Requires improvement

Humber 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)
RV941	Hawthorne Court	Hawthorne Court	HU17 7AS
RV980	St Andrew's Place	St Andrew's Place	HU3 3SW

This report describes our judgement of the quality of care provided within this core service by Humber NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

- **we rated Humber NHS Foundation Trust as requires improvement because**:
- The pharmacist inspector found that the emergency drugs pack at St Andrew's Place did not contain several emergency drugs. This issue has been dealt with through a warning notice issued to the trust 17 May 2016.
- Patients care plans were of variable quality and did not include details of nursing interventions or care required.
- Patients did not attend their recovery meetings in person. Some patients did not feel as involved in their care as they would like to be. The psychiatrist worked part time, which meant that there was limited medical cover.
- Staff at St Andrew's Place did not check fridge temperatures every day as per the trust policy and national guidance.
- The trust admitted patients to the units with no clinical rationale or particular identified rehabilitation/ recovery need when their acute wards were full.

However:

- Staff used the trust's supportive engagement policy to manage patients' observation levels. This meant they engaged patients in a conversation enhancing the therapeutic relationship rather than just routinely noting their whereabouts.
- Staff at both units were up to date with their personal appraisal and development reviews and received supervision in line with the trust's compliance target. This meant that ward managers were able to support their staff's professional development and monitor standards of care and treatment.
- Patients were encouraged to take ownership of their physical health needs wherever possible. We saw evidence of self-completed health improvement profiles in patients' records.
- The service had introduced protected engagement time during the daily overlap between shifts. Staff used this time to actively engage with patients, facilitate their leave and encourage activities.
- Staff treated patients with kindness and respect. Interactions between staff and patients were warm and supportive. During the morning meetings, staff were attentive and flexible to patients' needs.
- The service was piloting an outreach service aimed at supporting patients for six weeks following discharge. This helped patients make their transition from the ward to the community successfully and identified when further input was need.
- The service provided meaningful activities and therapies that aided a patient's rehabilitation and recovery. Staff regularly sought patients' views about the type of activities they wanted to participate in.
- Both units benefitted from strong local leadership that had a positive impact on staff and patients.

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:**
- The pharmacist inspector found that several drugs were missing from the emergency drugs pack. This issue has been dealt with through a warning notice issued to the trust 17 May 2016.
- Staff at St Andrew's Place did not check fridge temperatures every day as per the trust policy and national guidance.

However:

- Both units were clean and well maintained with good standards of hygiene and infection control practice.
- Staff used the trust's supportive engagement policy to manage patients' observation levels.
- Staff were skilled in de-escalation techniques, which meant the service had low levels of restraint.
- Overall compliance with mandatory training was in line with the trust's target compliance rate.

Are services effective?

Good

- **we rated effective as good because:**

- Staff prescribed patients their medication in line with NICE guidelines.
- Patients were encouraged to take ownership of their physical health needs wherever possible.
- The service used protected engagement time to actively engage with patients, facilitate their leave and encourage activities.
- The service provided a pathway for unregistered staff to gain an NVQ level 3 in health and social care.

However:

- Patients care plans were of variable quality and did not contain sufficient detail about nursing interventions.

Are services caring?

Requires improvement

- **we rated caring as requires improvement because:**

- Patients did not attend their own multi-disciplinary recovery meetings and had limited access to the psychiatrist.

However:

Summary of findings

- We saw positive and warm engagement between staff and patients.
- Patients reported staff respected their privacy and were attentive and flexible to their needs.

Are services responsive to people's needs?

Good

we rated responsive as good because:

- The service was discharge-oriented with an overall average length of stay of 203 days.
- The multi-disciplinary team discussed each patient's progress towards discharge at the weekly recovery meetings.
- Staff organised the structure of the day around patients' needs.
- The service was piloting an outreach service, which provided six weeks support to patients discharged in to the community.
- The service provided meaningful activities and therapies that aided a patient's rehabilitation and recovery.
- The service responded to patient feedback and changed the time of the morning meeting to accommodate patients' wishes.

However:

- The trust admitted patients to the units with no clinical rationale or particular identified rehabilitation/recovery need when their acute wards were full.

Are services well-led?

Good

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

- The service provided care that reflected the trust's visions and values.
- Ward managers were proactive in ensuring systems and processes were effective.
- There was strong local leadership at both units.
- Both units had twice achieved accreditation with the Royal College of Psychiatrists inpatient mental health services programme.

Summary of findings

Information about the service

Humber NHS Foundation Trust has two long stay, rehabilitation mental health ward for adults of working age who live in Hull and East Riding.

- Hawthorne Court is an 18-bed rehabilitation and recovery inpatient unit with a controlled access and exit via an airlock. It provides a specialist assessment, care, treatment and rehabilitation service for adults experiencing severe and enduring mental illness.
- St Andrew's Place is a 13-bed inpatient unit. It provides recovery and rehabilitation for people making the transition from mental health wards back to living in a community setting. There is a self-contained flat, which helps people prepare for independent living before moving on.

Both units are for male and female patients who are either admitted informally or detained for treatment under the Mental Health Act (1983).

We previously inspected Hawthorne Court and St Andrew's Place in May 2014. Hawthorne Court was meeting the essential standards. At St Andrew's Place, we found some areas for improvement; the unit had addressed these issues and was compliant at the time of our inspection.

