Requires improvement

Mersey Care NHS 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)
RW401	Rathbone Rehabilitation	Ward	L13 4AW
RW41K	Sid Watkins Building	Brain Injury Rehabilitation Ward	L9 7LJ

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

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

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

Summary of findings

Ratings

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

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

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 gave an overall rating for long stay/rehabilitation mental health wards for working age adults of **requires improvement** because:

- The ligature assessment on Rathbone Rehabilitation was out of date; actions from previous years did not appear to have been completed. Previous assessments did not take into accounts the risks in the garden such as the gym.
- Brain Injury Rehabilitation Ward did not have access to ligature cutters for all staff. These were locked in the clinic room in a cupboard that only certain staff could access.
- There was an average of 2 shifts per week left on Rathbone where staff numbers were below what was clinically required. There was also a high level of sickness.
- 1:1 supervision rates of staff were not in line with trust policy.
- Mandatory training records showed that staff at Rathbone Rehabilitation Ward, were not up to date with required training, which was set at 95%.
- Staff were not appraised in line with trust policy, 3 staff had not been appraised for 2 years.
- Knowledge and access information for IMHA and IMCA services was out of date.

However:

Wards were clean, tidy and well maintained. There was good medical cover from doctors and a nurse practitioner to take the lead on physical health assessment. Staff carried out audit of patients care plans and of infection control risks. Safeguarding training was up to date and there was generally good knowledge around safeguarding procedures. NICE guidelines were followed for prescribing and offering therapies such as Cognitive Behavioural Therapy. Staff were observed to have a caring attitude towards the patients and the interactions were positive.

Patients reported feeling safe on the ward and they were supported after being discharged through follow up groups. There was a comprehensive range of disabled equipment and wards were adapted to have very good disabled access. Wards had activity timetables that were generic but also produced individualised activity plans that were of a multi-disciplinary approach. There were procedures in place to listen to and escalate complaints, the services showed they listened to and adapted according to patient feedback. Morale of staff was reported as good and staff felt free to raise concerns. Rathbone Rehabilitation Ward was AIMS accredited whilst Brain Injury Rehabilitation was accredited with Headway meaning that they were providing a service that was of a high quality and measured against national standards.

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:

- Although the ligature assessment on Rathbone Rehabilitation Ward was completed within the time frame set by the trust, actions from previous years were not documented as having been completed. Previous assessments did not take into accounts the risks posed by equipment in the garden such as the gym.
- Brain Injury Rehabilitation Ward did not have access to ligature cutters for all staff. These were locked in the clinic room in a cupboard that only certain staff could access.
- There was an average of 2 shifts per week left with staff numbers below clinically required on Rathbone Rehabilitation, there was also a high level of sickness shown in the data pack we reviewed. This evidence was reinforced when we reviewed staff records on the ward.
- Mandatory training levels were not at the 95% target imposed by the trust.

However, all areas complied with Department of Health Same Sex Accommodation Guidelines, clinic rooms were well stocked with medicines and resuscitation equipment. Wards were clean, tidy and well maintained and the Brain Injury Rehabilitation Ward had used patient experience and feedback to design and furnish parts of the ward. There was good medical cover from doctors and a nurse practitioner to take the lead on physical health assessment. Staff carried out audit of patients care plans and of infection control risks. Safeguarding training was up to date and there was generally good knowledge around safeguarding procedures. Staff were able to recognise and report incidents as expected.

Are services effective?

Good

We rated effective as **Good** because:

- We saw that there were timely physical health assessments upon admission, care plans were created from these and regularly reviewed and updated.
- There was good access across the service for professionals to provide physical and mental health therapies. The programmes from these professionals were individualised to the patients and found to be comprehensive.

Summary of findings

- We were told that NICE guidelines were followed for prescribing and offering therapies such as Cognitive Behavioural Therapy. Wards used recognised assessment tools such as Health of The Nation Outcome Scale, Camberwell Assessment of Need and United Kingdom Rehabilitation Collaborative to measure outcomes and their effectiveness.
- Staff were able to attend regular formulation meetings in order for staff to discuss and reflect on the management of patients under their care.

However, 1:1 supervision levels were not in line with trust policy and the handover we observed appeared to lack structure; with no summary of patient's risks or care plan.

Are services caring?

Good

We rated caring as **Good** because:

Staff were observed to have a caring attitude towards the patients and the interactions were positive, patients reported feeling safe on the ward and they were supported after being discharged, through follow up groups. Carers we spoke with provided positive feedback of the services provided and that they and the patients were involved in their treatment.

However: there were comments about named nurses changing and there being a lack of staff on the ward at Rathbone Rehabilitation. We observed a staff member at the Brain Injury Rehabilitation Ward to have a personal mobile phone on them during the shift which was used during the medicine round, the staff member also signed medication records before administering the medication in a communal area.

Are services responsive to people's needs?

Good

We rated responsive as **Good** because:

- The wards had good proven referral pathways into their beds from community, acute and forensic services. There were good links with the acute services to respond to a patients change in clinical need.
- There was a comprehensive range of disabled equipment and wards were adapted to have very good disabled access.
- There were also a wide range of therapy and activity rooms available. Wards had activity timetables that were generic but also produced individualised activity plans that were of a multi-disciplinary approach.

