Good

Rotherham Doncaster and South Humber NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Quality Report

Woodfield House
Tickhill Road Site,
Weston Road
Balby
Doncaster
DN4 8QN
Tel: 01302 796000
Website: https://www.rdash.nhs.uk

Date of inspection visit: 14-18 September 2015
Date of publication: 19/01/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXE92	Great Oaks	Mulberry House	DN16 2JX
RXE12	Swallownest Court	Kingfisher Psychiatric Intensive Care Unit, Osprey Ward, Sandpiper Ward	S26 4TH
RXE00	Trust Headquarters - Doncaster	Brodsworth Ward, Cusworth Ward, Skelbrooke Psychiatric Intensive Care Unit	DN4 8QN

Summary of findings

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

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

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as good overall because:

- the wards had up-to-date environmental risk assessments and good systems and process for keeping the environment safe
- wards had the required skill mix and it was unusual for them to be below their required number of nurses on duty
- staff understood how to keep people safe where there were ligature risks.
- the wards were clean and had good systems for managing the environment, including infection prevention
- there were good quality risk assessments, risk management plans and care plans for the patients and these were recovery focused
- there was good inter-agency working between the inpatient and community teams and staff described good morale within them
- we saw that interactions between the staff and patients on the wards we visited were respectful and professional
- we saw staff acknowledged carers views in meetings, even if the carer was not present.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- the wards had up-to-date environmental risk assessments and staff understood how to mitigate against ongoing ligature risks
- the wards were clean and had good systems for managing the environment, including infection prevention
- wards had the required minimum number of nurses on duty
- staff used a simple red-amber-green (RAG) rating system to communicate risk assessments for each of the patients and improve communication about risks across the multi-disciplinary team
- there were good quality risk assessments, risk management plans and care plans for patients.
- Staff had good knowledge of how to help people who were vulnerable. They understood how to recognise types of abuse and how to raise safeguarding concerns.

However:

- There were blind spots in the main corridors of the acute wards, which meant staff did not have a clear line of vision in those areas
- one ward had no female-only lounge provision
- Risk assessments were not being completed on all occasions in relation to section 17 leave
- The average compliance of staff with mandatory training was 61%. This was significantly below the trust target of 90%
- oxygen cylinders were not stored securely on cylinder holders or trolley on two wards
- staff told us they had reported the excessive heat in the clinic room on Swallownest and in the meantime were planning to store medications in the medicine fridges if heat remained high for three days or more.

Are services effective?

Good

We rated effective as good because:

- Staff assessed people's physical health on admission
- patients had care plans that were personalised, recovery focused, and the majority had been given a copy
- there was good inter-agency working between the inpatient and community teams
- staff had regular line management supervision and there were regular audits to ensure minimum standards were being maintained

Summary of findings

- there were efficient systems in place to remind clinical staff about MHA responsibilities and the timescales involved.

However

- The trust was using a paper based clinical record and a computerised record. This was confusing and risked information not being available when required
- there were no positive behaviour plans in place.

Are services caring?

Good

We rated caring as good because:

- We saw patients felt able to contribute to discussions about their care and progress
- interactions between staff and patients on the wards we visited were respectful and professional
- we saw carers' views were acknowledged in meetings, even if the carer was not present
- a named nurse system ensured assessments, care plans and effective reviews for each patient were in place
- there were high levels of support from the Cloverleaf advocacy service.

However:

- there was an article of clothing on Kingfisher ward for patients to use if needed while in seclusion. This item was damaged and so would not ensure privacy and dignity
- some carers and patients told us they had concerns about staff attitudes
- carers also told us they had not been offered a carer assessment. In addition, they felt they did not have access to all the information they required

Are services responsive to people's needs?

Good

We rated responsive as good because:

- there had been a significant reduction in delayed discharges across the inpatient wards
- patients had access to their rooms, the gardens and to drinks and snacks at any time of day or night
- there were multiple activities available on the wards either through the occupational therapists, the ward staff or from access to the games rooms, play stations or gym equipment

Summary of findings

- wards had improved their patient led assessment of the care environment scores year on year and rated higher than average when compared to national figures in privacy, dignity, and ward environmental conditions
- there was evidence the trust responded to the complaints it received.

However:

- There was no record kept of which patients did, or did not, attend the arranged group activities. This made it difficult to evaluate their effectiveness and to monitor if they were cancelled due to issues such as staffing shortages.

Are services well-led?

Good

We rated well-led as good because:

- the trust visions and values were displayed in the units and the staff were aware of these
- the service had responded to previous concerns via an independent review and was able to update on progress in the action plan set previously
- supervision and appraisal was embedded across staff teams
- there were positive working relationships within staff teams and morale was described as good
- teams described positive and supportive relationships between themselves and senior managers.

Summary of findings

Information about the service

Rotherham Doncaster and South Humber NHS Foundation Trust has five acute wards for adults of working age, spread across three hospital sites. These wards provide care for patients aged 18-65 who require hospital admission for their mental health problems.

Brodsworth and Cusworth are two 20 bed wards located at Tickhill Road hospital in Doncaster. Osprey and Sandpiper wards each have 18 beds at Swallownest Court in Rotherham. Mulberry House is a 19-bed ward at Great Oaks Hospital in Scunthorpe. All of the wards admit both males and females.

Rotherham Doncaster and South Humber Foundation Trust also has two wards that provide intensive care services for the most unwell patients who present higher risk; Kingfisher ward is a five bed psychiatric intensive care unit at Swallownest Court. Skelbrooke ward is a five bed psychiatric intensive care unit at Tickhill Road Hospital. Both wards admit males and females.

