Requires Improvement

Southern Health NHS Foundation Trust

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

Quality Report

Headquarters
Tatchbury Mount
Calmore
Southampton
Hampshire
SO40 2RZ
Tel: 023 8087 4036
Website: **www.southernhealth.nhs**.uk

Date of inspection visit: 7-10 October 2014
Date of publication: 25/02/2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Elmleigh	RW1AM	Elmleigh male and female acute wards and psychiatric intensive care unit	PO9 2JJ
Melbury Lodge	RW119	Kingsley ward – male and female acute wards	SO22 5DG
Antelope House	RW1GE	Saxon ward; Trinity ward and Hamtun ward	SO14 0YG
Parklands Hospital	RW1AC	Hawthorns 1 (PICU) and Hawthorns 2 (acute)	RG24 9RH

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Southern Health 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 Southern Health NHS Foundation Trust and these are brought together to inform our overall judgement of Southern Health 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 Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 
Are Acute wards for adults of working age and psychiatric intensive care units safe?	**Requires Improvement** 
Are Acute wards for adults of working age and psychiatric intensive care units effective?	**Requires Improvement** 
Are Acute wards for adults of working age and psychiatric intensive care units caring?	**Good** 
Are Acute wards for adults of working age and psychiatric intensive care units responsive?	**Requires Improvement** 
Are Acute wards for adults of working age and psychiatric intensive care units well-led?	**Requires Improvement** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We gave an overall rating for acute wards for working age adults and the psychiatric intensive care unit (PICU) of **requires improvement** because:

- Elmleigh acute wards and PICU in particular had insufficient, suitably trained staff covering the unit as a whole, including a health based place of safety that was in use almost every day.
- There were significant shortfalls in staff training particularly in respect of the safe restraint of people and emergency life support which meant people using the service were at risk of harm in an emergency. Emergency equipment at Elmleigh was kept in the PICU treatment room a significant distance from the acute wards. As a result there was a risk of delay in the event a person collapsed or suffered a cardiac arrest on the acute wards.
- We found ligature risks on all wards. These were usually known to staff and some wards had taken action to address or mitigate the risks. However, some ligature risk assessments failed to record any action to address risks and Elmleigh ward managers had not implemented, or followed up, actions identified to remove risks that had been highlighted ten months ago.
- There was a lack of opportunities for physical activity on some of the PICUs.
- At Elmleigh there was significant shortfalls in areas of training, inconsistent provision of supervision to staff and a poor records on the completion of staff appraisals when compared with other similar services within the trust.
- We received mixed responses from people when we asked them about their involvement in their care. Some people told us they were listened to by staff and able to contribute to decision making whereas others said they had not been involved in developing their care plan and did not have a copy.
- The planning and delivery of the service was not always responsive to people's needs. For example, the seclusion room on Hamtun ward at Antelope House was not fit for purpose. The design did not allow staff to easily observe people in the room. The design of the wards was different at different locations. Some wards were clearly segregated with separate female and male wards and facilities and many bedrooms had ensuite bathroom and toilet facilities. However, we found that some of the bathrooms and toilets at Parklands Hospital were labelled as 'unisex' and during our inspection we saw that women used the bathrooms on the male corridor. This was contrary to Department of Health guidance as women had to walk past male bedrooms to get to the bathroom.
- At Elmleigh it was not clear how the information was being used to improve the service. The monthly performance dashboards for Elmleigh PICU and acute wards for July, August and September showed little discernible improvement on a range of measures, including training and appraisal, and in some areas performance was worse.
- At Elmleigh most staff did not feel engaged in ward improvements and were disappointed in the lack of support they received from managers.
- Most wards used performance data and feedback from people using the service to identify areas for improvement and bring about changes in the service except at Elmleigh where the systems in place were not effective in bringing about continuous improvement.

However, most people experienced kind and considerate care from staff and were positive about the support they had received. Carers we spoke with on all wards we visited reported feeling involved in their relative's care. At Elmleigh a café had been set up on the acute wards where people and their relatives could buy drinks and cakes. There was a small seating area that allowed people to meet with relatives in a more relaxed setting away from the main acute wards. At Melbury Lodge a carer's guide, containing information about the service, had been developed in conjunction with the carer's council that was available for friends and relatives.

The diverse needs of people were considered. At Melbury Lodge innovative work had been carried out to ensure that people's spiritual needs were integrated into their everyday care and treatment. Information on how to complain was available on the wards and most people using the service told us they knew how to make a complaint if they wished.

Most people on all wards had care plans in place that addressed their assessed physical and mental health

Summary of findings

needs and any individual risks identified. There were a range of meaningful and therapeutic activities available for people on the wards. On some wards an activities programme was provided across seven days.

Staff on some wards were aware of research and developments in acute mental health care and we noted the implementation of new approaches based on evidence and best practice. For example, the 'safewards' initiative was being implemented on the wards and considerable progress had been made with this in some areas. At Melbury Lodge the service had developed a spiritual assessment as part of a holistic approach to determining people's needs. This was based on evidence that people recover faster and recovery is more likely to be sustained when health professionals work with people to explore their spirituality.

Most staff (except at Elmleigh) had completed their mandatory training and received regular clinical supervision.

We saw good examples of multi-disciplinary team working which supported people's care, treatment and discharge from the wards. Records and information systems mostly supported the effective delivery of care and treatment to people.

Governance structures were in place and in most wards were effective. Staff understood their roles and responsibilities and lines of reporting on the wards. Performance was monitored and key performance indicators included workforce, patient experience, operational measures and quality and safety measures. Performance information was actively used to address shortfalls and bring about improvements in some wards.

Some wards were very well-led. Most staff spoke positively about their line managers and reported feeling able to raise any concerns they had about standards of care. People using the service were asked for their feedback about services and this sometimes led to changes in the service provided. Most wards used performance data and feedback from people using the service to identify areas for improvement and bring about changes in the service except at Elmleigh where the systems in place were not effective in bringing about continuous improvement.

Summary of findings

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

Are services safe?

The acute wards for people of working age and psychiatric intensive care units (PICU) required improvement. Elmleigh acute wards and PICU in particular had insufficient suitably trained staff covering the unit as a whole. There were risks that there not enough staff on any given shift that were suitably trained in how to restrain a person safely and/or provide emergency life support which meant people using the service were at risk of harm in an emergency. Emergency equipment available to the acute wards was kept too far away from the acute wards which meant there was a risk of delays in the event of a person having a cardiac arrest. Known ligature risks on wards at Elmleigh had not been addressed in a timely manner which put people's safety at risk.

Requires Improvement

Are services effective?

Most staff had completed their mandatory training and received regular clinical supervision. However, at Elmleigh we found significant shortfalls in areas of training, inconsistent provision of supervision to staff and a poor record on the completion of staff appraisals when compared with other similar services within the Trust. Consequently there was a risk that the service provided to people was ineffective.

Requires Improvement

Are services caring?

Care and treatment delivered at all acute ward and PICU locations was caring and considerate. People's involvement in their care and treatment was inconsistent varying from those who were very involved in the development of their own care plans and others who were not. Carers reported feeling involved in their relative's care.

Good

Are services responsive to people's needs?

The planning and delivery of the service was not always responsive to people's needs. The seclusion room on Hamtun ward at Antelope House was not fit for purpose. The design did not allow staff to easily observe people in the room. Some wards were clearly segregated with separate female and male wards and facilities. However, some of the bathrooms and toilets at Parklands Hospital on the male corridor were labelled as unisex and were used by women. This was contrary to Department of Health guidance as women had to walk past male bedrooms to get to the bathroom. The diverse needs of people were addressed particularly well at some locations. At Melbury Lodge people's spiritual needs were integrated into their everyday care and treatment.

Requires Improvement

Summary of findings

Are services well-led?

Some wards were very well-led and managers were visible. Most staff spoke positively about their managers and reported being able to raise concerns about standards of care. However, at Elmleigh most staff did not feel engaged and reported a serious lack of support from managers. Most wards used performance data and feedback from people using the service to identify areas for improvement and bring about changes in the service except at Elmleigh where the systems in place were not effective in bringing about continuous improvement.

Requires Improvement

Summary of findings

Background to the service

The acute admission wards at Southern Health NHS Foundation Trust are based at four hospital sites: at Elmleigh, Melbury Lodge, Antelope House and Parklands Hospital. They all provide inpatient mental health services for adults of working age. There are three psychiatric intensive care units (PICU) based at Elmleigh, Antelope House and Parklands Hospital.

Elmleigh, in Havant, has two acute wards with 11 beds each. One ward is for females and one for males. In addition there is an eight bed PICU on the same site.

At Melbury Lodge in Winchester, Kingsley Ward is an acute admission ward for twenty-five patients but is divided into separate male and female wings.

Antelope House serves the City of Southampton, although it accepts people from a wider geographical area covered by Southern Health NHS Foundation Trust. It has two acute inpatient wards, one male (Saxon) and one female (Trinity). Each of these wards has twenty beds. In addition Antelope House has a PICU (Hamtun) which provides more intensive support and has ten beds.

Parklands Hospital is in Basingstoke and has Hawthorns 1, a PICU with eight beds. Six beds are usually for males and two for females but could be reversed. Hawthorns 2 (acute) has 24 NHS beds for both males and females.

INSPECTION HISTORY

All the locations had been inspected before. Elmleigh was last inspected in November 2013 and was found to be compliant with regulations. Melbury Lodge was last inspected in April 2014 and was found compliant.

Antelope House had been inspected five times since registration by the Care Quality Commission.

In August 2013 we identified concerns with care and welfare and medicine records. We made compliance actions asking the provider to take action in order to ensure that people were in receipt of safe and adequate care. We inspected again on 2 December 2013 to review the progress the provider had made. We found that the provider had taken some steps to improve care planning and medicine records. However, although the care plans were individualised for mental health needs they did not always detail the support and care each patient required for physical health needs. Records such as risk assessments did not reflect concerns related to patients' physical health. We issued a warning notice to the provider stating our concerns with continued non-compliance, stating that they needed to have taken action by 31 January 2014.

We inspected on the 6 February 2014 to review the progress the provider had made with regard to the warning notice and the concerns we had with the care and welfare plans for patients. However, concerns remained regarding Hamtun ward. There continued to be a lack of information in risk assessments and care plans regarding peoples' physical health needs, placing people at risk of not receiving care to meet their needs. This inspection resulted in compliance actions in

four areas: providing care, treatment and support that meets people's needs; caring for people safely and protecting them from harm; staffing; and quality and suitability of management.

We inspected the wards for older people at Parklands Hospital in November 2013 and found some areas of non-compliance. We found that there with problems with the systems for managing medication and that the resuscitation equipment was not properly maintained. We also found that the quality of the care plans and how care was recorded was variable, that people's capacity and consent was not routinely assessed or recorded, and that not all people were routinely involved in their care. The acute wards and PICU at Parklands Hospital had not been inspected.

Our inspection team

Our inspection team was led by:

Chair: Shaun Clee, Chief Executive, 2gether NHS Foundation Trust, Gloucestershire

Summary of findings

Team Leader: Karen Wilson, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team included CQC inspection managers, inspectors, Mental Health Act reviewers, pharmacy inspectors, CQCs national professional advisor for learning disabilities, analysts and inspection planners.

There were also over 100 specialist advisors, which included consultant psychiatrists, psychologists, senior nurses, student nurses, social workers GPs, district nurses, health visitors, school nurses and an occupational therapist. In addition, the team included Experts by Experience who had personal experience of using or caring for someone using the types of services that we inspected. Five Experts by Experience were involved in the inspection of mental health and learning disability services and two were involved in inspecting community health services.

Why we carried out this inspection

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

How we carried out this inspection

To 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?

Before visiting, we reviewed a range of information we hold about the trust's acute wards and psychiatric intensive care units and asked other organisations to share what they knew. We carried out announced visits during the week commencing 6 October 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, student nurses and doctors. We talked with people who used the services about their views and experiences of the wards. We observed how people were being cared for and talked with carers and/or family members We reviewed care or treatment records of people who use services. We carried out an unannounced inspection visit to Elmleigh on 17 October 2014 and to Antelope House on 22 October 2014.

What people who use the provider's services say

People using acute wards for people of working age and psychiatric intensive care units (PICU) services were generally very positive about the staff and doctors and described them as kind and collaborative. People we spoke with reported feeling safe and said that access to staff when required was generally good. They told us they were listened to. Most people told us they had access to a good range of therapeutic and occupational activities, although this varied from ward to ward.

Summary of findings

Good practice

ALL LOCATIONS

- People using the service could attend therapeutic groups provided through the intensive support programme and could often continue to do so after discharge.

MELBURY LODGE

- Melbury Lodge had successfully integrated spirituality and recovery approaches as part of providing holistic care to people using the service.
- There was evidence of strong input from psychology services at Melbury Lodge.
- At Melbury Lodge a 'recovery focussed narrative' approach had been developed and put into practice in response to feedback from people using the service. This approach aimed to achieve greater collaboration between people using the service and health professionals when planning and reviewing care.

ANTELOPE HOUSE

- There was good planning and monitoring of people's physical health care

PARKLANDS HOSPITAL

- The acute ward employed a peer support worker, who worked with staff and people using the service to support them and their input into service development.

Areas for improvement

Action the provider MUST or SHOULD take to improve

ELMLEIGH

- The provider must ensure that appropriate and safe staffing levels are consistently maintained at Elmleigh based upon a detailed review of the needs and acuity of people using the acute wards and PICU.
- The provider must ensure that emergency equipment including resuscitation equipment and an automated external defibrillator is located on or close to the acute wards at Elmleigh.
- The provider must ensure that high quality clinical supervision and performance appraisal should be provided to Elmleigh ward staff at regular intervals and that staff are adequately supported to provide effective and safe care and treatment.
- The provider must address shortfalls in basic life support and intermediate life support training at Elmleigh and ensure all staff are appropriately trained.
- The provider must address shortfalls in proactively reducing incidents for safer services (PRISS) training at Elmleigh and ensure all staff are appropriately trained.
- The provider must ensure that ligature risks at Elmleigh, identified for removal, are removed.
- The provider must ensure that systems in place to assess and monitor the quality of service provision at Elmleigh are effective in bringing about improvements.