Summary of findings

- There were procedures in place to listen to and escalate complaints, the services showed they listened to and adapted according to patient feedback.

However;

We heard there were communication difficulties with the community mental health team which lead to patients not accessing appropriate accommodation when ready. There was limited outside space at the Brain Injury Rehabilitation Ward, food was of poor quality and at Rathbone Rehabilitation Ward nursing staff were expected to cover activities due to the lack of an occupational therapist.

There was a lack of information available to patients who could not speak English; we found that patients were not clear on how to complain. Staff considered the needs of a patient whose first language was not English and arranged an interpreter. When this was unsuccessful staff had learned phrases to communicate more effectively with the patient and included a phrase sheet in the patient file.

Are services well-led?

Requires improvement

We rated well-led as **Requires Improvement** because:

- There was a lack of robust assessments of ligatures in the garden area of Rathbone Rehabilitation.
- Not all staff were able to access ligature cutters at the Brain Injury Rehabilitation Ward.
- Appraisal records showed staff were not regularly appraised.
- 1:1 supervision rates of staff were not in line with trust policy.
- Mandatory training records showed that staff at Rathbone Rehabilitation were not up to date with required training.
- Staff were not appraised in line with trust policy.
- Knowledge and access information for IMHA and IMCA services was out of date.
- High levels of staff sickness at Rathbone Rehabilitation ward.

However,

Staff were aware of the trust values and initiatives and were aware of who ran the trust at board level. Morale of staff was reported as good and staff felt free to raise concerns with their manager, in group

Summary of findings

supervision and formulation meetings. There was leadership training available to staff. Both wards were accredited meaning that they were providing a service that was of a high quality and measured against national standards.

Summary of findings

Information about the service

The long stay/rehabilitation mental health wards for working age adults is part of Mersey Care NHS Trust. The service provides long term rehabilitation to persons with enduring mental health problems and acquired brain injury.

Rathbone Hospital has one long stay/rehabilitation mental health ward for working age adults: Rathbone Rehabilitation Ward, which is a 26 bedded unit providing long term rehabilitation for patients with a primary diagnosis of psychosis, who are informal or detained under the Mental Health Act. The service receives referrals from both the acute mental health services and secure forensic services

Sid Watkins Building has one long stay/rehabilitation mental health ward for working age adults: Brain Injury Rehabilitation Ward is a 12 bedded unit that provides inpatient rehabilitation to patients with an acquired brain injury who may have cognitive, functional, emotional and/or behavioural problems as a result. Both services work with individuals, carers and other agencies in order to maximise rehabilitation potential and quality of life.

Our inspection team

The team that inspected the Long stay/rehabilitation mental health wards for working age adults, consisted of six people experienced in mental health care: These were, an expert by experience, consultant psychiatrist, mental health nurse, and advocate and Mental Health Act reviewer.

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?

We visited two wards as part of our inspection of the long stay/rehabilitation mental health wards.

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

During the inspection visit, the inspection team:

- visited both of the above 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 17 patients who were using the service and/or their carer
- spoke with the managers and acting managers for each of the wards
- spoke with a service manager
- spoke with 22 staff members; including doctors, nurses, health care assistants pharmacists, bed manager and allied health professionals
- attended and observed a hand-over meeting
- attended and observed a Service user Support Group

Summary of findings

- carried out one Mental Health Act monitoring visit at Rathbone Rehabilitation Ward
- collected feedback from patients and carers using comment cards.
- looked at 19 treatment records of patients.
- carried out a specific check of the medication management on both 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 patients and their relatives during the inspection at Mersey Care NHS Trust. Most feedback we got was positive, patients felt safe and cared for and were happy with the therapies on offer. Many of the comments received were that the care was 'brilliant.'

There were three patients that were unhappy with the small amount of 1:1 time they got with their named nurse and that some of them were not sure who their named nurse was.

We attended a service user group for ex patients of the Brain Injury Rehabilitation Ward and there was very positive feedback given, including glowing reports from carers who had great faith in the service and said that it had really helped people down the road to recovery.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- Assess and manage the risks to the health and safety of the service users receiving care and treatment. This relates to the ligature assessment on Rathbone Rehabilitation.
- Ensure staff receive appropriate support, training and professional development. Supervision and appraisal is necessary to enable them to carry out the duties they are employed to perform.

Ensure that there are sufficient numbers of suitably qualified, competent, skilled persons deployed on Rathbone Rehabilitation Ward.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- Review handover structure and content to ensure that information on risk and care planning is being communicated effectively.
- Ensure that best practice is achieved during medication times. We observed that medicine cards were signed prior to medicines being administered.
- Review the leaflets available to patients as many were out of date with the wrong information.

Mersey Care NHS Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Rathbone Rehabilitation	Rathbone Hospital
Brain Injury Rehabilitation Ward	Sid Watkins Building

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 told us that they had received training on the Mental Health Act 1983 (MHA) and the Code of Practice: Mental Health Act 1983. This was confirmed by Brain Injury Rehabilitation Wards mandatory training records, Rathbone Rehabilitation Ward however had only trained 16.7% in this area.

