



## Surrey and Borders Partnership NHS Foundation Trust

# Long stay/rehabilitation mental health wards for working age adults

### Quality Report

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXXHE	Margaret Laurie House Inpatient Rehabilitation Unit	Margaret Laurie House	RH2 8HY

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

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

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

- The unit was safely staffed. There was a stable staff team, low vacancy rates and low sickness levels. Staff were in the main up to date with mandatory training. Supervision was robust and appraisal rates were high at 89%.
- A thorough ligature risk assessment had been undertaken by the trust following concerns on previous CQC visits. The trust was clear that risks were adequately assessed and those that remained were proportionate to a rehabilitation environment.
- Processes around safeguarding, complaints and incidents were in place and generally robust. All staff were aware of the procedures.
- Recognised rating scales were used to assess and monitor progress. The health of the nation outcome scales, the camberwell rehabilitation assessment, and the model of human occupation outcome scale were used regularly. The unit worked within the recovery model to enhance patients' independence and skills.
- Patients and carers spoke positively about staff and the unit and reported feeling supported and safe. Staff treated patients with respect and attended to individual needs.
- Carers were involved and invited to meetings on a regular basis with the patients' consent.
- Care records were good. All records contained an up to date risk assessment and crisis and contingency plans. Care plans were available in all records and were in the main holistic and recovery focussed.

- There was a well led leisure based activity programme and staff were committed to facilitating this. Patients were involved and helped to plan activities.
- Discharge planning started on admission. Of the 20 discharges in the last 12 months most patients had moved on to more independent living.
- Team morale was good and all staff reported a supportive team and good leadership.
- Regular team meetings took place and agendas were comprehensive and minutes were thorough.
- The unit had a strong student mentorship programme. It had close links with the university of Surrey to maintain a good teaching environment.

However:

- There were no alarm systems or call buttons in the unit, apart from the downstairs shower room. The building spanned three floors and had mixed sex corridors. There was a risk, especially at night, that staff or patients who needed help on the upper floors could not call for assistance.
- The 0.5 psychology post had been vacant since December 2015 and recruitment had been unsuccessful. This left a significant gap in service provision.
- There was a lack of non leisure based activities. Intensive vocational support was not evident.
- An acute care pathway review was underway and the model of rehabilitation provided was being reviewed. Staff felt unsettled and uninformed about the future of the unit. The unit did not have accreditation for inpatient mental health services.

# Summary of findings

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

### Are services safe?

We rated safe as good because:

- The ward environment was clean and environmental risk assessments and infection control audits were thorough and up to date.
- Up to date risk assessments and crisis and contingency plans were found in all nine current care records we reviewed.
- Safe staffing levels were established and staff were in the main up to date with mandatory training.
- Robust processes were in place for safeguarding and incident reporting.

However:

- There were no alarm systems or call buttons in the unit, apart from the downstairs shower room. The building spanned three floors and had mixed sex corridors. There was a risk, especially at night, that staff or patients needing help on the upper floors could not call for assistance.
- Smoking in undesignated places accounted for the greatest number of incidents and was a fire hazard. The unit had implemented various actions to address this.
- A pharmacist had not visited the ward in five months.

Good



### Are services effective?

We rated effective as good because:

- Care plans were present in all care records and contained up to date, holistic information. All patients had been given a copy of their care plan.
- There was evidence of physical assessments in the notes and of ongoing physical care. There was a health promotion group monthly and topics covered included smoking, diet and exercise.
- The occupational therapist was piloting wellbeing recovery action plans which included strategies for keeping well, dealing with difficulties and self management.
- Staff used recognised rating scales to assess and monitor progress.
- Staff were supervised and had regular appraisals.
- There were effective relationships within the multidisciplinary team and with outside agencies.
- Staff generally had good knowledge and understanding of the Mental Health Act and Mental Capacity Act.

Good



# Summary of findings

However:

- The 0.5 psychology post had been vacant since December 2015 and the trust had been unable to recruit. This left a significant gap in service provision for the unit.

## Are services caring?

We rated caring as good because:

- All interactions we observed with patients were caring and respectful. Staff showed good understanding of individual needs and acted sensitively towards patients.
- Patients spoke positively about staff and were happy at the unit.
- All four patients we spoke to felt involved in their care and treatment and had copies of their care plan.