We carried out Mental Health Act (MHA) monitoring visits to Hawthorne Court in May 2015 and to St Andrew's Place in November 2014. Following these visits, the trust provided an action statement telling us how they would improve adherence to the MHA and MHA Code of Practice.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Gilluley, Head of Forensic Services at East London Foundation Trust and CQC National Professional Adviser

Head of Inspection: Jenny Wilkes, Care Quality Commission.

Team Leader: Patti Boden, Inspection Manager (Mental Health) Care Quality Commission.

Cathy Winn, Inspection Manager (Acute) Care Quality Commission.

The team that inspected this core service included a CQC inspector, a CQC pharmacist inspector, two specialist registered mental health nurses and an expert by experience. Experts by experience are people who have experience of using health and care services.

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 and carers at focus groups.

Summary of findings

We inspected both long stay/rehabilitation wards on 12 and 13 April 2016.

During the visit, the inspection team:

- looked at the quality of the ward environment on both wards,
- observed how staff were caring for patients,
- spoke with 13 patients,
- spoke with two carers,
- collected feedback from patients using comment cards,
- interviewed the modern matron and ward managers for each of the wards,
- met with 18 other staff members; including the doctors, nurses, nursing assistants, occupational therapist and a social care associate practitioner,
- attended one clinical review meeting where patients were discussed,
- attended two hand-over meetings,
- attended two community meetings,
- reviewed in detail nine care and treatment records of patients,
- carried out a specific check of the medication management on each ward where we reviewed 24 medicine charts,
- examined policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We gave patients the opportunity to give feedback on the service they received prior to our inspection via comment cards left at both units. We did not receive any comment cards back from this service.

We spoke with 13 patients across both units about the care and treatment they received. We also looked at the patient satisfaction survey provided by the trust. Patients praised the relaxed environment and friendliness of the staff. Two patients stated that staff explained information to them in a way they could easily understand. Patients also valued the time staff spent with them, encouraging them to have a structured day to help with recovery.

The patients' satisfaction survey showed that patients did not always feel involved in their care. At Hawthorne Court, two patients commented on 'monthly' recovery meetings and wanted increased contact with the psychiatrist. Two patients said they did not understand their care plans or changes to their medication. At St Andrew's Place, four patients found the discharge process to be slow moving and sometimes did not understand why their discharge was taking so long to arrange.

Good practice

The service had introduced protected engagement time, which took place during the two-hour overlap period when both day and late shift were on duty. Staff used this time to engage with patients and facilitate leave and activities.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure sufficient medication is available in case of emergencies.
- The trust must ensure that patients are able to participate in and influence their own recovery meetings. Patients must have regular access to a psychiatrist.

Summary of findings

- The trust must improve the quality of patient care plans and include how patients care and treatment will be achieved.

Action the provider SHOULD take to improve

- The trust should ensure that staff at St Andrew's Place check fridge temperatures every day as per the trust policy and national guidance.
- The trust should ensure that patients are only admitted to long stay rehabilitation wards where there is a particular identified rehabilitation/recovery need.

Humber 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
Hawthorne Court	Hawthorne Court
St Andrew's Place	St Andrew's Place

Mental Health Act responsibilities

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

Mental Health Act training did not form part of the trust mandatory training programme.

Staff had a good understanding of the MHA and code of practice. The trust had a Mental Health Act administration team, who advised and supported staff in the application of the Mental Health Act.

We reviewed seven out of 19 detained patients' records. The system for recording patients' section 17 leave was thorough. Detained patients received treatment authorised by the appropriate certificate. Copies of the certificates were kept with the patients' prescription cards. Staff clearly recorded capacity and consent to treatment in all patient records.

Staff regularly explained to patients their rights under section 132 and recorded their understanding.

Copies of the patients' detention papers and the reports by the approved mental health professionals were in order.

Patients had access to independent mental health advocates.

Notice boards at both units clearly displayed information about patients' legal status and rights under the Mental Health Act.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act 2005 was mandatory. Overall, the service was compliant with trust's target compliance rate.

Staff had a basic knowledge of the Mental Capacity Act and we saw examples of good practice. Staff discussed the progress made in applying for appointeeship on behalf of two patients during the recovery meeting. Patients' records contained decision specific capacity assessments and showed that staff held best interest meetings where appropriate.

There was no deprivation of liberty safeguards in place. The majority of patients were detained under the Mental Health Act.

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

Hawthorne Court and St Andrew's Place's Place provided patients with a clean, comfortable, well-maintained but dated environment. For example, at St Andrew's Place the communal lounge was a thoroughfare for accessing other parts of the building. A refurbishment plan was underway to improve facilities available to patients at this unit. The plans also included replacing any remaining handles and taps identified as a possible ligature risk.

Due to the layout of the buildings, both units had blind spots where patients could not be observed and there were existing ligature risks. The service had up to date, robust ligature risk assessments and management plans in action. During handover meetings, staff held a comprehensive daily discussion of patient risk and required observation and engagement levels. This meant staff had a good awareness of risk to each individual patient and were able to manage ligature risks effectively.

Both units complied with Department of Health guidance on same sex accommodation, with gender separation achieved by accommodating males along one corridor and females along another. As each unit also had a self-contained flat within the premises, there was room for flexibility of patient mix. Communal bathrooms were available on each corridor as the bedrooms were not ensuite. Patients had access to female only or male only lounges at each location.

All staff carried personal alarms programmed to panels located throughout the unit. This meant that if staff triggered their alarm, responders could identify the area with an incident and offer assistance. All patients we spoke with said they felt safe on the units.