ANTELOPE HOUSE

- The provider must ensure that the seclusion facility on Hamtum ward complies with the Mental Health Act Code of Practice and allows continuous observation of people by staff.

PARKLANDS HOSPITAL

- The provider must ensure that women do not have to walk past male bedrooms to use bathrooms and toilets, in accordance with Department of Health guidance about gender separation on mental health wards.

Action the provider SHOULD take to improve

ALL LOCATIONS

- The provider should ensure that there is sufficient and detailed recording and documenting of mental capacity and consent to treatment in people's care records.
- The provider should ensure all people using the service are involved in discussions and decisions about their care and this is consistently recorded in their care records.

Summary of findings

ELMLEIGH

- The provider should ensure that staff are appropriately trained and actively support people to stop smoking.
- The provider should ensure there are sufficient opportunities for physical exercise for people on Elmleigh PICU.

MELBURY LODGE

- The provider should ensure that bedroom doors at Melbury Lodge provide sufficient privacy for people whilst enabling staff to maintain adequate visual observations.
- The provider should ensure recording of the determination of people's mental capacity is detailed and includes evidence underpinning the judgement at Melbury Lodge.
- The provider should ensure that explanations of people's rights under section 132 of the Mental Health Act 1983 are consistently documented at Melbury Lodge.
- The provider should ensure that on-going and planned work to improve the environment, in terms of removal of ligature risks, is completed at Melbury Lodge.

ANTELOPE HOUSE

- The provider should ensure that, at Antelope House, individual risk assessments are completed for people prior to going on section 17 leave and this should be recorded appropriately.
- The provider should ensure that episodes of restraint in the 'face down' position are minimised and only used in exceptional circumstances in line with Department of Health guidelines on the safe use of restraint.
- The trust should ensure that enhanced observations of people using the service are recorded accurately and contemporaneously.
- The trust should ensure that, on Hamtun ward, the blanket restrictions in place in respect of a limit of two telephone calls a day, no baths after 10.00pm and restrictions on the availability of snacks and drinks to people using the service are reviewed to make sure that people's individual needs are being met.

PARKLANDS HOSPITAL

- The provider should ensure that where CCTV cameras are used in communal areas and on individual wards at Parklands Hospital that people using the service are informed of this.
- The provider should ensure environmental risk assessments of the acute wards at Parklands Hospital are completed clearly, action taken to remove risks, and a record made of arrangements in place to manage or mitigate the risks.
- The provider should ensure at Parklands Hospital that the dirty utility facilities, such as a sluice sink and disposable bed pan macerator, are not in the laundry room where people's clothing is washed, because of the risk of cross contamination.

Southern Health 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
Elmleigh male and female acute wards and psychiatric intensive care unit (PICU)	Elmleigh
Kingsley male and female acute wards	Melbury Lodge
Saxon ward, Trinity ward and Hamtun ward (PICU)	Antelope House
Hawthorns 1 (OICU) and Hawthorns 2	Parklands Hospital
<Placeholder text>	<Placeholder text>

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 found all legal documentation in relation to detention under the Mental Health Act 1983 was in order. There was a system in place to ensure that the operation of the Mental Health Act met legal requirements.

All lawful authority appeared to be in place with some use of section 62 to cover a period of time between requesting a second opinion appointed doctor (SOAD) and receiving a SOAD certificate. At Melbury Lodge we noted that a local form recording the use of section 62 for medication was completed on a form designed for ECT; this was promptly amended during our visit.

Consent to treatment forms were attached to medicine charts in line with the Mental Health Act 1983 Code of

Detailed findings

Practice and although some medicines prescribed exceeded the recommended British National Formulary (BNF) doses, these were reviewed daily and risks assessed and care planned in line with the person's treatment plans.

Section 17 leave was recorded in a standardised system, and risk assessments were usually completed before leave was authorised. On the acute ward at Parklands Hospital we saw that some expired section 17 leave forms remained on file, which should have been removed so that people's current leave status was clear. On the PICU at Parklands Hospital all the current Section 17 leave forms were kept in a separate file for ease of reference for staff.

There were clear notices on the doors of wards advising people of their position in respect of leaving the ward depending on whether they were formal or informal patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found evidence in people's records of appropriate use of the Mental Capacity Act 2005 (MCA). Nurses and doctors were able to articulate how the MCA might impact on informal patients. Some staff were not aware of the recent legal judgements and there had been no applications for a deprivation of liberty safeguards (DoLS) on most of these wards. We looked at the records of several people on different wards specifically focusing on the MCA. We found no instances of people who lacked capacity and who met the criteria for an authorisation for a deprivation of liberty safeguards application.

Staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Some of the staff we spoke with gave examples of occasions when "best interest" decisions and possible capacity issues had been discussed. Capacity and consent was recorded, but not in a standardised way or using trust forms, so it was not always easy to find this information. Although we saw that capacity was routinely assessed, it did not always include the detail of why the person was deemed to have capacity or not, and did not always record the person's' views.

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

Track record on safety

Staff we spoke with knew how to recognise, report and record incidents. Performance data showed that incidents that had occurred on the acute wards and PICUs were monitored and investigated by managers. Where learning was identified this was shared with staff and appropriate improvements were made. Some of the staff we spoke with told us about the "Hotspots" newsletter, which included information about learning from around the Trust. The newsletter was on display in some ward offices.

Learning from incidents

The Trust shared information about incidents and near misses that had occurred in other services across the Trust with staff. Wider learning from incidents reported by NHS England was also shared.

Staff told us that if there were repeated incidents that involved the same person, this was reviewed by the multidisciplinary team. A doctor told us that there was a "learning from clinical events" meeting every other month where any incidents were discussed. Incidents were also discussed in the consultant's weekly meeting to ensure appropriate learning took place.

There were standard questions and checklists for staff to respond to when recording certain types of incidents in Trust reporting system. This included following falls and restraints, and helped ensure that key information was recorded.

Safeguarding

Staff we spoke with were aware of safeguarding procedures, how to identify possible abuse of vulnerable people and knew how they should report such incidents. Staff provided examples of when safeguarding referrals had been made to the local authority safeguarding team. People using the service we spoke with told us they felt safe on all the wards we visited.

We noted significant ligature risks on all the acute wards and PICUs we visited. Ligature risk assessments had been carried out in all wards but the local response to the identified risks was inconsistent throughout the Trust's acute services.

At Melbury Lodge we noted significant ligature risks particularly in the showers, bathrooms and bedrooms of people using the service on both wards. The most recent ligature risk assessment, carried out in June 2014, identified most of the ligature risks and staff were aware of them. In addition, managers on the wards had developed a photographic report detailing the ligature concerns This had been shared with senior managers in order to emphasise the risks posed to people using the service. In response to this action had been taken to make the ward safer. Two bathrooms had been prioritised for action with a re-fit due to begin at the end of October 2014. There were additional plans to replace all the sinks in people's bedrooms. In the meantime bathrooms, showers and toilets were kept locked when not in use and detailed individual risk assessments of people took place in order to mitigate the risks posed by the environment.

Similarly on the Antelope House acute wards we saw ligature risks in the activity room, phone room, and bathroom. All these rooms were kept locked and were used with staff present or when risk assessment indicated they are safe to use. On Hamtun ward, the PICU at Antelope House, we found that a ligature risk assessment had been carried out but was not signed or dated. This was quickly remedied when pointed out to staff. Staff we spoke with were aware of the necessity of assessing people's risk of self-harm before allowing access to rooms where ligature risks might be present. Where risks were apparent people used these rooms with a staff member present.

At Parklands Hospital there were several environmental risks on the acute ward, which included areas that were difficult to observe and ligature points. There were ligatures in the bathrooms and bedrooms, which were a particular risk as they were where people spent time unobserved.

Requires improvement

Are services safe?

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

Records showed that a ligature point assessment had last been carried out on the acute ward in September 2014, and this had identified the potential ligature points and risks we had seen on the ward. In response, some actions had been taken to reduce the level of risk. This included removing the risk, or putting in bids for renovation or replacement. However, the ligature risk assessment forms were not completed consistently, and it was not possible to tell from them which risks were to be removed or replaced, and what action was currently being taken to mitigate this.

There was a similar picture at Elmleigh. A ligature risk assessment had been carried out on the acute wards and PICU in January 2014. Some of the high risk ligature points identified were in areas used by people using the services, for example, toilet areas and bedrooms. We noted that for the acute wards actions to be taken by staff to reduce or mitigate the risks identified were recorded on the ligature risk assessment action plan. However, we saw that for some areas of the PICU when moderate or high risks had been identified there were no actions recorded in respect of how the risks were being managed on a day to day basis. Consequently there was a risk that staff were not consistently taking action to mitigate the risks identified.

The area risk register for Elmleigh stated that 'door stops throughout Elmleigh present a ligature risk' was rated amber. The mitigating action was stated to be 'estates to action, awaiting virement'. The risk presented by the door stops had also been identified in the ligature risk assessment conducted in January 2014. However, we saw during our inspection in October 2014 that no action had been taken to remove the doorstops. When we raised our concerns with managers they told us they did not know when the work was to take place. Despite identifying the risk in January 2014 no action to remove the door stops had been taken in almost ten months and no follow up action appeared to have been taken by staff to ensure the work was completed.

We reviewed a record of all incidents reported on Elmleigh acute wards and PICU in the three months between July and September 2014. We noted that 11 of these incidents (six on the acute wards and five on PICU) were categorised as 'self harm ligature/asphyxiation' or 'self harm ligature point'. The most serious harm resulting from the incidents was recorded as 'moderate, medical treatment/short term harm', while four were said to have caused minimal harm to people using the service. There were clearly risks to people using the service from ligature points on the acute wards and PICU. Little action had been taken to address the outstanding environmental risks that could be reasonably modified and the management of known risks was not always clear, which meant that risks to people remained.

Overall, medicines were safely managed on all the wards we visited. Medicines were kept in locked cabinets and where an electronic prescribing system was used this ensured that when medicines were administered this was accurately recorded. At Elmleigh, managers had identified a problem with staff omitting signatures from medicine administration records which was being addressed.

Medical devices were checked regularly to ensure they were fit for purpose. For example, weekly checks were carried out on the emergency equipment and recorded.

All the wards we visited were clean and tidy. People using the service we spoke with reported there were cleaners on the wards every day. Most people told us that the ward was usually clean. At Parklands Hospital PICU we saw that there was a sluice sink and a macerator (for washing disposable cardboard bed pans) in the laundry room where people using the service washed their clothing. Staff told us that the macerator and sink were not used. However, the macerator was switched on and there was wet grey pulp inside, which suggested it had recently been used. Having a macerator and washing machines in use in the same room meant there was a potential risk of cross infection or contamination.

Assessing and monitoring safety and risk

Performance indicators from September 2014 showed that the Elmleigh PICU had a staff vacancy rate of 16%. Staff absence rates were high and the use of bank and agency staff was 25% in PICU and 22% on the acute wards. The trust was recruiting more staff and using bank and agency staff to maintain staffing levels.

At Elmleigh, staff and people using the service in all areas told us they had concerns about staffing levels.

Requires improvement

Are services safe?

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

Staff said that as a result of insufficient numbers of staff they felt unable to provide the level of care to people they wanted to. People using the service on both acute wards and PICU consistently told us there were not enough staff on duty to meet their needs and described long waits for medication, cancelled activities and escorted leave that could not take place. The PICU ward manager acknowledged there were difficulties facilitating people's section 17 leave.

Minutes from a care team meeting in PICU on 6 October 2014 showed that staff had raised concerns about the number of newly qualified staff on the ward which had an impact on the administration of medicines to people. Patients were experiencing delays in receiving medicines because newly qualified staff were still completing medicines competencies and there were insufficient staff able to administer medicines on the unit in a timely manner. However, staff informed us that patients were no put at risk by the delays.

The acute wards manager told us that minimum staffing levels on the acute wards were two staff on each ward, one qualified and one unqualified, which he described as "the bare minimum". This was in addition to the unit shift coordinator and the band 6 team leaders who were usually available from 9am to 5pm on week days. Both wards had 11 beds and were described as being always full. The manager said he would have preferred to have three staff on each ward. The manager also told us that staffing levels had been determined following a divisional skill mix review in 2013. However, other managers in the unit were unclear how staffing levels had been determined and questioned whether there were sufficient staff to ensure patient safety at all times. One manager told us that staffing levels had been the same for the last six years despite an increase in the acuity of people using the service. Safer staffing conference calls were held weekly to make sure that minimum levels of staff were deployed on each shift but basic staffing numbers were not questioned at these meetings.

We reviewed reports of all incidents that had occurred on acute wards and PICU in the three months between July and September 2014. We noted that there were nine incidents reported as 'staffing levels/mix issues'. Staffing within Elmleigh acute areas was rated red on the area risk register with the negative impact on patient safety noted. However, the only mitigating action identified was 'weekly conference calls, daily review'. There was no date recorded on the risk register by which this would be addressed and no clear actions stated, aimed at a long-term solution to the concern.

Staff told us there were occasions when only one staff member or even none on a particular shift on PICU were trained in how to restrain a person safely (training known as proactively reducing incidents for safer services or PRISS). PICU staff usually needed to rely on staff who were PRISS trained coming from the acute wards to assist in an emergency.

The PICU manager told us there were always a minimum of four PRISS trained staff on each shift across the two acute wards, the PICU and health based place of safety. The manager told us that the unit daily morning meeting reviewed staffing levels and the training status of staff for upcoming shifts and sought additional staff if required. When we reviewed records of the daily morning meeting we saw that this did not always happen. The manager also told us there was no information available to the service about the training completed by 'bank' or 'agency' staff, which made it difficult to ensure there were enough PRISS trained staff available on each shift. There was therefore a risk that there were insufficient suitably trained staff available in the event of a person requiring restraint or in circumstances where two people needed restraining at the same time. The provider had not taken appropriate steps to ensure there were sufficient suitably trained staff available in order to safeguard people's health, safety and welfare.

