on section132 rights. All patients had their rights read to them under section132 of the MHA but some not as frequently as good practice suggests, which is every three months. Patients had their rights read to them from an information sheet. This is contrary to MHA code of practice. In addition, the rights leaflet for patients detained under section 3 of the MHA, quoted the wrong period of stay (six months when it can be a year).

We found that one patient's detention paperwork was not kept on file. The detention renewal form and AMHP application for section 3 of the MHA had to be retrieved from MHA office.

We reviewed eleven prescription charts. Ten patients were detained under MHA and all medications prescribed were

Detailed findings

listed correctly on the T2 (certificate of consent to treatment) and T3 (certificate of second opinion) forms. However, one record revealed that the wrong dose of lorazepam had been administered on two occasions (1mg instead of 500mcg).

We found that staff did not support and promote the use of independent mental health advocates; consequently there was little take up among the patients. An independent mental health advocate is a specialist mental health advocate available to offer help to patients under arrangements which are specifically required to be made under the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 (MCA) was part of the provider's mandatory training. Staff compliance with the training was 86% across all the wards. When asked, staff could explain the basic principles of mental capacity assessments and felt supported in the use of the Act.

There were no patients subject to Deprivation of Liberty Safeguards (DoLS). Qualified nursing staff knew there was a policy in relation to MCA and DoLS on the trust's web site.

Good

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean environment

The complex assessment and recovery service (CARS) was temporarily based in a low secure facility that was laid out in a quadrangle and surrounded by a high fence. There were fish eye convex mirrors to mitigate potential blind spots due to the layout of the corridors. It was a rehabilitation ward for men and each patient had an individual bedroom. There were two bathrooms, a shower room and a number of toilets available but no ensuite facilities.

Lime Walk House was a stand-alone mixed sex ward with several corridors allowing for male and female patients to occupy separate areas of the ward. Patient bedrooms were single occupancy and en suite. The corridors had blind corners, where there was no clear line of sight. This risk was mitigated by undertaking hourly observations on patients. The patients admitted to Lime Walk House were assessed as being less complex and less at risk than those admitted to the other rehabilitation wards. Doors to external areas had alarms and were sometimes locked if there was a patient with high risk of absconding. Patients were told when doors were locked.

Rosewood was a mixed sex ward based inside an inpatient unit. Female patients had separate living, recreation, and sleeping space from male patients. Bedrooms were single occupancy and had en suite shower facilities. There were also two flats situated off the female living area for patients to develop the independent living skills required for discharge. Most admissions in to the flats were for six weeks.

Both Rosewood and Lime Walk House complied with Department of Health guidance on same sex accommodation.

The wards were clean with well-maintained décor and furnishings. The notice boards all displayed infection control information and monthly cleanliness audit results from the modern matron's inspection. However, the CARS temporary environment showed signs of wear and tear in the furnishings and there was evidence of smoking in the bathrooms.

All wards had ligature risks assessments and management plans. A ligature risk audit identifies fixtures and fittings to which patients might tie something to strangle themselves and identifies actions to mitigate the risks to the patients. We reviewed the ligature risk audit for the CARS ward and the management plan. The audit was of good quality and comprehensive, clearly identifying ligature points, their location and rating of risk. The management plan contained photographs showing how the ligature points could be used and made it very clear to all staff what the risks were.

On Rosewood, some ligature and environmental risks were identified as not being addressed via the capital programme and were highlighted as a moderate concern on the risk register. Risk assessments detailed the ligature risks in specific bedrooms and informed individual risk management plans for high ligature risk patients. Lime Walk House balanced ligature risks against positive risk taking. For example, leaving the laundry rooms and toilets open for patient use when there were ligature points such as electrical outlets/cables and window hinges. Staff told us that if there was a risk to patients that could not be managed safely then the patient would be moved to an environment that best met their needs and ensured their safety.

All Patients had fobs to their own rooms and could go into their rooms freely. On the CARS ward there was a nurse call alarm system with alarms in the bedrooms and bathrooms. There was an air lock to gain entry to and from the ward but this was because the service was temporarily located in a low secure facility.

All wards had functioning clinic rooms that were clean, tidy and equipped with the appropriate resuscitation equipment and emergency drugs. We saw that staff routinely checked the clinic rooms to ensure everything was in working order and in date. Medication was dispensed from the clinic, using a drugs trolley containing individual drawers with the patient's name on it.

Good

Are services safe?