Good



## Are services responsive to people's needs?

We rated responsive as good because:

- Discharge planning was good. Of the 20 discharges over the last 12 months the majority had moved on to more independent community living.
- There were no current delayed discharges and a discharge coordinator worked closely with the unit.
- There was a well led and comprehensive leisure based activity programme including some evenings and weekends.
- Patients had full access to their rooms and a kitchen. The gardens were always available for use and were large and well maintained.

However:

- Very few patients found paid work post discharge. There appeared to be a lack of individual vocational support for patients.

Good



## Are services well-led?

We rated well-led as good because:

- Governance systems on the ward were robust.
- Staff were happy with the leadership at ward level. Medical leadership was effective.
- Team morale was good and staff reported a supportive atmosphere.
- The unit had a strong student mentorship programme and close links with the university of Surrey.

However:

Good



# Summary of findings

- The unit was part of the acute inpatient pathway but felt somewhat isolated from the rest of acute services. Staff were not always aware of senior management.
- Some staff were feeling unsettled by the service review which was underway.
- The unit had not participated in AIMS accreditation.

# Summary of findings

## Information about the service

Margaret Laurie House is an inpatient unit for 12 people of working age who have enduring mental health problems and complex needs. It had one mixed sex ward based in Reigate and provided short term therapeutic rehabilitation in a structured and supportive environment. It had 24 hour nursing support and other multi professional interventions. The aim of the service was to help individuals regain lost life skills and move to more independent living.

It was the only trust wide rehabilitation unit and took referrals from across Surrey.

This is the third inspection of Margaret Laurie House. At the last inspection in 2014 there were no compliance actions.

## Our inspection team

The team that inspected this core service comprised: one Care Quality Commission (CQC) inspector, one Mental Health Act reviewer, one consultant psychiatrist, one occupational therapist, one nurse and one social worker.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about this service, asked a range of other organisations for information and sought feedback from patients using the service.

During the inspection visit, the inspection team:

- Visited Margaret Laurie House and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with four patients who were using the service.
- Spoke with one carer of a patient.
- Spoke with the ward manager.
- Spoke with six other staff members including doctors, nurses, nursing assistants, an occupational therapist and a community development worker.
- Reviewed nine prescription charts.
- Reviewed 13 care records, nine current and four historic.
- Observed an art activity group.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

# Summary of findings

## What people who use the provider's services say

- Patients and carers we spoke with were positive about the service and the care they received.
- Patients were complimentary about the staff and said they felt respected and safe.

## Areas for improvement

### Action the provider **SHOULD** take to improve

#### Action the provider **SHOULD** take to improve

- The trust should review the lack of an alarm/call system in the unit.
- The trust should continue to closely monitor the potential risk to safety of patients due to mixed sex corridors, especially at night when the corridors are not continuously observed by staff.
- The trust should review the need to provide individual vocational rehabilitation plans for patients.

## Surrey and Borders Partnership NHS Foundation Trust

# Long stay/rehabilitation mental health wards for working age adults

### Detailed findings

#### Locations inspected

##### Name of service (e.g. ward/unit/team)

Margaret Laurie House

##### Name of CQC registered location

Margaret Laurie House Inpatient Rehabilitation Unit

#### 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.

- A Mental Health Act monitoring visit took place as part of the inspection of Margaret Laurie House. CQC will provide the trust with a separate report for this.
- Mental Health Act training was mandatory and 88% of staff were up to date.
- We reviewed four records of the most recently detained patients and found these generally to be in good order. One record had no approved mental health professional report on the file. One record had no discharge paperwork on file even though the patient had been discharged from section the previous week.
- Capacity to consent to treatment was assessed on admission and at appropriate intervals.
- Patients' rights were routinely explained on admission and at regular intervals.
- Section 17 leave was authorised through a standardised system. Some copies had been sent to the Mental Health Act office for uploading onto the electronic records system (SystemOne) and were not available to view. Of those we viewed, copies of leave forms had been given to patients and they were aware of conditions attached to their leave.
- Staff had an awareness of guardianship and were considering this in regards to one patient who was ready to move on but reluctant to leave the unit.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training was mandatory and 87% of staff were up to date.
- Consent to treatment was assessed on admission and at regular intervals.
- Staff were able to discuss the main principles of the Mental Capacity Act and were able to give examples of when capacity may need to be assessed. We were given examples of patients who had been unable to manage their money. However, we did not see any formal capacity assessments in the notes regarding the patients' ability to manage their finances.
- Staff told us that any formal capacity assessments were discussed in the multidisciplinary team and the doctor carried out the assessment.
- Staff were aware of the deprivation of liberty safeguards (DoLS) and best interest decisions. There had been no recent DoLS applications.

