Edith Shaw Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

We rated Edith Shaw as requires improvement because:

- The unit did not fully meet the rehabilitation needs of patients due to the lack of a full onsite multidisciplinary team to deliver a recovery focus service. Staff and patients reported there was insufficient occupational therapy (OT) support to meet the needs of the patients. OT staff numbers and input as well as the lack of recovery focus in care plans also indicated this.
- The units planned establishment of nursing staff on a shift was two qualified staff to meet the needs of the patient group. We heard from staff and saw in rotas that only one qualified staff member was on shift routinely between Thursday and Sunday due to current vacancies.
- Staff under-reported incidents that were potential safeguarding concerns to external agencies.
- Care records did not consistently show patients' views on and involvement in their care.
- The staff recruitment processes were not consistent applied to staff at a senior level. Employment files for board members did not contain evidence how they were selected, references or disclosure and barring service checks.
- The portable wooden steps used to help patients onto the unit's minibus were not sufficiently sturdy to steady and support patients safely.
- The unit had blind spots in the bedroom corridors. Staff reduced the potential danger from these by taking into account individual patient risk factors when allocating bedrooms, and using staff observations.
- The provider generally managed the application of the Mental Health Act well. However, we found errors in completion of forms relating to the MHA and the unit had not updated its Mental Health Act policy in line with the changes in Mental Health Act code of practice. Both of which have been addressed since inspection.
- There were gaps in some of the medicines charts even though the provider had tried to address the issue. Documentation on the medicine charts was unclear if the doctor had reviewed some PRN medication ('as required') within a two week period.

However:

- The unit was safe, clean, well maintained and allowed patients a degree of autonomy. The hospital had identified ligature points in the ligature risk assessment and put measures in place to reduce the danger from these. Ligature points are places to which patients intent on self-harm might tie something to attempt to strangle them. All staff followed infection control procedures. The unit was well adapted for disabled access. All patients personalised their rooms and held their own bedroom keys.
- Electronic and paper records systems were well co-ordinated and easy to access. Staff carried out appropriate checks on medicines storage and emergency equipment to ensure high standards of safety.
- Patients received good physical healthcare support from staff, the local GP and a practice nurse who visited the unit weekly. There were effective arrangements for out-of-hours medical cover and staff confirmed they could have medical support day and night. Staff we talked to spoke positively about the unit describing a good team working ethos, and said that management were supportive.
- Patients received meals that met their health needs and personal preferences and had access to drinks and snacks throughout the day.
- Staff used the least restrictive options to manage challenging behaviour including de-escalation (calming down) techniques. Staff rarely used physical restraint or rapid tranquillisation. Staff told us they received training in physical restraint and knew how to report incidents and safeguarding concerns, and received debriefs following all adverse events.

Summary of findings

- Staff received induction, training, supervision and appraisals. They also had access to regular team meetings. There was good interaction between staff, patients and relatives; patients felt listened to and relatives felt involved.

Summary of findings

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Requires improvement

Edith Shaw Hospital

Services we looked at:
Long stay/rehabilitation mental health ward for adults of working age

Summary of this inspection

Background to Edith Shaw Hospital

Edith Shaw Hospital is located in Leek, Staffordshire. The unit is an independent mental health hospital run by the provider, John Munroe Hospital Limited (also known as John Munroe Group). The hospital provides care for up to 13 female patients (aged 45 years and above) who have complex and long-standing problems including long term mental health needs, learning disabilities or problems with substance misuse. Patients may be detained for treatment under the Mental Health Act (MHA) 1983 and have histories involving the criminal justice system (CJS).

At the time of our visit, the hospital had 13 patients between the ages of 61 and 92 years old. Eight were detained under the MHA, one was detained under the MHA and involved the CJS, two were subject to the Deprivation of Liberty Safeguards (DoLS), and two were informal (able to leave if they so wish).

Edith Shaw Hospital has a registered manager and provides the following regulated activities:

- treatment of disease, disorder or injury
- assessment or medical treatment, for persons detained under the Mental Health Act (1983)
- diagnostic and screening procedures.

Edith Shaw Hospital registered with the CQC on 13 January 2011. It re-registered in 2015 due to changes to become a limited company. The CQC has carried out two inspections at the hospital, in February 2013 and October 2013. At the last inspection, we found the hospital to be non-compliant with the following essential standard:

- people's personal records, including medical records, should be accurate and kept safe and confidential. The provider did not always maintain accurate records of patients' care and medication needs. This was a breach of regulation 20 (1) (a) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2010. This had been addressed before this inspection.

A MHA monitoring visit took place on 5 December 2014 and identified a number of issues, which the hospital has since addressed.

Our inspection team

Team leader: Kathryn Mason

The team that inspected the service comprised three CQC inspectors, a Mental Health Act reviewer and a specialist medical advisor.

Why we carried out this inspection

We inspected this 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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about this service, asked a range of other organisations for information, sought feedback from two clinical commissioning groups (CCG) and conducted telephone interviews with six carers/relatives.

During the inspection visit, the inspection team:

- visited the hospital site and looked at the quality of the ward environment and observed how staff cared for patients
- spoke with four patients who were using the service
- spoke with the manager of the hospital
- spoke with 19 other staff members including the doctors, nurses, healthcare support workers, student nurse, occupational therapist, chef, housekeeping staff, art psychotherapist, psychologist, Mental Health Act Administrator, training officer, human resources officer, GP and visiting pharmacist
- looked at nine care records of patients
- reviewed three sets of records for detained patients
- looked at two Deprivation of Liberty Safeguard (DoLS) authorisations
- attended a community outing
- observed two patient activities (hand massage and pampering session)
- carried out a specific check of the medication management on the ward and looked at six treatment cards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients and relatives were complimentary about their experiences of care and happy with the care they received. They commented on the clean environment and good catering. Carers and relatives described staff as being friendly, polite and warm and having good interaction with patients and relatives.

Patients told us they felt safe at the unit. Staff treated them with respect and dignity. Patients were free to express their views and staff took these into account in planning their care.

Relatives told us that staff included them in care planning and gave them regular written progress updates. However, one carer expressed concern at having no contact with their relative's doctor. Another relative commented on the environment, saying it could be noisy at times.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There was a high threshold for reporting safeguarding concerns. We inspected incident logs and found that eight incidents that occurred between two patients and staff had not raised this as a safeguarding concern.
- Staff reported there was only one qualified nurse on day shifts from Thursday to Sunday due to the number of vacancies instead of the allocated two qualified nurses on shift.