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

Rosewood or Lime Walk House did not have seclusion facilities. Patients were transferred to acute wards if the need arose. On the CARS ward there was a seclusion room but staff confirmed the facility was not used and they did not have one at their usual base.

Safe staffing

On the rehabilitation wards, minimum safe staffing levels were reviewed following the Francis Report (a government enquiry into Mid Staffordshire Foundation Trust). There was a staffing ratio of one qualified nurse to eight patients across the service. Lime Walk House was well staffed with establishment levels of 12.1 qualified nurses and 13 Health care assistants. The day shift comprised three qualified staff and six health care staff to care for 20 patients. There were no vacancies although one nurse was on secondment. The manager could increase staffing levels to meet clinical needs or staff sickness and maintain the safety of patients and staff on the ward. On the day of our visit extra staff had been brought in as six patients were attending the Cheshire show.

The CARS ward had increased staffing levels at the weekend due to the remote location of the service. This enabled more activities to be available for patients. It was unusual for planned activities or escorted leave to be cancelled due to staff shortages on this ward.

Rosewood had the highest number of vacancies for qualified nurses (28%). However, following a recruitment drive new staff were scheduled to start in September 2015. Sickness levels at Rosewood were higher than for the other rehabilitation wards, currently 8% overall for the last six months. However, over the last four months they had improved steadily. Sickness levels were monitored using an e-rostering tool, which allowed ward managers to address the issue and impact on their ward.

Staff were redeployed from both Rosewood and Lime Walk House to assist with shortages on acute wards. Staff told us this impacted on Rosewood as escorted leave was cancelled on occasions and planned activities rescheduled.

Staffing level fill rates for the three month period ending April 2015, showed an overall fill rate of 96% for registered nurses on a day shift across the service and 90% for night shifts. Staff either worked additional hours, or bank staff that were familiar with the wards were used to cover unfilled shifts. However, during April, the staffing levels at Rosewood were maintained by using additional health care staff in place of registered nurses.

During the day the staff mix was complemented by a team of occupational therapists and psychology staff for each ward. Due to consultant vacancies, one consultant covered the CARS ward, Lime Walk House and another unit in the area. Recruitment was underway and almost complete. On Rosewood, a temporary consultant had been in post for three months.

Training was a mixture of e-learning or face to face engagement. The ward manager monitored compliance with mandatory training monthly and discussed it in supervision. The ward clerk sent staff reminders and booked them on available dates that coincided with their shift patterns. Mandatory training comprised of training that was either a one off or updated yearly or three yearly. The trust's target for compliance was 85%. For clinical staff, only Lime Walk House complied with the yearly updated training achieving 86% in June. For the three yearly updated mandatory training both the CARS and Lime Walk House met the target achieving 92% and 98% compliance. Rosewood achieved 81% compliance. Reasons for non-compliance were: staff either new or on long term sick/ maternity leave or awaiting more dates to become available. Overall, non-clinical staff achieved a compliance rate of 100% in June for mandatory training.

Assessing and managing risk to patients and staff

All of the patient risk assessments we looked at were regularly updated and amended on the electronic information system. Patients were risk assessed using the clinical assessment of risks to self and others template. This is a clinical decision support tool that aids practitioners in their assessment and management of the risks presented by the patient. Each patient had a risk assessment on admission. This was completed as part of the 72 hour care plan. Lime Walk House only admitted patients who were assessed as not being a suicide risk. Patients were assessed before admission to ensure suitability for the ward. Initially, patients were placed on 15 minute observations (level two) until settled and familiar with the ward. Observations levels were changed when there were concerns about a patient in line with the therapeutic observation policy.

Good

Are services safe?

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

In addition, we looked at patients' observation levels and found that level of observations being carried out were generally up to date. Risks and presentation were clearly documented and discussed in patients' care plans. However, one care plan had not been updated to reflect 15 minute observations and there was no record of why observations were increased.

On all the wards, staff used verbal de-escalation techniques, such as communication skills, verbal interaction and conflict resolution to manage violence and aggression. There was one episode of restraint recorded in the last 12 months at Lime Walk House and no incidents recorded on the CARS ward. The ward manager told us that staff were anxious when the original unit opened as they felt they needed a seclusion facility. However, over time staff confidence had grown and they developed good skills in de-escalation and increased observations.