In addition, when we reviewed the minutes of the three morning planning meetings, we saw that none of these identified whether there were sufficient staff trained in basic life support or intermediate life support (BLS or ILS) to meet people's needs in an emergency. A manager told us that this was not considered when the staff rosters were set. Records provided to us on the day of our inspection showed that only just over half of staff on PICU were up to date with basic life support or intermediate life support training. Eight staff were

Requires improvement

Are services safe?

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

overdue the training. Consequently there was a risk that people would be at risk of harm in the event of a collapse or cardiac arrest if adequately trained staff were not available.

At Melbury Lodge there were sufficient staff on the wards to ensure that people were cared for safely. However, staff raised concerns about the high usage of bank and agency staff on the wards to cover staff shortages. There were similar reports from staff at Antelope House and recruitment drives were underway aimed at addressing the shortfall in permanent staff on several of the wards and PICUs we visited. General staffing levels were increased in accordance with changes in people's needs, for example, when someone required one to one observation.

At Parklands Hospital all the staff we spoke with on the acute ward told us that there were usually enough nursing and care staff on the ward. We were told that the skill mix had been reviewed last year, which had created additional posts. Staff told us that they rarely used agency staff and gaps in the staff rota were usually filled by staff from the ward. The PICU at Parklands Hospital provided a member of staff for the health based place of safety when required. To cover this the ward had an additional full time post during the day to partially compensate for this. This was in contrast with the PICU at Elmleigh where the health based place of safety was expected to be covered from existing staff numbers. This put further strain on an area where there were often insufficient suitably trained staff.

Staff on different wards told us that activities organised for people were sometimes cancelled because of staff shortage, but generally activities took place as planned. This was confirmed by people using the service we spoke with. The majority of people using the service we interviewed at Antelope House raised issues in respect of agency nurses, stating it felt difficult when staff they did not know came onto the ward.

There was adequate medical cover on most of the wards, which included consultant psychiatrists. At Elmleigh there was one junior doctor on-call at night for the acute wards and PICU. The doctor was required to cover two inpatient units at night and was therefore not always present on Elmleigh. We were told by staff that there could be delays in the doctor coming to the ward when requested if they were busy elsewhere in the county. There was a consultant psychiatrist on call out of hours who could be contacted for telephone advice and could attend the ward if required.

There were systems in place to assess and monitor people's physical health and identify changes or deterioration in health. The 'track and trigger' system alerted staff to the need to escalate concerns to medical staff for review. We saw that records of physical health assessments and monitoring were usually up to date.

We found little evidence of proactive work to offer smoking cessation help and advice to people on the wards we visited but if people wished to have nicotine replacement therapy this was provided. Staff told us they did not generally receive specific training in this area.

We reviewed the care records of several people on each ward we visited. These showed that although there were inconsistencies between wards, individual risk assessments were generally in place for most people and had been carried out on admission. Where risks had been identified plans had mostly been put in place to address these. Risk was a standing item for discussion at multi-disciplinary team meetings and at the handover from one shift to another. We observed risks to people being discussed in the lunchtime staff team handovers we attended.

At Melbury Lodge individual risk assessments were comprehensive and updated regularly. Where risks had been identified there were plans outlining actions for staff to take to mitigate the risks. However, at Antelope House we found there was insufficient recording of risk assessment prior to agreeing section 17 leave for people detained under the Mental Health Act 1983. There was a risk that appropriate mitigation of risks was not in place as they had not been safely assessed. In contrast records at Melbury Lodge showed a robust system for granting leave with clear parameters and review dates set. There was clear evidence of risk assessment and records of people's appearance recorded in the event they should become absent without leave (AWOL) and not return from their permitted leave.

At Parklands Hospital individual health care records showed that a risk assessment was completed for all

Requires improvement

Are services safe?

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

people when they were admitted, and from this an initial care plan was developed. However, the level of detail varied as did the reflection of the identified risks in the care plans developed.

At Parklands Hospital staff told us that prone or 'face down' restraint was only used if necessary to administer medication, and the person would be turned face up as soon as possible. All restraints were recorded on the Trust's incident reporting system, and monitored by senior staff.

On Hamtun ward at Antelope House we noted that there had been 59 episodes of restraint, eight of which were in the 'face down' position over a ten month period between December 2013 and September 2014. This is indicates practice may be contrary to Department of Health guidelines' Positive and Proactive Care: reducing the need for restrictive interventions. These guidelines state that: 'Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor'. (April 2014.)

Potential risks

At Elmleigh we found that there was one emergency 'grab' bag/automated external defibrillator (AED) available to the acute wards and the PICU and this was stored in the treatment room on the PICU, at the far end of the ward. This meant that if a person collapsed or suffered a cardiac arrest on one of the acute wards staff would need to carry the 'grab bag' and AED through three sets of locked doors from the PICU to the ward to reach the affected person. There was a risk that this would cause a delay in a person receiving life saving treatment. Senior staff told us there had been discussions for several years about placing emergency equipment in a suitable place between the acute wards and PICU so that it could be accessed promptly by all staff in an emergency but this had not happened.

A person on Elmleigh had a care plan in place to address a serious allergy. The care plan stated that the person was at risk of anaphylaxis as a result of the allergy and that adrenaline was to be used to treat the person in an emergency. The patient's care plan did not indicate where the adrenaline auto-injector for the use in an emergency was kept. We asked a member of staff where the adrenaline was kept should the person require treatment for anaphylaxis. They told us it was in the emergency 'grab' bag which was located on the PICU. The treatment room on the PICU was located at the far end of the ward and there were three locked doors for staff to negotiate when bringing the emergency kit to the acute ward. We found the person was being put at unnecessary risk because the adrenaline was being stored in another ward and would not be promptly accessible in an emergency.

An incident occurred on the Elmleigh PICU on the day of our visit and emergency assistance was requested from staff the acute wards. There were identified responders from both acute wards but we observed on the female ward that all staff responded and went to the PICU. This left the female ward without any staff members we were able to locate, for a period of several minutes. There was a risk that the absence of staff meant people would not receive the care or levels of observation they needed.

Records confirmed that resuscitation equipment for use in an emergency was checked regularly by staff to ensure it was fit for purpose. Ligature cutters were kept in the staff office and staff knew where they were stored. This meant staff would be able to respond promptly in an emergency.

Our findings

Elmleigh

Track record on safety

Staff knew how to recognise, report and record incidents. Performance data showed that incidents that had occurred on the acute wards and PICU were monitored and investigated by managers and addressed. For example, following a number of signature omissions from medicine administration records all prescription charts were being checked weekly. Three errors of this nature by the same nurse meant they needed to repeat their medicine competency checks to ensure they were safe to administer medicines.

Learning from incidents

The Trust shared information about incidents and near misses that had occurred in other services. We saw a notice displayed on the staff office wall which identified mental

Requires improvement

Are services safe?

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

health learning 'hot spots'. This helped ensure learning from incidents was shared amongst the staff team. Wider learning from incidents reported by NHS England was also shared.

Safeguarding

Staff received training in safeguarding vulnerable adults and children during induction. Staff we spoke with were aware of how to identify the possible abuse of vulnerable people and knew how they should report such incidents. Medical staff told us that safeguarding was a set agenda item and discussed at every multi-disciplinary team meeting. A dedicated safeguarding meeting took place on the unit every week, at which all risk events were reviewed to determine whether they involved safeguarding concerns.

A ligature risk assessment had been carried out on the acute wards and PICU in January 2014. The assessment identified areas in the environment with the highest risks in terms of ligature points. Some of the high risks identified were in areas used by people using the services, for example, toilet areas and bedrooms. We noted that for the acute wards actions to be taken by staff to reduce or mitigate the risks identified were recorded on the ligature risk assessment action plan. However, we saw that for areas of the PICU where moderate or high risks had been identified there were no actions recorded in respect of how the risks were being managed on a day to day basis. Consequently there was a risk that staff were not consistently taking action to mitigate the risks identified.

In addition we identified mental brackets on the wardrobes in patient bedrooms on the PICU where wardrobe doors had been removed. This were ligature risks but had not been recognised as such by staff. We fed this back to the PICU manager.

We reviewed the risk register for Elmleigh which was provided to us by a senior member of staff. This showed that 'door stops throughout Elmleigh present a ligature risk' was rated amber on the area risk register. The mitigating action was stated to be 'estates to action, awaiting virement'. The risk presented by the door stops had also been identified in the ligature risk assessment conducted in January 2014. However, we saw during our inspection in October 2014 that no action had been to remove the doorstops. Managers told us they did not know when the work was to take place. On the day of our unannounced inspection, 17 October 2014, ward staff called senior managers in the Trust to raise concerns about the doorstops. We were told that they would be removed the next week. Despite identifying the risk in January 2014 no action to remove the doorstops had been taken in almost ten months and no follow up action appeared to have been taken by staff to ensure the work was done.

We reviewed a record of all incidents reported on Elmleigh acute wards and PICU in the three months between July and September 2014. We noted that 11 of these incidents (six on the acute wards and five on PICU) were categorised as 'self harm ligature/asphyxiation' or 'self harm ligature point'. The most serious harm resulting from the incidents was recorded as 'moderate, medical treatment/short term harm', while four were said to have caused minimal harm to people using the service. There were clearly risks to people using the service from both identified and non-identified ligature points on the acute wards and PICU. Little action had been taken to address and manage the known risks which meant that risks to people remained.

We reviewed all medicine administration records on the acute wards. We found that although most were completed appropriately a few signatures were missing from the charts without explanation as to why. It was therefore not clear whether the particular medicines had been administered. The ward manager acknowledged this was a recurrent problem that was being actively addressed. We noted that medicines were stored securely on the wards. Fridges used to store medicines were monitored daily to ensure temperatures were within acceptable limits and medicines therefore remained effective. Medical staff told us that careful attention was paid to high dose prescribing when this occurred.

Medical devices were checked regularly to ensure they were fit for purpose. For example, weekly checks were carried out on the emergency equipment and recorded.

There were suitable infection prevention and control measures in place. People using the service told us the Elmleigh wards were generally kept clean and tidy.

Assessing and monitoring safety and risk

We reviewed performance data for the acute in-patient wards and PICU at Elmleigh. Performance indicators in September 2014 showed that the PICU had a staff vacancy rate of 16%. Staff absence rates were high and the use of bank and agency staff was 25% in PICU and 22% on the acute wards. \the trust was recruiting more staff and using bank and agency staff to maintain set staffing levels.

Requires improvement

Are services safe?

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

Staff in all areas told us they had concerns about staffing levels. They said that as a result of insufficient numbers of staff they felt unable to provide the level of care to people they wanted to. On the PICU staff told us there were many occasions when there was only one qualified nurse on duty on the ward. When this happened the PICU was described as "very unsafe." People using the service on both acute wards and PICU consistently told us there were not enough staff on duty to meet their needs and described long waits for medication, cancelled activities and escorted leave that could not take place.

People using the service reported not getting escorted leave as granted under section 17 of the Mental Health Act 1983. The PICU ward manager acknowledged there were difficulties facilitating section 17 leave. A person using the service on the PICU told us they were supposed to have two periods of leave per day for 30 minutes each time. However, there were rarely enough staff available to escort them and they left the ward for half an hour once every few days. Another person using the PICU described staff as "rushed off their feet." A person using service on the acute wards similarly told us they managed to get agreed leave every other day, rather than every day. The manager of the acute wards told us they thought that most section 17 leave was honoured but there was no central record kept of how often leave had been cancelled.

Staff in PICU also told us people using the service were sometimes unable to use the garden because of staff shortages as there was no one available to supervise them.

On the male acute ward we saw that one to one time with staff was advertised as on offer to people between 3.30 and 4.30pm every day. However, people using the service on the ward told us they were either unaware of this or that it did not happen in daily practice as staff were too busy.

Minutes from a care team meeting on the PICU on 6 October 2014 showed that staff had raised concerns about the number of newly qualified staff on the ward which had an impact on the administration of medicines to people. People were experiencing delays in receiving medicines because newly qualified staff were still completing medicines competencies and there were insufficient staff able to administer medicines on the unit in a timely manner although staff informed us that patients were not put at risk by delays.

There was one junior doctor on-call at night for the acute wards and PICU. The doctor was required to cover two inpatient units at night and was therefore not always present at Elmleigh. We were told by staff that there could be delays in the doctor coming to the ward when requested if they were busy elsewhere in the county. There was a consultant psychiatrist on call out of hours who could be contacted for telephone advice and could attend the ward if required.

The acute wards manager told us that minimum staffing levels on the acute wards were two staff on each ward, one qualified and one unqualified, which he described as "the bare minimum". This was in addition to the Unit Shift Coordinator and the Band 6 Team Leader who were usually available from 9am-5pm on week days. Both wards had 11 beds and were described as being always full. The manager said he would have preferred to have three staff on each ward.

The manager went on to explain that staffing levels had been determined following a divisional skill mix review in 2013. However, other managers in the unit were unclear how staffing levels had been determined and questioned whether there were sufficient staff to ensure patient safety at all times. One manager told us that staffing levels had been the same for the last six years despite an increase in the acuity of people using the service. Safer staffing conference calls were held weekly to make sure that minimum levels of staff were deployed on each shift but basic staffing numbers were not questioned at these meetings.

We reviewed reports of all incidents that had occurred on the Elmleigh acute wards and PICU in the three months between July and September 2014. We noted that there were nine incidents reported as 'staffing levels/mix issues'. Staffing within Elmleigh acute areas was rated red on the area risk register with the negative impact on patient safety noted. However, the only mitigating action identified was 'weekly conference calls, daily review'. There was no date recorded on the risk register by which this concern would be addressed and no clear actions stated, aimed at a long-term solution to the concern.