# Are services safe?

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

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

## Our findings

### Safe and clean environment

- Margaret Laurie House was a large victorian building spanning three floors. The ground floor had one bedroom and the other two floors had 11 bedrooms across mixed sex corridors. None of the rooms were en suite. The corridors were arranged so that gender separation was maintained with males at one end of the corridor and females at the other. There were separate male and female bathrooms positioned at either end of the corridor. Patients did not have to walk through an area occupied by another sex to reach toilets and bathrooms. Rooms were lockable and patients had individual keys. The ward complied with the same sex accommodation guidance. There was access to a female only lounge.
- The building had many blind spots and ligature risks. However the trust had completed a ligature risk assessment specific to Margaret Laurie House. It had identified the unit as low risk in terms of patient profile, history of ligature risks and history of self harm. The multidisciplinary team agreed that Margaret Laurie House provided rehabilitation for low risk patients moving back into the community. Therefore a totally ligature free environment was unnecessary and inappropriate. Patients were risk assessed before admission and on a daily basis and were moved to a more secure environment if needed.
- The ward environment was clean and had a homely feel. The cleaning schedule was detailed and up to date. Margaret Laurie House scored 100% in the Surrey and Borders 2015 patient-led assessments of the care environment (PLACE) audit score for cleanliness.
- The environmental risk assessment was up to date and the infection control audit was thorough. Actions were documented and recorded. Hand washing audits, methicillin-resistant staphylococcus aureus returns, mattress and pillow audits were all in date and checked regularly. Staff were reminded at team meetings to report any health and safety issues to the manager. However there was only one hand sanitiser at the entrance to the unit and there were no blue bins for infection control.

- The clinic room was tidy and emergency drugs were in date. Resuscitation equipment was available and checked daily. Equipment was checked regularly and calibration reminders were evident. There was no examination couch in the clinic room and we were informed that if necessary patients were examined in their rooms. One nurse we spoke to did not know that epinephrine injection auto-injectors (epi pens) were available in the clinic room.
- There were no alarm systems or call buttons in the bedrooms or bathrooms. The disabled access shower room on the ground floor was the only room that had an alarm system. This was a potential risk for patients, especially at night if they needed help and staff were on the ground floor. The mixed sex corridors could heighten this risk as staff were not continuously positioned on this floor overnight. Portable alarms were available for staff but we did not see all staff carrying them. Again, staff could not easily summon assistance if necessary. Recent team meeting minutes confirmed that staff had raised this as an issue at a recent board walk around. As a result the trust had arranged for a visit to the unit to look at putting a more effective alarm system in place.

### Safe staffing

- Safe staffing levels were established by the trust. The unit was staffed 24 hours a day, seven days a week. There was a minimum of three staff during the day consisting of one qualified nurse and two nursing assistants. Additional staff included the ward manager, occupational therapist, medical staff, community development worker and domestic staff. At night there was a minimum of two staff, one qualified nurse and one nursing assistant.
- There were two shifts per day. The morning shift started at 7am and finished at 8pm. The night shift started at 7pm and finished at 8am, which allowed for handovers between shifts.
- The team consisted of one band seven ward manager, one band six nurse, six band five nurses, two band three nursing assistants, two band two nursing assistants, one occupational therapist, one part time psychologist and one community development worker.