Rosewood had an incident of prone restraint resulting in rapid tranquilisation. Rapid tranquilisation should only be considered once de-escalation and other strategies have failed to calm the patient. The ward manager conducted a full review of the incident to ensure the procedures used met with National Institute for Health and Care Excelence guidance and trust policy. Following eight episodes of restraint, two of which were prone (face down) on Rosewood in May 2015, the patient involved was transferred back to an acute ward where their individual needs could be better met. Managing violence and aggression was mandatory training for all staff. Lime Walk House was the only ward to meet the trust target of 85% compliance.

Staff we spoke with had a good understanding and knew their responsibilities regarding making safeguarding alerts. At the time of our visit, following advice from the safeguarding team, staff raised a care concern. This was a low level concern about tension between two patients on a ward so staff took action to manage the situation. We looked at a safeguarding alert and viewed the trust policy, which showed that the staff nurse had followed procedure. Rehabilitation wards compliance with mandatory safeguarding training for clinical staff was 92% and 75% for non-clinical staff. All staff, including new starters, understood the processes involved in reporting safeguarding and incidents, how it was fed back into the system and follow up action.

Experienced staff were aware of the trust's search policy and the rationale behind it. Staff on all the wards told us they only carried out searches when there was an indication that a patient was accessing, or in possession of, contraband items. They recorded room searches as incidents following lessons learned from a serious incident the previous year. However, there were few incidents reported that related to searches for contraband items such as lighters. Staff on the CARS ward were reminded during a staff meeting about smoking issues, managing contraband items and the need to record any searches conducted as an incident. All wards stated they faced challenges trying to manage the trust's nicotine management policy. On Rosewood there was an increase in incidents relating to patients smoking in their rooms and in the courtyard area.

The trust's nicotine management policy has caused difficulties for all the rehabilitation services, especially as not all patients had unescorted leave. Trust policy was that patients should not smoke when escorted by staff. Staff on the CARS ward told us they did all they could to enforce the policy. For example, using diversion techniques, offering nicotine replacement therapy and asking politely for people to refrain. They confirmed they would avoid confronting a patient who insisted on smoking when out on a community visit.

Medications were administered from the clinic rooms. On Rosewood, staff reminded patients to go to clinic for their medication. Patients could follow a four step programme for self-medicating as part of their recovery. The pharmacist regularly attended the wards and offered patients one to one advice. Medication audits took place on a monthly basis.

Track record on safety

There were three serious incidents in the last year that resulted in the deaths of patients. One patient died as a result of an overdose. Two patients committed suicide, which took place off the wards. The incidents were investigated and improvements in safety implemented. Improvements in safety included: erecting fencing to prevent drugs coming onto the ward, documenting room searches as incidents, and adherence to the trust's missing person's policy. Following the most recent incident, the trust conducted a full post incident review. We also reviewed records relating to a serious assault and another to fire.

Good

Are services safe?

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

Reporting incidents and learning from when things go wrong

All staff we spoke with knew what incidents they should report and how to record incident using the electronic reporting system. We looked at an incident record regarding an assault. The incident was reviewed as per trust guidelines, recorded in the patient's risk management plan, and care planning developed around risk.

Incidents happening across the trust were communicated to the wards via a trust email. The most recent raised awareness that smoke detectors could be used as ligature points. Lessons learned were shared in handovers, team meetings and supervision, and a debrief was provided if required.

Staff told us their ward, and senior managers, fully supported and debriefed them following the serious incidents that involved patients they were caring for. Following investigations from the incidents, lessons learnt were fed back to staff.

Are services effective?

Good

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

Summary of findings

Our findings

Assessment of needs and planning of care

Care plans were held electronically and were accessible to all staff including those in other departments within the trust. This meant staff had immediate access to patient records when a patient transferred to another department.

We looked at 19 care plans overall. The care plans were regularly updated, holistic and recovery oriented. They reflected employment, physical health needs, finances, leisure, accommodation, mental health and included a 72 hour intervention plan. The patient's name was used followed by an action the patient should take, for example, "(Patient's name) will eat a healthy diet". Staff and patients told us that they worked together to agree the care plans but the style did not reflect the patient's views or the full range of their problems and needs. Care plans on all wards were supported by the use of the recovery star, which is a tool to create recovery-focused care plans in order to optimise individual recovery. However, the information gathered in the recovery star record we reviewed had no clear link to care planning. CARS were currently reviewing their use of this model of recovery. The recovery star records were held in paper form along with the clinical records.