Staff told us there were occasions when only one staff member or even none on a particular shift on PICU were trained in how to restrain a person safely (training known as proactively reducing incidents for safer services or

PRISS). PICU staff usually needed to rely on staff who were PRISS trained coming from the acute wards to assist in an emergency. Training records showed that eleven PICU staff had not had initial training or refresher training in PRISS.

We asked managers how they ensured that there were sufficient numbers of PRISS trained staff on duty during each shift. The PICU manager told us there were always a minimum of four PRISS trained staff on each shift across the two acute wards, the PICU and health based place of safety. The manager told us that the unit daily morning meeting reviewed staffing levels and the training status of staff for upcoming shifts and sought additional staff if required. At our unannounced visit to Elmleigh on 17 October 2014 we were provided with minutes of three recent morning meetings, two of these identified there was a 'full physical restraint team available'. In the record of the meeting on 15 October 2014 this was not recorded. The manager told us there was no information available to the service about the training completed by 'bank' or 'agency' staff, which made it difficult to ensure there were enough PRISS trained staff available. There was therefore a risk that there were insufficient suitably trained staff available in the event of a person requiring restraint or in circumstances where two people needed restraining at the same time. The provider had not taken appropriate steps to ensure there were sufficient suitably trained staff available in order to safeguard people's health, safety and welfare.

In addition, when we reviewed the minutes of the three morning planning meetings, we saw that none of these identified whether there were sufficient staff trained in basic life support or intermediate life support (BLS or ILS) to meet people's needs in an emergency. A manager told us that this was not considered when the staff rosters were set. We saw from training figures that there were a significant number of acute ward and PICU staff who were not BLS or ILS trained. Records provided to us on the day of our inspection showed that only just over half of staff on the PICU were up to date with BLS or ILS training. Ten staff were overdue the training. On 17 October 2014 the PICU manager told us that two of the four staff on duty on the PICU that day were PRISS trained but they did not know whether any of the four staff were up to date with BLS or ILS training. There was a risk that people would be at additional risk in the event of a collapse or cardiac arrest if adequately trained staff were not available.

We reviewed the care records of several people on the wards. These showed that individual risk assessments had been carried. Where risks had been identified plans had been put in place to address these. Risk was a standing item for discussion at the handover from one shift to another and we observed risks to people were discussed in the lunchtime staff team handover.

People underwent a physical examination and assessment on admission to the wards. Physical health was monitored using a 'track and trigger' system, which highlighted to staff when abnormal clinical observations needed to be escalated to a doctor. When physical health problems were identified we saw that people had care plans in place that addressed these. Fluid balance charts were completed for people for whom it was appropriate. People confirmed their physical health was checked regularly. All people using the service had an electrocardiogram (ECG) on admission.

The acute ward manager told us there was little proactive work to offer smoking cessation help and advice to people but if people wished to have nicotine replacement therapy this was provided. They also said that staff did not receive specific training in this area.

Potential risks

The modern matron provided us with a copy of a general workplace risk assessment, dated February 2014, which identified risks in the ward environment. This report stated that staff were aware of what to do in the event of a medical emergency. The emergency equipment was stated to be stored in a secure but readily accessible place.

However, we found that there was one emergency 'grab' bag and one automated external defibrillator (AED) available to the acute wards and the PICU and this was stored in the treatment room on the PICU, at the far end of the ward. This meant that if a person collapsed or suffered a cardiac arrest on one of the acute wards staff would need to carry the 'grab bag' and AED through three sets of locked doors from the PICU to the ward to reach the affected person. There was a risk that this would cause a delay in a person receiving life saving treatment. Senior staff told us there had been discussions for several years about placing emergency equipment in a suitable place between the acute wards and PICU so that it would be quicker to access in an emergency by all staff but this had not happened.

Requires improvement

Are services safe?

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

A person on the acute ward had a care plan in place to address a serious allergy. The care plan stated that the person was at risk of anaphylaxis in response to a serious allergy and that adrenaline was to be used to treat the person in an emergency. We asked a member of staff where the adrenaline was kept should the person require treatment for anaphylaxis. They told us it was in the emergency 'grab' bag which was located on the PICU. The treatment room on the PICU was located at the far end of the ward and there were three locked doors for staff to negotiate when bringing the emergency kit to the acute ward. We found the person was being put at unnecessary risk because the adrenaline was being stored in another ward and would not be promptly accessible in an emergency.

An incident occurred on the PICU on the day of our visit and emergency assistance was requested from the acute wards. There were identified responders from both acute wards but we observed on the female ward that all staff responded and went to the PICU. This left the female ward without any staff members we were able to locate, for a period of several minutes. There was a risk that the absence of staff meant people would not receive the care they needed.

Melbury Lodge

Track record on safety

The unit had a good safety record. Staff knew what kind of incidents they needed to report and how this was to be done.

Learning from incidents

Serious incidents were investigated and learning from incidents was fed back to staff directly or via a monthly trust bulletin. Staff confirmed that incidents and complaints were discussed in team meetings and individually in one to one meetings with line managers.

Safeguarding

Staff we spoke with were aware of safeguarding procedures. They knew how to recognise possible abuse and to report it appropriately. Staff provided examples of when safeguarding referrals had been made to the local authority safeguarding team. People using the service we spoke with told us they felt safe on the unit.

Medicines were safely managed. They were kept in locked cabinets and an electronic prescribing system ensured that when medicines were administered this was accurately recorded.

We noted significant ligature risks on the wards particularly in the showers, bathrooms and bedrooms of people using the service. Staff were aware of the risks and the most recent ligature risk assessment, carried out in June 2014, identified several ligature risks on the male and female wards. In addition, managers on the wards had developed a photographic report detailing the ligature concerns This had been shared with senior managers in order to emphasise the risks posed to people using the service. In response to this, action had been taken to make the ward safer. Two bathrooms had been prioritised for action with a re-fit due to begin at the end of October 2014. There were additional plans to replace all the sinks in people's bedrooms. In the meantime bathrooms, showers and toilets were kept locked when not in use and detailed individual risk assessments of people took place in order to mitigate the risks posed by the environment.

Assessing and monitoring safety and risk

There were sufficient staff on the wards to ensure that people were cared for safely. A minimum of five staff, two of whom were qualified nurses, provided cover across both wards on each shift. However, staff raised concerns about the high usage of bank and agency staff on the wards to cover staff shortages. There was an active recruitment campaign in progress aimed at addressing the shortfall in permanent staff. Staffing levels were increased in accordance with changes in people's needs, for example, when someone required one to one observation. Staff told us that activities organised for people were sometimes cancelled because of staff shortages, but generally activities took place as planned. This was confirmed by people using the service we spoke with.

We checked the care records of a sample of people using the service. We noted there were individual risk assessments in place. They were comprehensive and updated regularly. Where risks had been identified there were plans outlining actions for staff to take to mitigate the risks.

People using the service reported significant amounts of unescorted leave and the records showed a robust system for granting leave with clear parameters and review dates

Requires improvement

Are services safe?

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

set. There was clear evidence of risk assessment and records of people's appearance recorded in the event they should become absent without leave (AWOL) and not return from their permitted leave.

There were systems in place to assess and monitor people's physical health and identify changes or deterioration in health. The 'track and trigger' system alerted staff to the need to escalate concerns to medical staff for review. We saw that records of physical health assessments and monitoring were up to date.

Staff had been trained and knew how to restrain people safely. They were familiar with the latest guidance on safe positioning during restraint. There was no seclusion room available on the ward and staff used de-escalation techniques and physical restraint where necessary to maintain people's safety.

Potential risks

Records confirmed that resuscitation equipment for use in an emergency was checked regularly by staff to ensure it continued to be fit for purpose. Ligature cutters were kept in the staff office and staff we spoke with knew where they were stored. This meant staff would be able to respond promptly in an emergency.

Antelope House

Saxon and Trinity

On both Saxon and Trinity wards at Antelope House there was good evidence of safe practice. This was demonstrated through a review of case notes, speaking with staff, patients and their carers. We carried out a tour of the ward to review any environmental risks.

Learning from incidents and Improving safety standards.

All staff stated that they were aware of how to report an incident and that learning from incidents was shared in the weekly multi-disciplinary meeting.

Safeguarding.

All staff were aware of the safeguarding process, the named safeguarding lead and when and how to raise an alert. People using the service reported feeling safe on the ward and felt they were treated with dignity and respect.

A ligature risk assessment had been carried out and staff were aware of the policy. There were ligature risks in the activity room, phone room, and bathroom. All these rooms were kept locked and were used with staff present or when risk assessment indicated they were safe to use.

The ward was clean and hygienic and all bedrooms had an en-suite shower and toilet facility.

In medicines management there were areas of good practice such as electronic records which gave the exact numbers of tablets by drug supplied for short term leave. Staff also considered the impact of non-prescribed medicines (butane gas and alcohol) when prescribing. There were good relationships with the pharmacists and ward staff valued the contribution of the pharmacists and technician.

Staff clearly asked patients how they felt and asked them to score their pain or anxiety where relevant to them.

Assessing and monitoring safety and risk.

We found that all individual risk assessments were completed and up to date. People had been given full physical health screening and received on-going assessment of their physical health needs. However, we found through scrutiny of care records that there was insufficient recording of risk assessment prior to agreeing S17 leave. This could impact on how information was communicated and how staff might assess the risks should there be difficulties with leave arrangements or if a patient did not return to the ward as agreed.

Staffing levels were safe but all staff talked about staffing challenges. Although staffing levels were described as adequate, there continued to be high usage of agency nurses. A recruitment campaign was underway and staff had been successfully employed. We met new starters and were informed of new nurses joining the teams in coming weeks. Every single member of staff we spoke with highlighted that recruitment was their biggest challenge. The majority of people using the service we interviewed also raised issues around agency nurses, stating it felt difficult when staff they did not know came onto the ward.

Potential risks.

The trust staff survey reported that the trust was leaning towards worse than average ratings for staff working extra hours and feeling unsatisfied with their quality of work.

Requires improvement

Are services safe?

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

Hamtun (PICU)

Learning from incidents and Improving safety standards.

All staff stated that they were aware of how to report an incident and that learning from incidents was shared in the weekly multi-disciplinary meeting.

Safeguarding.

We interviewed five people using the service on Hamtun ward and most reported feeling safe on the ward. Staff were aware of who the lead for safeguarding was and how to raise an alert. Eighty nine per cent of staff had undertaken mandatory training in safeguarding.

Records showed that there had been 59 episodes of restraint on the PICU, eight of which were in the 'face down' position over a ten month period between December 2013 and September 2014. This is could indicate that practice is contrary to Department of Health guidelines 'Positive and Proactive Care: reducing the need for restrictive interventions.' These guidelines state that: 'Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor' (April 2014.)

The pharmacist inspector found an error in the recording of Type II diabetic prescribed insulin. The person's care plan clearly described the action to be taken if BM >20, the staff were also aware of the actions to take if the BMs were <4. However this had been deleted from the electronic record. The multi-disciplinary team meeting records clearly documented that the clinicians were concerned by the low BM results. We raised this with staff on the day of our inspection to ensure it was addressed.

We found that a ligature risk assessment had been carried out on the PICU but was not signed or dated. This was rectified on our return for the unannounced inspection on 22 October 2014. Staff we spoke with were aware of the ligature risk policy and the necessity of assessing risk of self-harm before allowing access to rooms where ligature risks might be present, such as the bathroom. These rooms were kept locked at all times and individuals were risk assessed prior to being allowed access these rooms. Where risks were apparent people used these rooms with a staff member present.

Potential risks.

We had some concerns about Hamtun ward in a number of areas and we undertook a further unannounced inspection on 22 October 2014. At our first inspection we found that one of the ensuite rooms at the end of the male corridor was allocated to a female patient. Whilst she had been placed on close observations, this presented risks. The Trust addressed this concern immediately and raised a safeguarding alert. On the unannounced visit we found that the Trust had changed the policy to ensure that this would not happen again. Staff we spoke with were all aware of this new directive.

Parklands Hospital

Track record on safety

The trust used an electronic incident reporting and management system. The staff we spoke with knew how to report incidents. The incidents were reviewed by the ward manager, and then sent to the central risk management team, who provided feedback to the ward if there were any gaps or concerns. Staff told us that incidents were discussed in the handover and the multidisciplinary meetings. The manager told us that a quarterly incident report from the Trust's risk manager was emailed to the ward and shared with staff. Some staff we spoke with told us about the "hotspots" newsletter, which included information about learning from around the Trust.

Learning from incidents

Staff told us that they discussed incidents during handovers and staff meetings. This included both individual and broader issues. Staff told us that if there were repeated incidents that involved a specific person using the service, then this would be reviewed in the multidisciplinary team meeting. A doctor told us that there was a "learning from clinical events" meeting that took place every other month where they discussed incidents, and that incidents were also discussed in the consultants' meeting each week. We saw an example of this from September 2014 that related to medication. For broader learning, one member of staff described an example where they had been given information about an incident that had occurred in another hospital.

We saw an example of a "Sharing Good Practice and Learning" template from Oct-Dec 2013, which discussed three themes that had been identified from incidents and complaints during that period and the action that was to be taken. We saw that the outcome of this had been discussed in a staff meeting in July 2014. There were

Requires improvement

Are services safe?

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

standard questions and checklists to respond to when recording certain types of incidents. This included following falls and restraints, and helped ensure that key information was recorded.

Safeguarding

There were several environmental risks on the acute ward which included areas that were difficult to observe, ligatures, and fire extinguishers in the corridors. There were ligatures in the bathrooms and bedrooms, which were a particular risk as people spent time unobserved in these areas.

We saw that there was a process for assessing and responding to environmental risks. Records showed that a ligature point assessment had last been carried out on the acute ward in September 2014, and this had identified the potential ligature points and risks we had seen on the ward. The risks were rated as high, medium or low. We saw that, in response, some actions had been taken to reduce the level of risk. This included taking action to remove the risk, or putting in bids for renovation or replacement. However, the ligature risk forms were not completed consistently, and it was not possible to tell from them which risks were to be removed or replaced, and what action was currently being taken to mitigate this.