# Are services safe?

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

- There was one band six vacancy which was due to be filled in March 2016. There was one band five vacancy which was due to be put out to recruitment in March when the current staff member in post was redeployed. There was one band two nursing assistant post which was filled by an NHS professional who was on a training programme within the trust and could apply for the job after six months. The 0.5 psychology post had been vacant since December 2016 and so far the trust had been unable to recruit.
  - Staff reported adequate staffing levels. Staffing rotas showed safe staffing numbers were maintained across shifts. Eighty- three shifts had used bank or agency staff between July and September 2015. No shifts were left uncovered during this period. Patient activities were rarely cancelled due to staff shortages. Each staff member had oversight of four patients on a shift. Extra staff could be booked at short notice if needed. Total permanent staff sickness was low at 2.3%. Electronic rostering was discussed at team meetings and annual leave was monitored and booked appropriately to ensure all shifts were covered.
  - Medical cover was adequate. There were two consultant sessions per week and two associate specialist sessions per week. Both had been revalidated in 2015. Telephone contact was available between sessions if needed. There was also one core trainee who was available to the ward 1.5 to two days per week. The duty doctor was available out of hours and in an emergency.
  - Mandatory training included a range of courses. Of the 18 courses available, only four were below the 75% target rate. These were infection control at 72%, clinical risk assessment at 60%, medicines management (qualified) at 50% and prevention and management of violence and aggression theory at 0%. The average completion rate for the service as a whole was 76%. Mandatory training was a fixed agenda item for the team meeting and compliance was monitored on a monthly basis. Staff were notified by email when training was about to expire.
- Assessing and managing risk to patients and staff**
- There was no seclusion room on the ward and restraint was never used. Staffing levels were not sufficient for restraint to be used appropriately. All staff were trained in conflict resolution and disengagement. All staff we spoke to said de-escalation techniques were used when needed. Patients were only accepted to the unit if they had a low risk of aggression. If emergency support was needed the police were called.
  - We reviewed 13 care records in total. Four of these were historic and nine were current. All the records we reviewed had crisis and contingency plans and an up to date risk assessment. There was evidence that risk was updated following an incident. However some risk assessments contained more information than others. Staff reported positive risk taking when appropriate.
  - Referrals to the unit were routinely assessed. Patients admitted to the unit had to be stable in their mental state. A past history of risk did not exclude patients but patients' assessed risk levels had to be stable in the last six months. There was regular ongoing assessment of risk and patients were moved to a more secure environment if needed.
  - A recent walk around by the board had placed the unit on the trust risk register as feedback had suggested staff did not feel confident in managing some of the more challenging patients. As a result staff were encouraged to report concerns to the manager or nurse in charge, work in pairs if indicated and escalate further if needed.
  - Patients were not routinely searched and this was only advocated in specific circumstances such as if drugs or alcohol were suspected. Staff told us trust policy was followed when searches happened.
  - The door was locked at 8pm for security. Patients were encouraged not to go out after this time but informal patients were not prevented from leaving if they chose to do so.
  - We reviewed nine prescription charts and found no significant issues. Four patients were self medicating in line with their care plan. Medication was reviewed regularly in the multidisciplinary team meetings and when needed. However a pharmacist had not visited the ward for over five months.
  - All staff we spoke to were aware of the safeguarding procedures and this was part of mandatory training. Staff were able to give examples of potential safeguarding concerns. Safeguarding was a standard agenda item for the team meetings and incidents were discussed. Staff were reminded to record any safeguarding as an incident.

# Are services safe?

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

- There was only one safeguarding referral in the last six months which involved a patient and staff member. This incident appeared to have been thoroughly investigated at trust level and actions agreed and implemented as a result.
- The new safeguarding guidelines that were introduced in the Care Act 2014 were discussed at team meetings. There was evidence at one team meeting that the safeguarding lead for children had been present. She had encouraged staff to report protection plans and child in need issues in care plans, and to attend child protection conferences when appropriate.
- We were informed that one young male patient had been returned to the unit recently by the police following a sexually inappropriate incident with a woman in a shop. This patient's room was in a mixed sex corridor that staff did not continually observe.

## Track record on safety

- There had been no serious incidents reported at ward level for the period 27/05/2015-20/10/2015. Staff reported no serious incidents after this time.

## Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. Incident reporting was a standard item on the team meeting agenda. Staff

were reminded to submit incidents to the electronic risk reporting system and were given advice of how and what to report. Incidents were routinely discussed at team meetings and learning shared. The ward manager attended trust meetings and disseminated any learning from incidents at trust level down to staff on the unit.

- Staff were debriefed after incidents but one staff member felt that this was sparse and informal rather than formal.
- Smoking in the unit had been recognised as a major issue. This had also been identified at the board walk around. The majority of incidents reported were around smoking in undesignated places. There was evidence that this had been discussed in team meetings and strategies implemented as a result. Staff were encouraged to continue to work with patients around this issue and were told to complete fire warden training. Other measures to address this looked at refurbishing the conservatory and turning it into a reading/activity room to discourage patients going there to smoke and also to increase staff presence in particular areas. A fire officer was due to attend the health promotion group to advise on the dangers of smoking in the building.