Entry to these is through an 'air lock' security system. Although males and females walked past each other's bedroom, each room has an en suite bathroom and staff try to ensure males and females are supervised. Both psychiatric intensive care units have an adjacent health based place of safety suite attached. There was external entry in to the health based places of safety and people detained into the suites did not need to access the rest of the inpatient areas.

The CQC undertakes regular Mental Health Act monitoring visits to all hospital wards where people may be detained for care and treatment. We carry these out at least once every eighteen months. During this inspection a Mental Health Act monitoring visit was undertaken on Skelbrooke and Brodsworth wards We had visited all of the acute admission wards within the previous eighteen months and were able to review the action plans for each ward to ensure they had been implemented.

Our inspection team

Our inspection team was led by Philip Confue, chief executive of Cornwall Partnership NHS Foundation Trust. Head of inspection was Jenny Wilkes, Care Quality Commission. Team leader was Jonathon Hepworth.

The team inspecting the acute wards for adults of working age and psychiatric intensive care units comprised: two CQC inspectors, one approved mental health practitioner, two psychiatrists, two nurses, a Mental Health Act reviewer and one expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them, or through contact with those using them – for example, as a carer.

Why we carried out this inspection

Our inspection team was led by Philip Confue, chief executive of Cornwall Partnership NHS Foundation Trust. Head of inspection was Jenny Wilkes, Care Quality Commission. Team leader was Jonathon Hepworth.

The team inspecting the acute wards for adults of working age and psychiatric intensive care units comprised: two CQC inspectors, one approved mental health practitioner, two psychiatrists, two nurses, a Mental Health Act reviewer and one expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them, or through contact with those using them – for example, as a carer.

Summary of findings

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well led?

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

During the inspection visit, the inspection team:

- visited all seven wards at the three hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 13 patients using the service
- spoke with the manager for each ward
- spoke with 24 other staff members, including doctors, nurses, occupational therapy staff and trainees
- observed medication being dispensed and reviewed 43 medication charts
- attended six meetings which included multi disciplinary team meetings that were holding care programme approach reviews, planning discharge from hospital or reviewing care shortly after admission
- attended and observed three hand-over meetings by nurses on the wards
- collected feedback from 11 patients and nine carers who attended focus groups held at the sites in the weeks leading up to the inspection
- looked at 46 treatment records that included care plans, risk assessment and risk management plans
- reviewed a sample of seclusion paperwork
- carried out a specific check of the medication management on three wards.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

The majority of patients we spoke to told us they were satisfied with the care they received. They told us staff treated them with courtesy and respect. They also told us they felt able to contribute to their care arrangements and review of progress.

However, some patients told us they were unhappy with how ward staff treat them and this was raised by some carers.

Good practice

The inpatient services at Mulberry House were to undertake the 'perfect week'. This involved a whole system approach to the management of ward admissions and discharges, and a review of the use of crisis care pathways and respite provisions. The ward was making plans in preparation for implementing this in October 2015.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should refrain from using the damaged item of clothing for patients to wear when placed in seclusion and assessed to be at high risk of self harm by use of a ligature.
- The trust should review its seclusion policy to ensure the use of a seclusion garment is detailed within the procedures.
- In line with regulation 20 Health and Social care Act 2008 (regulated activities) Regulations 2014 the trust should undertake responsibility in line duty of candour. This would be to the patients who informed us of the use of the damaged seclusion suit.
- The trust should review the temperature in the clinic rooms at Swallownest to ensure that medication is being stored appropriately and safely.
- The trust should undertake routine audits to monitor compliance against the trust seclusion policy and take remedial actions in the event staff are failing to follow required procedures.
- The trust should consider installation of mirrors to reduce blind spots in the main corridors of the acute admissions wards and the bedroom area of the Mulberry plus area.
- The trust should continue with the plan to ensure compliance with mandatory training across the inpatient wards, particularly where compliance is low for safeguarding training and management of violence and aggression.
- The trust should ensure section 17 leave risk assessments are completed before episodes of leave.
- The trust should provide female-only lounge area across all wards.
- The trust should prioritise the roll out of positive behaviour support plans for individuals who may be subject to restrictive practices such as restraint and seclusion.
- The trust should ensure oxygen cylinders are securely stored in cylinder holders or an appropriate trolley.
- The trust should repair the blinds in the seclusion rooms on Kingfisher ward and Mulberry house to improve natural lighting and identify alternative arrangements to maintain privacy if the blinds are open.
- The trust should review lighting arrangements in the seclusion room on Kingfisher ward to enable lights to be dimmed.
- The trust should ensure the clock is replaced in the seclusion facility at Mulberry house.

Rotherham Doncaster and South Humber NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mulberry House	Great Oaks
Kingfisher Psychiatric Intensive Care Unit, Osprey Ward, Sandpiper Ward	Swallownest
Brodsworth Ward, Cusworth Ward, Skelbrooke Psychiatric Intensive Care Unit	Trust Headquarters Tickhill

Mental Health Act responsibilities

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

We reviewed the actions the wards had taken to improve following their most recent Mental Health Act review visits. We saw there had been progress against these, in particular in the implementation of a monthly audit looking at the quality of care plans and other documentations.

Patients confirmed they regularly saw the advocate. They confirmed staff regularly read their rights and ensure they understand them. We were given assurances the trust was in progress and set to ensure a range of polices will have been reviewed and updated in line with the requirements identified in the revised code of practice.

During this inspection, we undertook a full Mental Health Act review on Skelbrooke ward and Brodsworth ward. The following areas were identified and the trust will be asked to provide a specific action plan detailing how they will address the following:

- not all identified risks were written in to the patients' care plans as required in the Code of Practice 34.19
- there was no record of the time a patients' detention under section 136 commenced
- leave accompanied by family was wrongly identified as escorted leave.
- responsible clinicians were not completing risk assessments prior to section 17 leave in all required cases
- there were no positive behavioural support plans in the clinical notes of the patients who had an episode of seclusion.