A ligature risk assessment had been completed for the psychiatric intensive care unit (PICU). We saw that the PICU had reduced environmental risks, and unsupervised areas did not have ligature points. There were no blind spots, and CCTV was used to monitor the garden and entry.

All people on the ward were checked at least once an hour. There was no one on one-to-one observations on the wards at the time of our inspection. We saw that people's levels of observation were recorded in their care records, and discussed in the daily handover meeting.

Records showed that there was a system for reporting and recording maintenance concerns. Staff told us that routine maintenance requests were usually dealt with quickly. During our inspection we observed a broken fire door magnet, which resulted in the door being propped open which the manager reported. The rest of the ward appeared adequately maintained.

People using the service we spoke with told us they felt safe on the ward. However, they said that they did not have keys to their rooms and some people were concerned about the security of their belongings. People told us that they were able to ask staff to lock their room doors, but they found it frustrating to have to do so.

The wards looked clean and tidy. The people we spoke with said that there were cleaners on the wards every day. Most people said the ward was usually clean, except for the bathrooms and toilets which could left dirty by other people using the service. On the PICU we saw that there was a sluice sink and a macerator (for washing disposable cardboard bed pans) in the laundry room, where people using the service washed their clothing. The housekeeping staff showed us that they had their own cleaning and disposal room, and told us they did not use the sink in the laundry room. Staff told us that the macerator and sink were not used. However, the macerator was switched on and there was wet grey pulp inside, which suggested it had recently been used. Having a macerator and washing machines in the same room is a potential infection control problem, because of the risk of cross contamination.

The safeguarding process was on display in the staff offices. The staff we spoke with were aware of the safeguarding process, and knew how to make a referral if necessary. Records showed that all staff had received safeguarding training.

During our last inspection of Parklands Hospital we inspected the wards for older people and found that there were inadequate systems in place for the management of medication. During this inspection we found that the service had satisfactory systems in place for managing medication. We identified some areas where errors had been made and informed the staff of this. This included two medications that were out of date, one medication had been signed against the wrong medication route, and oral liquids did not have opening dates so may have expired.

Assessing and monitoring safety and risk

All the staff we spoke with on the acute ward told us that there were usually enough nursing and care staff on the ward. We were told that the skill mix had been reviewed last year, which had created additional posts. Staff told us that they rarely used agency staff. They told us that any gaps were usually filled by staff from the ward, or from the Trust's bank of staff. There was adequate medical cover on the ward, which included consultant psychiatrists.

Requires improvement

Are services safe?

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

One person using the service on the acute ward told us that it was normally difficult to find staff as they spent a lot of time in the office. Another person said that if you went to the office it could sometimes take a long time for anyone to respond. However, other people we spoke with said that they always had access to staff when they needed them.

The staff we spoke with on the PICU told us that they were usually enough nursing and care staff, and they could adapt their staffing levels to meet the needs of the ward. Any additional shifts were usually worked by the ward's own or the Trust's bank staff. The PICU provided a member of staff for the Section 136 suite when required. To cover this the ward had an additional full time post during the day to partially compensate for this.

Staff we spoke with told us and individual health care records showed that a risk assessment was completed for all people when they were admitted, and from this an initial care plan was developed. However, the level of detail varied as did the reflection of the identified risks in the care plans. We saw that in the handover meetings each person's care was discussed, and this included changes to their mental health and management of risk.

The staff we spoke with told us that if a person was agitated they used verbal de-escalation to calm them, and only used physical restraint as a last resort. They told us they had received training in physical restraint, and this was confirmed by the training records. Rapid tranquillisation and seclusion were used if necessary, but their use was infrequent. Training records showed that most qualified staff had completed training in rapid tranquillisation. Staff told us that prone or 'face down' restraint was only used if necessary to administer medication, and the person would be turned face up as soon as possible. All restraints were recorded on the Trust's incident reporting system, and monitored by senior staff.

Potential risks

There was emergency equipment in place on both wards. During our last inspection of Parklands Hospital we inspected the wards for older people and found that the resuscitation equipment was not adequately maintained. During this inspection we found that the equipment was maintained, adequately stocked and routinely checked.

There were restrictions on taking potentially harmful items into the PICU, such as razor blades and cigarette lighters. Details of restricted items were listed at the entrance to the ward and in the information pack. When people arrived on the ward they were searched in the seclusion suite, before coming onto the ward.

Are services effective?

Requires Improvement

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

Assessment and delivery of care and treatment

Most people on all wards, whose records we reviewed, had care plans in place that addressed their assessed needs and any individual risks identified. There were care plans in place addressing people's physical as well as mental health needs.

On Hawthorn 2 at Parklands Hospital records of people using the service showed that people had their mental and physical healthcare needs assessed, and care plans developed from these. However, the daily entries of care were variable in quality. Some referred to the care plans and contained detailed information about interactions with the person while other entries were minimal, and contained limited information. They either did not refer to the care plan or referred to the wrong one.

The prescribing of medicines complied with NICE (National Institute for Health and Care Excellence) guidelines. Staff were informed of changes in policies and procedures and relevant NICE guidance in order to support their practice and delivery of effective care and treatment.

Staff on some wards were aware of research and developments in acute mental health care and we noted the implementation of new approaches based on evidence and best practice. For example, The 'safewards' initiative was being implemented on the wards and considerable progress had been made with this in some areas. 'Safewards' had introduced a variety of methods designed to reduce rates of conflict and containment in adult in-patient mental health settings.

At Melbury Lodge the service had also developed a spiritual assessment as part of a holistic approach to determining people's needs. This was based on evidence that people recover faster and recovery is more likely to be sustained when health professionals work with people to explore their spirituality.

In addition the wards at Melbury Lodge used a 'recovery focussed narrative approach.' This had been developed in response to feedback from people using the service and aimed to achieve greater collaboration between people and health professionals when planning and reviewing care. The approach encouraged recovery focussed conversations between staff and people using the service that began very soon after admission and facilitated person-centred care. The narrative focussed on the development of individual goals based on people's strengths and resources, helpful and unhelpful approaches, a safety plan, things to focus on now and people the person would like involved in their care. The approach improved pathways of care for people and involved only professionals actively involved in people's care and treatment. This meant people did not attend large traditional ward rounds that may have included professionals not involved in their care and which people using the service could find daunting.

The psychology department led a therapy programme for the acute wards, but people on the PICUs and receiving the support at home service were also able to access it. The programme was part of the intensive support programme (ISP) which was a trust-wide initiative that focused on promoting a recovery based culture. It included the use of mindfulness, and a type of cognitive behaviour therapy (CBT). Staff told us that most people using the service saw a psychologist for an initial assessment, and to determine what would be useful for them. They would then be given a programme which included, for example, mindfulness sessions, emotional coping and being a compassionate friend. It was particularly helpful that people could continue to attend and complete a course after they had been discharged from the wards to the intensive support team in the community.

There were other ward-based activities provided for people on all the wards. Occupational therapists (OTs) had recently started at Elmleigh and were providing group and individual activities for people. Staff told us that current affairs groups, walking groups, arts and crafts and baking activities were usually provided, although these were sometimes cancelled because of a lack of staff to facilitate them. At Parklands Hospital there was currently no OT on the acute ward, but the post was being recruited to. There was an activity programme seven days a week, but staff told us this varied and depended on the availability of staff. We saw an example of the programme which included a mix of creative groups, such as crafts and music, and therapy groups such as mindfulness and managing anxiety.

Are services effective?

Requires Improvement

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.

At Melbury Lodge both individual and group activities were offered to people. There was a varied activity programme in place five days a week. There were gym facilities available and some staff had received specific training to enable them to support people to use gym equipment safely. People using the service spoke highly of the activities and groups provided.

There were fewer activities available to people in the PICUs we visited. On the Elmleigh PICU there were no opportunities for physical activities and people using the service told us they had suggested an exercise bike but had had no response from staff. There were no gym facilities on site. This had a negative impact on people's physical health. On the PICU at Antelope House, Hamtun ward, the majority of people reported that there was very little by way of OT or activities on the ward. This was acknowledged by staff who reported that an OT was due to start at the end of the month. The impact of a lack of activities meant that people using the service were bored, lacked stimulus and were more likely to isolate themselves in their rooms.

The minutes of community meetings on both wards at Parklands Hospital showed that people liked some activities, but generally felt that there was not enough to do on the wards. Where there were activities, this was not always publicised, although this had improved.

Outcomes for people using services

Some wards were actively monitoring outcomes for people by seeking systematic feedback from them. At Melbury Lodge people's experiences on the unit were captured through the completion of patient surveys. Questionnaires to obtain feedback from people about their experiences included questions related to hope, agency or sense of control, opportunities to lead a full and meaningful life and relationships with staff. An analysis of surveys completed between July and September 2014 showed high levels of satisfaction with the care and treatment provided. For example, most people said that staff were aware of and had understanding of their individual needs; they knew who to talk to about any worries and concerns and were involved in decisions about their care.

The Elmleigh acute wards manager told us that the wards had only started using patient related outcome measures (PROMs) at the beginning of the week of our visit. Prior to this the ward had not been systematically measuring outcomes for people using the service. In the past the service had received generic feedback from trust patient satisfaction questionnaires which had made it difficult to identify and address concerns specific to Elmleigh.

At Parklands Hospital a peer support officer had been appointed to support the use of PROMs and the voice of people using the service. People using the service and staff were positive about this role.

Staff skill

Medical staff and allied healthcare professionals we spoke with in all wards reported being well supported by senior staff and having good training opportunities. Three newly appointed OTs were arranging for supervision from a more senior OT on another unit.

On most wards we visited nursing and care staff had completed their mandatory training and received regular one to one and group supervision. Some staff were undertaking additional specialist training.

For example, at Parklands Hospital, staff told us they had received training in how to restrain a person safely and in rapid tranquillisation. This was confirmed by training records. Staff said that the psychology team had provided intensive support programme (ISP) training for most of the nursing staff. This supported them to practice and promote a recovery approach throughout all their interactions on the ward, and not just within therapy sessions.

At Antelope House all staff we spoke with reported having regular monthly supervision and had completed a performance appraisal within the last year. On Hamtun ward staff described having reflective practice sessions with a psychologist who had helped them work more effectively in a challenging environment and reduce their levels of stress. An OT at Elmleigh told us that the Gibbs model of reflection was used in reflective practice meetings and this was helpful.

However, at Elmleigh ward most staff told us that they did not get regular one to one supervision from senior staff and often felt unsupported. Several staff said they had not had supervision for many months. Staff also told us they had not always had the opportunity for a debrief following incidents including assaults.

Are services effective?

Requires Improvement

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.

Elmleigh supervision records showed that most staff had attended group supervision but many had not had one to one managerial or clinical supervision in August or September 2014. The acute ward manager acknowledged pressures on staffing had meant that not all supervision had taken place as planned. Group supervision had been introduced as a way of ensuring more staff had space to discuss clinical issues. However, the quality of this as a way of conducting clinical supervision was not reflected in the minutes of meetings we reviewed. For example, minutes of a meeting in October showed that nine staff had attended one meeting which would have limited the time available to any one individual to discuss any clinical issues they had relating to people using the service. The staff business meeting was included as a group supervision meeting on the staff supervision matrix. However, minutes of the business meeting held on 17 September 2014 showed that most topics discussed by those present were of a practical nature such as repairs needed to the washing machine and tablecloths needing washing as well as announcements about new staff joining. It was not clear that this type of supervision was meeting the needs of staff.

The majority of staff had received an annual performance appraisal although some we spoke with at Elmleigh had not. Elmleigh acute ward and PICU performance data from September 2014 showed that the acute wards and PICU ranked 24 and 25 out of 25 similar services across the trust in respect of appraisal compliance. Appraisal compliance was rated red for both areas and there had been little change in performance in the last three months. Some staff raised concerns over the quality of appraisal they had received and said they did not get any feedback on how they could improve.

Most staff at Elmleigh had completed the required mandatory training. However, records provided on the day of our inspection showed that only just over half of staff on PICU were up to date with basic life support (BLS) or intermediate life support (ILS) training. Ten staff had not received the required training or were overdue for a refresher course. Similarly on the acute wards thirteen staff had not completed BLS or ILS training. This shortfall in training was confirmed by the performance dashboard for September 2014. When we asked senior staff whether there were any plans in place to address the training shortfalls they told us they were not aware of any. They said that obtaining places on courses was difficult as they did not always run frequently, there were staff shortages which prevented people attending training and travel time to venues was such that it compounded difficulties associated with attendance.

Training records at Elmleigh also showed that eleven PICU staff had not had initial or refresher training in proactively reducing incidents for safer services (PRISS). In addition, only 25% of required PICU staff had completed training in rapid tranquilisation. Several staff told us they had had to wait for several months after starting work on the acute wards or PICU before being able to complete PRISS training. This shortfall meant there was a risk to staff and people using the service as not all staff had been trained how to restrain a person safely. Although staff who had not been trained were not expected to restrain people this put additional pressure on colleagues. The trust did not have suitable arrangements in place to ensure that staff were appropriately supported to provide safe and appropriate care as significant numbers of staff had not received appropriate training, supervision and appraisal.

Multi-disciplinary working

We saw good examples of multi-disciplinary working on all wards we visited. For example, at Elmleigh managers reported good links with community mental health teams. A member of the intensive support team, who supported many people post-discharge, attended the ward multi-disciplinary team (MDT) meeting in order to facilitate the discharge of people to the community. A care navigator from the intensive support team helped address barriers to discharge and facilitated smooth transfers of care.

At Parklands Hospital we observed a staff handover meeting on both the acute ward and the PICU. This was attended by staff from different professions including medicine, nursing and psychology, and reviewed all the people using the service. There was a standard list of areas that were discussed during the meeting, and this was recorded in each person's care record. The meeting included a discussion of people's needs, responded to

Are services effective?

Requires Improvement

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.

changes, and reviewed previous care implemented. We saw that discharge, the care programme approach (CPA) criteria and implementation of the Mental Health Act 1983 (MHA) and Best Interests were discussed.