The use of the MHA was mostly good in the inpatient wards. The documentation we reviewed in detained patients' files was compliant with the MHA and the associated Code of Practice (CoP). Consent to treatment forms were attached to the medication charts as appropriate however one of these was out of date and one card had a medication registered on the card for a different reason than clinically indicated. Rathbone Rehabilitation Ward regularly reviewed the rights of the detained patients on the ward, the dates of these were put up on a board in the office so that staff were able to determine when they were next due to be read. We heard from staff that that they would review rights more regularly and followed the CoP, by reading them at Care Programme Approach meetings and tribunals.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff told us they had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However on further investigation it became clear that many staff were not able to recall the statutory principles and said they saw this as a medical responsibility.

Staff were aware of the MCA and DoLS, but the knowledge lacked depth. We were informed that there was one patient under DoLS. Staff could not say which patient this was or inform us of the restrictions. The DoLS protocol was displayed clearly in the ward office.

Brain Injury Rehabilitation ward there was evidence in the notes that capacity assessments had occurred for seven out of the nine patients. Rathbone Rehabilitation Reported that capacity was assessed on admission and recorded electronically. The recording of capacity assessments was evident on both wards.

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

Summary of findings

Our findings

Safe and clean environment

- Rathbone Rehabilitation ward was a very large ward but here were clear lines of sight down corridors. Wards were large, so it was not possible for staff to be on every part of the ward to observe patients. Each patient was on a level of observation that meant staff were required to know their whereabouts at certain intervals. Both wards had vistamatic bedroom windows that allowed staff to observe the patients when necessary and to maintain their privacy at other times.
- The Brain Injury Rehabilitation Ward had many ligature risks such as taps, grab rails and cupboards throughout. The ward had a clear admission policy that stated they will not admit anyone who is suffering from more than mild to moderate depression. The trust ligature risk assessment stated that all patients would have a risk assessment that would take into account environmental factors to minimise risks. On checking the risk assessments at this service, it was not clear that this environmental risk had been considered and the care plans formulated did not mitigate against these risks.
- Rathbone Rehabilitation Ward had a comprehensive ligature risk assessment with points identified and actions to minimise risk of service users tying ligatures. However, this risk assessment was from 29/04/14 and had not been updated for 2015. This was in line with the trust health and safety procedure to be completed by September. Actions from 2013 had been carried over to 2014 and it was not clear on the 2014 assessment whether or not the issues had been resolved. The garden area had gym equipment, a smoking shelter and benches that posed a ligature risk, these items were not included on the risk assessment so staff could not guarantee that the risk had been considered.
- Rathbone Rehabilitation Ward had only one bedroom which was not en-suite; this was situated on the male floor of the building and had access to a male only bathroom. Both the male and female areas of the ward had their own lounges. The Brain Injury Rehabilitation Ward was fully en-suite and had good disabled access; the ward had a female only lounge, this was compliant with Department of Health Same Sex Accommodation Guidelines.
- The clinic rooms of both rehabilitation wards were fully stocked with resuscitation equipment checked daily, ligature cutters, medication fridge and secured controlled drugs cabinet. There were separate examination rooms to the clinic which added privacy and dignity for the patient at times when the clinic room was busy. On the Brain Injury Rehabilitation Ward the ligature cutters were kept inside a locked cabinet in the clinic room, we were told that not all staff had the key for this cabinet. Patients were therefore not guaranteed that staff would be able to respond promptly to a ligature incident.
- Both wards were clean, tidy and well maintained. There was a cleaning schedule in place that rated areas by risk. The frequency of the cleaning was therefore adjusted for that area. Patients fed-back that the lavatories were not always very clean.
- Both wards had access to call bells for patients and staff. Whilst on Rathbone Rehabilitation Ward we witnessed two alarms, staff were not able to locate the origin of the first alarm and put it down to a 'false alarm', we saw that they were not able to turn one of the alarms off using the remote control, so the alarm kept ringing for some time. Staff could therefore not guarantee that they were able to locate a potential issue in a swift manner or ensure a peaceful environment for service users.

Safe staffing

- Safe staffing levels agreed for Rathbone Rehabilitation were 6 on the day shift and 4 on the night shift. This was with an agreed skill mix of 2 Registered Mental Health Nurses (RMN) and 4 Healthcare Assistants (HCA) in the day and 1 RMN and 3 NAs at night. The ward operated a long day policy meaning that there was 1 day shift and 1 night shift. The assistant manager reported that at times the number of nurse's differed, meaning, that there

could only be one RMN on a day shift with the numbers brought up using bank or agency HCA's. In the three months prior to our visit there were a total of 188 shifts that required extra cover, of these shifts 159 were filled leaving around 15% of shifts below numbers clinically required. It was reported by the manager that they tend to cover shifts with their own staff or bank and agency staff that are familiar with the ward, many of the bank staff are block booked.