At St Andrew's Place, the clinic room was immaculate, accessible and well organised. Hawthorne Court was clean, tidy, well organised, and adequately sized to allow for patient examination. At both services, staff undertook regular comprehensive checks of equipment, controlled drugs and stock medication to ensure everything was in working order and in date. At Hawthorne Court, an electronically monitored medication fridge enabled a graph to be produced showing temperature ranges remained within an acceptable range. This ensured the effectiveness of the medicines stored in the fridge. Emergency drugs and resuscitation equipment were present and documentation showed staff checked these regularly. However, the pharmacist inspector found that several drugs were missing from the emergency drugs pack. These were amiodarone, naloxone, and flumazenil and this issue has been dealt with through a warning notice issued to the trust 17 May 2016.

The service was clean throughout with good standards of hygiene and infection control. Cleaning records were up to date and completed regularly. There were effective systems in place to reduce the risk and spread of infection, with hand gel dispensers placed at the entrance to both units.

We saw domestic staff at Hawthorne Court actively responding to an environmental issue. In patient led assessment of the care environment the service scored above the national average, which was 97.5%. St Andrew's Place achieved scores of 100% and Hawthorne Court 99.7%.

Safe staffing

Managers at both units had inherited their staffing establishments from when the service was first established. At St Andrew's, the modern matron routinely adjusted the number of health care assistants on duty on the night shift to ensure safer staffing levels. Hawthorne Court had a staffing review in 2015 and identified the need for another qualified nurse on the night shift. The trust monitored the number of nursing staff working at each unit and the percentage of shifts that met their agreed staffing levels using a safer staffing dashboard.

The establishment level at St Andrew's Place was 10 qualified nurses whole time equivalent and 7.5 healthcare assistants. They had no existing vacancies having recently recruited two nurses. Sickness levels over the last 12 months were high at 15.9%, this was due to long term sick leave. In the last six months, the sickness level had fallen to 2.5% as staff returned to work. This was lower than the NHS average of 4.4%. Staff turnover rate for the same period was 16.6%. The unit used regular bank staff that were familiar with the ward to cover the required number of healthcare assistants at night, sickness levels, vacancies and leave. In

Requires improvement

Are services safe?

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the last three months, the unit used bank staff to fill 202 shifts to the minimum staffing levels. A review of the staffing rotas showed that all shifts achieved minimum establishment levels.

The unit operated three daily shift patterns of eight hours. The day and late shift each comprised of two qualified nurses and two healthcare assistants. The night shift comprised of one qualified nurse and two healthcare assistants.

At Hawthorne Court, the establishment level was 14.8 qualified nurses and 12.8 healthcare assistants. They had two qualified nurse vacancies. Two healthcare assistant vacancies were recently recruited to and pre-employment checks underway. The unit also used a regular agency nurse, working a fixed three-month contract. Sickness levels for the unit over the last 12 months were 4%, with one member of staff on long term sick. The staff turnover rate for this period was 9.9%. This was due to staff being promoted or retiring. Regular bank and agency staff that were familiar with the ward covered sickness levels, vacancies and leave. During the last three months, the unit had used bank and agency staff to fill 105 shifts to the minimum staffing levels. Shift rotas showed that a band 6 nurse had to cover four shifts during this period to achieve minimum staffing levels.

The service operated the same shift pattern as St Andrew's Place. The day and late shift each comprised of two qualified nurse and three health care assistants. The night shift comprised of one qualified nurse and health care assistants. The shift rotas showed that this was the minimum of staff employed on a daily basis. There was senior nurse cover most weekends. This was good clinical practice as it meant staff felt supported in their care of patients.

Staff and patients reported that a qualified nurse was always present in communal areas at Hawthorn Court. This varied at St Andrew's Place, which was an open rehabilitation ward although patients told us staff were highly visible. Patients received as a minimum, weekly one to one time with their named nurse and named key worker. This was in addition to daily involvement in therapeutic activities and the supportive engagement commitment. Notes from these regular meetings were present in patients' treatment records.

Patients and staff reported that leave always went ahead as planned. This was coordinated at the daily community meeting. Staff only cancelled activities when patients did not want to participate, never because of staffing shortages.

The psychiatrist covered both of the units, which where 13 miles apart and accessed through two busy town centres, working 0.4 full time equivalent on each unit. The Royal College of Psychiatrists suggests that a 14-bedded high dependency rehabilitation unit should have 0.5 full time equivalent psychiatry. A very new junior doctor started at the service during our inspection. This was their second placement but first psychiatric placement and they had no knowledge of mental illness, the Mental Health Act or the Mental Capacity Act. The limited medical cover and complex needs of some patients meant that the psychiatrist was not always free to see patients individually after the recovery meeting had taken place. The units had to contact the on call doctor if the psychiatrist was unavailable or not on duty. While nursing staff were able to increase patients' levels of observation, they needed a psychiatrist to decrease them. This meant that patients potentially remained on higher levels of observation than needed or clinically indicated.

