Tees, Esk and Wear Valleys 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)
RX3AD	Primrose Lodge	Primrose Lodge	DH3 3JX
RX3FL	Roseberry Park Hospital	Fulmar ward	TS4 3AF
RX3FL	Roseberry Park Hospital	Kirkdale ward	TS4 3AF
RX3MM	West Park Hospital	Willow Ward	DL2 2TS
RX3WE	163 Durham Road	Lustrum Vale	TS19 OEA
RX3AE	Earlston House	Earlston House	DL3 8DE
RX3PV	Park House	Park House	TS1 3LF

Summary of findings

RX3XK	Abdale House	Abdale House	HG2 8JJ

This report describes our judgement of the quality of care provided within this core service by Tees, Esk and Wear Valleys 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 Tees, Esk and Wear Valleys NHS Foundation Trust and these are brought together to inform our overall judgement of Tees, Esk and Wear Valleys 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?	Requires improvement
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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Overall summary

We have judged the service as good because:

- Overall, compliance with the requirements of the Mental Health Act and Mental Capacity Act was good. However, on two wards this could be improved.
- The wards had sufficient numbers and the appropriate skill mix of staff on duty at all times to meet patients' needs.
- The ward environments were clean and provided appropriate facilities to support patient's recovery.
- The wards delivered care and treatment which was underpinned by the principles of the recovery model and best practice guidance under the framework of the Care Programme Approach (CPA). Patient's social, occupational, cultural and psychological needs and preferences were assessed and reviewed regularly. There were effective multi-disciplinary team ways of working embedded on all the wards we visited with proactive partnership working with community based services. The service had a clear pathway in place to support patient's recovery from admission to discharge.
- Overall, medication management across the service was good. However on one ward we found some special instructions regarding the administration of medicines were not recorded on two patient's medicine administration records. The service had implemented a robust step down procedure to support patients in managing their own medicines in preparation for when they moved on from the wards.
- Overall, we received positive feedback from patients and their carers in relation to the care and treatment they received from staff. Patients had the opportunity to be involved in all aspects of their care including regular reviews.
- Compliance with mandatory training, supervision and appraisals was good overall across the service.
- The teams demonstrated good compliance with the requirements of the Mental Health Act (MHA). Overall, staff had a good understanding of the Mental Capacity Act (MCA) although on one ward, this could be improved. The trust is addressing this.
- Staff were positive and committed to the ward they worked on and motivated to continuously improve the service they provided. Two wards were AIMS accredited (Accredited for Inpatient Mental Health Services) as 'Excellence' through the Royal College of Psychiatrists CCQI (College Centre for Quality Improvement) network for inpatient wards and another two wards had implemented the Productive ward 'Releasing time to care' initiative. This demonstrated a commitment to quality improvement.
- One of the six wards which provided mixed gender accommodation did not meet the Department of Health guidance on same sex accommodation (SSA). Two female patients' bedrooms were located on the male corridor opposite the clinic room. This could compromise the privacy and dignity of patients on this ward.
- Environmental risk assessments were completed and reviewed regularly although these had not identified a serious risk which a low bannister posed to patients on two wards. The trust has taken action to ensure the bannisters are now safe.
- During previous visits to two wards, we identified a number of restrictive practices in place. The trust had implemented a framework to reduce these and many had ceased however we found that staff continued to search patients following unescorted leave on these wards, patients could not access the internet, have mobile phones and the bedroom windows were kept locked. These practices were not based on individual patients risk assessments.

Summary of findings

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

Are services safe?

Requires improvement

We have judged the service as requiring improvement in this area because;

- One of the six wards which provided mixed gender accommodation did not meet the Department of Health guidance on same sex accommodation (SSA).
- The clinic room at Earlston House was located directly opposite two female patients' bedrooms which were on a male corridor. We observed male patients queuing for their medication outside of the clinic room during our visit. This compromised the privacy and dignity of these patients. We did not receive assurance that staff fully understood the principles of the SSA guidance. The trust has submitted an action plan to address these issues although it was not clear from the plan that these two female patients had been moved from this corridor. The trust did relocate the clinic room during the course of our visit.
- At Abdale House, SSA was well managed but there was no female only lounge. The service addressed this during our visit by designating one of the lounges or therapy rooms as a female only lounge dependent upon the number of females accommodated at the time. Staff told us a notice would be put on the door of the room designated for this purpose so patients would know this was a female only area.
- Environmental risk assessments and individual patient risk assessments were completed and reviewed regularly. However on two wards, there was a bannister at the top of the stairs which led to patient's bedrooms. The bannisters were waist height. This meant it was possible for a patient to fall intentionally or otherwise over these bannisters. The risks associated with the banisters had not been identified through the environmental risk assessments on the wards and had therefore not been escalated onto the directorate or trust risk register.
- During the course of our visit to the service, the trust took action to make sure the bannisters were safe by carrying out the improvement work required.
- During previous visits to two of the wards, we had found a number of restrictive practices in place. The trust had implemented a framework to reduce restrictive practices and many had ceased. However staff continued to search patients following unescorted leave on these wards, patients could not access the internet, have mobile phones on the wards and the

Summary of findings

windows in patients bedrooms were kept locked. These practices were not based on individual patients risk assessments and therefore breached best practice guidance and the Mental Health Act (MHA) Code of Practice (CoP).

- The wards were clean and in good decorative order with well-maintained outside garden areas. Cleaning audits were regularly completed on the wards to ensure standards were maintained.
- The wards had sufficient numbers and the appropriate skill mix of staff on duty at all times to meet patients' needs.
- Overall, we found all the wards had good systems in place for the management of medication including the appropriate storage, dispensing and recording of medication. However, at Abdale House some special instructions regarding the administration of medicines were not recorded on two patient's medicine administration records.
- The pharmacy team had worked with some of the wards to develop and implement robust step down procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.

Are services effective?

Good

We have judged the service as good because;

- The wards delivered care and treatment which was underpinned by the principles of the recovery model and best practice guidance under the framework of the Care Programme Approach (CPA). Patient's social, occupational, cultural and psychological needs and preferences were assessed and reviewed regularly. There were effective multi-disciplinary team ways of working embedded on all the wards we visited. We found some good examples of how the teams had developed good working relationships with partner organisations both internal and external of the trust to support patient's recovery.
- Compliance with mandatory training, supervision and appraisals was good overall across the service.
- We found good compliance across the service with the requirements of the MHA. Overall, we found that staff had a good understanding in relation to issues regarding capacity and consent although we found there were some deficits in the understanding of some staff at Earlston House which was being addressed by the trust.

Are services caring?

Good

We have judged the service as good because;

Summary of findings

- We observed staff engaging with patients and their relatives in a caring, compassionate and respectful manner throughout our visit to the wards. Staff were attentive to patients needs and responded promptly when patients requested support.
- Overall, the feedback we received from patients was positive in relation to the care and treatment they received from staff. Patients had the opportunity to be involved in all aspects of their care including regular reviews. The service had systems in place to gain feedback from patients and their carers and we saw evidence to show that action was taken by the service in response to this.

Are services responsive to people's needs?

Good

We have judged the service as good because;

- The service had a clear pathway in place to support patient's recovery from admission to discharge. Patients had access to a range of recreational and therapeutic activities and facilities to support their recovery. The service met patients' diverse needs' and promoted patients' access to advocacy.
- All discharges were planned in advance through the Care Programme Approach process which identified the patients' aftercare needs'. The wards held regular community meetings with patients to gain feedback about the service.
- Patients at Abdale House had been involved in the plans to move to the new rehabilitation inpatient unit called The Orchards due to open in June 2015.
- Complaints were managed and responded to appropriately.

Are services well-led?

Good

We have judged the service as good because;

- The wards provided care and treatment which was underpinned by the principles of the recovery model in line with the trust vision and values. Staff were positive and committed to the ward they worked on. Staff felt supported by the management team and their colleagues within the wards.
- The wards had a range of embedded processes in place to monitor the quality and safety of the service they provided. Regular ward meetings took place with staff which included governance issues such as risks, complaints, incidents and patient feedback and audit outcomes.
- Two wards were AIMS accredited as 'Excellence' through the Royal College of Psychiatrists CCQI (College Centre for Quality

Summary of findings

Improvement) network for inpatient wards and another two wards had implemented the Productive ward 'Releasing time to care' initiative. This demonstrated a commitment to quality improvement.

Summary of findings

Background to the service

Tees, Esk and Wear Valleys NHS Foundation Trust have a total of seven registered locations in which eight long stay/rehabilitation mental health wards are based.

Fulmar ward is based on the Roseberry Park Hospital site. This ward is a locked 12 bed recovery focussed rehabilitation service for women aged 18- 65 years with complex severe and enduring mental health needs.

Kirkdale ward is also based on the Roseberry Park Hospital site. This ward is a locked 16 bed recovery focussed rehabilitation service for males aged 18- 65 years with complex severe and enduring mental health needs.

Park House is a 14 bed mixed gender open rehabilitation ward for patients aged 18-65 with complex mental health needs based in Middlesbrough.

Earlston House is a 15 bed mixed gender open rehabilitation ward for patients aged 18-65 with complex and enduring mental health needs based in Darlington.

Lustrum Vale provides 20 bed mixed gender accommodation for patients aged 18-65. The ward is based in Stockton on Tees and provides rehabilitation within an open environment.

Willow Ward provides 15 bed mixed gender accommodation for patients aged 18-65 at West Park Hospital, Darlington. The ward provides rehabilitation ward for patients with complex severe and enduring mental health needs.

Primrose Lodge is a 15 bed mixed gender open rehabilitation ward based in County Durham. It provides care and treatment for patients aged 18-65 with complex mental health needs within an open environment.