- Staffing levels at the Brain Injury Rehabilitation Centre had remained stable for some time; they were able to fill all shifts required in the 3 months leading up to the inspection.
- Data received prior to inspection stated that the sickness levels in Rathbone Rehabilitation were at 13.5%. On the day of the visit it was noted that there were a total of 17 out of 26 staff members being monitored for sickness/unacceptable absence. There were 4 vacancies for NAs, 2 RMNs on maternity leave, 1 RMN on secondment and there was a deputy manager suspended from the ward.
- Mandatory training completion was below the 95% expected at Rathbone. The Brain Injury Rehabilitation had above the 95% expected and was able to access specialist training, much of which was done in-house.
- Rathbone Rehabilitation Ward had recruited an assistant nurse practitioner to oversee physical healthcare for the patients doing ECG and blood tests. Staff reported that they had the ability to provide 1:1 time, activities and escorted leave the majority of the time. This meant that these activities were rarely cancelled. It was rare for these not to take place due to staffing levels, it was reported that it was a less than once weekly occurrence.
- There was medical cover through a specialist registrar and ward doctor throughout the day that would be able to respond to physical health problems and emergencies should they arise. Junior doctors had an on call system through the night to attend to emergencies and staff informed us they arrived promptly.

Assessing and managing risk to patients and staff

- At Rathbone the risk assessments were completed on admission and individualised so that the nurses could identify risks to the patients. These were reviewed regularly by the MDT and changed according to change in risk. However, at the Brain Injury Service the risk assessments completed did not always highlight historic risk that had been stated in previous risk assessments. For example a previous risk assessment had stated historic suicide attempts; this was not picked up in the updated risk assessment. Another patient had been reported to be experiencing low mood and anxiety; this was not captured in the risk assessment and had not been considered in the care plans. Risk assessments did not appear to dictate the level of observation for the service user on the ward; it was not clear therefore how decisions had been reached for observation levels.
- Rathbone Rehabilitation had a blanket rule for signing out of both formal and informal patients. Informal patients said they were happy with the arrangement. We saw that on both wards there the staff reported that there was a blanket rule that no patient would progress past hourly observations; this was the same at the Brain Injury Rehabilitation Unit. Due to this approach it was not possible for patients to gain more freedom and privacy from staff observational check. This meant that observation was not matched to level of need. Interestingly the level of observations did not impact on the length of leave allowed off of the ward.
- Brain Injury Rehabilitation had procedures in place to ensure safety of patients by completing a monthly infection control check. This involved observing hand hygiene techniques, mattress checks, and medical devices decontamination checklist, MRSA and C-Diff feedback and a monthly infection control environmental checklist.
- All staff were trained in Management of Violence and Aggression and restraint techniques were only used as a last resort. It was very rare that someone needed to be restrained; the service had experienced 2 restraints in 12 months. We saw good documented evidence of verbal de-escalation and the staff spoke of an emphasis on verbal de-escalation.
- Safeguarding training compliance was 96.7% across the service. Staff were knowledgeable of the trusts safeguarding policy and knew who the safeguarding leads were. They stated they were able to make

Requires improvement

Are services safe?

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

safeguarding referrals using Care Line which was a single point contact to refer to the local authority. Recent Safeguarding referrals had been made and it was clear that processes had been followed.

- The pharmacist of Rathbone Rehabilitation was the trust lead for medicines and was very clear about appropriate storage of medicines. The pharmacist attended the weekly MDT meeting. Controlled Drugs were recorded appropriately and checked daily.
- The Brain Injury Rehabilitation Ward assessed falls risk for patients and those at higher risk required a Multifactorial Falls Assessment. However, it was not evidenced in the electronic notes that it had taken place, so staff were not able to guarantee they had considered all risk management options for these patients. All patients on the ward received a Waterlow risk assessment to determine risk of pressure ulcers.
- Rathbone Rehabilitation had a separate children's visiting area so children could visit patients without entering the ward. Both services provided a private and safe space for families and children on the ward, in order to reduce any risk to them during visits.

Track record on safety

- A recent incident on Rathbone Rehabilitation that meant staff who were off sick due to an injury at work had been reported appropriately through the trust processes and as a result a RIDDOR notification had been made.

Reporting incidents and learning from when things go wrong

- Staff told us that they reported all incidents on an electronic system that was accessed and monitored by relevant teams within the trust. Staff we spoke with knew how to report incidents on the system.
- Following incidents on the ward Rathbone Rehabilitation held formulation meetings as a de-brief, with the clinical psychologist. These meetings were person centred and staff understood individual care needs. This helped staff use different approaches to managing difficult situations and improving quality of care.
- Both wards had systems and relationships in place with other wards to respond to a change in the needs of a patient. For example, where needed, Rathbone were able to refer to the local Psychiatric Intensive Care Unit.