The trust had a minimum compliance target of 75% for mandatory training. The ward managers reported that the trust training data supplied was incorrect and the units had a higher compliance rate than that formally attributed to them. The mandatory training matrix and monthly performance reports showed that, overall, the service was compliant with mandatory training. Mandatory training for staff included health and safety, infection control, information governance and fire training amongst others. At St Andrew's Place, equality & diversity training had the lowest compliance rate with only 55% of staff having completed it. Hawthorne Court achieved a mandatory training compliance rate of 80%. The only area of low compliance (58%) was intermediate life support for nurses. This was due to training courses not being available for nurses to refresh their skills. Staff received an email notifying them when training was due. Ward managers used the monthly performance reports to monitor compliance with training and reminded staff at team meetings when an area of mandatory training needed improving.

Requires improvement

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Assessing and managing risk to patients and staff

The service did not have a seclusion room. There were two reported incidents of seclusion at Hawthorne Court in the last six months and none at St Andrew's Place. There were five reported incidents of the use of restraint involving three patients at Hawthorne Court. Neither service reported any incidents involving the use of prone restraint or rapid tranquilisation. Prone restraint is a type of physical restraint that involves the person being restrained face down. Staff documented their use of restraint as an incident using electronic incident reporting system. This allowed the ward manager to identify any themes or patterns emerging from the use of restraint.

The trust used a supportive engagement policy to manage patient observations and staff at both locations were knowledgeable about its application. An assessment of patient risk determined observation levels. We reviewed nine treatment records in detail. Each record contained an up to date risk assessment and an individual safety plan. The service used the galatean risk and safety tool to assess patients. This was a web-based decision support system for assessing and managing the risks of suicide, self-harm, harm to others, self-neglect and vulnerability. Nurses completed the galatean risk and safety tool electronically then printed a copy off for retention in patients' files.

The team discussed the risk status of each patient at the daily handover meetings and reviewed an updated risk regularly. The patient safety plan identified the different level of engagement for each patient. Engagement was about having a conversation with a patient rather than just observing where they were. This improved staff understanding of their patients, making it easier to identify triggers and manage behaviours using de-escalation techniques. Staff gave examples of using distraction and low stimuli in the first instance. Both environments were calm and relaxed.

Both units used the engagement policy as a means of positive risk taking. For example, encouraging patients on high observation levels and lacking in motivation to take section 17 leave, accompanied at first. St Andrew's Place did not have any patients on one to one observations. Occasionally, a patient had their engagement levels raised to 15-minute intervals but then decreased as soon as practicable.

The trust had a policy for searching of patients and information about 'contraband items' was contained in patients' welcome packs. Staff did not routinely search patients. They carried out searches when they felt it to be necessary due to risk to self or others. Patient consent was sought and an explanation given for the search in line with the Mental Health Act code of practice in relation to searches. We saw evidence in patients' notes of how staff managed this and care planned on an individual basis.

Staff had a good understanding of safeguarding and were able to explain the safeguarding procedure to us. At St Andrew's Place, Staff carried badges outlining signs of abuse and displayed posters on information boards. Across the service, 89% of staff had received training in safeguarding of vulnerable adults and 83% in safeguarding children. Both units had a safeguarding link nurse within the teams. Safeguarding consideration logs showed staff had raised five considerations at Hawthorne Court since January 2015 and nine at St Andrew's Place and dealt with them appropriately.

We looked at the systems in place for medicines management. We assessed 24 prescription records and spoke with nursing staff that were responsible for medicines. Medicines were stored securely with the nurse in charge holding the keys.

There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Medicines requiring refrigeration were stored appropriately and temperatures were monitored using data loggers. However, at St Andrew's Place, staff did not check temperatures every day as per the trust policy and national guidance.

Administration records were completed fully; people received their medicines as they had been prescribed and in accordance with the Mental Health Act.

There were adequate supplies of emergency equipment, oxygen and a defibrillator. Staff checked these regularly to ensure they were fit for use.

Patients with physical health needs received appropriate reviews and monitoring. For example, we saw records of patients having regular blood tests where these were required.

There was a policy in place for self-administration. However, we saw service users were not routinely encouraged to take responsibility for their own medicines

Requires improvement

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at St Andrew's Place. The ward manager was addressing this and there were plans to introduce assessments for all service users. At Hawthorne Court, two patients were at different stages of self- administration.

Track record on safety

There were no serious incidents reported by St Andrew's Place. Hawthorne Court had recorded two serious incidents in the 12 months leading up to our inspection. The manager produced reports of both incidents, which detailed the investigation and actions taken. All relevant external bodies were informed and the patients' families. The manager reminded staff to keep up to date with mandatory training and increase vigilance to prevent patients bringing contraband items onto the unit.

Reporting incidents and learning from when things go wrong

Staff had a clear understanding of what constituted an incident and how to report it. St Andrew's Place reported 16 incidents between January and March 2016 and Hawthorne Court reported 22 incidents. We reviewed the incidents reported at both locations during the last three months. These included incidents related to violence and aggression, self-harm, inappropriate behaviour, activation of fire alarms and damage to property amongst others. A recent incident involved a patient using a mobile phone inappropriately. The service sought specialist advice to manage the incident correctly.

Staff told us they learnt outcomes from incidents either through feedback at staff meetings or in supervision. The ward managers held a debriefing session following any serious incident to ensure staff felt supported. Following a fire at Hawthorne Court, staff were debriefed straightaway, patients and staff were supported through the night and another debrief held at the daily morning meeting. This involved a discussion of what happened and what staff could have done differently.

Duty of candour was included in the incident reporting system as a prompt and actioned where necessary. Both ward managers were aware of the importance of being open and transparent with patients and their families and apologising if things went wrong. Staff interviewed identified the need for transparency in their work.