However:

- The environment was clean, well maintained and catered for people with mobility difficulties.
- Records showed that staff checked the clinic room and all emergency equipment to ensure it was in good working order and stored safely.
- All staff carried personal safety alarms to help ensure the safety of patients and staff. The unit had nurse call systems fitted throughout.
- In the three months from August to October 2015, bank and agency staff filled 170 shifts, most of whom were staff from the provider's regular nursing agency.
- John Munroe Hospital - Rudyard (3.6 miles away) provided out-of-hours medical cover through an on call rota system. Staff told us they could access medical input day and night.
- Staff were up-to-date with mandatory training. Records showed that the average rate for completed staff mandatory training was 86%.
- Staff rarely used physical restraint and rapid tranquillisation preferring to use a range of less restrictive techniques to manage challenging behaviour. Restraint incidents reported did not reflect this.
- We reviewed nine sets of care records, which contained up-to-date risk assessments and care plans that covered patients' physical health and mental health needs.
- Staff we spoke with at Edith Shaw knew how to recognise and report any suspected abuse or incidents. They were aware that the unit manager was the designated lead for safeguarding and available to provide support and guidance. Records showed

Summary of this inspection

that staff appropriately recorded and dealt with serious incidents and management shared learning from incidents. However, it was apparent that managers did not consistently report incidents to the local safeguarding authority.

- The design and layout of the three storey unit created blind spots. However, staff assessed all patients prior to admission and considered identified risks when allocating bedrooms.
- The ligature risk assessment identified potential ligature points on the bedroom window locks and on the taps in the ensuite bathrooms. However, in order to mitigate these risks, the unit assessed each patient's suicide risk on admission and developed a detailed management plan that described how to minimise any risks.
- We reviewed six medicines charts and found gaps in two of the records where staff had not signed the charts when dispensing medication even though managers had reminded them to do so a few months earlier.
- Documentation on the medicine charts was unclear if the doctor had reviewed some PRN medication ('as required') within a two week period.
- The portable wooden steps used to help patients onto the unit minibus were not sufficiently sturdy to steady and support patients during use.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Only sixty eight percent of staff had received training on the Mental Health Act (MHA), Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).
- At the time of our inspection, the Mental Health Act (MHA) manager had not received training on the revised MHA Code of Practice; however, she was aware that training was coming up in the New Year.
- The provider generally managed the application of the Mental Health Act well. However, we found errors in completion of forms relating to the MHA and the unit had not updated its Mental Health Act policy in line with the changes in Mental Health Act code of practice. Both of which have been addressed since inspection.
- The recovery model did not guide the unit's care. This meant that patients did not receive the high quality, rehabilitation interventions required from a recovery-focused service. Staff and patients reported there was insufficient occupational therapy input to meet all of the rehabilitation and recovery needs of the patients.

Summary of this inspection

- The service had a team comprising a psychiatrist, nurses and healthcare support workers. Access to other professionals including an occupational therapist and activity coordinators was limited and not based on site. Patients access to speech and language therapy and psychology via referral.
- Care records contained comprehensive admission assessments and care plans that staff reviewed regularly. However, care plans were not holistic. For example, only four out of nine care plans contained information about all the patients' needs. Only three care plans captured the patients' views on their care and treatment.
- At the time of our inspection, one patient's record contained no formal authorisation for treatment. This was rectified immediately when we informed the responsible clinician (RC)
- Pharmacy support comprising of six-monthly reviews was insufficient to meet the needs of the service.

However:

- The unit operated electronic and paper record systems. These were well coordinated and the records were organised, stored securely and easy to access.
- Patients received good physical health care. Staff completed physical health checks regularly. A local GP reviewed patients' physical health on an eight-weekly basis and a practice nurse visited the unit weekly.
- Prescribing practice was in line with the national institute for health and care excellence (NICE) guidance.
- The responsible clinician used a recognised rating scale to assess and record outcomes for all patients on a six-monthly basis.
- The provider carried out regular audits to help monitor the effectiveness of the service. These included environmental audits, clinical audits and audits on documentation.
- Staff received inductions, training, supervision and appraisals and had access to monthly team meetings.
- Care records contained the appropriate MHA documentation including detention and renewal forms, section 17 leave forms and statutory reports.
- Staff informed patients of their rights on admission and then every four weeks.
- The unit had devised a checklist to help ensure appropriate application of DoLS, which meant that staff made DoLS applications when required. At the time of our inspection, authorisations were in place for two patients.

Summary of this inspection

- Staff supported patients to make decisions where appropriate. Where patients lacked the capacity to make specific decisions, staff adopted a best interests approach.

Are services caring?

Good

We rated caring as good because:

- We observed good interaction between staff and patients. Staff spoke to patients in a way that was respectful and positive and patients and relatives said staff were polite and kind.
- Patients had access to advocacy services, provided by Asist. Leaflets containing information about the service were visible on the unit and in patients' bedrooms.
- Two relatives commented on improvements their relative had made since their relatives admission to the unit.
- All patients had files in their rooms that contained copies of their care plans, CPA reports, and individual profiles ('my story').
- Patients told us staff listened to their views and they had access to patients' community meetings that took place on a five-weekly basis.
- Staff supported patients to participate in the annual patient surveys.
- Relatives felt well informed because staff invited them to CPA meetings, and gave them a summary report after the meeting.

However:

- While patients and relatives said they were fully involved in their care, care plans and records did not document this, for example patients had not signed their care plans.
- Staff displayed a person-centred approach; they knew the patients well and understood their individual needs. However, this was not observable in the documentation recorded in the files.

Are services responsive?

Good

We rated responsive as good because:

- There had been no delayed discharges since January 2015.
- The unit worked closely with external professionals to ensure effective and coordinated discharge planning.
- The unit contained a lounge/dining area, which was used as the main communal area for both recreational and therapeutic activities.
- Patients had the opportunity to personalise their rooms to their own tastes and preferences, and held their own bedroom keys.

Summary of this inspection

- The unit was responsive to patients' needs. Staff told us of an example of the unit supporting palliative care at the patient's request.
- Patients had access to portable phones and two patients had their own mobile phones.
- Patients commented that the food was good and met their preferences and needs. They also said they had access to hot, cold drinks, and snacks throughout the day.
- Patients and their relatives knew how to make complaints and felt confident in doing so.
- The service handled complaints appropriately and staff received feedback on the outcomes and any learning from them.