Best practice in treatment and care

There was a recovery focused theme evident throughout the wards, which was underpinned by best practice guidance. The rehabilitation wards benefitted from the input of a psychology team, although this was a recent introduction at Lime Walk House. The psychology teams used resources such as 'mind over mood', which is a cognitive behavioural therapy resource from British psychological society. Patient outcomes were monitored using health of nation outcome scales. Recovery was measured by looking at length of stay, discharge to and readmissions.

Patients had access to physical health care with a GP and practice nurses providing fortnightly clinics on the ward. Three patients on Rosewood said physical health care was good, one patient said he had timely admissions to hospital, twice for surgery.

A bi-monthly 'metrics audit' was undertaken by clinical staff or ward managers from a different service. The audit comprised of a random 25% sample that looked at broad range of care and treatment. An action plan was generated to address any areas that did not achieve 100% compliance. The outcomes from these were displayed in the reception area of the wards.

Skilled staff to deliver care

We spoke with staff from a range of backgrounds: nursing, non-clinical and medical. They told us they were supported through supervision and appropriate training to achieve the skill set required for their role.

We attended a care programme approach review, this is a regular review to monitor the patient's needs, clinical progress and implementation of the care plan. Staff gave very clear and informative summaries of patients' progress and needs, demonstrating that staff had the necessary skills for their role.

Newly qualified nurses were supported by the pharmacist on the ward to complete a medicines competency framework as part of their preceptorship. This helped to familiarise nurses with medications, dosage, interactions and adverse reactions.

Staff had access to e-learning and were supported to undertake a range of different training to enhance the team skills. Specialist training was identified through supervision. For example, an occupational therapist was booked on three day course on personality disorder and a care support worker had been offered the opportunity to be involved in specialist care by becoming gym instructor.

Staff underwent annual appraisals and received regular combined clinical and management supervision in line with the trust policy. Non-medical staff received appraisals achieving 87% compliance across the rehabilitation wards for the last 12 months. The supervision document for staff had been redrafted to incorporate the provider's vision and values. Consequently, supervision addressed six core areas

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.

each one reflecting one of the '6C's' (care, compassion, competence, communication, courage and commitment). The clinical psychologist at the CARS ward provided a peer supervision group for staff, which was well attended.

Lime Walk House and Rosewood had peer support workers who encouraged patients to become involved with the recovery college. The workers also helped support relatives and carers by giving tips and offering insight into patients' behaviour.

Managers were able to explain the process for addressing poor staff performance.

Multi-disciplinary and inter-agency team work

There was a nursing handover at the beginning of each shift to update the oncoming staff about any changes in a patient's presentation, risks and safeguarding. There was a further handover by the nurses to occupational therapy at the start of their shift but before the daily community meetings. Rosewood held a daily multi-disciplinary team handover, which linked into the daily community meeting held directly afterwards.

Multi-disciplinary team meetings took place every two weeks and were attended by a range of medical and clinical staff. However, the meeting structure we observed on Lime Walk House was consultant led, involving a one to one discussion with the patient and little multi-disciplinary involvement.

Teams had developed good links with internal and external organisations such as GPs, housing organisations and the recovery college. On CARS a health care assistant worked alongside an outreach nurse, undertaking pre admission and post discharge liaisons and assisting with the physical health clinics. On Rosewood, patients had a choice to remain with their own GP or to register with a local GP surgery, which could help them build links within the community. Care coordinators maintained contact throughout the patient's placement in rehabilitation; attending meetings, ward rounds and reviews. Under the care pathway approach, a care coordinator manages a patient's care plan and makes sure it is reviewed regularly.

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

Staff received mandatory training in the use of the Mental Health Act (MHA) with 90% of staff compliant. Support and advice was provided from the trust's Mental Health Act office. Documentation for the MHA was held in paper form and stored securely with paper clinical records.

The standard of MHA documentation varied. We found good compliance with section 17 leave paperwork; authorising leave was given individually according to need and stage of recovery.

We found there was not sufficient emphasis on section 132 rights. At Lime Walk House all patients were informed of their rights under section 132 but not as frequently as good practice suggests. Patients on CARS and Rosewood patients were informed of their rights monthly. However, patients were read their rights from an information sheet. This is contrary to MHA code of practice. In addition, the rights leaflet for patients detained under section 3 of the MHA, quoted the wrong period of stay (six months when it can be a year). MHA rights were not discussed with patients during the multi –disciplinary meeting. At Rosewood we found that a patient's detention paperwork was not kept on file. The detention renewal form and AMHP application for section 3 of the MHA had to be retrieved from MHA office.