The trust has been sent a detailed report outlining issues identified during this review and will produce a statement of the actions that will be taken.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good understanding of the Mental Capacity Act, and how it related to patients. There had been no deprivation of liberty safeguards made by the wards in the last six months. Staff could access additional advice or guidance if this was required.

Capacity was being assessed on admission and regularly reviewed. In the majority of cases, consent to treatment was being recorded although this was not evident in every care record.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

Each of the inpatient mental health wards were required to undertake a regular ligature risk audit. This was because there was a higher risk of patients using fixed points to attempt suicide. Each of the wards we visited had an up to date ligature risk assessment completed. Although there remained possible ligature points in wards we visited, the staff had good plans in place in order to reduce the risks. The plans included supervising people closely if there were concerns about their risk of trying to commit suicide. Ensuite bathroom doors had pressure sensors across the top, which would be activated, and staff alerted, if weight was placed upon them. However, there were some ligature points that the trust had not identified in their plans and so we were less assured staff would be able to manage the situation.

The acute admission wards had blind spots along the main corridors due to the location of bedroom doorways and recesses along corridors. This included the area near the bedrooms of the area where the most vulnerable patients were during admission. We pointed out blind spots to staff during the visits and asked to them take action.

Each of the units had anti-climb security to prevent patients absconding on to the roof. There was appropriate fencing around each of the units and these were relatively discreet. There was access to outdoors at all sites with good quality gardens and quiet spaces. The exception was at Tickhill site. Staff told us they were hoping to be able to add plants, foliage and seating to soften the impact of the high perimeter fences in the garden areas where patients smoke.

With the exception of Kingfisher ward, all the wards complied with same sex accommodation guidance defined in the Mental Health Act Code of Practice. Specifically, each bedroom was for single person occupancy with en-suite provision and patients did not have to walk through an area occupied by the other sex to reach toilets or bathrooms. Staff explained how they allocated bedrooms to achieve an effective gender separation. Kingfisher ward did not have a female only lounge.

There were seclusion rooms on Skelbrooke ward, Kingfisher ward and Mulberry House. The rooms allowed for clear observation of people whilst in seclusion and in one, a convex mirror was fixed to enhance this. In order to access the toilet patients had to leave the seclusion room as none of the ensuite bathrooms were entered directly. Staff undertook an assessment of risk and if the risk were too high for the patient to use the bathroom, they would be given a disposable cardboard tray or bottle.

Staff could adjust the temperature in each of the seclusion rooms and there were two-way communication systems. The electric window blind on Kingfisher ward was broken and permanently closed and the blind at Mulberry house was purposefully kept closed. This was because the window was overlooked by a housing estate built close to the ward perimeter. There was little natural light in the rooms. The suites had adjustable internal lighting except Kingfisher ward where the lighting was fixed and bright. Staff told us a request for a dimmer switch was made when the suite was built but had not been completed. Patients would be able to orientate themselves by the clocks wall mounted and visible from within the seclusion rooms; however, the clock at Mulberry house had been removed and not returned by the date of our visit. A mattress on the floor provided the beds. However, on Kingfisher ward we were told an assessment of an individual's risk was undertaken in relation to their clothing. This was because some items of clothing could be used as a ligature. If a patient had been assessed to be at very high risk due to this their clothing would be removed and they would be required to wear a seclusion suit. This comprised of trousers and a vest made from a heavy quilted material, which was resistant to tearing and reduced the ligature risk. There was only the top of the garment as the bottom half had been damaged and removed in July 2015. Concerns regarding an individual's privacy and dignity if the remainder of the suit were to be used was raised at the time of the inspection and the trust removed the garment.

The wards were clean and the furniture was appropriate for the environments and well maintained, although with some anticipated wear and tear. There were clear clinical waste systems in place. The domestic and housekeeping staff maintained up to date records of completed cleaning rotas, retained in designated areas alongside cleaning

equipment. These demonstrated tasks were undertaken daily, weekly and monthly as required and were signed and dated to confirm completion. The cleaning records in-situ on the specific equipment however, such as the signage sheet for the dishwasher on Brodsworth ward, was not completed on a daily basis as required. Hand hygiene reminders and hand washing guides were well placed throughout the units as prompts for patients, visitors and staff and there were multiple antimicrobial hand rub units.

All bedrooms had nurse call systems and all staff carried personal alarms. On Skelbrooke ward staff carried two-way radios. Each of the wards had additional alarm call points along internal corridors and in the garden areas.

Safe staffing

The trust provided detail about the staffing levels on each of the wards. This related to the number of whole time equivalent nurses on each of the wards, the percentage of nursing staff that had left the ward in the 12 months prior to the inspection and the percentage of vacancies on each ward at the time of this inspection.

- Brodsworth ward: 21 staff in post, 9% staff leaving, 10% vacancy rate
- Cusworth ward: 21 staff in post, 0% staff leaving, 0% vacancy rate
- Skelbrooke ward: 15 staff in post, 13% staff leaving, 20% vacancy rate
- Kingfisher ward: 20 staff in post, 10% staff leaving, 0% vacancy rate
- Osprey ward: 19 staff in post, 10% staff leaving, 13% vacancy rate
- Sandpiper ward: 20 staff in post, 15% staff leaving, 9% vacancy rate
- Mulberry ward: 37 staff in post, 11% staff leaving, 12% vacancy rate

The trust target for effectively managing staff sickness on the wards was 5.4%. Each of the wards had the following staff sickness levels at the time of this inspection:

- Brodsworth ward 8%
- Cusworth ward 3%
- Skelbrooke ward 7%
- Kingfisher ward 7%
- Osprey ward 4%
- Sandpiper ward 5%
- Mulberry ward 7%

The acute admission wards operated an early, late and night shift and required two qualified and two unqualified staff for each of the early and late shifts. There was one qualified and two unqualified at night. Nursing staff told us the shifts would never fall below this number of staff on duty but there may be occasional skill mix changes to accommodate if there was a shortage of qualified staff. We reviewed the off duty for each of the wards for the six weeks prior to our visit and could see the wards had the required numbers of nursing staff on duty.