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

- Physical and mental health was assessed on admission and care plans were created and reviewed regularly. Review dates were highlighted on a board in the office, so that staff could see the deadline for reviewing the care. The care plans and risk assessments were audited monthly at Rathbone which showed that they had taken into account the level and nature of a patient's risk. This information was used to inform care plans.
- There was access to the cancer screening 'iVan' that visited the site for mammograms and general cancer screening.
- Speech and language therapy, podiatry and physiotherapy, visited Rathbone Rehabilitation when it was necessary. Brain Injury Rehabilitation had an in-house therapy team, consisting of occupational therapy, physiotherapy, psychology and speech and language therapy.
- Rathbone's nursing care plans were up to date, personalised and holistic. However, there were reports from patients that they did not have copies of their care plans. This was because patients had the option to keep it and if they did not want it, then it would be kept in 'My File', This was a file, containing care plans and individual information, that service users could have access to if they so wished.
- At the Brain Injury Rehabilitation Ward we saw that care plans were produced; however, nursing care plans appeared generic and did not consider patient's wishes.
- Occupational therapy, physiotherapy, speech and language therapy plans were made in collaboration with the patient. These were communicated within the team and the care plan was reflected in the weekly individualised activity plan. For example; a patient that required support with shopping, had a plan that was broken down step by step. This was helpful, in that it this was put on the wall in the bedroom, so they knew what was expected and what support was being offered. Staff could also see how best to support them. Another patient had clear steps of how they were to mobilise, this was individualised into an easy read format and put on the wall in their bedroom, so all could see how to support the patient. These plans were kept in the patient's electronic record and in paper notes that both staff and patients could access.
- Both wards used an electronic record system to store their confidential information. This system 'EPEX' was used to create care plans, risk assessments and to log notes about a patient's progress. The staff were able to print off care plans in order for the patients to read and sign, these were then stored in a patients file so that they were readily accessible.

Best practice in treatment and care

- The consultant psychiatrist at Rathbone Rehabilitation followed the best practice through NICE Guidelines on Psychosis and Schizophrenia in Adults. However, due to the complexity of the patient's presentation at Brain injury Rehabilitation they did not fit into specific NICE guidelines. Both units provided a MDT approach, using psychological and physical interventions. The consultant followed mental health treatment guidelines for prescribing.
- Individual Cognitive Behavioural Therapy (CBT), as set out in NICE guidelines on Psychosis and Schizophrenia in Adults, was not available to all the patients on Rathbone Rehabilitation. These were included in group CBT led by the psychologist. The Brain Injury Rehabilitation ward was able to offer psychological interventions through the clinical psychologist on a 1:1 basis for all of the patients on the ward. They also offered group work. All assessments were completed within the first week of the admission.
- Rathbone Rehabilitation had a lead nurse for physical health who kept an overview of the physical health needs of patients and ensured physical health care plans were kept up to date. Regular physical health-checks were taking place where needed and the dates of these were placed on a board in the office for all to see. Brain Injury Rehabilitation had a good connection with services such as the epilepsy clinic.
- Both wards used the Health of the Nation Outcome Scales (HoNOS) to assess and record outcomes for the patients on the ward. The Brain Injury Rehabilitation

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.

Ward was accredited with Headway, which provided a recognised sign of quality in brain injury care. They submitted statistics to the UK Rehabilitation Outcomes Collaborative, to help measure their success rate, which was 80%. Rathbone Rehabilitation was AIMS accredited; a standards-based accreditation program designed to improve the quality of care in inpatient mental health wards. They used the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) to explore whether there were unmet needs over a set time period.

- Both wards engaged in clinical audit for care plans and infection control. However, environmental audits were out of date on Rathbone Rehabilitation and were not completed on the Brain Injury Ward, despite needing to be done quarterly. We heard that these had not been done because of the move to a new building.

Skilled staff to deliver care

- The staff working on the Rehabilitation wards came from a range of professional backgrounds including nursing, medical, occupational therapy, psychology and social work. Other staff from the trust provided support to the ward, such as the pharmacy team. However at the time of our visit Rathbone Rehabilitation did not have an occupational therapist and had not done so for some time.
- Supervision records showed that individual supervision was not readily available to staff. There had been recent attempts to supervise staff but there were many who had gone 1 – 2 years with no supervision. The longest period of time, from reviewing staff supervision was 2 years 2 months with no supervision recorded. Staff had access to regular formulation meetings that looked at the management of patient and weekly group supervision. However, this did not grant a staff member the privacy to raise personal work issues or for specific review and feedback of performance. We reviewed six staff files for appraisal information, of the six there were three appraised two years five months prior to the inspection and there was no appraisal record for the other three.
- Medical and psychology specialist training available at Rathbone Rehabilitation Ward. The deputy manager reported that there was previously access to specialist training for nursing staff but this had stopped, they said that there was no recovery focussed training readily available. We saw that there was a range of training available from the MDT, many of the nursing staff had received training from physiotherapists, speech and language therapists and from the occupational therapists. Band 5 nurses were seeking to maintain professional development commitments, so were not able to attend specialist training.
- There was evidence submitted to the team to show that poor performance had been addressed, an issue with one staff member had been dealt with appropriately and the relevant agencies informed.

Multi-disciplinary and inter-agency team work

- Patient's records showed that there was effective multidisciplinary team (MDT) working. Care plans included advice and input from different professionals involved in people's care. Patients we spoke with confirmed they were supported by a number of different professionals on the wards. Rathbone Rehabilitation Ward were able to review each patient every four weeks in the MDT, they were able to access medical support from the Consultant Psychiatrist in between these meetings if needed. Brain Injury Rehabilitation reviewed their patients fortnightly and updated care plans in this meeting.
- We observed the nursing handover on Brain Injury Rehabilitation Ward and found it to lack structure, there was no summary of the patient care plan, current risks or discharge plan. During the handover a safeguarding issue was raised, we found that staff were not proactive in responding to this issue, this was brought to the attention of the ward manager shortly after.
- We heard that there was frustration in engaging care coordinators, this was evidenced by an email that was sent to care coordinator where a patients accommodation needs had not been met. As a result this had an effect on the length of time it took to find accommodation outside of hospital.