We looked at eleven prescription charts overall. Ten patients were detained under the MHA. The prescription charts were up-to-date. The relevant legal authorities for treatment were in place. All medications prescribed were listed correctly on the T2 (certificate of consent to treatment) and T3 (certificate of second opinion) forms. However, one record revealed that the wrong dose of an anti-anxiety drug had been administered on two occasions.

There were issues about the role of the IMHA across all the wards. An IMHA (independent mental health advocate) is a specialist mental health advocate available to offer help to patients under arrangements which are specifically required to be made under the MHA. We found that overall staff did not support and promote the use of IMHAs and consequently few patients engaged with the service. There was a small advocacy poster displayed on the information boards but no IMHA information.

Are services effective?

Good

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

Good practice in applying the Mental Capacity Act

All clinical staff undertook mandatory training in the use of the Mental Capacity Act. Compliance across the wards was 86%. When asked, staff could explain the basic principles of mental capacity assessments and felt supported in the use of the Act. We saw effective use of the Mental Capacity Act in a care pathway approach review. On Rosewood, the consultant regularly checked capacity and consent with each patient by asking the patient to explain in their own words issues relating to decision making and their current treatment.

At the time of our visit there were no patients on the rehabilitation wards subject to deprivation of liberty safeguards (DoLS). This is the procedure necessary to deprive a patient, who lacks capacity to consent to their care or treatment, of their liberty. It is done in order to keep a person safe from harm. Qualified nursing staff knew there was a policy in relation to MCA and DoLS on the trust's web site.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

Throughout our inspection, we observed a number of interactions between staff and patients. Each interaction was positive, respectful and pleasant. We saw a patient ask a nurse for prn medication (as needed). The nurse offered discrete and practical support, by speaking to the patient privately about his needs before giving the medication. Patients who attended the MDT meeting were treated with kindness and respect. They were introduced to everyone present and had their views listened to.

Patient feedback was positive about the care and treatment received. Staff were praised for being approachable, empathetic and responsive. Patients felt that they were treated with respect and listened to. Positive patient stories were displayed on Lime Walk House. However, two patients criticised night staff for not allowing them to leave the ward when they wanted to. This happened during the period of evening handover. Following a recent serious incident staff had asked patients to remain on the ward until the handover process was complete. This allowed oncoming nurses to observe and assess the patients' presentation before taking leave.

We spoke with 13 patients and 11 told us they felt safe on their ward. Patients at Lime Walk House said there was a good staff presence. However, on Rosewood one patient said he didn't feel safe as there was an issue with drugs and alcohol on the ward. This had been mentioned earlier that morning during the community meeting. Another patient said he was afraid when other patients became aggressive

However, there was concern about confidentiality as the whiteboard in the office could be seen by patients when it was open. The whiteboard contained information such as patient details and next of kin contact details

The involvement of people in the care that they receive

There was an excellent admission process that ensured patients were informed and oriented to the wards. Patients received pre admission visits followed up with a visit to the ward, relatives and carers could also attend. At Lime Walk House patients were encouraged to attend the café group on a Friday using unescorted leave. Visits lasted between two to three hours and a patient could have three to four visits before admission to help them become acquainted with the ward. Information packs were given before being admitted to the ward, these explained the ethos of the ward and protected therapeutic time.

At the Multi-disciplinary meeting we saw that patients were involved in their care. For example, a patient was reluctant to try new medication so the consultant attempted to educate the patient about the drug. An agreement was reached between the patient and the consultant not to review the patient's current plan but to provide educational leaflets and discussion about the new treatment option.

Patients and their families/carers were included in the care programme approach review and encouraged to participate. Families/carers were invited to attend at the patient's request and were given full opportunity to engage.

Staff on the wards recognised the importance of involving relatives and carers in the recovery process. There was a well-established carers' forum holding monthly meetings, which were well attended and sometimes took the form of social events like a barbeque. The carers' forum was organising a recovery festival to promote carer involvement. On one ward, relatives were able to join patients for tea or Sunday lunch. On Rosewood, some relatives were invited to join their family member for Christmas dinner if it was felt inappropriate for their relative to go home on leave. We spoke with two relatives who told us they felt welcomed and included in their relative's care.