The trust had a health-based place of safety attached to both of the psychiatric intensive care units (PICU) where the police brought people subject to detention under section 136 for a formal assessment. Staff told us a qualified nurse from the PICU must attend to oversee the section 136 assessment. At those times the ward could be left with only one qualified nurse so staff may need to be brought from other wards in order to manage the shortfall in qualified staff.

The ward managers told us they would access additional staff from the bank in order to ensure the right number of staff was on duty. They would also use bank staff to bring in more staff if there was a clinical need. The managers told us no agency staff were employed on to the wards and the trust bank provided nurses who were experienced at working on the wards and had been trained and inducted in to how the wards were working.

The following outlines the use of bank and agency staff by each of the wards. This data was from 1 January 2015 – 31 March 2015:

- Brodsworth ward: 105 shifts filled by bank and agency and five shifts unfilled
- Cusworth ward: 116 shifts filled by bank and agency and 17 shifts unfilled
- Skelbrooke ward: 172 shifts filled by bank and agency and no shifts unfilled
- Kingfisher ward: 127 shifts filled by bank and agency and five shifts unfilled

Good

Are services safe?

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

- Osprey ward: 60 shifts filled by bank and agency and no shifts unfilled
- Sandpiper ward: 56 shifts filled by bank and agency and no shifts unfilled
- Mulberry ward: 178 shifts filled by bank and agency and no shifts unfilled

Nurses told us they felt able to discuss any concerns they had about staffing and were well supported by the ward manager when they raised such issues. Ward managers told us they were encouraged to ensure there were adequate staffing on shift. In the event additional staff was required due to enhanced observations they were able to access this increased staffing. Ward managers regularly reviewed the staffing issues and the use of bank staffing on a regular basis with the modern matrons.

Patients told us they felt there were enough staff and they could have one to one time with staff. They confirmed there was always a staff presence in the communal areas at each of the wards we visited. Patients and staff told us it was highly unusual for escorted leave to be cancelled due to staff shortages and this only occurred in an urgent situation.

There was a dedicated consultant psychiatrist for each of the adult acute inpatient wards. They maintained responsibility for the patient if transferred to another ward as part of a planned care pathway, such as into a rehabilitation or psychiatric intensive care bed. All the consultant psychiatrists were in permanent posts.

Staff confirmed they were encouraged to attend training and to consider a range of training in addition to the core mandatory training outlined by the trust. Each of the wards we visited were non compliant with mandatory training and this meant staff could be considered not skilled to undertaking their work. The trust told us they communicated with all staff in April 2015 to advise that any staff who expected to progress a pay increment must have completed core mandatory training from October 2015.This requirement is on the trust risk register. The actions that the trust was taking meant they were aiming for 90% staff compliance with the training by end of December 2015.

At the time of this inspection the total compliance by staff for each ward was as follows:

- Brodsworth ward 55%
- Cusworth ward 61%
- Skelbrooke ward 57%
- Kingfisher ward 50%
- Osprey ward 67%
- Sandpiper ward 69%
- Mulberry ward 69%

Assessing and managing risk to patients and staff

Key information was written on a large white board in the main office. This meant staff were quickly updated in key areas such as risk, observation levels, dates that a review was required and reminders of tasks that required completion. These boards were located within the main staff offices, which automatically locked, and were in areas where they could not be viewed from outside the office.

Each patient's risk was rated as red, amber or green (RAG) and this was recorded on the white board against each patient's name. Red rating indicated an individual remained in an acute crisis, amber that there had been some considerable improvement although mental health and risks remained of concern. Green rating indicated a recovery from an acute episode. This would indicate appropriateness for the patient to be considered for discharge; either stepped down from the psychiatric intensive care ward or discharged from the hospital environment. As individual patient needs changed and risks increased and decreased the RAG rating system was amended on the white board to ensure this was communicated to all in the multi-disciplinary teams. The system was simple and well understood by the staff working on the wards.

The trust completed a functional analysis of care environment (FACE) risk assessment. FACE comprised a risk screen, enabling a more detailed assessment if risk was present in a particular area. Risk indicators were coded as present or absent across seven domains. These included violence, self-harm and self-neglect and then scored in severity. Staff had completed these in all the records we reviewed. FACE assessments were completed on admission and regularly updated, and in line with the policy. In five cases there was no updated risk assessment completed for section 17 leave. This should happen in accordance with the Mental Health Act Code of Practice.

Good

Are services safe?

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

All patients were on hourly observations, unless on enhanced levels of observation. Observations were appropriately recorded and staff were clear who was responsible for undertaking these checks at all times. There were clear procedures detailing when patients would be subject to a search of their property or persons and staff outlined the criteria for undertaking these.

There were no blanket restrictions in place on the wards. There were arrangements for accessing hot drinks and snacks, this included at night. Some of the patients seemed unaware of these arrangements. The wards had some banned items such as alcohol and knives and there were restrictions on some other items such as aerosol toiletries, razors and lighters as they were identified as a risk to safety. Arrangements were in place for patients to have access to these items but in a way that was overseen by the staff. Patients were not able to lock their rooms when they were not in them unless they asked a member of staff. Patients could lock their rooms from inside. Patients were aware of their rights and there was information confirming informal patients were able to leave the ward.