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

Staff assessed patients from out of area using a robust assessment pathway. Patients transferred from an acute ward within the trust came with their existing assessments and care plans. The transferring ward was responsible for reviewing and updating all accompanying documentation before the transfer took place. Staff used an admission/ transfer checklist to ensure all records were up to date and reviewed those that were not in a timely manner.

Staff used the recovery star outcomes model to develop a care plan in conjunction with the patient. The recovery star covers ten key areas linked to recovery. We saw evidence of patient involvement with their care plans. Staff told us they encouraged patients to complete the key areas of the star themselves and would assist a patient if they lacked motivation. Staff used the recovery star ladder to undertake regular reviews of the patient's progress towards identified treatment goals. The care plans were of variable quality and five out of the nine care plans we reviewed lacked information about nursing interventions or details about the care required. Despite the fact that we saw staff delivering interventions, care plans did not reflect this. Seven patients had received a copy of their care plan and two patients declined the offer. Patients had a separate care plan for the Mental Health Act that related to their rights.

Occupational therapists gained a base line assessment of patients' needs and highlighted specific interventions that patients may require using the model of human occupation screening tool .

Staff considered and addressed patients physical health needs with good evidence of this recorded in patients' notes and of interventions when required. There was a focus on health promotion and healthy living evident for a number of clients. Nurses used the health improvement profile to screen patients physical health needs initially. Thereafter, patients were encouraged to complete an updated health improvement profile review themselves. We saw four self-completed health improvement profiles in patients' records.

Staff coordinated paper records of patients care and clinical notes with electronic systems for recording risk assessments, incidents, admission information and patients personal contact details. All paper information was readily available when needed and stored securely in locked facilities.

Best practice in treatment and care

Both units provided care and treatment that followed best practice and National Institute for Health and Care Excellence guidance. For example, staff followed National Institute for Health and Care Excellence guidelines on prevention and management of psychosis and schizophrenia in adults, recognition and management of depression and anxiety and borderline personality disorder. At Hawthorne Court, we looked at 18 prescription records and found evidence of good practice. Patients with complex and potentially long-term needs were all prescribed medication within British National Formulary limits. The psychiatrist followed National Institute for Health and Care Excellence best practice guidance and did not routinely prescribe 'as required' psychotic medication or more than one anti-psychotic.

The psychologist role had been vacant since October. The service had been unable to recruit a suitable candidate to the post. In the meantime, they had access to a psychologist for half a day a week. There was a range of recovery-focused activities available at both units and a range of psychological therapies. The service offered patients psychosocial interventions and access to family therapy. The service had introduced protected engagement time, which took place during the two-hour overlap period when both day and late shift were on duty. Staff used this time to engage with patients and facilitate leave and activities.

All care records we reviewed showed the patient had ongoing physical health monitoring using national early warning scores amongst others. National early warning scores focused on six simple physiological parameters: heart rate, respiratory rate, blood pressure, level of consciousness, oxygen saturation and temperature. Patients confirmed that they had physical observations taken weekly or more frequently if staff had concerns.

Staff used a variety of evidence-based tools to assess and record severity and outcomes such as the **brief psychiatric rating scale,** the Krawiecka-Goldberg-Vaughan scale and Beck's The Beck Depression Inventory.

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.

Staff participated in various clinical audits. For example, a senior nurse carried out a monthly defensible documentation audit, which looked at a range of documentation issues. The results were published on the staff notice board and findings addressed during individual staff supervision. Other audits included daily equipment audits and infection control.

Skilled staff to deliver care

A range of healthcare professionals provided input to the service and supported patients. These included a psychiatrist, pharmacist, occupational therapist and assistants, junior doctor if available, nurses and nurse prescriber (Hawthorne Court only), social worker, keyworkers, admin and support staff. A pharmacist and psychologist visited the units weekly.

There was sufficient skills mix among staff at both units to meet patients' needs. All staff had access to supervision and were compliant with the trust policy on supervision. This stated that all staff should receive management and clinical supervision every four to six weeks

Compliance with performance appraisal and development reviews was high across both units, with both achieving a 90% compliance rate. This meant that ward managers were able to support staff with their professional development to provide quality care and treatment for patients. Staff that had not had a performance appraisal and development reviews were either on maternity leave or on long term sick.

All staff attended fortnightly team business meetings. We looked at minutes from several meetings held during the last three months. Minutes showed standard items on the agenda included policy updates, environmental issues, safeguarding and training.

Ward managers encouraged and supported staff to undertake specialist training that would enhance the skills within the team and lead to professional development. All unregistered staff had access to the National Vocational Qualification level 3 in health and social care through an apprenticeship scheme. This ensured staff had the right level of skill and provided a consistent approach to care. Three healthcare assistants were currently undertaking the qualification. Across the service, two qualified nurses had undertaken a dual diagnosis course and six nurses had undertaken training in managing complex cases.

There were structures in place for ward managers to manage performance within their teams. No staff were currently being performance managed.

Multi-disciplinary and inter-agency team work

The multi-disciplinary team held a weekly recovery meeting at each location. A range of healthcare professionals reviewed patients fortnightly. This was a paper review and patients did not attend their own recovery meeting. A nurse would feedback to the patient after the review. The rationale for this was that patients might feel overwhelmed facing several health care professionals. Patients could make an appointment to see the psychiatrist after the meeting finished. However, this did not always happen due to the complexity and number of patients detained under the Mental Health Act across the service and the limited medical cover.