Peer support workers told us they were involved in the trust's recruitment process and had been part of the interview panel for new staff.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access and discharge

There was a clear pathway for admissions. A central gatekeeping meeting was held once a week to discuss referrals in to the rehabilitation wards. Rosewood and the CARS ward admitted more complex patients than Lime Walk House. The CARS ward had no inpatients from the surrounding localities as it was not a trust specific resource. Further admissions to the ward were on hold until after it returned to its original location. The target group for this service were patients who previously were unable or unwilling to engage with rehabilitation services, the majority had multiple compulsory admissions to acute wards. Rosewood had the highest bed occupancy levels at running at 91%. Both the CARS ward and Lime Walk House were within the trust target of 85% for bed occupancy.

Patients always had access to a bed upon return from leave. One patient at Lime Walk House had been admitted to an acute ward for a few days for extra care, the patient's bed remained available during this period.

The discharge plan was constructed as part of the admission stage and was a central part of care plan. Planned discharge always involved a graded plan of extended leave, which included overnight leave. Rosewood had developed good relationships and links with local communities to try to secure tenancies for patients. However, CARS found it a challenge to fully engage the community mental health teams in the process of discharge, mainly due to difficulties identifying appropriate follow on accommodation.

One patient who was due to be discharged under a community treatment order had a robust relapse prevention plan developed by the psychology team. This involved recognising triggers and utilising coping strategies; and having care coordinators and a community mental health team in place to help support the patient to access further education.

The facilities promote recovery, comfort, dignity and confidentiality

There was a range of rooms and facilities to support therapies and activities across the service. These included the provision of television lounges, gyms, patient kitchens, meeting rooms and music rooms. All wards provided quiet rooms or quiet areas for patients. Female only lounges were available on wards that were mixed sex. Patient involvement was evident in some of the design artwork across the wards: mosaics at Lime Walk House, an art gallery corridor on Rosewood and free drawn designs on the corridors at the CARS ward.

Lime Walk House was bright and cheerful and had a homely feel to it. On Rosewood, the walls were painted in colours associated with positive moods creating a therapeutic environment. Some walls in communal areas had inspirational quotes on them.

All wards provided access to gardens. At Lime Walk House the gardens were well maintained and well stocked having raised flower beds, shrubs, patio plant containers and a patio area. There was a male and female conservatory giving access to the grounds. All the bedrooms on Lime Walk House looked out onto the grounds and each window was fitted with privacy screens. Rosewood had an inner courtyard that patients could access freely. The flats had their own outside garden space. The garden grounds at CARS included a football area, gardening and a fish pond. The area was adequately maintained and service users had free access to it. The CARS temporary location was due for demolition once the ward vacated the premises.

The rehabilitation service provided a wide and varied occupational therapy programme. Daily community meetings to discuss what patients wanted to do were well attended. Patient led planning groups organised the rota for shopping, personal laundry and room cleaning and reminded patients who was doing what that day. The community meetings were not held at the weekend.

Staff told us that patients discussed future activities at a monthly community forum. Past trips/activities had included the cinema, local attractions, swimming and badminton. Meaningful activities took place, we saw patients cooking brunch and gardening. Patients at Lime Walk House cooked for themselves two to three days a week and were given a daily allowance to help develop budgeting skills. One patient was being supported to continue working during his admission to the ward.

Are services responsive to people's needs?

Good

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

Some paid work was available to patients on Rosewood, for example, gardening and painting outdoor furniture. The recovery college was strongly promoted across all wards and all patients had been given a prospectus for September. We reviewed six patients' individualised activity plans on Rosewood. The plans listed the activities undertaken by individual patients. For example, fishing, baking, kung fu, swimming, gym, and a volunteering project. However, when we asked staff about the volunteering project they told us no one actually volunteered despite it being included in three patients' plans. Activity plans should only reflect the activities that the patient engages in.

On CARS, the trust provided a car and driver to ensure patients were still able to access their usual community activities as the temporary location was three miles from the nearest village with limited public transport. Most activities occurred during the week with visits into community happening more at weekends. The ward aimed to provide 25 hours activities per person each week and tried to ensure there was enough variety and opportunities for all, especially those whose motivation levels were low. Occupational and nursing staff described patients becoming involved in voluntary work and the recovery college but there was no one currently doing either. We reviewed nine individualised activity plans and saw a range of activities offered that were varied from person to person.