Information and Records Systems

Records and information systems supported the effective delivery of care and treatment. People had up to date risk assessments and care plans in place. These were reviewed regularly for completeness. Care records included people's goals and activities and sometimes included people's views.

We reviewed the records of seclusion kept on the PICUs. These included start and end times of periods of seclusion and notes recorded during two hourly checks on people. Detailed observations were made on a frequent basis which supported the delivery of care.

We found, however, that some agency staff did not have access to the electronic records system. This may have had a negative impact on continuity of care for people with information regarding risk not being available to or shared with agency staff in a timely manner.

On Hamtun ward at Antelope House we looked at five sets of notes in relation to regular observations of people. People were on enhanced observations due to increased risks to self or others. This usually meant having a nurse with them at all times, or being checked every five, 10 or 15 minutes. The purpose of documentation was to record accurately the person's whereabouts during that hour and their presentation or behaviour. We found consistent gaps in the recording of observation. The gaps could suggest that the prescribed level of observations were not being carried out or were not an accurate record of the care provided.

Consent to care and treatment

People's consent was sought before care or treatment was provided. Care and treatment was provided in line with provisions of the Mental Health Act 1983 and Code of Practice.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and how this applied to their practice. However, we noted that this was not always reflected in people's care records. For example, on Elmleigh PICU we found written entries in people's care records about capacity that lacked sufficient detail. A determination of a person's mental capacity did not always record the process by which the judgment was reached and the evidence underpinning the judgement. For example, we saw entries such as: "capacity and consent: s2" and "lacks capacity and insight." At Parklands Hospital we found that capacity and consent to treatment was being assessed and recorded by the responsible clinician (RC) and was reviewed and recorded in the progress notes during multidisciplinary reviews. The records showed that people had their treatment discussed with them, and their capacity to consent was assessed. However, there was no standardised way of recording this, and it was often recorded in the daily progress notes in the electronic records and was not easy to find.

At Antelope House and Elmleigh some blanket restrictions were in place for people newly admitted to the ward. The ensuite bathrooms in people's bedrooms were routinely kept locked for 24 hours after admission to the ward. Staff said this was so that they could manage ligature risks, get to know people and allowed for a more robust assessment of risk. At Antelope House PICU blanket restrictions were in place that allowed people only two telephone calls per day and not being allowed to have a bath after 10.00pm. There were also restrictions on the availability of snacks and drinks. It was not clear why these restrictions were in place on the PICU or how they benefitted people.

Assessment and treatment in line with Mental Health Act

People detained under the Mental Health Act 1983 (MHA) had their rights explained to them on admission to the ward and on an on-going basis to ensure they understood. People we spoke with confirmed they understood their rights and knew they had a right of appeal against their detention.

We noted, however, that records of the explanation of people's rights under section 132 of the MHA were variable. For some people records showed there had been regular attempts to explain their MHA status and rights, whereas for other people there were no records on file.

At Parklands Hospital we saw that the application of the Mental Health Act was discussed in multidisciplinary team meetings, as was the use of community treatment orders (CTOs) where this was appropriate. We saw that

Are services effective?

Requires Improvement

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.

people had access to Independent Mental Health Advocates (IMHAs) and used this service. The MHA documentation we reviewed was completed appropriately.

Our findings

Elmleigh

Assessment and delivery of care and treatment

The prescribing of medicines complied with NICE guidelines. Staff were informed of changes in policies and procedures and relevant NICE guidance in order to support their practice and delivery of effective care and treatment.

Most people, whose records we reviewed, had care plans in place that addressed their assessed needs and any individual risks identified. There were care plans in place addressing people's physical as well as mental health needs. On the PICU, however, we found that evidence of care planning was inconsistent. Many care plans showed clear evidence of people's participation in care planning with their views were recorded. However, one person's care records did not include current care plans at all. The ward manager confirmed this was the case and said they would follow up to ensure plans were put in place immediately.

There were some activities provided for people on the wards. Occupational therapists (OTs) had recently started at Elmleigh and were providing group and individual activities for people. Staff told us that current affairs groups, walking groups, arts and crafts and baking activities were usually provided, although these were sometimes cancelled because of a lack of staff to facilitate them. Some people were able to attend groups provided by the intensive support programme. These were facilitated by a nurse or psychologist and included short courses in emotional coping skills and being a compassionate friend. People could continue to attend and complete a course after they had been discharged from the wards to the intensive support team.

On the PICU there were no opportunities for physical activities and people told us they had suggested an exercise bike but had had no response from staff. There were no gym facilities on site. This had a negative impact on people's physical health.

Outcomes for people using services

The ward manager told us that the acute wards had only started using patient related outcome measures (PROMS) at the beginning of the week of our visit. Prior to this the ward had not been systematically measuring outcomes for people using the service. In the past the service had received generic feedback from trust patient satisfaction questionnaires which had made it difficult to identify and address concerns specific to Elmleigh.

Staff skill

Ward staff told us that they did not get regular one to one supervision from senior staff and often felt unsupported. They told us that one to one supervision should have happened monthly but several staff said they had not had supervision for many months. Staff also told us they had not always had the opportunity for a debrief following incidents including assaults.

Supervision records showed that most staff had attended group supervision but many had not had one to one managerial or clinical supervision in August or September 2014. The acute ward manager acknowledged pressures on staffing had meant that not all supervision had taken place as planned. Group supervision had been introduced as a way of ensuring more staff had space to discuss clinical issues. However, the quality of this as a way of conducting clinical supervision was not reflected in the minutes of meetings we reviewed. For example, minutes of a meeting in October showed that nine staff had attended one meeting which may have reduced the time available to any one individual to discuss particular clinical issues they had relating to people using the service. Staff told us that group supervision did take place but not all staff were able to attend.

The staff business meeting was included as a group supervision meeting on the staff supervision matrix. However, minutes of the business meeting held on 17 September showed that most topics discussed by those present were of a practical nature such as repairs needed to the washing machine and tablecloths needing washing as well as announcements about new staff joining. It was not clear that this type of supervision was meeting the needs of staff.

Other types of group supervision were acknowledged to be useful by staff. An OT told us that Gibbs model of reflection was used in reflective practice meetings and this was helpful.

Are services effective?

Requires Improvement

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

The majority of staff had received an annual performance appraisal although some we spoke with had not. However, acute ward and PICU performance data from September 2014 showed that the acute wards and PICU ranked 24 and 25 out of 25 similar services across the trust in respect of appraisal compliance. Appraisal compliance was rated red for both areas and there had been little change in performance in the last three months. Some staff raised concerns over the quality of appraisal they had received and said they did not get any feedback on how they could improve.

Although most staff mandatory training was up to date records produced on the day of our inspection showed that only just over half of staff on PICU were up to date with basic life support (BLS) or intermediate life support (ILS) training. Ten staff had not received the required training or were overdue for a refresher course. Similarly on the acute wards thirteen staff had not completed BLS or ILS training. This shortfall in training was confirmed by the performance dashboard dated September 2014. When we asked senior staff whether there were any plans in place to address the training shortfalls they told us they were not aware of any. They said that obtaining places on courses was difficult as they did not always run frequently, there were staff shortages which prevented people attending training and travel time to venues was such that it compounded difficulties associated with attendance.

Training records provided to us during the inspection showed that eleven PICU staff had not had initial or refresher training in proactively reducing incidents for safer services (PRISS). In addition, only 25% of required PICU staff had completed training in rapid tranquilisation. Several staff told us they had had to wait for several months after starting work on the acute wards or PICU before being able to complete PRISS training. This shortfall meant there was a risk to staff and people using the service as not all staff had been trained how to restrain a person safely. Although staff who had not been trained were not expected to restrain people this put additional pressure on colleagues. The trust did not have suitable arrangements in place to ensure that staff were appropriately supported to provide safe and appropriate care as significant numbers of staff had not received appropriate training, supervision and appraisal.

Staff new to the trust told us they had undergone a period of induction before starting work on the unit but that PRISS and BLS/ILS had not been covered during that time.

Doctors told us they received good training, supervision and appraisal on the acute wards and PICU. Three newly appointed OTs were arranging for supervision from a more senior OT on another unit.

Multi-disciplinary working

Managers reported good links with community mental health teams. A member of the intensive support team, who supported many people post-discharge, attended the ward multi-disciplinary team (MDT) meeting in order to facilitate the discharge of people to the community. A care navigator from the intensive support team helped address barriers to discharge and facilitated smooth transfers of care. The MDT was assisted by a resettlement officer who worked closely with the team and people using the service to identify suitable accommodation post discharge.

The MDT met three times a week and the ward manager said this had helped people move on more quickly and effectively.

There was one occupational therapist based on each ward which was a recent development in the service. A psychologist was due to start working on the ward and it was hoped this would improve access to psychological therapies.

MDT meetings were used to work with community colleagues to plan for people's discharge from hospital. The wards had good relationships with a range of disciplines, community teams and agencies. This meant that people's needs were assessed in a holistic way taking into account their psychosocial needs as well as medical needs.

Information and Records Systems

Records and information systems supported the effective delivery of care and treatment. People had up to date risk assessments and care plans in place. These were reviewed regularly for completeness. Care records included people's goals and activities and sometimes included people's views.

We reviewed the records of seclusion kept on the PICU. These included start and end times of periods of seclusion and notes recorded during two hourly checks on people. Detailed observations were made on a frequent basis which supported the delivery of care.

Are services effective?

Requires Improvement

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.

Consent to care and treatment

People's consent was sought before care or treatment was provided. Care and treatment was provided in line with provisions of the Mental Health Act 1983 and Code of Practice.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and how this applied to their practice.

Some blanket restrictions were in place for people newly admitted to the ward. The ensuite bathrooms in people's bedrooms were routinely kept locked for 24 hours after admission to the ward. Staff said this was so that they could manage ligature risks, get to know people and allowed for a more robust assessment of risk.

Assessment and treatment in line with Mental Health Act

Documentation relating to the operation of the Mental Health Act 1983 (MHA) was generally good. Detention papers were held on people's legal files and on most, approved mental health professional reports were in evidence. Records of section 17 leave showed a thorough approach to where and with whom the leave could be permitted and included clear parameters of the leave with review dates. Old and out of date forms were crossed through to avoid confusion.

Information on people's rights under the Mental Health Act 1983 (MHA) was provided to people detained on the wards. People we spoke with understood their rights under the MHA. . People had access to the Independent Mental Health Advocate and some had taken opportunities to appeal to the Mental Health Tribunal against their detention. People using the service who were not detained under the Act also understood their rights.

Melbury Lodge

Assessment and delivery of care and treatment

Staff told us that care and treatment was delivered to people in line with national guidance and standards. Staff were aware of research and developments in acute mental health care and we noted the implementation of new approaches based on evidence and best practice. For example, The 'safewards' initiative was being implemented on the wards and considerable progress had been made with this. 'Safewards' had introduced a variety of methods designed to reduce rates of conflict and containment in adult in-patient mental health settings. The service had also developed a spiritual assessment as part of a holistic approach to determining people's needs. This was based on evidence that people recover faster and recovery is more likely to be sustained when health professionals work with people to explore their spirituality. The prescribing of medicines was compliant with National Institute for Health and Care Excellence (NICE) guidelines.

The wards used a 'recovery focussed narrative approach.' This had been developed in response to feedback from people using the service and aimed to achieve greater collaboration between people and health professionals when planning and reviewing care. The approach encouraged recovery focussed conversations between staff and people using the service that began very soon after admission and facilitated person-centred care. The narrative focussed on the development of individual goals based on people's strengths and resources, helpful and unhelpful approaches, a safety plan, things to focus on now and people the person would like involved in their care. The approach improved pathways of care for people and involved only professionals actively involved in people's care and treatment. This meant people did not attend large traditional ward rounds that may have included professionals not involved in their care and which people using the service could find daunting.

Individual and group activities were offered to people. There was a varied activity programme in place five days a week. There were gym facilities available and some staff had received specific training to enable them to support people to use gym equipment safely. People using the service spoke highly of the activities and groups provided. We observed a group taking place that was run by the unit occupational therapist (OT). The plan for the group was clear and well prepared. The OT clearly understood people's needs and was involved in their day to day care. People were involved in the activity throughout.

People had care plans in place that addressed their assessed needs and any individual risks identified. People's strengths and needs were clearly stated. People's physical health as well as their mental health needs were assessed. We saw that where particular problems or risks were identified care plans were in place to address them. However, there were no specific smoking cessation programmes available for people who may have wanted to give up or reduce consumption of tobacco.

Are services effective?

Requires Improvement

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.

Outcomes for people using services

People's experiences on the unit were captured through the completion of patient surveys. Questionnaires to obtain feedback from people about their experiences included questions related to hope, agency or sense of control, opportunities to lead a full and meaningful life and relationships with staff. An analysis of surveys completed between July and September 2014 showed high levels of satisfaction with the care and treatment provided. For example, most people said that staff were aware of and had understood their individual needs; they knew who to talk to about any worries and concerns and were involved in decisions about their care.

Staff skill

Staff had received training in support of their roles and responsibilities on the wards. Learning needs were identified through an individual appraisal process and appropriate training provided, where possible, to meet those needs. The statutory and mandatory training matrix for the wards confirmed that most staff were up to date with the required training. Several staff had attended additional training in more specialist areas such as dialectical behaviour therapy, a therapy designed to help people change patterns of behaviour that are not effective.

Staff told us they received regular managerial and clinical supervision. The unit supervision tracker showed us that most nurses and health care support workers received individual supervision monthly. There was a weekly reflective practice meeting available for staff which allowed them to consider their practice in a group setting. In addition staff were offered opportunities for a debrief following incidents, which they told us was helpful.

Junior medical staff told us they received good support from their consultant psychiatrist. They considered they had excellent supervision and access to training.

Multi-disciplinary working

We found evidence of excellent team working on the unit. All staff we spoke with told us the multi-disciplinary team worked well together and there was good co-operation between different disciplines. This enabled the delivery of holistic care and treatment to people.