We observed the review of six patients at a recovery meeting as part of the inspection. During the meeting the psychiatrist asked to speak with a patient who had not been with the service long to find out why they had not been taking their prescribed medication. The patient engaged well and made a few requests about their care. The psychiatrist discussed the requests with the patient giving a thorough explanation and reaching a compromise about medication that was acceptable to the patient. This was the only patient the consultant invited in, out of the six patients discussed. The patient did not appear in any way overwhelmed by the meeting.

We observed two handovers. The service used a standard form that covered the basics of handover. Staff discussed issues such as physical health care, risk management, safeguarding issues, current presentation and discharge planning for each individual patient. Staff handed over new patient details thoroughly. This ensured that staff coming on duty were up to date with all aspects of patient care and treatment.

The service had established good working relationships with external services such as community mental health teams, general practitioners and local authority safeguarding teams. Staff told us they invited care coordinators to meetings and care programme approach reviews although they did not always attend. However, they did attend pre discharge meeting for patients and staff worked closely with them to secure patient discharge. The social care worker based at Hawthorne Court, liaised with social services to provide a necessary link for patients.

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.

St Andrew's was currently undertaking a pilot outreach service, providing six weeks of aftercare to discharged patients. This helped further build good relationships between community mental health teams and the service.

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

Mental Health Act training did not form part of the trust mandatory training programme. However, staff we spoke with were knowledgeable in the application of the Mental Health Act and received support from the central Mental Health Act administration team where appropriate. The service had arranged training in changes to the Mental Health Act Code of Practice and available staff from both units had attended. A qualified nurse acted as a Mental Health Act link attending steering group meetings and fed back relevant information to staff where appropriate.

Overall, the service had 19 patients detained under the Mental Health Act at the time of the inspection. We reviewed patients' current leave forms and found the system for recording section 17 leave was thorough. Patients were aware of how much leave they could take and used it. Staff encouraged patients to discuss any leave requests they might have at the daily morning meeting and facilitated leave arrangements.

Seven of the nine patient records we reviewed were for detained patients. These detained patients records showed they were receiving treatment authorised by the appropriate certificate. We saw that copies of the certificates were kept with the patients' prescription cards. Staff clearly recorded capacity and consent to treatment in all patient records.

Patient records showed staff regularly explained to patients their rights under section 132 and recorded their understanding. We saw notice boards at both units that clearly displayed information about patients' legal status and rights under the Mental Health Act.

Copies of the patients' detention papers and the reports by the approved mental health professionals were in order.

Patients had access to independent mental health advocates. Staff knew how to refer and support patients to engage with the advocacy service. Independent mental health advocates help people who use services have their opinions heard and make sure they know their rights under the law. All patients we spoke with confirmed that they knew how to contact the independent mental health advocates should they require advocacy support. Both units displayed information on the advocacy service on their Mental Health Act notice board.

Good practice in applying the Mental Capacity Act

Training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was mandatory. Figures supplied by the trust showed that overall the service was compliant with trust targets for Mental Capacity Act training. Hawthorne Court achieved a compliance rate of 90%.

Staff we spoke to understood the principles of the Mental Capacity Act and were able to give us examples of how they had assessed people's capacity. We saw appropriate examples of capacity assessments and best interest decisions in patient records.

At the time of our visit, there were no Deprivation of Liberty Safeguard (DoLS) applications in the twelve months leading up to inspection. A Deprivation of Liberty Safeguard application becomes necessary when a patient, who lacks capacity to consent to their care and treatment, has to be deprived of their liberty in order to care for them safely. It has to be demonstrated that this is in the patient's best interests and the least restrictive option.

Requires improvement

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

We observed two daily meetings, two handovers and interactions between staff and patients during the inspection. We saw positive and warm engagement with patients across the service. There was evidence of a positive therapeutic relationship between staff and patients. During the morning meetings, staff were attentive and flexible to the group needs and the agenda allowed for free flowing conversation. Staff communicated positive, empowering and hopeful messages throughout.

Patients reported that staff respected their privacy and spoke positively about the support and interactions they received from them. They commented that staff were highly visible and approachable at both locations.

The shift handovers showed that staff had a good understanding of each patient's individual needs and how they were feeling. Staff spoke about patients in a professional, non-judgemental, and compassionate manner. There was evidence that staff considered carers' views and needs.

The involvement of people in the care that they receive

Both units had informative welcome packs given to patients on admission to help orient them to the unit and explain the care and treatment provided. Staff encouraged patients to join in activities and events rather than remain in their rooms.

We saw patients take ownership of their physical health needs, completing health improvement profile reviews as necessary and being aware of diabetes care and physical observations. Staff encouraged patients to complete the care plan and helped those patients who struggled. Although staff gave patients a copy of their care plan, three patients we spoke with could not remember receiving a copy. Two patients said they did not understand their care plans or changes to their medication.

Patients were actively involved in the discharge planning process, viewing flats for suitability and expressing their preferences for discharge from the units. Four patients we spoke with found the discharge process to be slow moving and sometimes did not understand why their discharge was taking so long to arrange.

The patient satisfaction survey for the service showed that all patients who responded found staff to be friendly and helpful. However, patients did not always feel as involved in their care as they would like to be. Patients did not participate in their recovery meeting, which was a fortnightly review of their care and they had limited contact with the psychiatrist. This showed a lack of service user focus and involvement in a fundamental recovery process. Two patients we spoke with wanted increased access to the psychiatrist and believed the recovery meeting took place monthly.