Abdale House is a nine bed mixed gender open rehabilitation recovery unit for working age adults with mental health needs. The service aims to support patients to manage their mental health needs by using a variety of evidence-based therapies, activities and recovery programmes and to help them make a recovery.

Lustrum Vale, Earlston House, Abdale House, Primrose Lodge and Willow Ward have not been inspected by CQC inspectors before however all the rehabilitation wards have received a Mental Health Act monitoring visit from CQC mental health act reviewers since their registration by the Care Quality Commission. There are no current enforcement or compliance actions being taken by the CQC in relation to any of the rehabilitation wards visited during this inspection.

Our inspection team

Our inspection team was led by:

Chair: David Bradley, Chief Executive, South West London and St Georges NHS Trust

Team Leader: Patti Boden, Inspection Manager, Care Quality Commission

Head of Inspection: Jenny Wilkes, Head of Hospital Inspections, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a consultant psychiatrist, a CQC inspection manager and inspector, a head of hospital inspections, three mental health nurse specialist advisors, two mental health act reviewers and a pharmacist.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

Prior to the inspection we reviewed a range of information we held about long stay/rehabilitation mental health wards for working age adults and asked other organisations to share what they knew. We also held public listening events and focus groups for patients who used the service.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists.

We carried out the following announced visits;

Abdale House on 20 and 21 January 2015

Fulmar Ward and Kirkdale Ward on 27 January 2015

Willow Ward, Earlston House and Primrose Lodge on 28 January 2015 and

Lustrum Vale Ward and Park House on 29 January 2015.

During the inspection visits, the inspection team spoke with:

- 37 patients who were using the service
- three relatives of patients using the service and
- 47 members of staff; including ward managers, modern matron, service managers, doctors, nurses, student nurses, psychologists, social workers and occupational therapists.

We attended and observed one multi-disciplinary team meeting, a recovery group for patients and one patient community meeting.

We also:

• collected feedback from 30 patients using comment cards

• looked at 32 treatment and care records of patients

• carried out a specific check of the management of medication

• looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 37 patients and three relatives across the service. They all told us that staff were kind, caring and treated them with respect. We observed good interactions between staff and patients throughout the service. Patients appeared relaxed and comfortable in the presence of staff. We observed staff engaging with patients and their relatives in a caring, compassionate and respectful manner.

Patients on Willow, Lustrum Vale and Fulmar ward completed comment cards for the feedback comment boxes we had left on each ward during our visit to the service. We received positive comments from patients on each ward regarding staff attitudes towards them. However we also received some negative comments regarding the attitudes of some staff on Fulmar ward.

Good practice

- The pharmacy team had worked with some of the wards to develop and implement robust step down procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.
- We found some good examples of how the teams had developed good working relationships with partner organisations both internal and external of the trust.

Summary of findings

This included the use of volunteers through a voluntary agency to support patients and good links with community mental health teams, housing organisations and the trust wide recovery college.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure that Earlston House is compliant with the Department of Health guidance regarding Same Sex Accommodation (SSA) to ensure patients privacy and dignity is protected.
- The trust should ensure that the restrictive practices on Kirkdale ward and Fulmar ward are reviewed to make sure they are based upon patients individual risk assessments. These include; searching patients following a period of unescorted leave, the locking of bedroom windows and access to the internet and mobile phones on these ward.
- The trust should ensure that staff at Earlston House fully understand the principles of the Department of Health Same Sex Accommodation (SSA) guidance and issues in relation to the Mental Capacity Act on the ward.
- The trust should ensure that where evidence indicates that a patient does not have capacity, that a capacity assessment is completed in accordance with the Mental Capacity Act.
- The trust should ensure that the clinic room is relocated on Earlston ward to ensure the privacy and dignity of patients on the ward.
- At Abdale House, the trust should ensure that special instructions regarding the administration of medicines are recorded on all patients' medicine administration records.
- The trust should ensure compliance with the requirements of the Mental Health Act and Code of Practice documentation at Abdale House.
- The trust should ensure patients who lack capacity at Abdale House are referred to the advocacy service and information regarding the IMHA service is available to them.

Tees, Esk and Wear Valleys NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Primrose Lodge	Primrose Lodge
Fulmar ward	Roseberry Park Hospital
Kirkdale ward	Roseberry Park Hospital
Willow ward	West Park Hospital
Lustrum Vale	163 Durham Road
Earlston House	Earlston House
Park House	Park House
Abdale House	Abdale House

Mental Health Act responsibilities

The mental health act reviewer looked at the rights of patients detained under the Mental Health Act (MHA) across the service. They found that MHA documentation was present and available for inspection and in order across most of the wards. However at Abdale House in the case of one patient we were unable to locate copies of the original detention orders within the patient files and we found the patient files to be disorganised with some containing old and duplicated information as well as information pertaining to previous detentions under the Act.

There was good compliance with the requirements of the MHA across the wards however there were some issues we

identified at Abdale House which required addressing. We found there was a standardised process in place for authorising leave under section 17 of the MHA. Patients we spoke with were aware of their leave authorisation and any conditions attached to this. However at Abdale House we found the leave forms were ambiguous as patients were granted both escorted and unescorted leave and it was not clear under what circumstances a patient requiring escorted leave would be allowed to leave the premises unescorted. The outcome of section 17 leave was recorded although this did not always include the patient's own view of their leave. It was also not clear whether patients were always given copies of their leave forms as this section was rarely completed. We found old and superseded leave forms in the current leave file which could lead to some confusion about a patient's current leave status. We also noted that the Ministry of Justice (MoJ) form detailing the conditions of leave for the restricted patient was not present in the leave file alongside his section 17 form. All of the issues relating to the recording of MHA documentation which had been identified through mental health act monitoring visits to the wards over the past 18 months had all been addressed.

Patients were aware of their rights under the MHA and there was evidence that these were repeated at least three monthly as stipulated in the trust policy. We found however that staff frequently repeated patients' rights at more regular intervals than this requirement at CPA meetings or when a patients' comprehension was limited in line with best practice. Independent Mental Health Advocate (IMHA) services were routinely offered to patients on all the wards with the exception of Abdale House. Section renewals had been made in good time. Reports by Approved Mental Health Professionals (AMHP) were kept with the patients section papers.

We found comprehensive records of the responsible clinicians' discussions with patients regarding capacity and section 58 requirements in line with the Mental Health Code of Practice (CoP). On the sample of patients' prescription charts we looked at, there were no discrepancies between medications being administered and medication listed on the T2 (certificate of consent to treatment) and T3 (certificate of second opinion) forms. All authorised medication was within the British National Formulary (BNF) limits.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our visit, there were no patients subject to deprivation of liberty safeguarding (DoLs) on any of the wards we visited.

Overall, we found that staff had a good understanding in relation to issues regarding capacity and consent although this was not included in the trusts' compulsory training. However, we did have some concerns regarding the understanding of some of the staff at Earlston House. This was based on staff providing us with conflicting information about whether two female patients had the capacity to consent to their bedrooms been located on a male corridor. It was evident from checking the patients' records, that they did not have the capacity to consent with this decision. There was no evidence to show that a capacity assessment had been carried out in line with the Mental Capacity Act (MCA). We discussed this with staff on the ward at the time of our visit. We did not receive assurance that staff fully understood the principles of the mixed sex guidance and issues in relation to the MCA on the ward.

We raised our concerns with the trust on the day of our visit. The trust has submitted an action plan to us which details action they have and will take to address the concerns we raised.

Requires improvement

Are services safe?

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

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

Summary of findings

We have judged the service as requiring improvement in this area because;

- One of the six wards which provided mixed gender accommodation did not meet the Department of Health guidance on same sex accommodation (SSA). The clinic room at Earlston House was located directly opposite two female patients' bedrooms which were on a male corridor. We observed male patients queuing for their medication outside of the clinic room during our visit. This compromised the privacy and dignity of these patients. We did not receive assurance that staff fully understood the principles of the SSA guidance. The trust has submitted an action plan to address these issues although it was not clear from the plan that these two female patients had been moved from this corridor.
- At Abdale House, SSA was well managed but there was no female only lounge. The service addressed this during our visit by designating one of the lounges or therapy rooms as a female only lounge dependent upon the number of females accommodated at the time. Staff told us a notice would be put on the door of the room designated for this purpose so patients would know this was a female only area.
- Environmental risk assessments and individual patient risk assessments were completed and reviewed regularly. However on two wards, there was a bannister at the top of the stairs which led to patient's bedrooms. The bannisters were waist height. This meant it was possible for a patient to fall intentionally or otherwise over these bannisters. The risks associated with the banisters had not been identified through the environmental risk assessments on the wards and had therefore not been escalated onto the directorate or trust risk register.
- During the course of our visit to the service, the trust took action to make sure the bannisters were safe by carrying out the improvement work required.
- During previous visits to two of the wards, we had found a number of restrictive practices in place. The trust had implemented a framework to reduce restrictive practices and many had ceased
- However, staff continued to search patients following unescorted leave on these wards, patients could not access the internet, have mobile phones on the wards and the windows in patients bedrooms were kept locked. These practices were not based on individual patients risk assessments and therefore breached best practice guidance and the Mental Health Act (MHA) Code of Practice (CoP).
- The wards were clean and in good decorative order with well-maintained outside garden areas. Cleaning audits were regularly completed on the wards to ensure standards were maintained.
- The wards had sufficient numbers and the appropriate skill mix of staff on duty at all times to meet patients' needs.
- Overall, we found all the wards had good systems in place for the management of medication including the appropriate storage, dispensing and recording of medication. However, at Abdale House we found some special instructions regarding the administration of medicines were not recorded on two patient's medicine administration records.
- The pharmacy team had worked with some of the wards to develop and implement robust step down procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.