Inpatient staff were required to undertake the trust managing violence and aggression training, this was a five-day course with an annual refresher and divided into four modules. Compliance with undertaking this mandatory training was significantly below trust target of 90%: module A; 66%, module B; 64%, module C; 64% and module D; 14%. Despite the low training figures staff described feeling confident in their skills in managing these types of incidents. The trust had informed staff of the need to complete all mandatory training.

Staff told us seclusion was only used as a last resort however there were no positive behaviour support plans in the clinical records. These would detail interventions to support patients to avoid violent and aggressive episodes. The trust was in the process of rolling out their "positive and proactive care" strategy. There were information leaflets detailing the intention to reduce restrictive practice and on Skelbrooke ward a notice board had been devoted to providing information for patients and visitors. Some key staff on the inpatient wards had undertaken the trust training and there were plans in place for more staff to be trained in the interventions as part of the trust strategy.

The following details of episodes of restraint and seclusion were provided by the trust for the period between November 2014 and July 2015:

- Brodsworth ward: eight episodes of seclusion, 26 episodes restraint, of which three were in the prone position
- Cusworth ward: 25 episodes of seclusion, 47 episodes restraint, of which two were in the prone position
- Skelbrooke ward: 34 episodes of seclusion, 61 episodes restraint, of which six were in the prone position
- Kingfisher ward: 30 episodes of seclusion, 36 episodes restraint, of which four were in the prone position
- Osprey ward: 18 episodes of seclusion, 25 episodes restraint, of which five were in the prone position
- Sandpiper ward: 22 episodes of seclusion, 26 episodes restraint, of which three were in the prone position
- Mulberry ward: 34 episodes of seclusion, 53 episodes restraint, of which seven were in the prone position

Track record on safety

Between July 2014 and June 2015, the trust recorded 43 serious incidents. Data provided by the trust indicated that Mulberry and Brodsworth wards both had one serious and untoward incident in this period and none were recorded for the other wards. The ward staff described there were protocols in place for requesting police attendance and support in the event of a significant risk issue that the staff were unable to manage effectively.

Reporting incidents and learning from when things go wrong

Incidents were escalated through the electronic risk reporting system. There were processes in place for reporting, managing and investigating serious and untoward incidents within the trust. Staff understood the types of incidents and events that should be recorded on the electronic risk reporting system. Staff informed us feedback following incidents was through individual email, discussion at team meetings, and directorate newsletter and line management supervision. There were arrangements in place for staff to be-debriefed by someone external to the unit team in the event it was required. The nurse in charge would lead with ensuring patients received debrief where appropriate.

Good

Are services safe?

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

Staff could describe duty of candour and understood it meant apologising to people who may have been affected by errors occurring and harm caused. Some thought it only applied in incidents were actual harm occurred and were not aware it related also to near miss incidents.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

The Care Programme Approach (CPA) was the underpinning model ensuring that mental health needs were assessed, treatments planned, implemented and their effectiveness reviewed. CPA care coordinator responsibility remained with the locality mental health team where the patient was from. The wards operated a named nurse system and patients received regular one to one sessions with a named nurse or nominated other. People admitted to the wards were having comprehensive assessments undertaken.

We reviewed 46 care records. These showed that physical health examination were taking place on admission and ongoing needs associated with physical health were noted on individuals care plans. Care plans were up to date and personalised indicating the patient himself or herself had been involved in developing it. There were clear goals, these were recovery focused, and patients had been given copies.

The trust used the Silverlink system to record clinical information. This was the computerised record and there were paper files. Staff were comfortable with locating where information was being recorded. Differing clinical information was stored in different ways with some stored in both electronic and paper systems. The trust board informed us they were moving to the final phase of securing a new fit for purpose electronic clinical recording system.

We observed a discharge-planning meeting. Staff input into Silverlink during the meeting, directly recording clinical discussions. After the meeting a nominated person updated the care plan and risk assessments. The psychiatrist updated their electronic note entries within 24 hours of the meeting.

Best practice in treatment and care

Staff described good access to doctors, including out of hours. There was access to a range of physical health investigations and close links to the local acute hospitals. The inpatient wards used a range of standardised assessment tools including the Glasgow anti-psychotic side effect scale, the patient health questionnaire, the Addenbrooke cognitive assessment tool, a structured mental state examination and health of the nation outcome scales. Care plans incorporated goals that were recovery focused and there was evidence that patients' needs were reviewed and care plans updated as needs changed. Risk assessment and risk management plans were formulated using the FACE model. Patients' self-administered their topical medications and these items were stored in the clinic room.

We attended a case formulation meeting held at Swallownest. A clinical psychologist from child and adolescent mental health services facilitated this weekly meeting. It provided staff with an opportunity to reflect upon their practice and to explore the benefits of specific interventions in a psychologically informed way.

Ward managers and their deputy undertook a range of audits to monitor completion and quality of care plans, risk assessments and clinical records. In addition, there were regular audits of emergency equipment and medication administration. The wards were part of the trust audit into antibiotic use and the national NHS safety thermometer audit, the national audit of schizophrenia and clinical audit of physical health care. None of the nurses spoken with undertook clinical audits.

Skilled staff to deliver care

The wards were staffed with mental health registered nurses, heath care assistants and a dedicated consultant psychiatrist. Each unit had a team of occupational therapy staff and technical instructors whose time was divided across the wards providing one to one and group interventions. There was some psychological therapy input provided by the therapists based in the locality community teams but no dedicated input to each unit. Pharmacy staff attended the wards on a minimum weekly basis. There were students and trainees from each of the disciplines accommodated on clinical placements throughout the units we visited.

Ward managers were encouraged to recruit into all vacancies and there had been a number of staff newly recruited to posts within the wards. There were induction plans in place to ensure all new staff, including bank staff, were provided with consistent and good quality introduction to working within the ward and understanding of the systems and processes. Experienced nurses facilitated individualised on the job training for newly qualified nurses via the preceptorship programme.