Patients' families and carers were encouraged to engage in their care. This included attending meetings and reviews at the request of the patient. At St Andrew's Place, a carers support group was held one evening a month.

We noted posters advertising advocacy services displayed on information boards at both services. Patients and staff told us that there were good links with the advocacy service.

Patients were encouraged to give feedback on the service in a variety of ways. They could comment during the daily community meeting, complete the trust patient experience survey and family and friends test. 'You said we did' feedback from the monthly user group was visible on display boards at both units. Patients could also leave messages about their experience on the unit's 'discharge tree'.

Patients were involved in discussions on refurbishment plans for St Andrew's Place. They had developed a wish list for what they would like to see, and commented on colour schemes.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Bed occupancy at Hawthorne Court between 1 September 2015 and 31 March 2016 was 98% and 89% at St Andrew's Place for the same period.

The average length of stay for current patients for the 12-month period ending 29 February 2016 was 235 days at Hawthorne Court and 171 days for patients staying at St Andrew's Place. This reflects the complexity of needs for patients at Hawthorne Court. The service admitted patients from the trust's forensic wards as well as acute wards. Recently, the ward managers had taken a referral from the forensic services and assessed a patient. They agreed that admission would be to Hawthorne Court following a six-month gradual process. During this time, the patient would be oriented to the unit and given increased section 17 leave.

Bed pressures on acute admission wards led to inappropriate admissions affecting both units. The trust admitted patients to the units with no clinical rationale or particular identified rehabilitation/recovery need. Although these admissions were temporary, they unsettled existing patients, as staff had to concentrate care on patients that were more vulnerable.

Patients usually had access to a bed on return from leave. However, the trust recently insisted St Andrew's Place admit a patient to a leave bed. The patient came back early and had to be asked to remain on leave. Staff documented the incident and there was evidence of duty of candour in the records as staff discussed the issue with both patients.

The service was discharge oriented and patients had discharge plans. Staff involved patients in discharge planning, taking into account their preferences with regard to accommodation, and location. The multi-disciplinary team reviewed each patient's progress towards discharge during the weekly recovery meeting.

The delayed discharge rate for Hawthorne Court in the six months prior to our inspection was 4%. The trust reported there were no delayed discharges for St Andrews Place during the same period. The reasons for delayed discharge were due to funding and placement issues.

Staff arranged discharge times at a time that was convenient to patients, usually in the morning or afternoon. All patients were discharged with a risk and relapse plan developed with the community team pre-discharge.

Hawthorne Court readmitted one patient within 30 days for the period September 2015 – February 2016. At St Andrews Place, there were two readmissions. The unit readmitted one patient when staff running the pilot outreach scheme recognised the patient required extra support. The trust reported that there were no out of area placements during this period.

The facilities promote recovery, comfort, dignity and confidentiality

At both St Andrews Place and Hawthorne Court, there was a range of rooms and equipment to support the rehabilitation and recovery of patients. For example, there were clinic rooms to examine patients, games rooms, art rooms, faith rooms and communal lounges. There were a number of small lounges where patients could go to spend time alone or to meet with staff. Patients could access the external garden area at any time.

The layout of the environment at Hawthorne Court was more suitable to a rehabilitation ward as reflected in the Patient Led Assessments of the Care Environment, scores for privacy, dignity and wellbeing. Hawthorne Court scored 88%, which is above the national average (86%). St Andrew's Place scored 81%. However, an extensive refurbishment of the unit was underway, which should provide a more comfortable and recovery focused environment.

The units provided each patient with an informative and comprehensive welcome pack to help familiarise them with way the unit ran.

Patients had access to a public phone or used their own mobile phones to make phone calls in private. There was also access to the ward phone. In order to protect the confidentiality and dignity of patients, the service requested patients not to use the camera function of their mobile phones. Staff monitored this and responded to any reports of patients using this function.

Eight of the patients we spoke with said the food was good quality and they could access drinks and snacks when they needed to.

Are services responsive to people's needs?

Good

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

Patients at both units had the option of having a key. Documentation showed 90% patients at Hawthorne Court had their own key. Some patients declined the option of having a key. Patients had access to bedrooms during the day depending on risk and capacity. We saw some patients had chosen to personalise their bedrooms. The bedrooms provided a lockable storage space for patients to keep possessions safe.

The service had recently changed the time of the daily meeting, commencing half an hour later because of service user feedback. The meeting allowed for a level of planning to provide clients with meaningful activities and effectively using their days and time on the unit. Patients completed an interest checklist on admission, which allowed them to highlight areas of activity they had an interest in or would like to try.

Patients at both units had activities arranged on a daily basis. These included swimming, bowling, art group, yoga and the allotment. All activities were meaningful as staff used them as opportunities for patients to gain confidence with every day events such as crossing a road and finding a venue. Patients at St Andrews prepared their own lunches, budgeted, and shopped for the ingredients themselves. Hawthorne Court ran a breakfast group, where patients prepared and cooked food.

St Andrews had a mindfulness wall depicting patterns forming a nautical theme that patients could colour in at leisure. Within the patterns were hidden objects for patients to find. Mindfulness is a psychological therapy designed to relieve stress and anxiety.

During the weekend, patients prepared a Saturday night 'fake away', which was a healthier option to a takeaway. There were no pre-arranged activities on a Sunday.