# Are services effective?

Good 

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

## Our findings

### Assessment of needs and planning of care

- There was a thorough and up to date operational policy which stated the unit helped individuals to retain and develop life skills, link with the wider community and enable discharge as soon as possible. An initial assessment was completed by the doctor and another staff member prior to admission. The patient, care co-ordinator and carer were also present. The doctor took a brief psychiatric history, conducted a current mental state assessment and clarified diagnosis. The staff member conducted a rehabilitation needs assessment using the camberwell assessment of needs. The patient was seen in the multidisciplinary team meeting within the first week of admission. There was a formal review after two weeks and reviews two to four weeks thereafter. Discharge planning was an essential part of each review.
- Staff confirmed that all new admissions had a workable care plan within 72 hours compiled by the senior nurse and then the primary nurse took over responsibility for the care plan.
- We reviewed 13 care records including four historic records. All care records contained care plans which were holistic and up to date. Risk assessments were present for all patients although the detail included was variable. Crisis and contingency plans were present for all.
- Care plans and records showed evidence of individual planning. Examples included a care plan for weight management, a care plan regarding the specific vulnerability of the patient, and a care plan regarding advocacy. Carers' views were evident and in two records specific carers' assessments were mentioned.
- The occupational therapist assessed each new admission and individual activity programmes were written into care plans. Each week occupational therapy staff assessed the patients' ability to cook, shop, do laundry and other daily living skills.
- Team meeting minutes showed the team had discussed how to involve patients in their care plans. Audits were completed and improvements noted at the next meeting. Staff were encouraged to log dates for reviews of care plans in the diary.

- Physical assessments were carried out on admission and there was evidence of ongoing physical care. Detailed recording was variable. In one record there was only a brief note of physical health tests but later test results were found which evidenced ongoing care. A physical health promotion session was held monthly at the unit and topical issues such as diet and smoking were covered. Patients could be assessed and offered health advice. All patients were registered with a local GP.
- Patients were encouraged to self medicate following appropriate assessment and 50% of patients were self medicating.
- Records were kept electronically and stored securely. The trust had recently migrated the electronic system from rio to system one and this had created some issues. Some information had not migrated successfully and some health action plans were missing. Staff told us that the risk assessment tools were better using rio than system one.

### Best practice in treatment and care

- The ward manager informed us that national institute for health and care excellence (NICE) guidelines were used. The manager demonstrated to us that the NICE guidelines had been used for psychosis and drug and alcohol issues. Team meeting minutes documented discussions around NICE guidelines and updates were also available for all staff on the trust's internal electronic bulletin.
- The operational policy for the unit stated that the guiding principles of a recovery orientated mental health service (as set out in the National Institute for Mental Health in England guidance 2014) were used within the unit. The HoNOS rating scales were used in the care records we reviewed. The camberwell assessment for rehabilitation was used on admission to the unit and was repeated on discharge to track progress. The occupational therapist used the recognised model of human occupation for assessments. All staff stated that the new risk assessment used on systemone was not as robust as that which had been used on rio. This had been raised as an issue with the managers.
- Physical health was monitored. All patients were registered with a local GP and a physical health examination was conducted on admission. Team meeting minutes documented the need for staff to

# 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.

complete health action plans on system one and we saw these in the care records. Results of all investigations were also recorded. The occupational therapist was due to start a health promotion group. Medical staff were aware of guidelines and quoted good practice around clozapine, poly pharmacy and prescribing above British National Formulary limits. The service monitored commissioning for quality and innovation targets for smoking.

- Staff participated in clinical audits. Team meeting minutes recorded that record keeping audits were undertaken by nurses and nursing assistants. Other audits were listed and discussed on a regular basis.

## Skilled staff to deliver care

- The full range of mental health disciplines provided input to the ward. The multidisciplinary team consisted of nurses, nursing assistants, doctors, an occupational therapist, occupational therapy assistant and a community development worker. A music therapist visited the unit each Friday. Social work input was via the locality social work teams. The 0.5 psychology post had been vacant since December 2015 and so far the ward had been unable to recruit. This was recognised as a significant gap in service provision for the unit. There were many group activities. Leisure based activities were well thought out and comprehensive. However there was a lack of individualised vocational activities.
- The trust did not provide specialist rehabilitation training for staff. However staff were encouraged to attend recovery conferences and, when in post, the psychologist would offer a range of in house training sessions.
- Inductions were thorough. We reviewed the induction pack which was given to all new staff. Staff were expected to attend a week long mandatory training session which covered all the main mandatory training courses such as conflict resolution, risk assessment and safeguarding. A local induction pack was then sent to the unit for individual staff. New staff were set up with a buddy (a more experienced staff member) and there were opportunities for shadowing and on the job learning.
- Staff reported regular supervision. We reviewed four supervision records all of which had supervision contracts signed by staff and manager. All were within the trust target of 10 supervision sessions per year. Supervision records were thorough covering previous