There were a range of different disciplines represented in the multi-disciplinary team including a psychologist, occupational therapy staff and a part-time chaplain. Therapists offered different groups and individual therapeutic opportunities to people using the service. The chaplain said they very much felt part of the care team.

The multi-disciplinary team worked effectively together to ensure people's discharges from the wards were planned. People using the service told us they were kept informed about arrangements for their discharge and written information was provided on discharge that helped people's transition back into the community. There were good working arrangements with community mental health teams which helped facilitate discharge arrangements.

Information and Records Systems

Information management systems were in place that supported the delivery of care and treatment. We saw that care plans and risks assessments were in place and regularly updated to ensure they remained current and addressed people's needs.

Consent to care and treatment

People's consent was sought before care or treatment was provided. Where people were detained under the Mental Health Act 1983 consent was sought in line with the legislation.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and how this applied to their day to day work. However, we noted written entries in people's care records about capacity that lacked sufficient detail. A determination of a person's mental capacity was not always supported by written records showing the process by which the judgment was reached and the evidence underpinning the judgement. For example, we saw entries such as "capacity and consent: s2" and "lacks capacity and insight."

Assessment and treatment in line with Mental Health Act

People detained under the Mental Health Act 1983 (MHA) had their rights explained to them on admission to the ward and on an on-going basis to ensure they understood. People we spoke with confirmed they understood their rights and knew they had a right of appeal against their detention.

Are services effective?

Requires Improvement

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.

We noted, however, that records of the explanation of people's rights under section 132 of the MHA were variable with evidence that for some people there had been regular attempts made to explain their MHA status and rights, whereas for other people there were no records on file.

Antelope House

We found that the service provided by both Saxon and Trinity wards was effective. This was evidenced through information in the data pack and discussions with both staff and people using the service. We also reviewed case notes and observed a bed management meeting, as well as talked to external stakeholders.

Assessment and delivery of care and treatment

Both Saxon and Trinity wards had care plans in place for every individual which were up to date and signed by the person. This meant that care plans were personalised and that there was mutual consensus in developing the plans. This was in line with NICE guidelines on 'Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services.'

Physical health plans were in place and there was good evidence of on-going assessment of the physical health needs of every patient. This was essential for people's health and wellbeing. It has been widely recognised that the physical health of people with mental health problems has been neglected by health professionals and as a result their quality of life and life expectancy is reduced.

Ward managers and doctors were able to articulate clearly how they implemented National Institute for Health and Care Excellence (NICE) guidelines citing for example, medication management.

'Safewards' was being implemented on both Saxon and Trinity wards. The initiative aims to make psychiatric wards more peaceful, increasing safety and engagement and working to reduce coercion.

There were mindfulness meetings every morning. There were additional occupational activities in the afternoon. Patients reported that they enjoyed the activities.

Staff skill.

All staff we spoke with reported having had regular monthly supervision. Annual appraisals were completed. Eighty nine per cent of staff were up to date with mandatory training.

Multi-disciplinary working.

Saxon and Trinity wards had two weekly multi-disciplinary meetings; each person using the service was discussed in detail. The meetings were also used to work with community colleagues to plan for discharge. The ward had good relationships with a range of disciplines. This meant that people's needs were assessed in a holistic way taking into account their psychosocial needs as well as medical needs.

Information and Records Systems.

An electronic records system was used to record progress notes and risk assessments and general assessments. We found, however, that some agency staff did not have access to the electronic information system. This may have had a negative impact on continuity of care for people with information regarding risk not being shared in a timely manner.

Hamtun ward

Assessment and delivery of care and treatment.

Care plans were in place for every individual which were up to date and signed by the person. Physical health plans were in place and there was good evidence of on-going assessment of physical health needs for every person.

The over whelming majority of people reported that there was very little occupational therapy or activities on the ward. This was acknowledged by staff who reported that an occupational therapist (OT) was due to start at the end of the month. The impact of a lack of activities meant that people were bored, lacked stimulus and were more likely to isolate themselves in their rooms.

Every morning a community meeting was held where people asked what they would like to do that day, such as play pool or go to another ward to do a group, however these arrangements were ad-hoc. There was little structure to ward based activities and no access to a computer. These issues combined resulted in a lack of day time structure and meaningful activity for people.

Staff skill

Staff described having reflective sessions with a psychologist who had helped them work more effectively in a challenging environment and reduce their levels of stress.

Are services effective?

Requires Improvement

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.

Multi-disciplinary working.

Hamtun had two weekly multi-disciplinary meetings; each person was discussed in detail in these meetings. The meetings were also used to work with community colleagues to plan for discharge.

Information and records systems

We looked at five sets of notes in relation to regular observations of people. People were on enhanced observations due to increased risks to self or others. This usually meant having a nurse with them at all times, or being checked every five, 10 or 15 minutes. The purpose of documentation was to record accurately the person's whereabouts during that hour and their presentation or behaviour. We found consistent gaps in the recording of observation. The gaps could suggest that the prescribed level of observations were not being carried out. The ward manager was not able to offer an explanation of why this might be happening.

Consent to care and treatment.

We examined care records on Hamtun and found that the records lacked reference to issues of capacity and whether people were consenting to treatment and making informed decisions about treatment options. This is out of step with the Mental Health Act Code of Practice which states at 23.27 that; 'health professionals must determine whether a patient has the capacity to or refuse a particular form of medical treatment and if so, whether the patient does in fact consent.'

People using the service reported that their rights under Section 132 of the Mental Health Act 1983 had been explained to them on admission. We found evidence that Section 132 forms were ticked and rights repeated to individuals, who may have needed this explaining more than once. This was corroborated in interviews with people who used services.

The ward operated blanket restrictions on people such as only being allowed two telephone calls per day and not being allowed to have a bath after 10.00pm. There were restrictions on the availability of snacks and drinks as well as restrictions to internet access. It was not clear why these restrictions were in place and why they were thought necessary for everyone on the ward.

Parklands Hospital

Assessment and delivery of care and treatment

During our last inspection of Parklands Hospital we inspected the wards for older people and found that some of the risk assessments and care plans did not reflect the person or their needs. During this inspection, the sample of records we looked at on the working age adult wards showed that people using the service had had their mental and physical healthcare needs assessed, and care plans developed from these. The daily entries of care were variable in quality. Some referred to the care plans and contained detailed information about interactions with the person. However, other entries were minimal, and contained limited information and either did not refer to the care plan or referred to the wrong one.

People using the service had their physical health care needs monitored. Records showed that people had a physical healthcare assessment on admission. We saw that where concerns were identified these were followed up by medical staff, and expert advice was sort where necessary. People's physical healthcare observations (for example blood pressure, pulse, and blood sugar levels) were recorded onto a "Physiological Observation Chart Audit Track and Trigger Tool". This was a colour coded chart which highlighted when a person's observations were within a normal range, or when further action may be required. The charts made it easy to see changes over a period of time. The sample of charts we looked at had been completed as necessary. We observed that people's physical healthcare needs were discussed in the daily handover meeting.

Staff told us that there was currently no occupational therapist (OT) on the acute ward, but the post was being recruited to. There was an activity programme seven days a week, but staff told us this varied and depended on the availability of staff. We saw an example of the programme which included a mix of creative groups, such as crafts and music, and therapy groups such as mindfulness and managing anxiety.

The minutes of community meetings, for people who use the service, on both wards showed that people liked some activities, but generally felt that there was not enough to do on the wards. Where there were activities, this was not always publicised, though this had improved. The people we spoke with were positive about some of the activities

Are services effective?

Requires Improvement

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.

available, but agreed that they would like more to do. Both wards had free access to outdoor space. There was a garden from the acute ward and a tarmac garden for the PICU.

The psychology department led a therapy programme, predominantly for the acute ward, but people on the PICU and receiving the Hospital at Home service were also able to access it. The programme was part of the Intensive Support Programme (ISP) which was a trust-wide initiative that focused on promoting a recovery based culture. It included the use of mindfulness, and a type of cognitive behaviour therapy (CBT). A programme lasted for a number of weeks, so was accessible for people who were only in the service for a short period of time. Staff told us that most people using the service saw a psychologist for an initial assessment, and to determine what would be useful for them. They would then be given a programme which may include, for example, mindfulness sessions which ran each day in the service.

Outcomes for people using services

Staff told us that they were working on the development of Patient Reported Outcome Measures (PROMs) to monitor and improve the care of people on the ward. The use of PROMS was referred to in the staff and community meeting minutes (for people using the service) but it was not clear if people using the service understood its purpose, or how it impacted on their care. A peer support officer had been appointed to support the use of PROMs and the voice of people using the service. People using the service and staff were positive about this role.

Staff skill

Staff told us that the psychology team had Intensive Support Programme (ISP) training for most of the nursing staff. This supported them to practice and promote a recovery approach throughout all their interactions on the ward, and not just within therapy sessions.

The nursing and support staff we spoke with told us they were up to date with their mandatory training, and that they could access specialist training. Training records showed that most staff on the ward were up to date with most of their mandatory training. Staff told us that they had received training in how to restrain a person safely, and this was confirmed by the training records. PICU training records showed that most of the qualified staff had completed training in rapid tranquillisation.

Some staff were carrying out additional specialist training. The medical and allied healthcare professionals we spoke with, such as doctors and psychologists, told us that they received regular supervision and support, and were able to access training and continuing professional development.

We saw examples of clinical supervision records. These showed that issues were discussed and actions agreed. This included making improvements on the ward, lead roles, dealing with performance issues, identifying training needs, and discussing specific patient issues. The trust's monitoring information showed that all staff (up to the most recent information in August 2014) on the acute ward and PICU had had an appraisal. We saw an example of the trust's appraisal form. This included personal development, ISP groups, and responsibility for specific improvements on the ward.

Multi-disciplinary working

We observed a staff handover meeting on both the acute ward and the PICU. This was attended by staff from different professions including medicine, nursing and psychology, and reviewed all the people using the service. There was a standard list of areas that were discussed during the meeting, and this was recorded in each person's care record. The meeting included a discussion of people's needs, responded to changes, and reviewed previous care implemented. We saw that discharge, the care programme approach (CPA) criteria and implementation of the Mental Health Act (MHA) and Best Interest were discussed. Medication and therapies were reviewed. People's mental and physical healthcare needs were discussed. We saw that people had had CPA meetings, and discharge plans were discussed, which included working with the Hospital at Home team, which enabled people to be discharged sooner. The Hospital at Home team worked primarily with the acute ward. Staff told us that most of the people on the PICU were "stepped down" to the acute ward before being discharged.

Information and Records Systems

The trust used an electronic records system used by both the hospital and community teams. We saw an example where a person was seen to be relapsing in the community, this had been followed up, and the person subsequently admitted. From the records it was possible to follow the person's progress through the care pathway they had followed into hospital. Some papers records were also used, for example, records of physical healthcare

Are services effective?

Requires Improvement

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.

observations. Staff told us this made it easier to track changes, but if concerns were identified this and the action taken would be recorded on the electronic system. We saw examples of where this had occurred.

Consent to care and treatment

During our last inspection of Parklands Hospital we inspected the wards for older people and found that capacity was not routinely assessed or recorded. At this inspection we found that capacity and consent to treatment was being assessed and recorded by the Responsible Clinician (RC) and was reviewed and recorded in the progress notes during multidisciplinary reviews. Records showed that people had their treatment discussed with them, and their capacity to consent was assessed. However, there was no standardised way of recording this, and it was often recorded in the daily progress notes so was not easy to find.

Assessment and treatment in line with Mental Health Act

We saw that the application of the Mental Health Act 1983 was discussed in the multidisciplinary team meeting, as was the use of community treatment orders (CTOs) where this was appropriate. We saw that people had access to Independent Mental Health Advocates (IMHAs) and used this service. The Mental Health Act documentation we saw was completed adequately.

Good

Are services caring?

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

Summary of findings

Dignity, respect and compassion

We observed interactions between people using the service and staff on all wards and saw these were friendly and respectful. Most people using the service we spoke with on all the wards we visited said they received kind and considerate care from staff and described them as polite, compassionate, caring and empathic.

However, there were some exceptions. A few people at Parklands Hospital described unhelpful interactions with staff and said that a small number of staff had been impolite. At Elmleigh two people told us they had received responses from staff that they considered unsympathetic and distressing. On Hamtun ward, at Antelope House, a few people described staff who did not appear interested and did not engage with them.

Staff on all the wards were usually available to people and actively engaged with them. However, we observed periods of up to 45 minutes on an acute ward at Elmleigh when all staff appeared to be in the office with no attempted interaction with people in communal ward areas.

We saw that staff respected people's privacy and dignity on all wards. People we spoke with, and who gave feedback via comment cards, supported these observations. An analysis of patient surveys completed at Melbury Lodge between July and September 2014 showed that almost all people using the service considered they were treated with dignity and respect by staff.

However, on Hamtun ward at Antelope House, we noted that systems for administering medicines that involved people queueing for medicines meant that people were able to see and hear matters of a confidential nature relating to the person in front of them.

In addition, at Melbury Lodge, the majority of bedroom doors did not provide sufficient privacy and people had placed temporary coverings over window panels in the doors that made observation by staff difficult. Managers told us there was an agreement to replace the doors with ones that had specially designed privacy panels. This would significantly improve privacy for people as well as make unobtrusive observation by staff much easier.

Involvement of people using services

We received mixed responses from people when we asked them about their involvement in their care. Some people told us they were listened to by staff and able to contribute to decision making about their treatment and care. Whereas others we spoke with told us they had not been involved in developing their care plan and did not have a copy. This was common across most wards although people on the acute wards at Melbury Lodge were more positive about their level of involvement in care and treatment, including the development of care plans.

People using the service were encouraged to give feedback about their care and treatment. The majority of people we spoke with also told us that they understood what medicines they were prescribed and what they were for. Feedback from recent satisfaction surveys confirmed what people told us.

Information for people was available on all the wards we visited. This included information about the service, different types of medication, information about entering and leaving the ward, visiting times, and on how to make a complaint.