Adherence to the MHA and the MHA Code of Practice

- Staff told us that they had received training on the Mental Health Act 1983 (MHA) and the Code of Practice: This was confirmed by Brain Injury Rehabilitation Wards mandatory training records, Rathbone Rehabilitation Ward however had only 16.7% trained.

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.

- The use of the MHA was good in the inpatient wards. However, on observing a conversation on the brain injury ward between medical staff and nurses we found the staff were not clear on what sections of the MHA allowed patients to leave the ward.
- Consent to treatment forms were attached to the medication charts as appropriate, however, one of these was out of date and one card had a medication registered on the card for a different reason than clinically indicated.
- Rathbone Rehabilitation regularly reviewed the rights of the detained patients on the ward, the dates of these were put up on a board in the office, so that staff were able to see the deadline of when they were next due to be read. We heard from staff that that they would review rights more regularly and were following the Code of Practice, by reading them at CPA meetings and tribunals.

Good practice in applying the MCA

- Staff told us they had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However on further investigation it became clear that many staff were not able to recall the statutory principles and said they saw this as a medical responsibility.
- Staff were aware of the MCA and DoLS but the knowledge lacked depth. There was one patient under DoLS at Brain Injury Rehabilitation, the nurse in charge was not able to say which patient this was or inform us of the restrictions. The DoLS protocol was displayed clearly in the ward office.
- Patient's capacity was not always assessed on admission to the Brain Injury Rehabilitation ward but there was evidence in the notes that capacity assessments had occurred for seven out of the nine patients. Rathbone Rehabilitation reported that capacity was assessed on admission and recorded electronically. The recording of capacity assessments was evident on both wards. These assessments were comprehensive and answered the key questions.

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

- Staff were observed to have a caring attitude towards the patients on both wards. Activities and individual sessions went along as planned. We observed group work and individual therapy sessions and it was clear that the staff on the ward were knowledgeable of the patients. We were observed the physiotherapy and occupational therapy input on Brain Injury Rehabilitation ward, the interactions during the physiotherapy and level of staff support was caring and encouraging in its nature.
- At Rathbone Rehabilitation there was a sign on every patient's door asking staff to knock before entering. From our observations we saw that staff were mindful of patient's dignity and knocked before entering.
- We spoke to patients on the wards who spoke of the staff and their experience in a positive way. They reported feeling safe on the ward and enjoyed the facilities available. However, there were comments about named nurses changing and there being a lack of staff on the ward at Rathbone Rehabilitation.
- Staff supported patients with their rehabilitation needs, such as assisting with mobilisation, going to the shops and helping with cooking. Staff were able to offer individual and group support for cooking evening meals.
- We observed a service user support meeting for those that had been admitted to Brain Injury Rehabilitation Ward in the past. All the service users in this group were adamant that they would not be as far along the road to recovery, if it had not been for the excellent care they had received on the ward and the on-going care in the community.
- We spoke with carers at Brain injury Rehabilitation Ward who were very positive of the care given and that it was 'brilliant from the cleaner to the manager', many of the patients under their care had recovered from being bed bound to being mobile and able to communicate.
- When staff spoke to us about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs.
- We observed a staff member at the Brain Injury Rehabilitation Ward to have a personal mobile phone on them during the shift which was used during the medicine round, the staff member also signed medication records before administering the medication in a communal area. The 'do not disturb' tabard available was not being used. We saw that staff at Rathbone Rehabilitation were able to spend time with the patients in a medication round and showed good practice.
- The Brain Injury Rehabilitation Ward worked with a company called Compact who works with a local school to provide work experience for 6th form students. They often had a student on placement who would help out with the running of the ward and give them experience of 1:1 patient contact whilst giving the patients an opportunity to have the help of an extra person.
- The Brain Injury Rehabilitation Ward planned their move to the new building by involving the patients in the choice of furnishings.

The involvement of people in the care they receive

- Both wards offered an admission pack giving them information about the ward and its workings. On Brain Injury Rehabilitation this was available in an easy read format.
- Patients felt involved in the treatment they received although many did not have a copy of their care plan. On further investigation we found that patients had been offered copies but declined to keep them. These were kept in their own personal files that they could access.
- Rights to an Independent Mental Health Advocate were not advertised clearly. We heard from staff that they knew the names of the people providing the service but did not know the provider. The patient leaflets on display were out of date and gave details of the wrong service.
- Patients spoke positively of the involvement of families and carers, staff were able to update them with consent from the patient.

Good

Are services caring?

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

- Both wards provided community meetings for patients to have their say; these were evidenced and filed with actions which were followed up promptly.
- The Brain Injury Rehabilitation Ward had five ex-patients who were acting as volunteers on the ward. They offered a befriending service and were a positive face to the recovery of patients. They received the mandatory training provided by the trust. The volunteers coordinated an 'Action for Brain Injury' day in collaboration with Headway, who accredits the service. The day was opened by the trusts chief executive and the Lord Mayor of Liverpool. The day had an expert by experience panel for the public to ask questions around support and how they were helped.
- Rathbone Rehabilitation had a patient representative who was a patient on the ward; this role was a link between the patients and staff, to aide communication and to be a voice for the patients on the ward.
- Both wards used satisfaction surveys to gauge patient experience.