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.

Each of the wards held regular team meetings and these addressed key issues for the teams, discussed new policies and procedures and reviewed lessons learned from across the organisation. Ward managers ensured staff received regular line management supervision in line with the trust policy. These focused upon areas of work that required improvement or development, looked at working with colleagues as part of a team and addressed issues such as return to work plans following sick leave. The managers provided written outcomes from these meetings. Managers were responsible for ensuring staff had an annual appraisal and a detailed personal development plan (PDP) to address ongoing training and development needs. Managers confirmed the trust used information provided from the annual PDPs in order to plan specific training modules to support the staff to address any training deficit. An example of this was specific input for staff at Swallownest in order to develop front line staff skills in identifying possible childhood sexual exploitation victims.

At the time of the inspection 64% of the inpatient staff had an appraisal within the previous 12 months. Ward managers described actions taken in order to address poor performance within the nursing teams.

Multi-disciplinary and inter-agency team work

There were regular weekly multi-disciplinary team meetings attended by nursing staff, occupational therapists, a psychiatrist, pharmacists and, where indicated, psychologists. There was representation from the home treatment team and locality community mental health teams. There was a daily meeting attended by the unit based staff and psychiatrists where daily progress was reviewed, incidents and issues followed up, and decisions made on which clinical reviews would be prioritised that day.

We observed handover meetings where current inpatients, including those on leave from the ward, were discussed. Comprehensive information was passed between the nursing staff on the early shift to the staff coming on duty for the late shift. The wards did not utilise a handover book or sheet but individual staff made notes of key points to follow up. Nominated staff updated the white information boards with any relevant updates following these handovers.

Representatives from the community teams attended the multi-disciplinary meetings, and most usually, this was the access team. This team attended to discuss and review progress and looked to facilitate home leave arrangements and post discharge support.

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

Clinical staff told us of the valuable support provided by the Mental Health Act administrators. This included prompts and reminders to ensure required assessments and documentation were completed in a timely manner. MHA paperwork was located within both Silverlink and the paper clinical record.

We reviewed six clinical case notes relating specifically to section 17 leave arrangements. All had correct documentation completed in order to authorise the leave. However, in three of the cases, there was no evidence the risk assessment had been reviewed in relation to that leave

Good practice in applying the Mental Capacity Act

Some 98% of staff had received training in the Mental Capacity Act. Most staff did understand the core principles of the Mental Capacity Act including the Deprivation of Liberty Safeguards and all could explain how they could get detailed information and guidance if it was required.

Medical staff carried out an assessment of a patient's capacity to consent on admission and there were further discussions as part of the multidisciplinary meetings. Capacity decisions were decision specific. There was a tick box document to demonstrate completion of an assessment under the Mental Capacity Act and an entry in the contemporaneous notes to provide detail of the capacity assessment although in three cases we were unable to locate these. The designation of the person completing the MCA assessment was not requested on the paperwork. Consent was less routinely recorded within the tick box form located in Silverlink.

An individual's capacity was being regularly reviewed on all of the wards and this was recorded within the paper clinical files. We observed multi-disciplinary teams meetings where concerns regarding potential financial safeguarding were discussed. In addition to agreeing an appropriate action regarding a safeguarding referral, it was agreed to undertake a capacity assessment regarding the patient's money.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed staff were caring and responsive to patients and discussed their needs and care planning arrangements in a respectful manner. All of the wards we visited were calm and relaxed and we could see friendly, warm interactions. In the multi-disciplinary team meetings, patients were involved in the discussions and decision-making. We saw carer's views were acknowledged even if the carers were not present at the meeting. There was evidence of close working with the access team who provided home treatment during leave and post discharge, and other community-based services.

We spoke to nine carers individually and via the focus groups arranged prior to this inspection. Their feedback was less positive and they told us they had raised concerns with the trust already about staff attitudes as they had experienced some staff not being polite or respectful toward their family member. The carers we spoke to did say their own contact with staff and the wards had been very positive and they felt included and listened to by staff who always tried to ensure they were kept updated.

We sought views from patients via the focus groups in the weeks before this inspection as well as meeting individually with people when we visited the wards. There were mixed views expressed by patients who told us some staff were kind, respectful and helpful and others could be patronising, or say horrible things to, or about, patients in front of them. We were also told patients thought staff did not manage patient to patient bullying as well as they should.

There were concerns about patients' privacy and dignity whilst in seclusion. This was because the suit that was occasionally being used for high risk patients was damaged and so patients were wearing a top only and had nothing to cover their modesty. This was raised at the time of the inspection and the trust removed the garment.

The involvement of people in the care that they receive

Wards had welcome packs and patients confirmed they had received an orientation to the ward and a copy of the welcome pack when admitted. This included an information pack for carers. Patients told us their rights had been read to them on a regular basis.

The wards operated a named nurse system and they ensured that care-planning arrangements were regularly discussed and reviewed. In multi-disciplinary team meetings we saw patients were encouraged to be involved in group and other activities and how alternatives, such as individual sessions, would be offered for those patients who felt unable to get involved. We observed patients involved in discussions about medications and offered information about the types that were available to consider. We saw nurses were recording that patients were being offered copies of their care plans.

Some patients told us they had not felt included in decisions about their care and treatment even though we could see staff had documented in their clinical notes they had held discussions with them. It was difficult to know if this was because patients had been unwell at the time of discussion or if staff should have considered other ways of ensuring individuals had understood what had been discussed.

Cloverleaf advocacy services were promoted throughout all the inpatient units via posters and leaflets. Staff and patients told us advocacy workers attended the wards on a daily basis to make contact with people newly admitted and to attend clinical reviews and meetings where required. Despite this two patients told us they had no knowledge of the local arrangements for accessing advocacy.