Our findings

Fulmar ward, Kirkdale ward, Park House, Earlston House, Lustrum Vale, Willow Ward and Primrose Lodge

Safe and clean ward environment

We found that one of the wards, Earlston House was not meeting the Department of Health guidance on same sex accommodation (SSA). Two female patients' bedrooms were located on the male corridor. Male patients had to

pass these rooms to access the main ward area. The clinic room was also located directly opposite the two female bedrooms. This had been escalated on to the wards' risk register however from our observations we were not assured that the interventions on the plan to reduce the risk were being effectively implemented on the ward. At the time of our visit, we observed male patients queuing outside of the clinic room for their medication. The risk register plan stated that patients should be chaperoned when attending the clinic room. However staff told us that patients lined up for their medication voluntarily. This meant they were not always chaperoned by a member of staff. We were concerned that it was possible for a male patient to directly look inside a female patient's bedroom if the door was opened. This could compromise patients' privacy and dignity.

The ward had developed a 'risk assessment action plan' dated 26 June 2014 which identified actions required to ensure the ward was compliant with SSA requirements. The plan identified that a female patient could be located on the male corridor of the ward to meet the needs' of the service or patient where demand or need was identified. Under such circumstances, the plan stated that all female patients affected should have a capacity and risk assessment completed and an intervention plan in place which should be discussed with them. This discussion and their agreement should be documented on and after their transfer to the ward. From the care records we looked at, there was no evidence to show this process was being followed.

We discussed this with staff on the ward at the time of our visit. We did not receive assurance that staff fully understood the principles of the mixed sex guidance. We raised our concerns with the trust that same day. The trust assured us they would relocate the clinic room and address the breaches in SSA guidance we identified. The trust has since submitted an action plan to CQC which provides details of how they have moved the clinic room.It was not clear from the plan that these two female patients had been moved from this corridor.

At Park House all the bedrooms were ensuite with showers however there were no male bathrooms on the male corridor. There were two bathrooms on the female side with one located immediately behind the doors, the entrance to the corridor. Staff told us that if a male wanted to use this bathroom, they would be chaperoned by a member of staff who would stand outside the bathroom whilst it was in use to ensure the privacy and dignity of patients' was maintained at all times. Male patients using the female bathroom did not walk past female bedrooms to access the bathroom.

At Primrose Lodge, there was a bannister at the top of the stairs which led to patients' bedrooms. This bannister was waist height. This meant it was possible for a patient to fall intentionally or otherwise over the bannister. The risks associated with the bannister had not been identified through the environmental risk assessment on the ward and had therefore not been escalated onto the directorate or trust's risk register. We discussed this risk with staff on the ward at the time of our visit and with the trust that same day. The trust assured us they would address this risk. During our visit, the trust provided evidence of action they had taken to reduce the risks associated with the bannister. This action involved 'boxing' the bannister in to ensure patients were no longer at risk of falling over it.

There were a number of ligature risks on most of the wards we visited although these had been identified through environmental risk assessments which were regularly completed on the wards. Where a risk had been identified, there was an action plan in place to reduce the risk.

The wards were clean and in good decorative order with well-maintained outside garden areas. All the wards had completed a patient-led assessment of the care environment (PLACE). Scores for all the wards were in line with the national average regarding cleanliness and infection control and prevention although Earlston House scored the lowest within the trust for facilities with 83%. Cleaning audits were regularly completed on the wards to ensure standards were maintained. Fulmar, Willow, Lustrum Vale and Kirkdale ward were all purpose built with clear lines of sight. Primrose Lodge, Earlston House and Park Lodge were older buildings which had been adapted to provide rehabilitation for patients. These wards did not have clear sight lines due to the layout of the buildings. Staff on these wards told us that if a patient posed a risk to themselves or others which could not be safely managed on the ward, they would be transferred to a more appropriate environment to meet their needs and ensure their safety.

The wards all had a clinic room which were generally tidy and there was access to emergency resuscitation equipment and drugs which were checked regularly. Each

ward was supported by a pharmacist who conducted monthly medication checks. Electrical equipment had been portable appliance tested (PAT) annually as per trust policy. Staff had access to alarm and emergency call systems which were appropriate to the risks identified on the ward they were working. There was CCTV in operation on Fulmar and Kirkdale wards. Notices were displayed to inform visitors and patients of this.

Safe staffing

The wards had sufficient numbers and the appropriate skill mix of staff on duty at all times to meet patients' needs. On Kirkdale and Fulmar wards, there were at least two qualified nurses on duty at all times and at least one qualified nurse on the other wards. The wards had daily input from a consultant psychiatrist or ward doctor. Out of office hours, there was an on call system in place for medical cover. Staff and patients told us there were no problems accessing a doctor when required.

Staff vacancy rates and sickness levels were within or below expected limits when compared with similar services with the exception of Park House which had a sickness rate of 15.7% and Willow ward which was slightly over at 9.4%. Primrose Lodge had the lowest at 3.4%. The other wards had a sickness rate of between 4.9 and 7.3%. The ward managers told us they had the authority to increase staffing levels in response to increased clinical risks or unplanned sickness to maintain the safety of patients and staff on the wards. Where possible, permanent staff covered any staffing vacancies. Fulmar, Lustrum Vale and Park House each had a relatively high use of bank or agency staff to cover staff absence which ranged from between 135 to 205 shifts. On the majority of wards, most shifts had been covered by bank or agency staff when required. On Fulmar ward, 64 shifts had not been filled by bank or agency staff to cover staff sickness and 29 had not been filled on Kirkdale ward. Staff on Kirkdale and Fulmar wards told us that due to the locked environment on these wards, they requested staff who had worked on the wards previously to ensure they were familiar with the environment. This limited the availability of appropriately experienced bank or agency staff to cover staff shortages on these wards which is reflected in these figures. Park House, Kirkdale ward and Earlston House had the highest staff turnover ranging from between 17% to 19%. The other wards ranged from 0% to 9%.

Patients told us that ward activities or planned leave were rarely cancelled due to staff issues and where this had occurred, it was due to staff dealing with an emergency situation. All the wards had regular medical cover and an effective on-call medical system out of office hours.

Overall, patients we spoke with told us they had the opportunity to spend one to one time with their named nurse or a member of their allocated nursing team. All the wards allocated a member of staff to each patient for the duration of the shift. This information was displayed on the wards so patients knew who their allocated member of staff was for that day. We saw evidence in the care records which confirmed that patients had the opportunity to speak with staff on a one to one basis regularly.

Staff and patients told us that escorted leave was rarely cancelled. Where leave was cancelled, we were told it was rescheduled within 48 hours. On Fulmar ward, the number of leaves cancelled per month was displayed on a board which was located at the entrance of ward. Staff were able to provide information regarding a peak which had occurred where nine planned leaves had been cancelled in a one month period and action they had taken to reduce this. We were able to see from the board that the level of cancelled leave had reduced significantly following action taken by the ward to manage this.

Assessing and managing risk to patients and staff

Fulmar ward was accessed via an 'air lock' which was constantly monitored and managed by staff. This was because the ward was located within the perimeter fence of the forensic medium secure services. Kirkdale ward was also a locked rehabilitation ward however the ward was located outside of the medium secure perimeter fence. The main door to the other wards was kept locked with access via an intercom system. Staff told us this was for security reasons to enable them to monitor access to the wards as some were stand-alone wards in the community. There were posters on the internal door to inform patients of how they could leave the ward and their rights in relation to this.

Previous Mental Health Act monitoring visits identified restrictions imposed on patients on Kirkdale and Fulmar ward which were not based on patients' individual clinical risks. The trust had implemented a, 'Trust Framework on the use of Restrictive Practices within the Forensic Service' which was completed in January 2015 to reduce these practices. The framework states, 'Locked rehabilitation

Requires improvement

Are services safe?

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

services will operate such that the presumption is that the person will not be subject to restrictions, unless risk assessment for the individual is that the restriction is required, subject to regular review' and ' There will be no blanket restrictions in place in any unit regarding searches. In other words, it is possible for an individual in any unit not to require either a routine room search or rub-down search after unescorted leave if the risk is low enough.'

We found that most of the restrictions had since ceased however, some restrictions were still in place. All the patients on both these wards were subject to detention under the Mental Health Act (MHA) 1983 therefore they required authority under section 17 of the MHA before they were allowed to leave the wards. We were told by staff and patients on these wards that all patients were routinely searched on initial admission to the ward and following any period of unescorted leave they had taken. This was not based on patients' individual risk assessments or their clinical need. On Kirkdale and Fulmar ward, patients' bedroom windows were all kept locked. Staff told us this was to reduce potential ligature risks although the windows were specifically designed to be anti-ligature. Staff told us this practice was currently under review. Patients on these two wards were not allowed mobile phones on the ward and did not have access to the internet. Staff told us the trust was in the process of installing computers with internet access for patients on these wards although they were unable to confirm a date for completion of this work.

Each patient had a FACE risk assessment completed on admission. FACE is a nationally recognised evidenced based risk assessment tool which covers areas such as the patients' risk of self-harm, risk to others and risks due to their vulnerability. These were reviewed every month or in response to any incidents or changes in the patient's presentation. Where a risk had been identified, a care plan was in place to reduce or manage the risk. We saw evidence showing risk assessments and care plans of patients involved in any incidents were updated in a timely manner and appropriate action was taken to manage potential future risks. With the exception of Fulmar and Kirkdale wards, we were told that observation levels would be increased as a temporary measure if a patient's mental health deteriorated however if it was required on a longer term basis, or if the risks were too high for the patient to be safely managed on the ward, then they would be transferred to a more suitable environment.