However:

- The majority of patients were from outside the local region.
- The unit did not contain a therapy room or activities of daily living (ADL) kitchen, and the multi-use room used as a quiet area or for meeting visitors was also used for multidisciplinary team meetings, at which times it was unavailable to patients.
- Patients and staff complained about the lack of therapeutic and rehabilitative activities on site. The need for transport made it difficult for them to access the occupational therapy (OT) unit on another of the provider's sites (3.6 miles away).
- The care plans that did document individual needs took into account patients' cultural and spiritual preferences and staff supported patients to meet their individual religious needs.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Recruitment processes for all board members were not robust, for example, not all board members had employment files, those files that were present did not contain evidence of recruitment processes, references and Disclosure and Barring Service (DBS) checks required for all board members involved in services.
- Although staff reported incidents appropriately, there was no systematic approach to analysing trends and patterns, which reduced the opportunities to learn from incidents, identify themes and make improvements.

However:

- Staff stated they were aware of the organisation's philosophy focusing on maintaining dignity, individuality and privacy of

Summary of this inspection

patients, patients and family participation in their own care planning and meeting patient needs through a range of group and individual activities to improve mental health and wellbeing.

- Staff reported they were familiar with most of the senior managers and reported that they were visible on the unit and described an open and transparent culture in which they could raise any issues or concerns.
- The unit had effective governance systems and processes to help ensure the delivery of high quality and safe care.
- Although the employment records for clinical staff showed that the appropriate checks were made at recruitment, this was not the case for board members. Not all board members had employments files, those files that were present did not contain evidence of recruitment processes, references and Disclosure and Barring Service (DBS) checks required.

Detailed findings from this inspection

Mental Health Act responsibilities

Training records indicated that 68% of staff had received training on the Mental Health Act (MHA). The training lead outlined several strategies to address this low completion rate.

Staff showed a good understanding of the MHA and the Code of Practice. There were nine patients detained under the 'Act, two were subject to the Deprivation of Liberty Safeguards (DoLS) and two were informal.

MHA documentation for detained patients was up-to-date, stored appropriately and compliant with the MHA and the Code of Practice.

Staff completed consent to treatment and capacity forms for detained patients appropriately, and attached them to the patients' medication charts.

Staff explained patient rights on admission and regularly thereafter. Staff gave patients an information leaflet about their rights as well as information about the advocacy service.

One patient record contained no Section 62(2) at the time of our inspection. The unit had requested a Second Opinion Appointed Doctor (SOAD) prior to the three-month treatment rule expiring; however, the SOAD had only recently visited and had not yet provided a statutory treatment form (known as a T3). Therefore, staff could possibly treat the patient in the absence of any lawful authority. The responsible clinician (RC) conceded this was an oversight on his part, and before we left the RC had completed a section 62 form to administer urgent treatment.

Asist, a local organisation, provided independent mental health advocacy (IMHA), independent mental capacity advocacy (IMCA) and generic advocacy services to Edith Shaw Hospital. There were leaflets on the unit. Staff and patients could refer to the service.

Staff knew how to contact the MHA manager in the provider's head office in Leek, and had an awareness of her role. This included ensuring all the detention paperwork was in order, sending alerts and reminders for renewals of sections, processing manager's hearings and tribunals, checking that care programme reviews were planned and that treatment authorisations were in place. The MHA manager completed monthly audits on section 17, 58 and 132 forms and processes.

A MHA monitoring visit on 5 December 2014 identified the following issues:

• staff were not aware that one of their patients was subject to a DoLs authorisation

• staff could not locate a Ministry of Justice authorisation for section 17 leave for a patient subject to section 37/41 of the MHA

• discrepancies in statutory treatment forms

• prescriptions did not correspond with the treatment authorised.

We looked at these during our inspection and found that staff had addressed these.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed that 68% of staff had received training in the Mental Capacity Act (MCA). Staff demonstrated a fair understanding of MCA and could apply the five statutory principles.

Staff told us they were aware of the policy on MCA and Deprivation of Liberty Safeguards (DoLS) and they knew whom to contact for advice.

Two patients were subject to DoLS. The unit used a checklist to help determine if DoLS applied, which was in line with recent guidance, the 'Cheshire West' ruling. Staff applied for DoLS authorisations where relevant and records showed the status of the authorisation.

There were arrangements in place to monitor adherence to the Mental Capacity Act.

Detailed findings from this inspection

Staff supported patients to make decisions and where appropriate, staff assessed and recorded a patient's capacity to consent. When a patient lacked the capacity to make a specific decision, staff used the best interests' framework, recognising the importance of the patient's wishes, feelings, culture and history. Care records contained detailed information on how staff had assessed a patient's capacity to consent or refuse treatment.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are long stay/rehabilitation mental health wards for working-age adults safe?

Requires improvement

Safe and clean environment

- The unit was safe and clean, both internally and externally. It had a secure front door and secure garden / parking area to the rear with closed-circuit television (CCTV) and intercom facilities at the rear gate and front door. The rear of the building was flat sealed ground with a smoking shelter including a bench and raised garden beds.
- The environment was clean and maintained to a high standard. Edith Shaw Hospital had a dedicated maintenance worker, who addressed all repairs in a timely manner.
- Staff followed infection control principles and an audit process was in place.
- There was an operational lift and stair chairlift from the ground floor to the rooms upstairs, which was helpful to patients with mobility difficulties. The unit had a hoist on site. All staff received training in its safe and proper use. Staff checked it was in working order at every use.
- The clinic room was clean, tidy and the temperature was controlled. It was located on the first floor. The clinic room contained weighing scales (both standing and seated) and blood pressure monitoring equipment but there was no examination couch. Staff undertook physical examinations of patients in the privacy of their own bedrooms or at the local GP surgery when required. Emergency medicines were present, in date and regularly checked. The medicine cupboard and fridge were clean and tidy. Staff checked clinic room and clinic fridge temperatures regularly to ensure they were within safe limits for medicine storage. Staff checked all the emergency equipment such as automated external defibrillators and oxygen to ensure it was in good working order.
- It was noted that despite care plan and medication audit there were gaps in two of the records where staff had not signed the charts when dispensing medication. Documentation on the medicine charts was unclear if the doctor had reviewed some PRN medication ('as required') within a two week period.
- To help ensure the safety of patients and that of staff, all staff carried personal safety alarms. The unit had nurse call systems fitted throughout and bedrooms had portable nurse call alarms.
- There was a large assisted bathroom on each floor, which contained all the appropriate equipment to lift and support patients with mobility difficulties. The equipment was in good working order and well maintained.
- Every room had a cleaning schedule on the wall, which the domestic staff signed daily on completion of cleaning. However, there was not an overall cleaning schedule to track cleaning of the hospital. Domestic staff locked the trolley containing cleaning products when they were on the unit.
- The design and layout of the house over three floors created blind spots. All patients received risk assessments prior to admission and these informed the allocation of bedroom.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- There were potential ligature points on window locks and taps in the ensuite bathrooms. Staff had identified these in the detailed ligature risk assessment. Staff assessed patients' suicide risk on admission and developed detailed individual risk management plans describing how to minimise these risks identified. There were ligature cutters located on every floor for use in an emergency.
- Staff used portable wooden steps made on site to help patients enter the unit minibus. However, we found these were not sufficiently sturdy to support and steady patients during use.