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

- Beds on the Brain injury Ward were split, so that eight were trust beds and four were privately available or able to be purchased by other CCG's. Rathbone Rehabilitation had a waiting list of around six months.
- Neither ward admitted patients into leave beds.
- Patients on each ward were only ever moved between wards due to a change in clinical need, beds were not used as sleep over beds from other wards**.**
- Rathbone Rehabilitation had strong links with psychiatric intensive care wards inside the trust; they had used this service to transfer a patient two weeks prior to the inspection. The Brain Injury Rehabilitation Ward had a policy of not admitting patients with severe mental health problems. Anyone wishing to use the service that they deemed was not appropriate would be referred to the acute mental health service. They would then be reassessed for rehabilitation services if necessary.
- We heard from staff that there were delays in finding suitable accommodation outside of hospital, due to communication difficulties with the community mental health team.

The facilities promote recovery, comfort, dignity and confidentiality

- Both wards had separate examination rooms to the clinic room, there were rooms for arts and therapies. Brain Injury Rehabilitation had a gym and a balcony with furniture. There was a lift to go down to the court yard. However, we saw that there were only three tables and seven chairs in the dining room and only five chairs around the TV in the lounge. This would not allow all patients the opportunity to sit together when the ward was full.
- Every patient had their own bedroom space; there were multi-faith rooms and separate lounges for females. Patients could meet visitors in a private space on both wards; Rathbone Rehabilitation had a separate visitor's room off of the ward as well.
- Rathbone Rehabilitation had a phone that was broken and had been for some time, however, patients were free to use their mobiles and use the Wi-Fi which was supplied by the trust.
- There was ample access to outside space at Rathbone Rehabilitation; there was a gym, flower beds for the patients to grow plants and vegetables and push bikes for the patients to use. The outside space at Brain Injury Rehabilitation was limited and shared with other wards in the building; they did however have their own balcony.
- Reports from patients were that the food was of a poor quality and there was also a lack of choice. Recent PLACE scores had highlighted this prior to the inspection. Food was delivered, heated up on the wards and served by the staff on duty. There were opportunities for patients to cook their own evening meal.
- Hot drinks and snacks were available 24 hours a day on both wards. Patients were allowed to bring their own food onto the ward. There were active plans which were individualised to support patients off the ward to shop and cook as part of an occupational therapy programme.
- Patients on both wards were able to personalise their rooms, they were able to bring in TV's on Rathbone rehabilitation.
- All bedrooms at Rathbone Rehabilitation were locked and patients had their own key.
- Both wards had an activity timetable, providing weekday activities. However, there were only weekday activities on the Brain Injury Rehabilitation Ward. They did an individual weekly activity timetable, including therapies for each patient on the ward. Rathbone did not have a full time occupational therapist, so the onus was on the nursing staff to provide activities for the patients on the ward. These were allocated to the staff on duty each morning by completing a shift planner.

Meeting the needs of all people who use the service

Are services responsive to people's needs?

Good

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

- Both wards had disabled access, with all areas of the ward disabled friendly. Rathbone Rehabilitation offered two disabled adapted flats with large bathrooms and kitchens with electronic height adjustable work surfaces. We observed these being used by a disabled patient and it was apparent that they had promoted their independence.
- The Brain Injury Rehabilitation Ward was equipped with a hoist, privacy screen, and a rise and fall bath, in the two bathrooms for those with mobility issues. There were two bedrooms with ceiling track hoist that went through the bedroom and into the bathroom. Individualised mobility guidelines were on display in these rooms to inform staff how to assist mobilisation. A private lift was available down to the courtyard for those needing it.
- The Brain Injury Rehabilitation Ward provided full length mirrors which were used for certain patients to help their coordination when dressing.
- The welcome packs given to new admissions contained information about treatments, rights as an inpatient, access to advocacy and the complaints procedure.
- Interpreters were available to staff and were used to help assess patients' needs and explain their rights, as well as their care and treatment. However no leaflets available in different languages were on display so it was unclear how the staff would manage patients that were not able to speak English.
- We heard from staff that they were able to meet the dietary requirements of religious and ethnic groups.
- There was a separate space for patients to access spiritual literature; the staff informed us that they were able to contact a variety of religious groups to offer spiritual support on the ward.

Listening to and learning from concerns and complaints

- Information about making a complaint was available in the welcome pack and displayed on the walls in the ward on a generic trust poster. It was not obvious at the time that the complaints procedure was on these posters, so it was not clear if patients were well informed. Some patients we spoke to were not sure how to complain and did not feel confident to place a complaint with staff; others felt that there was no need for complaint.
- Complaints on the wards were referred to the manager and the complaints department if they could not be dealt with locally on the ward. We heard that patients were offered the opportunity to make formal complaints. Issues on the ward were also resolved through community meetings.
- Feedback around complaints was communicated through staff meetings; Rathbone Rehabilitation often spoke about complaints in their formulation meetings.