minutes, training, appraisals, work performance, case load and time for reflective practice. Of the four records we reviewed all had up to date appraisals. Eighty nine per cent of staff on the unit had had appraisals in the last 12 months.

- Team meetings were held monthly. A standard agenda was followed covering staffing, policies, safeguarding, training, supervision, serious incidents and any other business.

## Multi-disciplinary and inter-agency team work

- Multi disciplinary team meetings (MDTs) happened every Thursday. The full range of disciplines attended and staff were aware of what issues needed to be discussed during the meeting. All new assessments were discussed at the MDT. Ward rounds occurred every Tuesday morning. Staff reported good MDT working relationships.
- Staff reported effective handovers within the team. This was mainly recorded on system one. Handovers happened at 7am and 7pm. There was a further shift planning discussion when all staff started work at 9am. The staff nurse in charge distributed work according to needs, gender and other specified issues.
- There were good working relationships with community teams and other wards. The care coordinator from the community team attended regular MDT meetings. The community development worker had close links with care coordinators and invited them to meetings on a regular basis. Staff from the unit visited potential community placements with patients. The unit periodically organised open days for managers and staff from other services.
- A discharge co-ordinator attended the MDT and worked closely with the ward on any potential delayed discharges.
- Social work support was accessed from the locality teams.
- The forensic pathway for the trust was managed by the community forensic team. They conducted a gateway assessment and, if more secure rehabilitation was needed, worked with NHS England to find a more suitable placement.

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

- Mental Health Act training was mandatory. Eighty eight per cent of staff were up to date.

# 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.

- From January 2015 to January 2016 the unit had received one patient detained under section 37 (a court order) of the Mental Health Act, six patients detained under section three (treatment orders) and 12 informal patients. At the time of the inspection all patients were informal.
- We reviewed the detention paperwork of the four most recently detained patients. Recording was generally good. One record did not have a copy of the AMHP report and there was no discharge paperwork for one patient who had been discharged from section the previous week.
- Consent to treatment was assessed on admission in all four of the records we reviewed and assessment was repeated when appropriate.
- There was evidence that patients had their rights read to them on admission and repeated at appropriate intervals. Independent mental health advocacy was provided by an external organisation. A poster on a noticeboard gave contact details so patients could contact the service themselves.
- Section 17 leave was adequately managed. We were unable to review many copies as these had been sent to

the MHA office for uploading and the office had not had time to complete this. Copies of leave forms were given to patients and they were aware of conditions attached to leave.

- Guardianship was discussed in relation to one patient who was ready for discharge but did not want to leave the unit.

## Good practice in applying the Mental Capacity Act

- Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training was mandatory. Eighty seven per cent of staff were up to date.
- There had been no DoLS applications in the last six months.
- Staff were aware of capacity and were able to discuss the main principles of the Act. Staff were able to give examples of when patients' capacity might need to be assessed. Staff were able to discuss capacity to manage finances for a few patients but we did not see any formal capacity assessments. We were told the doctor completed any necessary capacity assessments.
- Staff confirmed that capacity was discussed at MDT meetings and there was a plan to use a capacity checklist in supervision.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- All interactions we observed with patients were caring and respectful. Staff showed good understanding of individual needs and acted sensitively towards patients. Warm and friendly language was used when discussing patients.
- Patients spoke positively about staff and were happy at the unit. All four patients we spoke with felt safe and supported by the staff. They felt involved in their care and treatment and felt they were listened to. Patients were treated with respect and staff always knocked before entering their rooms.
- The Surrey and Borders PLACE score 2015 at Margaret Laurie House for privacy, dignity and wellbeing was 93%.