Safe staffing

- The hospital had 10 Whole Time Equivalent (WTE) qualified nurses and 17 WTE healthcare support workers. At the time of our inspection, there were two vacancies for qualified nurses and none for healthcare support workers. Edith Shaw hospital did not use a recognised staffing tool such as the Keith Hurst Mental Health Staffing Tool to review the number and grade of staff required. The number of staff had been the same for the past three years.
- Staffing levels comprised two registered nurses and four healthcare support workers on day shifts and one registered nurse and two healthcare support workers on night shifts. There was an additional member of staff on each shift for each patient nursed on one to one observation levels.
- In the 12 months to September 2014, 134 days were lost due to staff sickness. This was predominantly due to three staff on sick leave with long- term conditions. The staff sickness rate in the 12 months to 31 March 2015 was 2.1%.
- The staff turnover for the same period was 25%. Staff told us that healthcare support workers created the majority of these vacancies. We observed most of these vacancies to be filled at the time of our inspection.
- There were 170 shifts filled by bank and agency staff in the three months from August to October 2015. The manager told us that John Munroe Group nursing agency provided regular staff for most of the unit. There were no shifts left unfilled. There was evidence in care records of patients being offered regular 1:1 time with staff. Staff reported there was regularly only one qualified nurse on day shifts from Thursday to Sundays due to vacancies, which was visible on staff shift rotas. The unit had not recorded this on the hospital's risk register. The registered manager stated that there was no link between the current qualified nursing and any clinical incidents or medication errors.
- Staff told us that staff rarely cancelled patients Section 17 leave due to insufficient staffing.
- Staff told us that John Munroe Hospital - Rudyard (3.6 miles away) supplied the out-of-hours medical cover through an on call rota, and staff told us they could access medical support day and night.
- Records showed that the average rate for completed staff mandatory training was 86%.

Assessing and managing risk to patients and staff

- Staff detailed an individual risk assessment and risk management plan for each patient plan identifying what support they required. The unit used positive behaviour support strategies for managing challenging behaviours.
- All sets of care records that we looked at contained detailed up-to-date risk assessments and risk management plans. Staff also documented risks in appropriate care plans.
- Staff told us the clinical team discussed risks in ward rounds before leave was authorised. Staff also reassessed the patient on the day of leave. Staff completed a form called "risk assessment and leave outcome record form" with the location of the leave, the purpose, the outcome of the leave, a description of the patient and any incidents. Staff also checked the clinical notes. The unit graded risks from low to high.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- There had been six reported incidents of restraint between January 2015 and June 2015, none of which had been incidents of prone restraint. Staff tried to manage behaviours that challenge by offering one to one support, applying distraction techniques, moving to the quiet lounge and administering PRN (pro re nata) 'as required' medication. Staff reported that when using restraint it was usually level one; offering support and guidance and for the shortest time possible. At times when level two is required; restricting movement in any way, staff reported and recorded as incidents.
- The unit operates a policy of no seclusion and does not have a seclusion room. There had been no recorded use of seclusion, long-term segregation or de-facto

seclusion. Seventy nine per cent of staff had completed training in physical restraint techniques (MAPA) to manage aggression and violence. Those outstanding were predominantly new members of staff and those staff on long-term sick leave.

- Staff addressed any issues such as falls with input from the occupational therapist. Appropriate care plans were in place. Staff reported all incidents related to falls.
- All nine sets of the care records we looked at contained up-to-date care plans that covered physical health and mental health issues. However, care plans were not holistic. Care records were risk orientated and lacked a recovery focus expected in a rehabilitation hospital. This was in line with the lack of occupational therapy input of one day a week in to the unit which was predominantly for attendance of team meetings.
- We did not see any care plans capturing the patient's views about their care and treatment. Staff had not completed this field with patient views or explanation.
- All care records had evidence of informed consent documented and assessments of mental capacity.
- There had been four safeguarding concerns raised since January 2013 to the date of inspection and no safeguarding alerts. The most recent safeguarding concern related to a patient's allegation of a staff assault. Unit management managed this appropriately and involved the police.
- Staff demonstrated a good understanding of how to identify and report any suspected abuse. Staff knew their manager was the designated lead for safeguarding and that he was available to provide support and guidance.
- All staff received adult and child and adult safeguarding training by a trainer approved by the local authority (Staffordshire County Council).Training records showed that 79% of staff were up-to-date with their safeguarding training. The remaining 21% of staff were newly recruited and yet to receive training.
- There was a unit safeguarding policy in place in line with Staffordshire County Council safeguarding procedures. The policy states clearly that significant harm requires consideration, action and reporting. However, there appeared to be a lack of clarity in the staff's understanding of the definition of significant harm resulting in a high threshold for reporting safeguarding concerns. Staff and managers were uncertain about the requirements of the local safeguarding board and the CQC for providers to report incidents of actual or suspected harm or abuse.
- We reviewed six medicine administration records and found that staff had not signed for at least one dispensing in two of the records. Managers were aware of this issue and the notes of staff meetings in March and June 2015 included a reminder staff about signing off medications appropriately.
- Staff had not reviewed five out of the six medication records which had PRN (pro re nata – 'as needed') medication prescribed in the past 14 days. The manager rectified this immediately when raised.