Meeting the needs of all people who use the service

The service was able to accommodate patients and visitors with mobility issues. Both units had rooms adapted for use by patients with disabilities. However, the service decided that as St Andrew's Place could provide a better facility than Hawthorne Court they would accommodate patients with mobility issues where the need arose.

Information leaflets were available in different languages on request. The service had previously used an interpreter for a patient. They could access interpreters through the trust's legislation department.

Both units had well organised display boards that contained information about treatments, local services, patients' rights and how to complain.

The service was able to meet patients' individual dietary requirements for health and culture, requesting specialist diets for patients who needed them at Hawthorne Court. This included meals for patients who required vegan, vegetarian or coeliac diets as well as kosher or halal meat if required. At St Andrew's Place, patients could plan for and buy any particular food that met their own dietary requirements.

Each unit had a faith room and could make religious texts available to patients. Staff were respectful of people's cultural and spiritual needs. They supported external visits to places of worship and arranged for the chaplain or different faith representatives to visit if leave was not possible.

Staff gave us examples of how they provided support to meet the diverse needs of their patients including those related to disability, ethnicity, faith and sexual orientation. The ward managers were knowledgeable about equality and diversity issues and knew how they could manage patients' needs within the service.

Listening to and learning from concerns and complaints

Hawthorne Court had received one formal complaint in the 12 months prior to the inspection, which was not upheld. Ward managers investigated complaints using the set procedure and timeframes contained in the trust policy.

There was information on how to complain displayed on notice boards and in the welcome packs staff gave patients. The welcome pack explained that detained patients had the right to raise complaints about the Mental Health Act directly with the Care Quality Commission. It also explained how to make complaints and the support available from the patient advice and liaison services. The patients we spoke to said they would complain either directly to staff, or at the daily morning meeting. If the wanted to make a formal complaint they would use patient advice and liaison services.

Staff we spoke with knew the complaints procedure and felt able to manage informal and formal complaints. Ward

Are services responsive to people's needs?

Good

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

managers shared learning arising from complaints with staff at the business meetings. Staff received individual feedback during supervision and discussed how to handle things differently in the future.

The service received six compliments through patient advice and liaison services during the 12 months prior to inspection. This did not take into account the compliment cards each unit received directly.

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 vision was to be caring, compassionate and committed. The trust values were:

- putting the needs of others first,
- acting with compassion and care at all times,
- continuously seeking improvement,
- aspiring to excellence,
- valuing each other and teamwork.

The service displayed the visions and values across both units. They used 'the 6 Cs of nursing' (care, compassion, competence, communication, courage and commitment) to further support their commitment to the vison and values. It was evident from staff interactions with patients that the visions and values had translated into every day practice.

Staff knew who senior managers in the organisation were through trust emails and the photographs displayed at each unit. However, the majority of staff stated that senior managers rarely visited the units.

Good governance

The service ensured systems and processes were effective. We found that staff received appropriate levels of mandatory training, supervision and appraisals. Vacancy rates and absence rates were currently within trust and national averages. Both units were able to fill any staffing shortfall using regular bank staff. Staff reported incidents appropriately and received feedback and lessons learned at team meetings or during individual supervision.

The service was monitored using key performance indicators to measure performance in areas set around the health and safety matrix and clinical information such as seven-day follow-ups on discharge. Ward managers received monthly key performance indicators reports, which identified any performance shortfalls. They used this information to address concerns and plan service delivery effectively. The trust held a quarterly performance review meeting and produced a report for the modern matron and service manager to evaluate.

The ward managers said they had sufficient authority to run their units, however, inappropriate admissions were out of their control. The trust operated a centralised recruitment system and prioritised nurse recruitment to acute wards and wards with lower staffing levels. This meant the units could not recruit nurses directly or be involved in the process for recruiting nurses wanting to work in rehabilitation. This was a particular concern to Hawthorne Court, who had several nurses due to retire in the next 12 months.

The long-term rehabilitation wards did not have any items on the trust risk register.

Leadership, morale and staff engagement

There were no local staff surveys relating specifically to long-stay rehabilitation wards.

Overall morale was good and staff reported working in happy teams. We observed strong local leadership across both units, which staff and patients confirmed. All staff we spoke with felt supported by their colleagues and held in positive regard. They were enthusiastic about their roles and thought stress levels were healthy and manageable.

Several staff mentioned the limited engagement with the senior management team.

Staff knew the whistleblowing process and said they would be able to raise concerns if the need arose without fear of victimisation.

Commitment to quality improvement and innovation

Both units had twice achieved the Royal College of Psychiatrists' accreditation for inpatient mental health services programme with excellence. Accreditation for inpatient mental health services programme was a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. St Andrew's Place renewed their accreditation in 2015 and Hawthorne Court in 2016.

The service was piloting an outreach initiative, which provided patients with six weeks of support following discharge. The aim was to support the transition from ward to community and prevent relapse. The outreach service had identified a patient struggling with residual psychotic symptoms and readmitted them in the short term to assist their recovery.

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 9 HSCA (RA) Regulations 2014 Person-centred care We found that the provider had not enabled or supported patients to participate in making decisions relating to their care and treatment to the maximum extent possible. How the regulation was not being met: Five out of nine care plans lacked information about nursing interventions or details about the care required Patients did not attend their own recovery meetings and had limited access to the psychiatrist. This was a breach of Regulation 9 (3) (b) and (d)