### The involvement of people in the care that they receive

- Patients were assessed before admission and orientated to the unit on arrival. Each patient had a key nurse and dedicated weekly one to one time.
- Patients felt involved in their care plans. All nine of the current care plans viewed had been signed by the patient and a copy had been given to the patient. One patient had a folder with their care plan and medication information in it. Patient involvement in care plans was discussed at one team meeting and staff were encouraged to promote this. All patients we spoke to said they were involved in ward rounds and were given information about their care and treatment. Patients were given support prior to multidisciplinary team meetings to discuss what they would like to talk about in the meeting.
- Planning meetings happened every Monday and patients were directly involved in planning the weeks' activities. Food shopping, menus and cooking rotas were agreed at this meeting. Staff encouraged patients to source their own activities to increase independence. Patients were also encouraged to contribute to the cost of activities agreed as a group. Community meetings happened every Wednesday and patients felt involved. Patients' views were listened to by staff and feedback on ideas was given.
- Staff were encouraged to promote 'your views matter' with patients. Responses were then discussed at community meetings. An example was that patients were not aware they could have access to a pharmacist. The admission checklist had been changed to inform patients of this.
- Eighty 'your views matter' forms had been completed over the last 12 months and an overall satisfaction rate of 76% was recorded. Safe staffing audits had been completed with patients between August and September 2015 and had a 98% satisfaction rating. Three spot carer surveys had been completed between December 2015 and March 2016 with a 79% satisfaction score.
- Patients had access to advocacy and the community development worker made regular referrals to advocacy and the citizens advice bureau.
- Carers were involved and were routinely invited to meetings with the consent of the patient. The carer we spoke with gave positive feedback although was concerned about moving on plans.
- A periodic service review took place on 19 January 2016. All areas scored well and some areas such as safeguarding and safety, personalised care, quality and management scored 100%.

# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

- The bed occupancy rate for the six month period prior to our inspection was 83%.
- Between January 2015 and January 2016 there were 19 admissions and 20 discharges. The average length of stay was 272 days.
- There were three people on the waiting list for admission. Referrals from acute services were given priority over people living in the community.
- Discharge planning began on admission. Discharges appeared well planned and included all relevant parties. Dates for discharges were agreed at reviews once all objectives had been met or no further progress was likely. A discharge notification was sent immediately to the GP and care coordinator and a detailed discharge summary was sent within two weeks.
- The Camberwell rehabilitation assessment was repeated at discharge to show progress made.
- Discharge packages showed increased independence. Of the 20 discharges, four patients returned to their own flat or family home, seven moved to 24 hour supported accommodation, one moved to a warden controlled flat with a support package and one moved to a housing association home with floating support. Three patients returned to acute services following a relapse in their mental state.
- Patients were only moved due to clinical reasons. A patient had been transferred back to acute services the week prior to our inspection following an increase in agitated behaviour and an assault on staff. This appeared to have been appropriately managed.
- Patients always had access to a bed on return from leave.
- A discharge coordinator attended the MDT meetings. There had been no delayed discharges in the last 12 months. One patient was ready for discharge but did not want to leave and guardianship was being considered as an option.
- We were told that any referrals for more secure rehabilitation were managed by the community forensic team which covered Surrey. They conducted an initial assessment and liaised with NHS England to arrange a more suitable placement if necessary.
- The trust were preparing to review the rehabilitation pathway with a view to supporting people in specialist

placements to return to Surrey. Personality disorder development training was being considered to support people with more challenging behaviours. This was still only at proposal stage at the time of the inspection. Some staff members reported feeling unsettled by these plans.

### The facilities promote recovery, comfort, dignity and confidentiality

- Separate therapy rooms were not available on the ward. Some rooms had a dual purpose and could be used for therapy at certain times, such as the dining room, conference room, small occupational therapy room or TV room. There were no specific visitor rooms but again the rooms mentioned above could be accessed. There was a conservatory in the garden which was in need of refurbishment. Plans were in place to update this and new furniture, window blinds and flooring had been ordered. Plans included using it as a reading room, quiet activity room and a room for visitors.
- There was a female only lounge on the ward and one patient reported she had helped decorate it and had chosen furnishings.
- A pay phone was available for patients. Patients had full access to their personal mobile phones. A computer was available for use.
- The main kitchen was locked to keep patients safe from sharp objects but a smaller kitchen was open for patients to access hot and cold drinks and snacks 24 hours. A main meal was cooked each day by a patient supported by staff.
- Alcohol within the unit was prohibited but patients could drink outside of the unit and were encouraged to keep within government guidelines.
- Patients had full access to their bedrooms. They had individual keys to their rooms and a lockable drawer in their rooms for valuables. Patients were able to personalise their rooms.
- Activities were provided seven days a week. They were organised on a group and individual basis and included some sessions in the evening and at weekends. A range of activities were offered such as the gym, arts, voluntary work. The occupational therapist and community development worker facilitated the sessions. A local college had attended the unit to run a course in gardening and patients were encouraged to use the local social club and other community facilities.