Track record on safety

- The unit reported two serious incidents requiring investigation over a 12-month period July 2014 to July 2015. The weekly incident log held all incidents regardless of their nature, which restricted the ability to identify trends. For example, we found a trend that staff had not identified, raised or reported of a sequence of assaults between two patients.
- In March 2015, a patient alleged a staff member hit her. The provider involved the police and took appropriate action. In July 2015, a patient injured a staff member, which resulted in absence from work.
- The provider had one never event in the 12 months to December 2015. In December 2014 an unknown person withdrew a significant amount of money from a patient's account, at a bank machine. Staff reported the incident to the police.

Reporting incidents and learning from when things go wrong

- Staff/teams discussed learning from incidents in staff meetings and at handovers. Staff and patients received debrief and support after all incidents. This enabled the learning of lessons related to both good practice and areas of practice requiring improvement.
- Healthcare support workers had access to reflective discussion at the end of every day to support each other and their learning.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff we spoke with knew how to recognise and report incidents. The ward manager and responsible clinician reviewed all incidents on a weekly basis. The manager discussed all incidents at the John Munroe Hospital Group governance group on a monthly basis.
- We reviewed the incident log and found an obvious trend of eight incidents that occurred between two patients. Staff had not raised this as a safeguarding concern.

Duty of Candour

- Staff we interviewed stated they were aware of their responsibilities of making patients aware of errors and taking responsibility for these. All patients were involved in debriefs after any incidents they were involved in, action taken to support and rectify error and apologise where necessary.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Edith Shaw operated both a paper documentation and electronic system in tandem. Mentor, the electronic record programme documented all daily clinical notes. A working folder held all care plans, risk assessments, an overview of patient information for unfamiliar staff, the pre-admission assessment, the risk screening tool, management plans and care plan reviews. Staff used Health of the Nation Outcome Scale (HoNOS) to assess and record outcomes. All records were organised and stored securely, and team members could easily access patients' records when needed.
- There was a lack of recovery-focused activities provided by an occupational therapist to promote rehabilitation and skill maintenance of patients, which staff of a rehabilitation setting need to provide. Patients lacked occupation based assessments under the framework of a recovery model of practice to highlight what social, leisure and functional needs patients had.
- We looked at nine records and found that all contained a comprehensive assessment completed on admission. Staff completed care plans, and reviewed and updated them regularly. Care plans were not always holistic; only three of the nine records we reviewed had care plans that captured the patient's views about their leave, treatment, mental health, daily living skills, and activities. Only four care plans showed the full range of the needs of the patient. There was inconsistent evidence of discharge planning expected within a rehabilitation service.
- In eight of the nine of the records we checked, we saw details of regular physical health checks including blood pressure and weight monitoring and physical health needs assessment.
- In one file, we saw a care plan for "quality of life and meaningful activity". However, this care plan had been discontinued from October 2015 because of the reduced presence of occupational therapy staff available to carry out this activity.
- Staff updated patients care plans following any changes in a person's treatment or presentation. Staff had not consistently recorded patient views in care plans, and where this was required the space was left blank and no explanation was provided.
- The multidisciplinary team held Care Programme Approach (CPA) reviews on a regular basis. However, we saw little evidence of patients' involvement. Again, patients' comments were left blank and no explanation was given.

Best practice in treatment and care

- Ward staff referred patients for occupational therapy (OT), psychology, speech and language therapy assessment and intervention. One of the patients' records we reviewed showed psychology input. However, there was a reported lack of OT led therapeutic activities on the unit.
- Psychology input was on a basis of need. A psychologist attended meetings every six weeks with multidisciplinary team members to discuss patient need at the unit. The unit received one afternoon of psychotherapy each week focused on the assessment of three patients at the time of our inspection.

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Requires improvement

- Staff informed us that psychology professionals previously ran a staff support group. This had stopped due to a staff redundancy.
- The responsible clinician for Edith Shaw Hospital used the Health of the Nation Outcome Scale (HoNOS) a recognised rating scale to assess and record severity and outcomes for all patients on a six monthly basis.
- The unit maintained close links with a local GP surgery to monitor the physical health needs of patients, and staff ensured kept physical health care plans up-to-date. A practice nurse attended the unit on a weekly basis and the GP reviewed all patients on an eight-weekly basis. Records showed that staff completed annual health checks and regular physical health checks, however, in one file, we were unable to see evidence that the patient had received a physical health care check in the last 12 months.
- The manager of the unit carried out a wide range of regular audits to monitor the effectiveness of the service provided. They conducted a range of audits on a weekly or monthly basis such as fire, clinic room, controlled drugs and environmental. The manager gave staff a summary of findings and any actions required.

Skilled staff to deliver care

- The on-site team consisted of responsible clinician (doctor) two days a week, nurses, and healthcare support workers. A community based social worker also provided input to the unit when required. The occupational therapist and an activity coordinator both worked at the unit one day a week, and an occupational therapy technician worked at the unit on a referral basis and attended the ward to undertake equipment audits and checks. Additional multidisciplinary team members were available on referral including the speech and language therapist, art psychotherapist and psychologist.
- Occupational therapy provided input one day a week, which predominantly consisted of a team meeting. Occupational therapy technicians and activity workers did not have an office base at the unit. Nursing staff therefore led on as many activities as they could however those we observed were predominantly leisure and social activities without a skill development and independent functioning Occupational therapy staff care plans did not clearly describe what therapeutic activities activity workers were required to carry out for each patient instead focused on falls and physical assessment. Staff reported there was insufficient occupational therapy (OT) input and activity-based therapies at the unit. Some staff said the OT visited the unit once a week, however, other staff did not know OT staff.
- The unit received six monthly pharmacy input from an external pharmacist, which management and staff recognised did not fully meet the pharmacy needs of Edith Shaw Hospital. Furthermore, a mental health pharmacist did not provide the pharmacy support, which would be the most appropriate for the unit's patient group. We interviewed the pharmacist during our inspection. The pharmacist was not aware of any errors in prescribing, yet two of the six medication records we reviewed had at least one prescription not signed or dated. Unit management were taking steps to change pharmacy provision to meet the units' needs.
- A training manager based at Cross Street headquarters supported Edith Shaw. Completed training records could be analysed and summarised by individual staff members or training sessions but not by total workforce. This was in the process of change.
- The training manager was aware of communication challenges within the staff group i.e. not all had email accounts and had systems in place to help ensure effective communication around training needs.
- New staff received a two-week induction-training programme. Day one covered fire, health and safety, the control of substances hazardous to health (COSHH), moving and handling, infection control and basic life support. Day two comprised level 2 food and hygiene training for all staff. Further induction training covered personal safety, management of actual and potential aggression (MAPPA), equality and diversity, privacy and dignity, duty of care, working in a person-centred way and effective communication.
- Staff received appraisals and had access to monthly team meetings. The average rate of staff that had an appraisal in the last 6 months from August 2015 was 76%. The average rate of staff supervision for this same period was 84%.