Each ward had a carers champion and the three units participated in the Triangle of Care. This was a best practice guide supporting better partnership working between patients, their carers and mental health services. The trust had a carers' charter and a young carer charter and we saw examples of promotional posters and information leaflets. The local triangle of care meetings provided updates to the trust wide triangle of care steering group and each unit was working toward completing its own action plan. The staff provided information to patients and carers about support available through the recovery college. Despite this, carers told us they did not feel they had access to the right sort of information when the person they cared for was admitted. None of the carers we spoke to could recall being offered a carer assessment.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The Royal College of Psychiatrists recommends a ward occupancy level of 85% for effective care. The trust provide the following data for bed occupancy from October 2014 – July 2015:

- Brodsworth ward 91% mean occupancy rate
- Cusworth ward 96% mean occupancy rate
- Skelbrooke ward 94% mean occupancy rate
- Kingfisher ward 99% mean occupancy rate
- Osprey ward 97% mean occupancy rate
- Sandpiper ward 90% mean occupancy rate
- Mulberry ward 96% mean occupancy rate.

At Swallownest, there were was a practice of patients "sleeping out" from the acute admission ward into a bed on the rehabilitation ward. In the majority of these cases patients considered for a period of inpatient rehabilitation, would be referred for a number of days as a trial to identify if this was the appropriate pathway. If an appropriate acute inpatient bed was not available for an urgent admission then someone would be moved from Osprey or Sandpiper wards. Only someone no longer considered to be in an acute phase of their illness would be asked to move to an available bed elsewhere in the hospital.

Managers informed us this did not compromise the care of the patient being moved as only patients assessed as amber or green in the RAG rating system would be considered and only if the patient agreed to the move. Staff within the Swallownest unit were routinely rotated between the rehabilitation, acute and psychiatric intensive care wards and managers told us this was to maintain staff skills of working within the different types of environment and to maintain the required skill set. As such moving patients from an acute ward was not felt to compromise care to either the acute patient or affect the rehabilitation model in place on the receiving ward. There were protocols in place and systems understood by all the staff about ongoing medical responsibility and care planning and risk management arrangements.

On Mulberry ward, they subdivided the ward into an area called Mulberry Plus. This was a smaller replication of the main ward with its own lounge, kitchen and garden area and an additional locked door entrance with provision for two beds. A staff office and clinical room operated from this area. The patients nursed within this environment were assessed to be the most vulnerable of the ward cohort, requiring high intensity, low stimulus environments that could be managed within the unit.

The psychiatric intensive care wards Kingfisher and Skelbrooke had a seclusion suite which could be used by all the wards on site. Admissions in to the PICU were managed locally which at times required the transfer of patients from one ward in order to accommodate another of greater need.

Between October 2014 and March 2015 there were 37 delayed discharges across all of the inpatient services. Managers told us the majority delays were due to trying to identify an appropriate bespoke placement or accommodation that was most able to meet their needs. There were four delayed discharges at the time of this inspection across the seven wards.

Between October 2014 and July 2015 the trust reported 37 delayed discharge recorded patients across the trust of which 17 patients had been admitted to Mulberry house. During the visit, there were two delayed discharges still on the ward. Managers told us usual reason delay was waiting for an appropriate placement to be identified and funding agreed. These delays are usually associated with patients with the highest need who require complex care packages.

The facilities promote recovery, comfort, dignity and confidentiality

Patients were allowed access to their mobile phones and in addition, there was a pay phone available for with an appropriate privacy hood. The exception to this was on the psychiatric intensive care units were a cordless landline was available for patients who could take the phone into a room to hold a private conversation.

All of the wards had access to outdoor space. The garden spaces were of good quality and provided opportunity for patients to access additional areas. The outdoor spaces at Swallownest Court were spacious, well designed and well stocked with multiple seating areas and quiet spaces.

On Brodsworth ward the external garden, where patients smoked, was bare with little seating. Skelbrooke ward garden had high concrete walls and no landscaped gardening. Staff told us they were striving for improvements to the garden areas.

Are services responsive to people's needs?

Good

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

Patients told us the quality of the food was good but the portion sizes were small. We observed patients were able to ask for seconds. Staff told us they think there had been an improvement in the quality of food since new providers took over the contract.

Patients could make hot drinks until late into the evening and there was access to cold water and fruit squash. Most wards staff provided hot drinks at set times throughout the day and evening. Staff could make additional hot or cold drinks outside of these times if asked. Not all the patients were aware of this and assumed that if there was no hot water out, they were not able to have a hot drink.

Patients at Swallownest told us there was limited hot water in the showers and there was insufficient time to complete hair washing before the hot water runs out.

Three patients at Mulberry House told us items have gone missing from their rooms including mobile phones and they were unable to secure their belongings. There were small lockable safes located within the wardrobes, and under mattress lockable storage. Belongings could be placed in storage boxes kept in a secure room. Patients tended to store restricted items such as razor blades and aerosol toiletries in addition to more expensive personal items such as jewellery, lighters and wallets.

There was a range of activities at each of the units including offered groups such as cooking, walking, art and crafts and work in the gardens plus individual assessments and relaxation interventions. Occupational therapy staff told us it was difficult to provide some groups due to lack of dedicated space at one of the sites.

There were comprehensive activity timetables for each of the acute wards but attendance logs were not maintained. It was not possible to know who attended each group, or if any had been cancelled due to staff shortages. Some clinical notes made no mention of the patient undertaking structured activities despite these being detailed as part of their care plans.