The wards did not have any operational seclusion rooms although Willow ward had a seclusion room which had been decommissioned. There were 5 incidents involving the use of seclusion room on Fulmar ward between April 2014 and September 2014. In these instances, staff had accessed a seclusion room located on another ward within the building. There had been no other reported use of seclusion across the service. Where seclusion had been used, staff had followed the trust's policy and procedures and care record documentation evidenced this.

The number of incidents involving the use of restraint was relatively high on Fulmar ward over the 6 month period between April and September 2014 with 126 incidents reported, 33 of which involved the use of the 'prone' or face down position. The trust were aware of the high number of prone restraints used within the trust and had developed a, 'Restraint reduction action plan' for implementation during 2014/2015 in addition to a 'Force reduction project' which had an identified aim of prone restraint being, 'continually reduced within inpatient services, working towards zero usage ending the use of prone restraint within the trust' with a target date for completion of April 2015. Staff we spoke with were aware of the project. At the time of our visit, it was not possible to determine that the action plan had made a positive impact on the number of prone restraints used on Fulmar ward as a further seven episodes had occurred during both October and November 2014.

On Willow ward there were 16 incidents, 5 of which involved the use of the 'prone' position one of which resulted in rapid tranquilisation being administered. On Kirkdale ward, there had been 4 incidents involving the use of restraint, 1 of which included the use of the 'prone' position.

Staff told us that they did not always record how long a patient had been restrained in the prone position for on the datix reporting system. However, all the staff we spoke with told us they immediately 'turned' a patient if they needed to use the 'prone' position to safely manage the patient to the floor. They told us they did not use prone restraint unless there was a clinical reason to ensure the safety of the patient and a care plan was in place to manage the risks associated with the use of prone restraint for the individual patient.

Requires improvement

Are services safe?

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Staff had a good understanding around safeguarding issues and how to raise an alert. Safeguarding training was compulsory within the trust and the majority of staff had completed the training.

All the wards had a child visiting protocol in place which identified a designated room for child visiting to take place. All child visits had to be booked in advance to ensure sufficient numbers of staff were on duty to support the visit and the ward was safe to facilitate this.

Across all the wards, we found staff compliance with safeguarding training was high and was monitored regularly by the ward managers to ensure this was maintained. Staff we spoke with were knowledgeable about their responsibilities regarding making safeguarding alerts and told us they felt supported by the trust to do so.

We reviewed 28 prescription charts across the service. Overall, we found all the wards had good systems in place for the management of medication including the appropriate storage, dispensing and recording of medication. At Park House, there were six out of 13 patients on the ward who had been administered an 'as required' hypnotic medication for over seven days. Staff told us this had been reviewed on a weekly basis by the multi-disciplinary team. We found that where rapid tranquilisation had been used, staff had followed best practice guidance to ensure the physical needs' of the patient was monitored regularly and trust policy was adhered to.

Track record on safety

There had been one serious incident reported to the trust in the past 12 months which had been on Kirkdale ward and related to illicit drugs being found on the ward. This incident had been dealt with appropriately by staff.

The ward managers told us that learning from trust wide incidents was discussed in the ward team meetings. This was confirmed by staff we spoke with and evidenced in the team meeting minutes we looked at. Agenda items for the team meetings included safeguarding, complaints, learning from incidents and safety alerts. Minutes were made available to staff unable to attend the meetings.

Reporting incidents and learning from when things go wrong

The wards had an electronic datix incident reporting system which was completed following any incidents. Staff knew how to use the system and what their responsibilities were in relation to reporting incidents. Staff at Park House told us that following a serious incident which had taken place involving a patient they were caring for, they were fully supported by their manager and had access to de-briefing sessions.

The wards held regular shift handovers to ensure that on-coming staff were made aware of any incidents which had taken place on the ward, who had been involved and the outcome of the incident.

Abdale House

Safe and clean ward environment

We looked at the design layout and cleanliness of the ward where patients were cared for and found the environment was safe and suitable given the age of the building. Staff were not able to observe patients in some areas of the building due to the design and layout of the building. The building dated back to the turn of the twentieth century.

At the last inspection completed 23 April 2013 there was an issue about the poor state of the building. This issue had been fully addressed. Remedial works and some redecoration had taken place since our last visit.

The 2014 infection control audit for Abdale House was a 94% achievement against the audit pass mark of 80%. Four areas were identified where improvement should be made. For example cleaning the surfaces of wipeable furniture. The service also used 'safer food better business' for managing food preparation and storage. This included cleaning of the kitchen and domestic fridges and freezers. We saw the service was monitoring the operational temperature of the fridges and freezers daily and there were cleaning schedules in place for the cleaning of the kitchen area.

There were a number of ligature points throughout the building and these were identified on the ligature risk assessment with the exception of the stairwell, some fixed curtain rails in lounges and hinges on wardrobes. The ligature risk assessment identified the risk in each room and bedroom within the house, although these did not link to the individual risk management plans of the patients occupying them. The ligature risks had been raised at a quality assurance group meeting and funds for work to be done to reduce the ligature risks requested. Some work

Requires improvement

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was completed and other work not done as the service was due to move to a new building in April 2015. This was recorded on the action plan for the risk management of the ligature points.

Permanent staff knew where the ligature cutters were located and told us they knew how to use them. The building was safe with the exception of the stairwells. There were two sets of stairs at either end of the house. These stairwells had low level bannisters and patients could jump or fall from the top to the next floor and were at risks of significant injury. We raised this risk with the trust that day. The trust assured us they would address this risk. During our visit, the trust provided evidence of action they had taken to reduce the risk associated with the bannister. This action involved 'boxing' the bannister in to ensure patients were no longer at risk of falling over it.

There was a nurse call system throughout the building

From the entrance hall there was access to the staff office (which doubled as the clinic), dining room, kitchen, utility room, two lounges, and the multi-functional activity room. There were two bedrooms on the ground floor and we observed that one was occupied by a male patient and one by a female patient. The mixed sex accommodation was managed by having male bedrooms at one side of the house and female bedrooms at the other and designating the bathrooms as male or female only. However the male and female designated accommodation had access to bathroom/toilet facilities in them so these facilities were not shared. There was no separate female only lounge. During our visit, the trust addressed this issue by creating a female only lounge.

We saw that staff checked the emergency equipment daily. The equipment included appropriate resuscitation equipment and emergency drugs. Staff had training in life support techniques.

Alarms were available in each room in the ward and staff knew how to respond if the alarms were activated.

Safe staffing

We looked at the staffing levels in Abdale House to ensure they met the needs of the patients. We reviewed the staff rotas for the weeks prior to and during our inspection and saw that staffing levels were in line with the levels and skill mix determined by the trust as safe and were displayed in the building. Staffing was flexible.

The ward manager was able to adjust staffing levels daily to take into account patients care and treatment needs. The manager said since they commenced in post staffing levels and skill mix had remained the same. Normal staffing levels were one registered staff nurse and one health support worker. This could adjust to two registered nurses on duty. There were two staff on duty during the day and night. There was support from a full time occupational therapist (OT) and technical instructor. The staff roster indicated where bank staff were on duty. The manager said agency staff were rarely used, except during the last three months due to exceptional circumstances of staff sickness. All bank staff were familiar with the ward and patients.

The manager had the authority to bring in additional staff if needed. Staff told us that sometimes one to one activities were cancelled due to staffing levels. They said they tried to facilitate one to one activities with the support of the technical instructors. One patient said they were supported to attend college with support from staff. The OT did the one to one sessions for the recovery star with patients. Staff told us there had been a few occasions when section 17 leave had been cancelled as too few staff were on duty. However between 9am and 5pm there were often OT and medical staff in the building to support section 17 leave. The service only accepted patients who already had unescorted leave if they were detained patients. This meant staff did not need to escort these patients when leaving the building.

Bank staff completed a corporate induction. This included training on fire safety, safeguarding adults and equality and diversity. One told us they still had to complete first response and management of violence and aggression training.

Staff told us there were arrangements in place to deal with medical emergencies both day and night. They told us there was a junior doctor on call both day and nights as part of the junior doctor rotation and they were one mile away at the main hospital.

Assessing and managing risk to patients and staff

Risks to individuals were effectively assessed and managed on admission and following any incidents. These included clinical and health risks and risks of harm to the patient and to others. Patients were involved and risk assessments were patient-centred, proportionate and reviewed

Requires improvement

Are services safe?

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regularly. Staff used a recognised risk assessment tool. For example we saw the functional assessment of the care environment (FACE) used to assess risks to and from patients.

There were several entrances and exits to the building. Staff told us as part of the referral and risk assessment of patients they had to be a low risk to themselves or others as well as having unescorted leave arrangements in place. They said if a patient presented as a risk due to their mental health deteriorating they would be assessed in an acute mental health ward. This was because Abdale House could not support acutely ill patients.

Where patients were not detained under the Mental Health Act 1983 (MHA) they were able to leave the ward at will. We saw six of the nine patients were not detained and observed patients telling staff when they were going out and what plans they had. These arrangements were not challenged by staff but they asked patients to inform them of their leaving/return to the building for fire safety reasons.

Abdale House followed the trusts observation policy. The ward admission criteria stated that patients who required more than general observations could not be admitted. Clinical risk assessments were in place and staff encouraged patients to say how they were feeling and talk to staff if feeling suicidal. The focus was on positive risk taking so patients were working towards independent living and recovery.