The quality of the patient environment is assessed yearly in the NHS. The rehabilitation wards were assessed by site. Lime Walk House scored higher than trust and England averages for cleanliness and ward food. Patients on Rosewood and CARS had complained about the quality and lack of variation in their meals at the daily community meetings. Meals were delivered already prepared and chilled for reheating on the wards. Ward managers had raised concerns about this and were monitoring the situation.

Patients were able to personalise their rooms with photographs but were not allowed their own duvets and covers because of infection control policies. All bedrooms had an area for secure storage. Patients could access their rooms using a personal fob.

Each ward provided a private space with a pay phone for patients to use. The PALS complaint line number and the care quality commission contact details were next to the phone.

Meeting the needs of all people who use the service

There was a good provision of information on display including physical health, recovery, healthy lifestyles, carer and family activities, photographs of staff and their role but minimal information about advocacy.

Patients were encouraged and supported through the different stages of the self-medication process. Overall, 12 patients were at different stages of self-medication. At Lime walk House there was an electrocardiogram on site to monitor patient's physical responses to the complex drugs being prescribed.

The wards were able to accommodate patients with physical disabilities. There was access to interpreters if they were needed, although this didn't happen very often. Patients could access spiritual support at the nearby district general hospital or in the community. When necessary spiritual support could take place on the ward. We saw a chaplain lead patients and staff at Redwood in a small service in memory of a patient who had recently passed away.

Listening to and learning from concerns and complaints

Information about the patient advice and liaison service and how to make a complaint was displayed on the ward. Patients could also use service user feedback forms or complain directly to a member of staff. Attempts were made to resolve complaints at ward level in the first instance, addressing less formal complaints through the daily community meetings and handovers. Patients were given ample opportunity to express any concerns or issues they had during the review we attended but only had praise for the treatment and care they received.

There were no formal complaints at Lime Walk House or the CARS ward in the last 12 months. Rosewood had received a formal complaint from a patient, which was investigated and upheld. The complainant received an apology and changes were made to the communal areas as lessons learned. In addition complaints and outcomes were discussed at the monthly team meeting and also via individual emails. Staff confirmed that if there were issues they would receive feedback.

Are services well-led?

Good

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

Summary of findings

Our findings

Vision and values

The provider demonstrated their commitment to their vision and values by displaying 'the 6 C's' (caring, compassion, competence, communication, courage and commitment) on information boards across the wards and incorporating them into supervision documents. Consequently, staff were aware of them and some of the values were evident in the actions of staff. Senior management had a visible presence on all wards. This was particularly so following serious incidents, when senior managers and trust members attended the wards to support and debrief staff.

At Lime Walk House, the modern matron visited the ward at least once a month, conducting an infection control audit. On Rosewood, the service manager attended two to three handovers weekly to support staff and remain up to date with patients' progress.

Good governance

Ward managers had access to and could monitor key performance information regarding their wards. This included staffing levels and sickness, which were managed through e- rostering and monthly checks to ensure compliance with mandatory training, supervisions and appraisals.

All staff knew how to access policies and procedures.

There were good governance systems and processes in place. A range of audits were carried out to improve the quality of care and treatment. Ward managers met with staff every three months to disseminate and discuss incidents. There were also locality specific senior manager meetings where incidents were discussed and lessons learned outlined.

All the wards held regular team meetings, which included governance issues such as team performance and audit outcomes, incidents, risks and complaints. Ward managers said they had the autonomy to manage their wards and were supported in their day to day management by a resource manager and ward clerk.

Leadership, morale and staff engagement

Staff could describe duty of candour and knew about the providers' whistleblowing process. They felt they could raise issues and concerns without fear of victimisation.

The modern matron ran monthly leadership days for ward managers and nursing clinical leads.

Morale was good across Rosewood and Lime Walk House. The teams were generally happy and supportive of each other. We were told by clinical staff that there was a good working relationship between all members of the multi-disciplinary team. The ward clerk on Rosewood produced a monthly newsletter for staff that highlighted social and work events.

On CARS ward, staff were more isolated due to the temporary relocation of the ward. Occupational therapy staff highlighted difficulties in implementing new ways of working and stated the team were either not receptive to it or did not think the time was right to make changes.

Commitment to quality improvement and innovation

Rosewood and CARS participated in the Accreditation of Inpatient Mental Health Services initiative and were awaiting confirmation of accreditation.

Some members of clinical staff participated in the provider's zero harm implementation plan. This was a human factors course aimed at improving patient safety in a clinical setting