Are services well-led?

Requires improvement

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

- Staff were aware of the values of the trust and spoke to us about the 'perfect care', 'no force first' and 'zero suicides' initiatives that they were bringing in.
- Staff had met the trust board. The trust's vision and strategies for the service were evident and on display, posters were on the wards with their faces and e mail addresses on so that they were able to contact them directly.

Good governance

- Individual supervision rates across the service were not in line with the trust policy of 4-6 weekly at Rathbone Rehabilitation. Staff were not supervised for a number of years, but were able to access group supervision and formulation meetings.
- Whilst there were systems in place to assess for ligatures and mitigate the associated risk, Rathbone Rehabilitation's garden area was not considered an area needing assessment.
- Staff we spoke with were not able to access ligature cutters on the brain injury ward due to them being placed in a locked cupboard.
- Appraisal rates at Rathbone were two years out of date and there was 3 out of 6 staff that had not received a yearly appraisal in line with trust policy.
- Mandatory training completion was below the 95% expected at Rathbone. The Brain Injury Rehabilitation had above the 95% expected and was able to access specialist training, much of which was done in-house.
- Shifts on Rathbone Rehabilitation were short of the numbers clinically required 15% of the time. This meant that an average of two 12.5 hour shifts per week in the 3 months prior to inspection was left short staffed.
- The staffing levels did not appear to be detrimental to the care that the patients were receiving but affected the staff and their ability to access support through training, appraisal and supervision.
- We heard that incidents were reported appropriately and there was the ability to move patients according to clinical need.
- Staff were able to participate in clinical audit of infection control and care plans, they used recognised assessment tools to measure outcomes for patients and gauge their effectiveness.
- Knowledge of accessing the IMHA and IMCA services was not up to date, there was out of date information on the ward and staff were not sure of who was providing this service.
- Staff knew about the complaints procedure but there appeared to be a lack of clear information on how to complain available to the staff.
- Staff were able to spend time with patients on the ward but appeared to be over stretched on Rathbone Rehabilitation having to cover activities and leave due to the lack of an occupational therapist. We saw that on the Brain Injury Rehabilitation ward there was ample time for staff to spend with patients.
- The managers of both wards told us they had access to leadership training and development. This covered the theory of management as well as scenarios and techniques that could be used in practice. Most staff felt supported by their immediate line manager. Management and leadership training was available for Band 6 nurses.

Leadership, morale and staff engagement

- Data received prior to inspection stated that the sickness levels in Rathbone Rehabilitation were at 13.5%. On the day of the visit it was noted that there were a total of 17 out of 26 staff members being monitored for sickness/unacceptable absence. There were 4 vacancies for HCA's, 2 RMN's on maternity leave, 1 RMN on secondment and there was a worker suspended from the ward.

Are services well-led?

Requires improvement

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.

- Morale of the staff was reported as good, the staff were involved in patients care no matter what role or responsibility. Consultants were open to discussion and were seen on the ward most days.
- There were large periods of time between appraisals for staff on Rathbone Rehabilitation and were not conducted in line with trust policy.
- Staff felt free to raise concerns, this was encouraged in group supervision at Rathbone Rehabilitation. They incorporated concerns about patients, the ward and de-brief in the weekly formulation meetings.
- We heard that turnover of staff at Brain Injury Rehabilitation Ward was very low.
- The Brain Injury Rehabilitation Ward was finding the recent move only six weeks prior to the inspection a challenge due to it being a new environment for both patients and staff. The lack of outside space was an issue for patients who had transferred from the previous site, the community meeting minutes stated that the patients did not like the new environment as it felt like 'an office'. Staff reported that the new building was much more clinical than the previous.

Commitment to quality improvement and innovation

- Rathbone Rehabilitation Ward was accredited with AIMS as an excellent ward, they have engaged in research around occupational therapy and in Human Rights Based Risk Assessment. Brain Injury Rehabilitation were accredited with Headway. Mersey care is the first NHS organisation to receive this approved provider status.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 Regulated Activities Regulations 2014 Care and treatment must be provided in a safe way for service users. Rathbone Rehabilitation Ward had a comprehensive ligature risk assessment with points identified and actions to minimise risk of service users tying ligatures. However, this risk assessment was from 29/04/14 and had not been updated for 2015 but this was in line with trust policy. Actions from 2013 had been carried over to 2014 and it was not clear on the 2014 assessment whether or not the issues had been resolved. The garden area had gym equipment, smoking shelter and benches that posed a ligature risk, these items were not included on the risk assessment so staff could not guarantee that the risk had been considered. This is a breach of regulation 17

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 Regulated Activities Regulations 2014 Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. Individual supervision rates across the service were not in line with the trust policy of 4-6 weekly.

This section is primarily information for the provider

Requirement notices

Mandatory training completion was below the 95% expected at Rathbone. Appraisal rates at Rathbone were two years out of date and there were staff that had not received a yearly appraisal in line with trust policy.

In the three months prior to our visit there were a total of 188 shifts that required extra cover, of these shifts 159 were filled leaving around 15% of shifts below numbers clinically required.

This is a breach of regulation 18 (2)(a)