Staff told us due to staffing levels the service could not practice physical restraint so all de-escalation was verbal. If required staff would contact the police but this would be exceptionally rare. Staff told us it had been five years since the last incident involving physical aggression had occurred. Staff confirmed restraint, prone restraint and seclusion had not been used in the service.

We were told by staff that searching of patients was rarely carried out and staff could only recall one occasion when drugs were suspected of being bought into the unit.

The trust had a safeguarding policy which operated alongside the County Council policy. For vulnerable adults staff could refer to either the trust lead or North Yorkshire County Council (NYCC) lead. For children there was a service level agreement with Harrogate Council and an identified liaison contact. Staff told us patient vulnerability and safeguarding was discussed at every multi-disciplinary team (MDT) meeting. There had been one alert made to NYCC and staff reported very good relationships between the local council and the trust. Staff were aware of how to report safeguarding incidents and who the trust and local council safeguarding leads were. Staff were trained in safeguarding adults and described how to contact the trust or/and the local authority. They told us information about safeguarding adults and children was on the trust intranet and we were shown an information folder kept in the office. Information provided by the trust showed there were no safeguarding incidents reported at Abdale House in 2014.

Medicines were being stored securely at the service. We checked the receipt, storage and administration of medicines. We saw the trust pharmacist reviewed medicine management arrangements on a regular basis and signed medicine cards to record they had looked at these. We noted medicines were safely administered. However we saw that some special instructions regarding the administration of medicines was not recorded on two patient's medicine administration records. The prescribed medicines were for the control of diabetes and long term gastric conditions. These should have been administered before and with food but these instructions were not recorded on the medicine administration record. When asked about this, the staff nurse on duty was not aware the instructions needed recording.

The staff office was also used as the clinic and we were informed that patients would be invited in to the office to receive their medication. We were concerned about how this arrangement might impact on patient privacy particularly when there were other members of staff working in the office at the same time. We were also concerned about how this may distract staff administering medication when other patients or staff were in the office at the same time.

Track Record on Safety

In the last year there had been one serious untoward incident involving a patient. We saw staff had been informed of any learning from the incident.

Reporting incidents and learning from when things go wrong

Incident recording and reporting was effective and embedded in the service. All incidents on the ward were recorded via datix the incident reporting system the trust used. Incidents tended to be burns and cuts and things going missing. No incidents had been reported between

Requires improvement

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October to December 2014. All staff had access to datix. Incidents reported were reviewed by the team leader and manager if necessary. Learning from incidents took place through handover and minutes of staff meetings. Staff told us the team had opportunity to debrief following incidents and there was lots of available support throughout the organisation.

Staff and patients were provided time to talk about how any incidents had affected them, and look at what would improve the experience if it happened again. Staff said they would speak to patients straight away following an incident and if necessary seek further advice from their manager or a doctor if necessary.

Are services effective?

Good

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

Summary of findings

We have judged the service as good because;

- The wards delivered care and treatment which was underpinned by the principles of the recovery model and best practice guidance under the framework of the Care Programme Approach (CPA). Patient's social, occupational, cultural and psychological needs and preferences were assessed and reviewed regularly. There were effective multi-disciplinary team ways of working embedded on all the wards we visited. We found some good examples of how the teams had developed good working relationships with partner organisations both internal and external of the trust to support patient's recovery.
- Compliance with mandatory training, supervision and appraisals was good overall across the service.
- We found good compliance across the service with the requirements of the MHA. Overall, we found that staff had a good understanding in relation to issues regarding capacity and consent although we found there were some deficits in the understanding of some staff at Earlston House which was being addressed by the trust.

Our findings

Fulmar ward, Kirkdale ward, Park House, Earlston House, Lustrum Vale, Willow Ward, and Primrose Lodge

Assessment of needs and planning of care

Patient care records were electronically held. This meant that if a patient was transferred from one ward to another within the trust, staff receiving the patient had immediate access to their care records. In the care records we looked at, we saw that each patient had a comprehensive assessment completed as part of the admission process. This included the patient's social, occupational, cultural and psychological needs and preferences. There was evidence that psychology led formulation meetings took place where patients care and treatment was planned by the MDT. Patients received regular physical health assessments and reviews. The care plans were underpinned by the principles of the recovery model and the recovery star was fully embedded in practice on the majority of the wards we visited. Discharge planning was implemented under the framework of the Care Programme Approach (CPA) in line with best practice. This is a particular way of assessing, planning and reviewing a patient's mental health care and treatment needs.

All patients were registered with their own general practitioner (GP). The service also had an 'in reach' GP provision for patients on Fulmar ward, Kirkdale ward and Primrose Lodge. Physical health assessments were undertaken on a monthly basis and on-going monitoring of patient's needs was incorporated within their treatment plans.

Best practice in treatment and care

The wards delivered care and treatment which was underpinned by the principles of the recovery model and best practice guidance.

Patients were able to access psychological therapies including cognitive behavioural therapy, group therapy and family therapy as part of their treatment as recommended by National Institute for Health and Care Excellence (NICE) for the treatment of psychosis and schizophrenia. We were invited to attend a, 'Step recovery group' at Primrose Lodge which demonstrated how this was implemented in practice by the ward.

From reviewing medication charts, we found evidence to show that staff followed NICE guidance when prescribing medication and following the use of rapid tranquilisation.

Patients remained registered with their own local GP and each patient had an allocated care co-ordinator in line with the requirements of the Care Programme Approach (CPA).

There was evidence the teams assessed patients needs' using a range of social, physical and psychological rating scales.

The pharmacy team had worked with some of the wards to develop and implement robust step down procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.

Skilled staff to deliver care

We spoke with a range of staff across the seven wards including the ward managers, modern matrons, service

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managers, doctors, nurses, student nurses, psychologists and occupational therapists. Staff told us they were fully supported by the service to access training to assist them within their role.

Compliance with mandatory training, supervision and appraisals was good overall across the service. The ward managers took responsibility for ensuring compliance was adhered to. Most wards had notice boards in the staff room which RAG rated compliance with training, supervision and appraisals. Staff told us this had helped to improve compliance as any gaps were easily identified.

Staff we spoke with told us they were supported by their manager to access training relevant to their role and we were provided with evidence of this.

The ward managers were able to provide us with examples of action they had taken to support staff who were not meeting expectations and action they had taken to address this through the use of line management supervision, staff training and disciplinary action if needed.

Multi-disciplinary and inter-agency team work

We attended one multi-disciplinary team (MDT) meeting. MDT meetings were carried out under the framework of the Care Programme Approach (CPA) and were attended by a range of staff involved in the patient's care which included support workers, nurses, occupational therapists, psychologists and medical staff. Other professionals involved in the patients care such as a dietician or physiotherapist attended as required. Patient's relatives or carers were invited to attend in line with the patient's wishes.

The wards held regular hand overs to ensure that on-coming staff were made aware of any change's which may impact on the delivery of the care or treatment a patient required.

We found some good examples of how the teams had developed good working relationships with partner organisations both internal and external of the trust. This included the use of volunteers through a voluntary agency to support patients and good links with community mental health teams, housing organisations and the trust wide recovery college.

Adherence to the MHA and the MHA Code of Practice

We found good compliance across the service with the requirements of the Mental Health Act (MHA). The mental health act reviewer looked at the rights of patients detained under the MHA across the service. They found that MHA documentation was present and available for inspection and was in order. There was good compliance with the requirements of the MHA across the wards. All of the issues relating to the recording of MHA documentation which had been identified through mental health act monitoring visits to the wards over the past 18 months had all been addressed.

Patients were aware of their rights under the MHA and there was evidence that these were repeated at least three monthly as stipulated in the trust policy. We found however that staff frequently repeated patients' rights at more regular intervals than this requirement at CPA meetings or when a patients' comprehension was limited in line with best practice. Independent mental health advocate (IMHA) services were routinely offered to patients and section renewals had been made in good time. Reports by approved mental health professionals (AMHP) were kept with the patients' section papers.

We found very comprehensive records of the responsible clinicians' discussions with patients regarding capacity and section 58 requirements in line with the Mental Health Code of Practice (CoP). On the sample of patients' prescription charts we looked at, there were no discrepancies between medications being administered and medication listed on the T2 (certificate of consent to treatment) and T3 (certificate of second opinion) forms. All authorised medication was within the British National Formulary (BNF) limits.

We found that there was a standardised process in place for authorising leave under section 17 of the MHA. Patients we spoke with were aware of their leave authorisation and any conditions attached to this.

Good practice in applying the MCA

At the time of our visit, there were no patients subject to DoLs on any of the wards we visited.

Overall, we found that staff had a good understanding in relation to issues regarding capacity and consent although this was not included in the trusts' compulsory training. However, we did have some concerns regarding the understanding of some of the staff at Earlston House. This was based on staff providing us with conflicting

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information about whether two female patients had the capacity to consent to their bedrooms been located on a male corridor. There was reason to doubt from checking the patients' records, that they had the capacity to consent with this decision. There was no evidence to show that a capacity assessment had been carried out in line with the Mental Capacity Act (MCA). We discussed this with staff on the ward at the time of our visit. We did not receive assurance that staff fully understood the principles of the mixed sex guidance and issues in relation to the MCA on the ward.

We raised our concerns with the trust on the day of our visit. The trust has submitted an action plan to us which details action they have and will take to address the concerns we raised.

Abdale House

We looked at the care records of seven patients and found they were personalised and recovery focused. A comprehensive and timely assessment had been completed for each patient after admission. Care records showed that a physical examination had been undertaken and that there was ongoing monitoring of physical health problems. There was a range of professionals involved in patients care such as occupational therapy, nursing and clinical staff. A GP visited the service every week to monitor patients' physical health and refer to other professionals if required.