Multi-disciplinary and inter-agency team work

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The unit had regular weekly and effective clinical review meetings that involved the relevant members of the multidisciplinary team working with the patient.
- The unit had regular handovers at the end of each shift. Due to the timings of shifts, we were unable to attend a handover during our inspection.
- The unit had very effective partnership working with the GP, and close links to the commissioners.
- Staff told us that they had developed good working relationships with the local GP and practice nurse. The practice nurse visited on a weekly basis and the GP saw all patients were every eight weeks. The GP had remote access to his files while at Edith Shaw, which enabled continuity of care.

Adherence to the MHA and the MHA Code of Practice

- Training records indicated that 68% of staff had received training in Mental Health Act (MHA). Records indicated that the unit had combined this training with the mental capacity act (MCA) and Deprivation of Liberty Safeguards (DoLS) training, which is not best practice. The majority of staff showed a good understanding of the Mental Health Act and the Code of Practice. The training manager was aware of challenges in communicating with staff about training requirements as not all had email access. Plans were in place to address this through formally writing to staff at both their work and home addresses.
- The documentation we reviewed in detained patients' files was up-to-date, stored appropriately and compliant with the Mental Health Act and the Code of Practice.
- Detention papers were available for inspection. Nine of the 13 patients were detained under the Mental Health Act (MHA), two were subject to the Deprivation of Liberty Safeguards (DoLS) and two were informal. Patients detained on a section in connection with the criminal justice system (forensic section) the original hospital order was kept in their file. We also saw that the responsible clinician submitted an annual report to the Ministry of Justice (MoJ) for patients on a forensic section.
- Where a patient had previously been on a Community Treatment Order (CTO), we saw the statutory forms relating to recall and revocation. We also saw the appropriate renewal forms.
- In one file, we found good evidence of a discussion on consent to treatment between the patient and the RC prior to the completion of a statutory treatment form (known as a T2).
- Staff kept the statutory treatment forms in a file along with the medication charts. The responsible clinician (RC) was aware of the changes to the British National Formulary (BNF) and that numeric categories are no longer be used in the paper edition.
- We saw a T2 completed by an RC from the John Munroe Hospital. However, the patient had moved under the permanent care of the RC at Edith Shaw and so a new form was required. We informed the RC who completed a new T2 before we left. The RC also met with the patient and recorded their consent.
- Staff had requested a Second Opinion Appointed Doctor (SOAD) was prior to the three-month treatment rule expiring; however, the SOAD had recently visited but had not yet issued a statutory treatment form (known as a T3). This meant that the patient was at risk of receiving treatment in the absence of any lawful authority. We informed the RC, who immediately completed the section 62 form to administer urgent treatment
- Patients were provided with an explanation of their rights within a few days of admission and, thereafter, on a four-weekly basis and documented. Staff gave patients an information leaflet about their rights as well as information about the advocacy service. Information about MHA sections was also available in easy read format.
- Assist provided independent mental health advocacy (IMHA), independent mental capacity advocacy (IMCA) and generic advocacy services. Staff and patients could refer to the service. We saw leaflets on the unit. A detained patient was able to tell us the name of her advocate.
- The MHA manager has been working for John Munroe Hospital for 12 years. She was full- time and based at the head office in Leek; she visited Edith Shaw once a week. This role had two part-time assistants, two ward clerks and the reception staff as support. She held a qualification, "Mental Health Act Certificate in Practice "completed at Northumbria University. The MHA manager ensured all the detention paperwork was in order, alerts and reminders sent regarding renewals of sections, manager's hearings, tribunals, care

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Requires improvement

programme reviews and treatment. She carried out monthly audits on section 17, 58 and 132. At the time of our inspection, she had not received training on the revised MHA Code of Practice; however, she was aware that training was coming up in the New Year. She had not up dated current MHA policies for the unit to reflect the revisions to the MHA as she planned to update these policies after her training. We saw a copy of the new Code of Practice in the office.

Good practice in applying the MCA

- Training records indicated that 68% of staff had received training Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Records indicated that this was combined training with MHA which is not best practice. Staff demonstrated a fair understanding of Mental Capacity Act and could apply the five statutory principles.
- Staff stated they were aware of the policy on Mental Capacity Act and Deprivation of Liberty Safeguards and knew the lead person to contact about the Mental Capacity Act to get advice.
- The MHA manager also managed the DoLS on the unit. The MHA manager ensured she alerted all staff and appropriate steps taken before the expiration of the authorisation.
- We looked at two records for patients subject to DOLS. We found that staff made applications for DoLS authorisations where appropriate and records showed the status of the authorisation. The unit used a checklist, underpinned by current guidance, the Cheshire West ruling.
- Staff supported patients to make decisions where appropriate. When patients lacked capacity, staff applied the best interests' framework recognising the importance of their wishes, feelings, culture and history.
- The unit uses a form called "MHA form 119" to assess capacity for treatment. The form did not record the diagnostic assessment as set out in the requirements of the Mental Capacity Act.
- In one file, the RC assessed a patient's capacity on the prescribed form. However, this was not decision-specific. It stated "capacity to consent to care and treatment as well as capacity to decide about smoking and physical health".

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

- We observed good interactions between staff and patients. Staff spoke to patients in a way that was respectful, clear and simple and showed positive engagement and desire to support patients.
- Patients and families were complimentary about the support they received from the staff and felt staff provided the help they needed. Our observations and discussions with patients and their families confirmed that staff treated them with respect and dignity. Patients said staff were polite, kind and made them feel at home.
- Staff understood the individual needs of the patients and described how they supported patients' needs. Patients and relatives told us that staff knew the patients well and supported them in a way that made them feel comfortable.
- We observed strong links with carers and relatives through conducting six telephone interviews with carers / relatives out of the 13 patients at the unit. Two of the six relatives we spoke with reported that they were impressed with the progress their relative had made since admission to the unit.