We saw groups of patients and staff engaged in board games and jigsaw puzzles or sitting socialably in the main lounge areas. Each acute ward had play stations and a games rooms with pool tables. No one was using these during our visits' but all the required cues and balls were available for anyone to access. There was a range of gym equipment on the psychiatric intensive care wards and within the main units on all three sites. Key staff were trained to induct patients on the use of the equipment and the majority of staff on the wards were able to facilitate patients to use it. On each shift at Mulberry house a staff member was allocated to coordinate activities in the evenings and at weekends on all shifts.

The wards had regular patient led assessment of the care environment (PLACE) the most recent had been undertaken in February 2015. PLACE focuses upon four key themes and would in future focus on a fifth area of dementia. These demonstrated that the trust had made some significant improvements in key areas over 12 months. It also indicates however that cleanliness of wards remains slightly below the national average.

The trust was rated overall during its most recent PLACE assessment:

- Cleanliness (national average 97%) in 2015 95% an increase from 2014 score + 7
- Food (national average 88%) in 2015 88% an increase from 2014 score +6
- Privacy & dignity (national average 86%) in 2015 92% an increase from 2014 score+ 4
- Condition/appearance (national average 90%) in 2015 91% an increase from 2014 score +2%

Meeting the needs of all people who use the service

All inpatient rooms had en-suite shower rooms. There was no access to other bathrooms on the wards. At Great Oaks and Tickhill sites patients could access adapted bathrooms with associated equipment if required.

There were multiple leaflets and posters throughout the units detailing how to make a complaint. There were self-sealing "your opinion counts" individual comment cards, which were sent directly to the modern matrons. We saw responses given to 11 forms submitted over 12 months prior to the inspection. These included concerns regarding the ward environments being too hot, food portion too small and no Wi-Fi. A significant number of the comments were positive commendations for individual staff about the care and treatment received. Matrons told us they ensured the staff members involved received direct feedback about these.

There were interpreter services available in person or via telephone. There were leaflets on the wards including

Are services responsive to people's needs?

Good

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

information about "my care" advocacy, patient rights and about how to complain. Staff stated they could access these leaflets in other formats or languages if required. Patients confirmed this information was useful to them but two stated they had not received any written information about their medication. Patients confirmed they had access to spiritual support and were visited by their preferred religious minister. The PICU wards had tranquillity rooms that were adapted dependent upon a patient's wishes and provided a quiet space for faith, ritual and reflection.

Listening to and learning from concerns and complaints

We asked the trust to provide complaints data for each of the wards. Dissatisfaction with care and treatment or staff attitude was the main reason for a complaint being made. No complaints had been upheld.

Total number of complaints received between November 2013 –May 2015 2015:

- Brodsworth ward 10 complaints
- Cusworth ward four complaints
- Skelbrooke ward no complaints
- Kingfisher ward no complaints
- Osprey ward five complaints
- Sandpiper ward no complaints
- Mulberr ward no complaints

Multiple posters and leaflets encouraged people to raise their views as complaints or through positive feedback about their experiences of care and treatment. Patients knew how to raise concerns. Managers described how they attempted to resolve complaints at the earliest opportunity. They also described how they provided feedback to their teams about themes and issues raised as complaints or compliments.

Are services well-led?

Good

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

Our findings

Vision and values

We saw poster displays of the trust visions and values. In discussions with staff they were aware of the trust visions and values. These were reflected in the objectives of the inpatient services. Staff confirmed they had regular contact with the senior management team and the modern matron and other senior managers attended both units regularly. There had been recent visits from members of the executive team

Good governance

Staff could describe systems and processes that were in place for raising concerns. Staff reported incidents appropriately and there was evidence action was taken in response to concerns. Learning from incidents and complaints was shared within the teams through discussion at team meetings and in individual supervisions.

Ward managers described how the supervision culture had changed from staff feeling managers told them what they were not doing well into a more positive and learning culture for individuals. Line management supervision occurred regularly within the teams and staff were encouraged to seek clinical supervision. The teams had a clear understanding of safe staffing for their wards and it was rare for wards to be short staffed.

The number of incidents reported by the service was low and staff had a good understanding of the types of incidents and events that required reporting. The number of reported serious incidents on all the wards was low. Nursing staff confirmed incidents of serious and untoward incidents had been low in the most recent past.

Staff had a good knowledge of the Mental Health Act and the Mental Capacity Act. There were no deprivation of liberty safeguards but staff knew the core principles and where to go for information for advice. The trust took immediate action when concerns were raised about using the damaged seclusion suit at the Swallownest unit and removed it. The trust confirmed they were reviewing existing procedures and practice and will amend these if required.

At Mulberry House, the managers outlined the recommendations of the independent review undertaken by North Lincolnshire clinical commissioning group and local progress undertaken by the ward in response to those recommendations.

The ward and senior managers had a clear understanding about key performance indicators for their services and demonstrated they were achieving and improving on these. Environmental improvements were being carried out at Tickhill unit. There were continued improvements to the general environments as demonstrated by the PLACE scores.

Leadership, morale and staff engagement

Staff described good morale within their teams. People were generally happy in their job and felt part of a supportive team. Staff said they would feel confident about raising concerns without fear of recrimination.

Managers encouraged managers to fill the job vacancies. They also agreed to staff shortages being filled on all the shifts and there had been a significant improvement in fill rate in comparison to the data provided by the trust prior to the inspection. Turnover of staff was lower in comparison to the trust total figure. Managers took action managers to address sickness and absence.

Managers were encouraged to continue to develop their leadership skills, such as postgraduate training in supervision. They felt senior managers supported them to manage their wards effectively. There were clear communication systems in place between the wards and the senior managers. Senior managers were a recognised presence on the wards. Each ward held regular team meetings with set agendas and clear communication systems in place with all of the ward staff.

Commitment to quality improvement and innovation

The wards did not participate in the Royal College of Psychiatrists' accreditation for inpatient mental health scheme. The trust was committed to improving services and this was demonstrated in the environmental investments made within each of the wards.