All information to deliver care was recorded on the electronic patients' records called Paris. This was accessible to all staff. Staff also received information through the handover at each shift. Paper information available to patients included section 17 leave which was stored securely in a folder in the office. Patient files were kept in a locked cabinet in the office. Patients' care plans were printed and put there for ease as bank workers did not have access to Paris. The recovery star was available in a paper format.

Each patient had a number of different care and support plans in place to address their different areas of need. We saw support plans were regularly reviewed and saw evidence of up to date risk assessments and discharge plans. We were told staff organised one to one sessions during the week for each patient which care plans did not reflect the collaborative nature of this process as the patient's view was not evident in the plans that we reviewed. Care plans recorded the aim of the support patients needed but did not record goals or outcomes or have a space for the patient to record their view. However, we saw some work had been undertaken on the recovery star for some patients. We looked at a sample of these and found they clearly demonstrated the patient's views and wishes. However the recovery star seemed to operate as a standalone documents and the information they contained did not appear to be linked to the care and support plans we saw.

Best practice in treatment and care

Staff told us they followed NICE guidance when they prescribed medication. The ward had a nurse prescriber, who was a staff nurse. They worked with the consultant and the pharmacist on prescribing for patients. Regular audits were undertaken of the prescribing of medicines by the pharmacist and the service was developing separate medicines management care plans. There was a named pharmacist who checked prescription charts, for any contra-indications from medicines prescribed.

Currently the service was not part of a peer review system and did not use a recognised quality initiative system such as the Royal College of Psychiatrist accreditation system. They said the service was going to apply for accreditation once the move to the new build had been completed. They told us the trust provided a varied programme of education on the recovery model and the consultant psychiatrist was part of the trust recovery group which met every four months and had a six month symposium to discuss progress.

Patients had access to psychological therapies as part of their treatment. Referral to psychology services were made through the multi- disciplinary team.

Staff referred to the use of NICE guidelines and this was reflected in care plans we reviewed. We saw a policy that committed to the rehabilitation and recovery practice in the service. Some staff were not aware of this document. The recovery star was used as part of the commission for quality and innovation (CQUIN) framework from NHS England, which aimed to support operational improvements in the quality of services, whilst creating new, improved patterns of care.

The manager said staff engaged in clinical audits on the ward and gave examples of infection control, medication and care records as clinical audits completed on the ward.

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.

Skilled staff to deliver care

Staff were appropriately qualified and competent at the right level to carry out their work. Staff received a corporate induction which covered a variety of courses including safeguarding adults, health and safety and the MHA. They said the session on the MHA was a one hour session and additional courses were available throughout the year.

All staff had received mandatory training. There was specialised training available to staff but this was not local and staff said it was more difficult to attend/access. There was access to psychosocial intervention training offered externally.

There was effective supervision, appraisal and management of poor performing staff. All staff had received an appraisal. The manager said individual supervision was difficult due to the numbers of staff involved but group supervision took place, which was usually led by the OT. There was a leadership induction when the trusts merged and they became part of TEWV. The manager said they were involved in 'rapid improvement' workshops as part of the quality improvement systems in place which included staff performance. There were no current concerns about staff and concerns about staff performance were addressed promptly.

Multi-disciplinary and inter-agency team work

A multi-disciplinary team meeting (MDT) is a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the patients' needs and the condition or disease being treated.

The staff team was made up of nurses, clinicians, and occupational therapy staff. There was a multi-disciplinary collaborative approach to care and treatment. We were told the pharmacist and GP who held weekly surgeries at the service attended the MDT meeting as well as the junior doctor or clinical assistant. The psychologist attached to the recovery service did not routinely attend MDT meetings but would relay progress to the consultant psychiatrist prior to meetings. Social workers would attend on request if they were involved with an individual patient. Staff said other team members such as the OT and consultant psychiatrist attended handovers.

Staff told us there were good working relationships with the local authority and community mental health team care coordinators. They said discharge planning, transfer and transitions to other services were planned in advance and usually occurred as part of MDT or care programme approach (CPA) meetings.

There were effective handovers where staff were fully informed about patient needs.

Adherence to the MHA and MHA Code of Practice

We checked the records for all three detained patients and found evidence that effective systems and processes were in place for the administration of the Act. However, in the case of one patient we were unable to locate copies of the original detention orders within the patient files. We found that there was a system in place to ensure that detention documents were scrutinised and correctable errors were corrected within the specified period and in accordance with the Mental Health Act (MHA) and Code of Practice (CoP).

We found the patient files to be disorganised and those that we scrutinised contained old and duplicated information as well as information pertaining to previous detentions under the Act. We also found the electronic patient notes (Paris) difficult to navigate.

Patients were informed of their rights in accordance with section 132 on admission and where patients lacked capacity to understand, we found evidence that repeated attempts were made to ensure that patients continued to be given this information until they could understand it. However, in the case of one patient it was not possible to identify when they had been advised of their rights as there was no date on the section 132 form. Patients confirmed that they had regular discussions about their rights with staff and were aware of their legal status.

Patients had access to independent mental health advocacy (IMHA) service and information about this service, including the contact number which was contained within the section 132 rights leaflet. However patients lacking capacity were not automatically referred to the advocacy service. We were unable to find any information regarding the IMHA service displayed on notice boards anywhere within the service.

We reviewed the authorisation of section 17 leave for the detained patients. We found that the authorisation of leave was linked to comprehensive risk assessment. There did not appear to be any concerns with patients being able to

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access leave that had been authorised and we found that leave was therefore used appropriately as part of the patient's treatment plan. However, we found that the leave forms were ambiguous as patients were granted both escorted and unescorted leave and it was not clear under what circumstances a patient requiring escorted leave would be allowed to leave the premises unescorted. The outcome of section 17 leave was recorded although this did not always include the patient's own view of their leave. It was also not clear whether patients were always given copies of their leave forms as this section was rarely completed. Old and superseded leave forms were in the current leave file which could lead to some confusion about a patient's current leave status. We also noted that the Ministry of Justice (MoJ) form detailing the conditions of leave for the restricted patient was not present in the leave file alongside his section 17 form.

We reviewed a sample of the patient records and found that treatment was given under an appropriate legal authority. However, there was a T2 in place for one patient which appeared to authorise treatment with a nutritional supplement which would fall outside the definition of medical treatment for mental disorder as defined by section 145(4) of the Act.

Good practice in applying the MCA

Assessments of capacity were completed at key milestones in a patient's treatment and the assessment was documented and available in the medicine cards file. Staff had a corporate induction which covered the Mental Capacity Act (MCA). Staff showed us the forms within the Paris system they used to assess patients capacity to consent to care and treatment, which they completed routinely as part of the assessment process. Staff said they would if necessary seek initial advice about the MCA from a local social worker. They said there was also a department in the trust that gave support and advice when needed. Staff said applications for deprivation of liberty safeguards (DoLS) would be made if required but none had been made to date.

Good

Are services caring?

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

Summary of findings

We have judged the service as good because;

- We observed staff engaging with patients and their relatives in a caring, compassionate and respectful manner throughout our visit to the wards. Staff were attentive to patients needs and responded promptly when patients requested support.
- Overall, the feedback we received from patients was positive in relation to the care and treatment they received from staff. Patients had the opportunity to be involved in all aspects of their care including regular reviews. The service had systems in place to gain feedback from patients and their carers and we saw evidence to show that action was taken by the service in response to this.

Our findings

Fulmar ward, Kirkdale ward, Park House, Earlston House, Lustrum Vale, Willow Ward, and Primrose Lodge

Kindness, dignity, respect and support

We spoke with 30 patients and three relatives across the service. They all told us that staff were kind, caring and treated them with respect. We observed good interactions between staff and patients throughout the service. Patients appeared relaxed and comfortable in the presence of staff. We observed staff engaging with patients and their relatives in a caring, compassionate and respectful manner. We saw staff treating patients with dignity throughout our visit. All the vistamatic windows we saw in patients' bedroom doors were in the closed position and we observed staff knocking on patient's bedroom doors and calling to patients before entering their bedrooms.

Patients on Willow, Lustrum Vale and Fulmar ward completed comment cards for the comment boxes we left on each ward during our visit to the service. We received positive comments from patients on each ward regarding staff attitudes towards them. However we also received some negative comments regarding the attitudes of some staff on Fulmar ward.

The involvement of people in the care they receive

All patients referred to the rehabilitation service have the opportunity to look around the ward prior to being admitted. All the wards had information booklets for carers and patients which were specific to the ward. We saw evidence within the care records that patients and their carers were involved in their multi-disciplinary team (MDT) review meetings across the service. This was also confirmed when we attended a MDT meeting and spoke with patients on the wards.

The wards had several notice boards with information available to patients and carers. This included information about the patient advisory liaison service (PALS), carer questionnaires, advocacy, carer support meetings and external organisations carers' could approach for advice or support, spiritual support, complaints and a range of health promotion information leaflets.

Most of the wards held carer meetings to support relatives and carers of patients on the wards. From the minutes of the meetings we saw, it was clear that these were established and generally well attended.

The wards had various ways to gain feedback from patients which included suggestion boxes, questionnaires and regular community meetings. Access to advocacy was actively promoted on all the wards we visited. Some wards had 'You said-We did' boards which displayed action the ward had taken in response to feedback it had received from patients or their visitors.

Abdale House

Kindness, dignity, respect and support

Feedback from patients was positive about the way staff treated them. Patients commented very positively about the quality of care and treatment they received at Abdale House. Patients told us about a wide range of opportunities available to them in the community and we noted that all patients had daily leave. Most patients we spoke with were very happy to remain at Abdale House in the short term and had some ideas about when and where they would be moving to in the future.