The involvement of people in the care they receive

- Staff supported patients to access advocacy services provided by Asist. There were leaflets on the unit and in bedrooms relating to advocacy services. A detained patient told us the name of her advocate.
- The advocate interviewed at the time of inspection reported that unit staff were supportive and they were currently actively involved with two patient cases. They accepted referrals from any member of the team and the mental health act manager.
- Five out of 13 patients (38%) responded to the patient survey conducted in 2015. Results were positive for initial orientation to the ward, cleanliness, catering and

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

environmental maintenance. All five patients stated they had printed copies of their care plans. However, patients said there was insufficient psychological therapy available to them

- Patients told us staff listened to their views and offered copies of their care plans and reports.
- Staff provided patients with a file, which they kept in their room. The file included a copy of their care plans and Care Programme Approach (CPA) reports. Patients also had a file called 'my story'. This was a patient profile, which included their likes and dislikes, what made them happy and sad, and their food preferences.
- Relatives told us they felt very well informed and involved in care planning even when they were unable to attend CPA meetings. For example, after each CPA meeting, staff gave relatives a summary report.
- Patients had access to community meetings held on a five-weekly basis. The nurse in charge of the shift supported the meeting by facilitating discussions and taking notes. Records showed that community meetings took place regularly and clearly identified the issues raised and the actions taken.
- Staff encouraged all patients to participate in the annual patient survey and asked their opinions on the service and suggestions for changes. The manager acknowledged it needed to consider other opportunities to involve patients, for example, participation in the staff recruitment process.
- The staff team held CPA reviews on a regular basis, but we saw little evidence of patients' involvement. Patients' comments were not included in the CPA reports. There was no written explanation was documented for this.
- Although patients and their relatives reported that patients were actively involved in their clinical reviews, care planning, and risk assessments, and were encouraged to express their views, this was not evident in six of the nine care plans and risk assessment records we reviewed.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- From January to June 2015, the average bed occupancy was 97%. The board meeting minutes dated 7 July 2015 noted there was one bed available.
- Between November 2014 and February 2016 five patients had been discharged from the Unit. Patients discharged from the unit predominantly moved to residential homes or care homes. The unit worked closely with other healthcare professionals to ensure that discharges were planned and co-ordinated. All patients had an allocated social worker from their placing authority/local area. Staff discussed all discharges and transfers in the multidisciplinary team meetings.
- At the time of inspection, the patient group was aged between 61 and 92 years old. The majority of patients were from outside the local area. All patients had received care and treatment reviews within the last 12 months.
- Staff at the unit only moved patients to another unit for clinical reasons, which was an infrequent occurrence. There had been no delayed discharges since 1 January 2015.
- There was a lack of occupational therapy input to the unit to effectively deliver recovery focused activities and interventions for patients at the time of inspection due to maternity leave.
- If the staff were no longer able to safely manage a patient and it was deemed they needed more intensive care, the unit contacted the commissioners and asked them to find an alternative placement. The manger reported this to be a rare occurrence.

The facilities promote recovery, comfort, dignity and confidentiality

- The environment was a big, old house on a residential street.
- Due to the layout of the building, the lounge/dining area was the main communal area for watching TV, socialising and therapeutic activities. There was no specific therapy activity room or activity of daily living kitchen on the site. There was a quiet room where

patients could enjoy a quiet space, watch TV or meet visitors in private away from the main communal patient area. However, staff used the quiet room for multidisciplinary meetings, at which times it was unavailable to patients.

- There was no dedicated therapeutic activity space on the unit. Generally, the communal lounge/dining area was used for this purpose. There was a dedicated occupational therapy resource at John Munroe Hospital Rudyard site.
- There was a portable telephone, which meant that patients could make phone calls in private. Two patients used their own mobile phones.
- The unit had a large garden area, which included a smoking area that patients had access to throughout the day.
- The unit had a well-equipped clinic room.
- Patients and relatives told us that the quality of food was good and that meal times were flexible. Catering staff adapted menus to individuals' changing preferences and needs. Staff displayed the daily menu in the dining area. Patients had free access to the kitchenette in the lounge/dining area where they could make hot drinks and snacks anytime of the day or night throughout the week. Staff had ordered a fridge for this area.
- Edith Shaw Hospital was a female only hospital. Each patient had an individual bedroom fitted with a solid door. All patients had their own bedroom keys to help ensure privacy and security. Patients were able to personalise their own bedrooms with pictures, bedding and soft furnishings.
- Nursing staff offered patients a range of activities. During our inspection, we attended a community outing (a country drive in hospital minibus) and observed two patient activities (hand massage and a pampering session). There was no dedicated activities room on the unit to support therapeutic activities. The occupational therapy (OT) based at John Munroe Hospital – Rudyard presented access challenges for patients at the unit. The unit prioritised hospital appointments resulting in non-attendance at OT sessions. Staff told us there was insufficient occupational therapy (OT) and activity-based therapies input to the unit. The annual patient survey (2015) echoed this view. Four out of five respondents stated there were not enough activities at evening and weekends.

Meeting the needs of all people who use the service

- The provider carries out an annual patient survey for which the most recent was 2014/15 with a focus on patient views on care and treatment received by their doctors. Initially the response rate was very low so the unit made changes to create an introductory page and arrangements made to provide additional supports from advocacy or family members when required. Fifty three percent of questionnaires were completed and returned. Results showed patients were happy with service doctors provided however a couple of patients despite reportedly happy stated they would like more time.
- The provider had made appropriate adjustments to the environment to enable disabled access. The unit had a lift, a chair lift and assisted bathrooms for patients with mobility issues.
- The unit offered and supported patients with the choice of food they wanted to meet their dietary requirements and to meet their religious and ethnic needs. The patient survey of July 2015 reported positive feedback on the catering provided on the unit. The catering team onsite provided a flexible menu to accommodate different needs and wishes and serving times tailored to an individual patient's needs.
- Patients had access to information about the service, advocacy, support and complaints. Mental Health Act information was available in easy-read format.
- The unit operated holistic care plans with consideration given to patients' likes and dislikes, activities, cultural, religious, ethnic and spiritual needs. Staff discussed the care plans with patients and offered them a printed copy. Patients told us that staff supported them to meet their needs.
- Staff supported patients with their spiritual needs. Staff supported patients to attend church on Sundays, if they so wished.