# Are services responsive to people's needs?

Good 

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

- The community development worker was involved in recovery focused activities and there was evidence to show patients were encouraged to source their own community activities. Examples included guitar lessons, voluntary work, supporting a patient to clear their parents' house following a death.
- We observed a well organised art group which offered graded activities. Patients were encouraged to use social skills within the group and talk about their day/week.
- Most of the activities were leisure based and there was a lack of intensive vocational activities for patients. Non leisure based activities were lacking.
- There was limited time for one to one occupational therapy sessions with patients.
- Patients had access to the gardens which were large and well maintained. Patients were allowed to smoke in the garden.
- Notice boards were placed around the building and contained information on rights, advocacy and community resources. Independent mental health advocates were available. Leaflets on how to complain were also available.
- The community meeting was used to plan the week's activities and to plan the week's menu. Catering to individual needs was encouraged.
- The local church was involved with the unit and patients had access to a nearby mosque.
- One staff member showed awareness of communication issues, for example for a person with a learning disability.

## Listening to and learning from concerns and complaints

### Meeting the needs of all people who use the service

- A lift was available within the unit. There was one bedroom on the ground floor and a disabled access toilet and bathroom. However full wheelchair access within the building was not viable.
- There had been one formal complaint about the unit in the last 12 months. This was fully investigated and closed by the patient advice and liaison service (PALS). The patient was visited on the unit by the PALS team who discussed the complaint with her. The complaint was not upheld.
- Team meeting minutes evidenced that complaints were discussed and actions implemented.
- Verbal compliments had been given and staff encouraged patients and carers to complete the friends, family and carer survey.
- All patients we spoke with knew how to complain and all staff were aware of the complaints procedure.

# Are services well-led?

Good 

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

## Our findings

### Vision and values

- The trust had developed a quality improvement programme and we saw the service specific vision for Margaret Laurie House.
- Some staff were aware of trust values.
- Staff talked about the board walk around where members of the board visited the unit. Some staff were not aware of senior managers. The ward manager saw the director on a monthly basis and had regular supervision. She felt supported by senior management.
- Margaret Laurie House was part of acute inpatient services but it was the only rehabilitation unit in the county and was based in the community. The ward attended regular meetings with other inpatient managers but there was a general feeling that the unit was stand alone and somewhat isolated from the rest of acute services.

### Good governance

- Ward systems were effective. Staff had received mandatory training and were appraised and supervised. There was adequate staffing. Safeguarding, Mental Health Act and Mental Capacity Act procedures appeared to be followed and staff learnt from incidents, complaints and user feedback.
- There was evidence staff took part in clinical audits. Most of these were completed electronically and submitted to trust headquarters on a regular basis.
- The ward manager was able to submit items to the trust risk register.
- The ward manager stated she had the authority needed to fulfill the role.
- There was no administration support available for the ward which was problematic for staff.

### Leadership, morale and staff engagement

- Staff were confident in the ward manager. Morale in the team seemed high and all staff reported a strong, supportive team with good relationships. There was a relatively stable staff group and overall sickness levels were low at 2.3%.
- Medical leadership was positive and there was a regular training and leadership programme for the doctors.
- All staff reported good team work and rapport and felt able to raise issues within the team or within supervision. Whistleblowing processes were known and there were no concerns over bullying or harassment.
- There had been a recent team away day that had been funded by the unit taking part in a research project. Staff were involved in the planning of this.
- There was some concern from staff about the future of the unit. Staff were aware of the acute care pathway review but had not had reassurance about how this might affect them or the unit.

### Commitment to quality improvement and innovation

- The unit took part in a recent trial for asenapine (an antipsychotic drug). A £500 financial reward was used to fund the recent away day.
- Staff were proud of their student programme. Margaret Laurie House was seen as a teaching environment for student nurses and worked closely with the university of Surrey to provide placements. The unit was audited yearly to ensure it met the criteria for a working teaching environment.
- The unit was not accredited with AIMS. The ward manager said she was considering this for the near future.