Staff treated patients with dignity and respect and we saw staff approached patients courteously, spoke with them respectfully and used their preferred names. All patients we

Good

Are services caring?

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

spoke with said the attitude of staff towards their care was of motivated, positive engagement and support. One patient expressed to us that the staff treated patients with respect and compassion.

The involvement of people in the care they receive

We observed staff involved patients as partners in their own care and in making decisions with support where needed, including support from advocates. This was recognised by managers and staff as central to meeting rights for consent, choice and control during treatment and care.

Verbal and written information that enabled patients to understand their care was available to aid patients make comments about their care and treatment. We noted there was information displayed on notice boards about the trust complaint procedure. Staff made repeated attempts to help patients who were detained understand their rights. We were informed that staff organised one to one sessions during the week for each patient which provided an opportunity for patients to discuss their treatment and care.

Good

Are services responsive to people's needs?

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

Summary of findings

We have judged the service as good because;

- The service had a clear pathway in place to support patient's recovery from admission to discharge. Patients had access to a range of recreational and therapeutic activities and facilities to support their recovery. The service met patients' diverse needs' and promoted patients' access to advocacy.
- All discharges were planned in advance through the Care Programme Approach process which identified the patients' aftercare needs'. The wards held regular community meetings with patients to gain feedback about the service.
- Patients at Abdale House had been involved in the plans to move to the new service called The Orchards.
- Complaints were managed and responded to appropriately.

Our findings

Fulmar ward, Kirkdale ward, Park House, Earlston House, Lustrum Vale, Willow Ward and Primrose Lodge

Access, discharge and bed management

Each ward had a criterion which was used to assess patients referred to the service to ensure it was able to meet their needs. The wards accepted new referrals from a range of sources including the acute wards, secure services and community based settings. The wards at Lustrum Vale, Park House and Primrose Lodge had a single point of access into the service. They also had a liaison nurse who visited the acute wards on a regular basis to identify patients who may be appropriate to be transferred to one of the rehabilitation wards. This meant they could begin to engage with patients prior to them being discharged to the ward to ease the transition. On the other wards, if a patient was accepted to the service, staff would arrange to visit the patient on several occasions prior to them being transferred. This enabled staff and the patient to get to know each other and start to plan the next steps once the patient moved to the ward. Figures provided by trust show 98% of referrals were assessed within four weeks of referral across all adult services including the rehabilitation wards. Decisions to admit patients to the service were made with the involvement of the multi-disciplinary team (MDT), the patient and the patient's carers where appropriate.

With the exception of Fulmar and Kirkdale wards which were locked wards, staff told us that consideration was given to where the patient was living or wished to live when deciding which ward the patient should be admitted to. Admissions to the wards took place at appropriate times of the day with the majority planned in advance. Staff told us that occasionally, patients were transferred to a rehabilitation bed from the acute ward at short notice however, where this happened, the patient had already been assessed as appropriate for transfer.

Bed Occupancy figures for the wards over the past six months were; Earlston House 96%, Park House 100%, Primrose Lodge 87%, Kirkdale ward 72%, Willow 100%, Fulmar 86% and Lustrum Vale 89%. The average length of stay on the wards was consistent with the model of care provided on that particular ward. There were no reported delayed discharges over past six months on any of the wards.

Patient's designated bedrooms were allocated to the patient for the duration of their stay. This meant that following a period of leave, the patient always returned to their own bedroom.

All discharges were planned in advance through the Care Programme Approach (CPA) process which identified the patients' aftercare needs'. This also specified the follow up arrangements in place to support the patient post discharge. Re admission rates within 90 days of discharge over the past six months were low. Primrose Lodge had one and Willow had two. This indicates that the discharge process effectively supported patients to move from the wards to the community.

The ward optimises recovery, comfort and dignity

All the wards were calm and relaxed throughout our visit. They were in good decorative order, well maintained with access to suitable outside space.

There was a range of recreational and therapeutic activities and facilities to support patient's recovery which included therapy rooms, assessment kitchens, quiet rooms and main TV lounge areas. There were appropriate rooms available for family and visitors including child visiting.

Good

Are services responsive to people's needs?

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

Most of the wards had internet access for patients with the exception of Fulmar and Kirkdale. Staff told us that the trust was in the process of installing internet access for patients on these wards although they were unable to confirm a date for completion of this work. Each ward had a pay phone in a private area.

Patients told us they had no complaints about the quality of the food provision on the wards. They had access to tea and coffee-making facilities at all times and free access to their own bedrooms during the day.

Meeting the needs of all people who use the service

All the wards had a range of notice boards with information available for patients, carers and family members. Information was available on advocacy services, patient advice and liaison services (PALS) and complaints for patients to access help and support.

Patient's diversity and human rights were respected. Interpreters were available through the trust and care documentation could be translated into a range of different languages so that patients, family members or carers could understand what care and treatment was being provided.

Patients with specific dietary needs' were catered for.

Most of the wards had a designated multi faith room. On the wards where they did not, this was because the patient group had higher levels of independence and were able to access community based resources to meet their spiritual needs'.

The service provided wards which were compliant with the Disability Discrimination Act requirements.

Listening to and learning from concerns and complaints

There was a complaint process in place which was displayed on all the wards we visited. Information about how a patient or relative could make a complaint was also included in each ward information leaflet which was given to every patient and family carer at the time of the patient's admission. The wards had access to the patient advice and liaison service (PALS) which offered support to patients who wished to raise a concern, complaint or compliment regarding the ward they were on. The wards held regular community meetings with patients. Patients we spoke with confirmed they felt able to raise any issues informally within these meetings. They told us they felt listened to by staff.

Over the previous 12 months, the service had received one formal complaint on each of the following wards; Park House, Primrose Lodge, Lustrum Vale, Willow and Fulmar ward. Of these, three were not upheld, one was upheld and one was on-going.

Staff were aware and knowledgeable about the complaints procedure and how to escalate a complaint if needed. They told us they were made aware of the outcome of complaints within their own ward and across the service through ward meetings so learning could be shared.

Abdale House

Access, discharge and bed management

Patients were able to access care as close to home as possible as Abdale House was the long stay recovery service for North Yorkshire. The aim of the service was to provide patients with the skills to live as independently as possible. This meant patients were supported as part of a recovery pathway.

From September to November 2014 bed occupancy for Abdale House was 85%. In the service discharge was a key emphasis and was planned at the point of admission. We saw evidence of discharge planning. The consultant psychiatrist and staff told us the service maintained good links with other services such as acute inpatients and community mental health teams (CMHT's). Social services have maintained roles in CMHT's so good working relationships were in place.

Beds were available and if a patient went home there bed was available on return. Sometimes the service was asked to take a patient from an acute admission wards when the acute wards were full. However the service only took patients who were ready for discharge from the acute ward and had already been referred to or were known by the recovery services. The manager told us this happened about once every three months or longer. However the manager could refuse to accept a patient into Abdale House if they were not appropriate, but sometimes the transfer did take place. Currently three patients' discharges were delayed because the appropriate level of accommodation was not available.

Good

Are services responsive to people's needs?

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

The ward environment optimises recovery, comfort and dignity

Services promoted person-centred care, physical health, wellbeing and independence. The care environment was accessible for disabled patients.

We looked at the bedrooms of some patients with their permission and found they had been personalised in the way in which they chose.

The ward had a range of activities available to patients throughout the day and weekend which included independent living skills, recreational meaningful activities and also educational skills by way of learning new skills.

Patients were encouraged to develop skills in the activities of daily living. They were responsible for the cleaning their own bedrooms and each patient was allocated a daily job as part of the community cleaning rota. There was an emphasis on engaging with opportunities in the local community and each patient had a bus pass and daily leave in order to facilitate this. Patients were working towards being able to self-cater and could budget and shop for their own food. We saw patients making their own breakfast and they had the option of a hot or cold breakfast. Patients cooked community meals so they had the opportunity to have social contact together over a meal. On the day of the visit, patients were engaged in a wide range of activities including attending external catering courses, social outings, shopping trips and home leave. The occupational therapist was baking with some patients who remained in the unit. Patients told us that they felt well supported and encouraged to develop new skills.

The building had direct outside space in a large garden where patients could access fresh air. The service was based in a residential area and patients had access to all local amenities.

Patients had access to a telephone and held their own mobile phones.

Meeting the needs of all people who use the service

Prior to admission to Abdale House patients were invited to have a look around the unit and received a leaflet to take away. Patients had the opportunity to visit the service and share a meal and meet other patients. Patients were given as much access to the service as possible or needed until a bed was available for them.

During the visit we saw lots of leaflets available and information displayed about the recovery model. Patients who were detained had their rights regularly discussed with them. Patients were involved in their care and treatment through the recovery star which identified the supporting and focussed interventions needed to support them. The recovery star also identified the role of the patient in their recovery.

Patients had access to an advocacy service. They could feedback at daily community meetings that took place about what they thought of the service they were receiving or raise matters about their care and treatment. Patients could also give feedback via their friends and family making comments to the trust via the friends and family test. There was a comments box for patients to provide feedback if they did not wish to raise them in the community meetings or directly with the staff team. We saw a sample of community meeting minutes from December 2014 and January 2015 including the day of our visit. There was a set agenda for community meetings including activities, appointments and plans for the day, discussions about keeping safe when outside in the community, activities and meetings in the service for example MDT meetings. Patients were asked for their views on good things about Abdale House and what could be improved. They were also asked about their understanding of the fire procedure and complaints process and if they had any complaints. We saw patients made positive comments in the community meetings about the service they received. They were involved in service redevelopment with the planned move to a new site at Ripon in May 2015 and had input into the design and decoration of the new service.