Listening to and learning from concerns and complaints

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The unit received six formal complaints and one verbal complaint between 1 October and 27 February 2015. Five of these related to excessive noise at night by a single patient, one related to insufficient engagement by staff and the last was about receiving late medication. Staff resolved all of these patient complaints locally with the individuals concerned.
- There were no complaints referred to the Ombudsman within the past 12 months.
- Patients knew how to raise concerns and make complaints, and were confident that staff listened to them. Families and carers felt able to raise any concerns and complaints freely.
- Staff told us they were aware of the formal complaints process and knew how to support patients and their families when needed. Staff tried to resolve patients and families' concerns informally, and at the earliest opportunity.
- Staff received feedback, outcomes and actions relating to complaints and investigations during shift handovers and in reflection sessions.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Requires improvement

Vision and values

- The philosophy of the unit focused on maintaining dignity, individuality and privacy of patients, patients and family participation in their own care planning and meeting patient needs through a range of group and individual activities to improve mental health and wellbeing.
- Staff understood and agreed with the philosophy of the organisation. The responses in the staff survey supported these statements.
- Staff knew who their immediate unit managers and senior managers were and told us that they were very visible and accessible on the unit.

Good governance

- The unit had governance processes in place to manage quality and safety including risk registers, incident logs and staff supervision and management structures. The manager used these methods to give information to senior management in the organisation to monitor quality and safety of the unit. The manager attended the organisation's clinical governance meeting, which discussed quality and safety issues.
- The provider gave the manager the freedom to manage the unit and administration staff to support the team. The manager said that they could raise concerns and submit them to the hospital risk register if deemed necessary.
- There was a good 'read and sign' system in place for the dissemination of policy changes. This included a rating system to highlight the degree of changes made to individual policies and any training required as a result.
- Healthcare support workers attended a reflective discussion session at the end of each shift but this forum was not available to the whole team.
- On inspection of a random sample of human resources (HR) files for clinical staff, we found that recruitment checks and processes were in place and completed. The provider conducted that the disclosure and barring service (DBS) checks upon recruitment of all staff but there was no mechanism to review this during employment.
- On inspection, there were unrecognised trends in incident logs, resulting in under-reporting of safeguarding concerns and incomplete representation of information on the hospital risk register. The unit risk register was a live document regularly reviewed locally at the unit and at an organisational level.
- The training officer recognised the need for a full workforce-training matrix to provide an overview of outstanding training needs. Action was underway to address this. Although the provider had identified the staffing levels and skill mix for shifts, it did not meet these consistently resulting in frequent understaffing of qualified staff. Staff had not identified this to be a risk.

Fit and proper person test

- During inspection of the human resources files the board members, we found gaps in the recruitment processes, designed to ensure board members were of good standing and appropriately skilled and qualified for their roles. For example, not all board members had

employments files; those files that were present did not contain evidence of recruitment processes, references and Disclosure and Barring Service (DBS) checks required for all board members involved in services.

Leadership, morale and staff engagement

- The board sought staff views through an annual staff survey. However, the most recent survey in July 2015 yielded only four responses out of a possible 32 (12% response rate) rendering findings unrepresentative of the total workforce. The unit planned to repeat the staff survey in January 2016 prior to which they will consider how to promote staff engagement.
- In the 12 month period from April 2014 to March 2015, the staff sickness rate was 2.05%. This was predominantly due to three staff requiring leave for long-term health conditions
- The provider had not received any grievances or allegations of bullying and harassment in the 12 month period to September 2015.
- Staff told us that they were aware of the provider's whistleblowing policy and felt free to raise concerns.
- Our observations and discussions with staff confirmed that teams worked well together, and staff supported each other. They all spoke positively about their roles and demonstrated their dedication to providing high quality patient care.
- Staff told us that managers were accessible to staff, had an open culture, invited new ideas on how to improve the service and willing to share ideas. Staff told us that the managers were very approachable and encouraged openness and transparency when things go wrong.
- Staff told us they were open and transparent when things went wrong. Staff discussed incidents within the team and with patients and their families. Patients' families told us that staff informed them of errors and gave feedback.
- Leadership of the unit was primarily from a medical and nursing focus given the limited fulltime / onsite nature of the wider multidisciplinary team.

Commitment to quality improvement and innovation

- The unit had not participated in any quality improvement programmes or been involved in any research.

Outstanding practice and areas for improvement

Outstanding practice

None applicable

Areas for improvement

Action the provider MUST take to improve

- The provider must take steps to update all Mental Health Act (MHA) policies in line with revised MHA code of practice dated April 2015.
- The provider must ensure that robust processes and procedures are in place to ensure that current directors meet the fit and proper person regulation.

Action the provider SHOULD take to improve

- The provider must take steps to ensure the consistent reporting of safeguarding concerns to the local safeguarding authority.
- The provider should strengthen the multi-disciplinary leadership on the unit to fully meet the patient groups' rehabilitation needs.
- The provider should provide sufficient therapeutic activities for the patient group throughout the day, evenings and weekends.
- The provider should take steps to improve the safety of patients' access to and from the minibus. Portable steps are safe and fit for purpose.
- The provider should ensure that all Mental Health Act (MHA) documentation is complete and accurate.
- The provider should consider separate training for MHA, mental capacity act (MCA) and deprivation of liberty safeguarding (DoLs) and that staffs completion of training is robustly monitored.
- The provider should ensure that it meets safe staffing levels to enable a qualified member of staff to be present in communal areas at all times.
- The provider should comply fully with dispensing and administering medicines practices.
- The provider should put in place robust processes and procedures to identify trends and themes in incidents, and take action, where appropriate.
- The provider should consider adopting systems for review and analysis of data/effective data analysis to inform learning and service improvement.
- The provider should endeavour to appropriately record service users and carers views and involvement in care
- The provider should ensure pharmacy support is sufficient for service needs and a robust audit processes in place to monitor medicines management processes.
- The provider should put in place robust mechanisms for the effective documentation and monitoring of cleaning of the premises.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider does not have robust recruitment processes in place for directors This was a breach of Regulation 17(1)(2a)(2d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have an implementation plan in place for the MHA revised code of practice. Not all staff were trained in the revised code and all policies and procedures had not been updated. This was a breach of Regulation 17 (2) (a)