Adjustments had been made to the ward where patients required disabled access and accessible bedrooms. For example one patient said they had been accommodated on the ground floor following a recent injury and they could not access the stairs.

A choice of meals was available to meet the particular dietary needs connected to religion and the patient's individual needs or preferences.

Listening to and learning from concerns and complaints

Patients were encouraged to provide feedback about their concerns via the complaints procedure which was

Good

Are services responsive to people's needs?

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

displayed throughout the building. On admission patients were given an information booklet about the service. This told them about the process for making compliments, comments, concerns or complaints. These could be raised locally at daily community meetings, via the comments box, in person to staff, or via the patient advice and liaison (PALS) service via e mail, Freephone or in writing.

The trust had a patients' experience/complaints group which evaluated the performance of the complaints procedure and how feedback about complaints was provided. This meant the trust continuously reviewed and acted on feedback and complaints about the quality of care and used this information to improve services. The only concern which was raised with us by patients during the visit were some inflexible practices which did not appear to be appropriate for a recovery service. For example the television was not allowed to be switched on until 4pm. Some patients told us they were given £4.00 a day to shop for their evening meal. They said they would prefer to pool a few days money together or add their own money to this allowance. They told us they felt this severely limited their choices about what they could buy and did not support them to develop skills in budgeting required for more independent living.

Are services well-led?

Good

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

Summary of findings

We have judged the service as good because;

- The wards provided care and treatment which was underpinned by the principles of the recovery model in line with the trust vision and values. Staff were positive and committed to the ward they worked on. Staff felt supported by the management team and their colleagues within the wards.
- The wards had a range of embedded processes in place to monitor the quality and safety of the service they provided. Regular ward meetings took place with staff which included governance issues such as risks, complaints, incidents and patient feedback and audit outcomes.
- Two wards were AIMS accredited as 'Excellence' through the Royal College of Psychiatrists CCQI (College Centre for Quality Improvement) network for inpatient wards and another two wards had implemented the Productive ward 'Releasing time to care' initiative. This demonstrated a commitment to quality improvement.

Our findings

Fulmar ward, Kirkdale ward, Park House, Earlston House, Lustrum Vale, Willow Ward and Primrose Lodge

Vision and values

All the staff we spoke with were positive and committed to the ward they worked on. The wards provided care and treatment which was underpinned by the principles of the recovery model. This was in line with the trust vision and values and reflected in the services 'rehabilitation strategy' which staff were aware of. Staff told us that the development of the, 'rehabilitation strategy' had helped the service to develop its own identity within the trust and a shared vision for the future of the service. This meant that staff at all levels were clear about the vision and direction of the ward they worked on and the service as a whole. They told us that the modern matrons and the service managers were accessible and made regular visits to the wards in addition to senior managers from the trust who also visited the wards.

Good governance

Kirkdale and Fulmar ward were part of the forensic governance structure and directorate whilst the other wards were part of the acute mental health directorate. All the wards held regular ward meetings with staff which included governance issues such as risks, complaints, incidents, patient feedback and audit outcomes.

These meetings fed into the directorate monthly governance meetings which the matrons and service managers attended. The matrons within the trust met monthly to monitor and review clinical quality issues. This meant there was a governance structure in place which enabled the two directorates to share learning across all the wards within the rehabilitation service.

Ward managers had access to key performance information regarding their wards which was available electronically. This included information about staff compliance with appraisals, training, supervision, absence levels, current vacancies and bank and agency staff usage. Overall, we found compliance with compulsory training, appraisals and supervision was high across the wards.

The ward managers told us they had the authority and support of senior managers to escalate any issues of concern they had to the directorate governance meetings through the matrons or service managers. They also received feedback from these meetings through regular meetings they had with the matrons and service managers.

The wards participated in clinical audits. Some of these were led at trust level whilst others were internally generated by the wards. These included clinical issues such as infection control, care records, environmental audits and medication.

Leadership, morale and staff engagement

We found all staff we spoke with to be committed, highly motivated and proud of their work and the teams they worked within. Staff felt supported by the management team and their colleagues within the wards. Staff told us they felt confident raising any concerns or idea's to improve the service they may have with their manager and were confident they would be listened to. There were a number of ways staff told us they shared their views which included staff meetings, away days and governance meetings. Staff

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told us the senior manager and matron for their ward was visible and supported them well. They reported their ward manager and team were open to trying new ways of working to improve the service they provided.

Commitment to quality improvement and innovation

The wards had a range of embedded processes in place to monitor the quality and safety of the service they provided. These included regular internally generated audits, team meetings and away days, patient feedback through the patient liaison and advice service (PALS), suggestion boxes and community meetings. Some of the ward managers provided examples of how they had changed practice in respond to feedback they had received from patients or their family.

Two of the wards, Primrose Lodge and Willow ward were both AIMS accredited as 'Excellence' through the Royal College of Psychiatrists CCQI (College Centre for Quality Improvement) network for inpatient wards. This meant they were members of a peer network which ensured that learning was shared with other organisations and demonstrated a commitment to quality improvement. Both the wards were accredited as 'excellent' during their last peer review.

Both Fulmar ward and Lustrum Vale had implemented the Productive ward 'Releasing time to care' initiative which is a nationally recognised programme aimed at increasing the time staff have to spend with patients by enabling staff to use their time more effectively.

Abdale House

Vision and values

Staff said they had regular contact with senior trust managers who visited the service. They told us the organisations' values were about patient care, providing a high quality service and improving this all the time. Staff said there were visits from the executive team. We were told the chief executive had visited the service three or four times. Staff spoke positively about the senior and executive management team.

Good governance

The trust provided us with data about the monitoring of the governance process at Abdale House which contributed to the trust wide governance process.

Staff received mandatory training which included training on safeguarding adults and children, health and safety, manual handling of objects, equality and diversity, fire safety and infection control. The range of staff completing mandatory training in 2013-2014 ranged from 84% for infection control to 97.3% for safeguarding children. Abdale House achieved an 89.6 % rate with mandatory training in December 2014.

Abdale House achieved an 88% supervision and appraisal rate in December 2014.

Shifts were covered by a sufficient number of staff of the right grades and experience. No staffing shortages were reported at Abdale house in the three months from October to December 2014. Sickness in December 2014 was 7.85% against a target of 4.50%. This was due to unexpected injuries to staff outside of working time.

No incidents were reported at Abdale House for the last three months October to December 2014.

Staff learnt from incidents, complaints and patient feedback. One serious incident had been reported in 2014 and actions had been taken from lessons learnt. No complaints had been received by the ward over the past year.

The ward used the trust key performance indicators (KPIs) to measure service performance. Data from performance information was used and reviewed against KPI's. This information was sent to the manager and cascaded to the team leaders. The manager would then get feedback on 'breach information' when KPI's had been missed.

We were provided with the last three months governance report from November and December 2014 and January 2015 for Abdale House. The quality reports covered incident reporting, clinical effectiveness, audit updates, action plans, NICE guidelines and compliance. Monthly audits including health and safety work place inspections took place. We saw the work based risk assessment completed in 2013 and reviewed September 2014, which was comprehensive and detailed. The governance process included staff and patient experiences audits and action plans. Audits included fire safety audit/inspection 20th March 2014 where no issues were raised. A monthly audit of infection prevention and control in September 2014 was completed with an action plan to address some areas for

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.

improvement but the issues raised cannot be completely resolved until the service moves to the new building. Governance also covered the risks and identified risks to the service such as the recent staff sickness increase.

Leadership, morale and staff engagement

Staff said they were respected by their management team. Staff told us local leadership was good. Staff morale was good despite the proposed move to the new buiding. Staff told us they felt involved in the plans regarding the new move to Orchard House.

Staff told us they felt very confident about raising concerns. They were aware of the whistle blowing policy and how to access this. They told us they were actively encouraged to raise concerns.

The manager had clear authority to do their job and had good administration support which was shared with the assertive outreach team. Staff told us that since the change of provider systems had much improved which benefited patient care. They said the approach to patient care was more systematic in service delivery and the records systems in place supported good assessment, treatment and care of patients. The vision and direction of service development was clearly articulated by senior managers. Staff said they had noted more engagement with senior managers since the provider changed to Tees, Esk and Wear Valleys Trust.

Some staff had concerns about plans to introduce 12 hour days from traditional shifts, which may have a significant impact on part time staff which they reported had affected staff morale. However this was out to consultation and no decisions had been made.

The service had team meetings which addressed local service developments, the move to the new building, staff training, staff recruitment, performance monitoring and governance. We saw the notes from the team development day from December 2014, which was arranged as part of the team building process in preparation for the move to the Orchards. This day covered what the team wanted in terms of how it was going to work together based on developing a team ethos and value base. The exercise also looked at the impact of change in moving to a new location and how this may impact upon team values. Comments from staff were that change should not impact upon patients care and the move to the new building should be discussed honestly and openly with patients and families. There was also recognition that patients and staff would need to be supported through the move to the Orchards. We saw ideas had been shared about lessening the impact of change. For example visiting other similar services and seeking psychological support during change. There was an evaluation of the day with what worked well and feedback from staff was positive.

Commitment to quality improvement and innovation

The service was not currently part of a peer review system and did not use a recognised quality initiative system such as the Royal College of Psychiatrist accreditation system. They said the service intended applying for accreditation once the move to the new build had been completed.

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 10 HSCA (RA) Regulations 2014 Dignity and respect We found that the registered person had not protected people against the risk of having their privacy and dignity needs met. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At Earlston House, we found breaches in compliance with the Department of Health guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP) which could compromise the dignity and privacy of patients. At the time of our visit, two female patients' bedrooms were located on a male corridor.