Information was made available for people on the independent advocacy services available to them. Most people we spoke with were aware of the advocacy service, and some people had used the service and found it helpful. An advocate we spoke with at Antelope House reported a good relationship with all the wards. They felt welcome on the wards and received regular referrals from staff. We particularly noted that at Parklands Hospital a peer support officer was employed to provide additional support to people. We received positive feedback from staff and people using the service about this role.

Community meetings were held regularly on all wards that allowed people to feedback issues of concern to staff. We observed the weekly community meeting on Kingsley ward at Melbury Lodge. Although a small number of people attended they were encouraged to

Good

Are services caring?

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

get involved and all had a chance to contribute to the discussion. Some ward managers provided written responses to people about issues raised in meetings and how they were being addressed.

It was notable that the acute wards at Melbury Lodge had introduced a 'recovery focussed narrative' approach to care in direct response to feedback from people using the service regarding their dissatisfaction with large ward rounds. The service had responded positively to feedback and acted upon suggestions from people using the service.

Emotional support for people

Carers we spoke with on all wards we visited reported feeling involved in their relative's care. They stated they felt staff were caring and sensitive to their needs and provided relevant information. Staff told us they supported and involved carers and relatives in accordance with the wishes of people using the service. There were private areas where people could meet with friends and relatives.

At Elmleigh a café had been set up on the acute wards, although this was only open for short periods every day. People and their relatives could buy drinks and cakes from the café. There was a small seating area that allowed people to meet with relatives in a more relaxed setting away from the main acute wards.

At Melbury Lodge a carer's guide had been developed in conjunction with the carers council, who met every two months, and this was available for friends and relatives of people admitted to the ward.

Our findings

Elmleigh

Dignity, respect and compassion

Most people using the service, we spoke with, were positive about the staff and doctors and described them as kind and collaborative. People told us they liked the newly appointed occupational therapists and were well supported by them. They said they were usually treated with respect by staff. We observed many positive interactions between staff and people. Staff appeared caring and compassionate and responded to people's concerns.

Some individual staff on the wards were named and highlighted by several people using the service as being very compassionate and providing excellent care. However, some people also described less positive experiences. Two people reported negative statements made to them by staff which they had found unsympathetic and distressing.

However, we observed periods on the acute ward of up to 45 minutes when all staff appeared to be in the office with no attempted interaction with people in communal ward areas. One person who needed help to shower because of physical health problems said that staff had not offered to help them in this respect. We discovered later in our visit there was a shower adapted for people with disabilities available to people but the person had not been advised of this.

Involvement of people using services

We received mixed responses from people when we asked them about their involvement in their care. Many people using the service we spoke with told us they had not been involved in developing their care plan and did not have a copy. Whereas other people told us they were listened to by staff and able to contribute to decision making about their treatment and care. On the PICU people using the service could articulate their care quite clearly but some said they had not been party to the creation of care plans and did not have a paper copy.

Information was made available for people on the independent advocacy services available to them.

Community meetings were held regularly that allowed people to feedback issues of concern to staff. We were shown evidence of written responses to issues raised in meetings later addressed by the ward manager.

Emotional support for people

A café had been set up on the acute wards, although this was only open for short periods every day. People and their relatives could buy drinks and cakes from the café. There was a small seating area that allowed people to meet with relatives in a more relaxed setting away from the main acute wards.

Melbury Lodge

Dignity, respect and compassion

People using the service were positive about the care and treatment provided on the wards and said they were treated with dignity and respect. Nursing staff were

Are services caring?

Good

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

described by people as "extremely nice", "helpful" and "polite." We observed many positive and considerate interactions between people using the service and staff during our visit to the wards.

An analysis of patient surveys completed between July and September 2014 showed that almost all people using the service considered they were treated with dignity and respect by staff.

With one exception the bedroom doors did not provide sufficient privacy and people had temporary coverings over window panels in the doors that made observation difficult. Managers told us there was an agreement to replace the doors and include specially designed privacy panels that would significantly improve privacy for people and make unobtrusive observation by staff much easier.

People had lockable storage in their rooms that allowed them to secure their valuables.

Involvement of people using services

People using the service told us that staff took their views into account when care and treatment was planned. We observed the weekly community meeting for people using the service. The meeting was chaired by a staff member who was supported by the chaplain. Although a small number of people attended they were encouraged to get involved and all had a chance to contribute to the discussion.

The service had introduced a 'recovery focussed narrative' approach to care in direct response to feedback from people using the service regarding their dissatisfaction with large ward rounds. This showed the service responded positively to feedback and suggestions from people using the service.

People using the service were encouraged to give feedback about their care and treatment.

Most people told us they were involved in the development of their care plans. The majority of people we spoke with also told us that they understood what medicines they were prescribed and what they were for. Feedback from recent satisfaction surveys confirmed what people told us.

Emotional support for people

A carer's guide had been developed in conjunction with the carers council, who met every two months, and this was available for friends and relatives of people admitted to the ward. Staff told us they supported and involved carers and relatives in accordance with the wishes of people using the service.

Antelope House

Saxon and Trinity ward

Dignity, respect and compassion.

Overall we met very caring staff on both these wards. There were clearly some very passionate staff that showed warmth, empathy and kindness to people using the service. We observed people to be treated with dignity and respect. The people who fedback through interviews and feedback cards overwhelmingly supported these observations. People using the service were overwhelmingly positive about permanent staff describing them as compassionate, caring and empathic.

Involvement of people using services.

Advocacy services were on site and we interviewed a member of their staff. They reported a good relationship with all the wards and felt they were welcomed on the wards and received regular referrals from staff.

Staff informed us that interpreters were used in ward rounds to ensure that people whose first language was not English had their needs communicated with the assistance of an interpreter.

Emotional support for people.

We interviewed two carers from each of these wards. Both carers reported feeling involved in their relative's care and stated that they felt staff were caring and sensitive to people's needs. One carer stated that it had been difficult getting information in Polish.

Hamtun ward

Dignity, respect and compassion.

We were concerned that breaches to confidentiality and a lack of dignity in relation to people queuing for medication were occurring. People in the queue were able to see and hear matters relating to a confidential nature of the person in front of them.

We also found that people had no access to hot drinks or any healthy snacks and that these were kept locked away.

When we interviewed patients, we received very positive feedback about staff but some people told us that whilst many staff were caring and kind there were some who did not appear interested and did not engage with them.

Good

Are services caring?

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

Involvement of people using services

There was a community meeting every morning to discuss the plans for the day and garner views on activities for the day such as playing pool.

There was work happening to increase peer support and ensure more active involvement of people using services expressing and inputting their views on the delivery of care.

Emotional support for people

Hamtun ward had regular input from a psychologist and an occupational therapist was due to start at the end of the month. One day a week the wards had access to chaplains who would see people and offer spiritual guidance.

Parklands Hospital

Dignity, respect and compassion

The interactions we observed between people using the service and staff were friendly and respectful. The people we spoke with were mostly positive about the staff. People told us that most of the staff were approachable, treated them with respect, and were caring and helpful. However, some people told us that there were exceptions, and that a small number of staff were not helpful or polite.

Involvement of people using services

We saw a welcome folder for the acute ward, and an information pack for the PICU. These included information for people admitted to the ward, such as about access to and from the ward, use of phones, access to food and drink, and information about advocacy and visiting. We were told that these were given to people when they arrived on the ward. Some of the people told us they had received information and been shown around when they arrived on the ward, but others were not sure, or said they did not need it because they had been there before. The PICU community meeting minutes informed people using the service that they could get an information pack if they did not have one.

There were noticeboards on the wards, which included information about the service, and different types of medication. The information on display included information about entering and leaving, including for informal service users on the acute ward, visiting times, how to make a complaint, and advocacy. There were CCTV cameras covering the communal areas of the hospital and on individual wards. However, there were no signs informing people of these, and this was not included in the ward information pack.

During our last inspection of Parklands Hospital we inspected the wards for older people and found that some of the people were involved in their care planning but others were not. During this inspection the records we looked at on the working age adult wards also showed a variable level of involvement in care planning. Some entries contained information on the person's views, and this included what they had said during the ward round.

Staff we spoke with told us there was not a dedicated place on the electronic records system for recording people's views or involvement. We saw an example of where a person had been given a copy of their care plan, and this was recorded in the care plan. We saw that care plans could be printed off, and there was a space for people to sign that they had received and agreed with them, but the information was not clearly presented. One nurse told us that they pasted the key information from the electronic record into a Word document to make it easier for the person to read.

The people we spoke with gave mixed views of their involvement in their care planning, but most felt this was limited. One person told us that they did not have a copy of their care plan, although they had been asked about this the day before the inspection for the first time. They did not feel involved in their care or that they were given choices. Another person knew about some aspects of their care, even though they did not know what was actually in their care plan. Most of the people we spoke with told us they did not have a copy of their care plan.

There were notices on display about advocacy services. The people we spoke with were aware of the advocacy service, and some people had used the service and found it helpful. The acute ward employed a peer support officer, who worked with people on the ward. We received positive feedback from staff and people using the service about this role.

Emotional support for people

The relatives of a person who had used both wards told us that they were satisfied with the care provided, and had found the staff helpful and supportive towards themselves and their relative. They felt they had been involved in the process. The people we spoke with told us that, where appropriate, their relatives were involved in their care, and were allowed to visit them on the ward. There were areas for people to meet with their relatives in privacy.

Are services responsive to people's needs?

Requires Improvement

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

Summary of findings

Planning and delivery of services

Facilities and premises were generally appropriate to people's needs, although we received mixed feedback from people with physical disabilities about how well the facilities and premises catered to their particular needs. For example, one person, who used a wheelchair, told us they had struggled to use the shower although another person said this had not been difficult for them.

The seclusion room on Hamtun ward at Antelope House was not fit for purpose. For example, it did not provide observable access to the toilet area. Staff acknowledged there was a "blind spot" which prevented them being able to see the person. The seclusion room was located in the middle of the ward and all other people using the service could easily observe who was being placed into seclusion. The observing nurse was stationed within a working office which was full of distractions. The sole duty of the observing nurse was to provide continuous observation of the person in seclusion and provide reassurance and verbal de-escalation. However, as there was no window in the door of the seclusion room this proved impossible to do. This was contrary to the Mental Health Act Code of Practice (2008) which states a seclusion room needs to provide privacy from other patients; enable staff to observe the patient at all times; and allow safe, observable access to toilet and washing facilities.

The design of the wards was different at different locations. Some wards were clearly segregated with separate female and male wards and facilities and many bedrooms had ensuite bathroom and toilet facilities. However, we found that some of the bathrooms and toilets at Parklands Hospital were labelled as unisex and during our inspection we saw that women used the bathrooms on the male corridor. This was contrary to Department of Health guidance as women had to walk past male bedrooms to get to the bathroom. We fed back our concerns to the ward manager. They told us they were aware of these and had put in bids to have remedial work completed.

Diversity of needs

People told us the food provided was of good quality and there was sufficient to eat and drink. People were provided with a choice of meals which catered for different needs and preferences, including religious and cultural needs. People were able to access snacks and drinks whenever they wanted to except on Hamtun ward where there were restrictions.

At Melbury Lodge the spiritual needs of people were considered very important and the approach to care and treatment ensured these were integrated with people's other needs and recovery goals. The chaplain attended the ward on a part-time basis, two days every week, and took part in the weekly multi-disciplinary team meeting. The chaplain worked with new admissions to the wards to identify their faith and spiritual needs and collaborated with the person and nursing staff to develop an appropriate care plan. There was a multi-faith room available to people throughout the day. Wards at other locations told us people a chaplain visited the ward once a week.

Right care at the right time

All acute ward staff told us there was a constant pressure to find beds for people who needed to come into hospital. It was sometimes not possible to provide a bed for people from the local area because wards were full and people were placed elsewhere within the Trust or outside. This sometimes meant that people were admitted a long way from friends and family which did not aid their recovery. There were frequently people sleeping over on other wards as there were insufficient beds available to always meet the demand.

Records showed that the trust monitored the number of beds used within the service. There had been a higher turnover of people on the ward since the introduction of community crisis team services aimed at preventing admission to hospital. The crisis teams focused on facilitating the early discharge of people from the acute wards.

Learning from concerns and complaints

Information on how to complain was available on the wards and most people using the service told us they knew how to make a complaint if they wished. One person told us how they had been helped by a member of staff to make a written complaint about the care they received during a previous admission. Staff provided people with information about the Patient Advice and

Are services responsive to people's needs?

Requires Improvement

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

Liaison Service (PALS) and the Trust's complaints process. Staff told us that information about complaints was fed back to them by senior staff which meant they were able to learn from these and make improvements.

Our findings

Elmleigh

Planning and delivery of services

All bedrooms on the acute wards and PICU had ensuite facilities. The acute wards were divided into male and female wards, each with their separate lounges. The PICU was a mixed ward with separate lounges for males and females. Bedroom areas on PICU were mostly segregated. While bedrooms had en-suite showers and toilets, males and female bedrooms could be on the same bedroom corridors, depending on the gender of the people needing PICU beds.

The seclusion suite was located very close to people's bedrooms in the PICU which meant that the locking and unlocking of doors sometimes disturbed those people with rooms nearby.

Diversity of needs

People told us the food provided was of good quality and there was sufficient to eat and drink. Snacks and drinks were available throughout the day and night. People were provided with a choice of meals. A variety of meals could be provided to cater for people's different needs and preferences, including religious and cultural needs. People were able to access snacks and drinks whenever they wanted to.

Interpreting services were available when required to ensure that people with particular communication needs could be assessed and could understand and contribute to their care and treatment.

Right care at the right time

Performance data showed that re-admissions to the wards within 30 days and 90 days of discharge were similar to other acute wards within the trust.

The ward manager told us that the ward was always full and there were often people sleeping over on other wards as there were insufficient beds available to always meet the demand. This was the case on the day of our visit.

Learning from concerns and complaints

Information on how to complain was available on the wards and people told us they knew how to make a complaint if they wished. One person told us how they had been helped by a member of staff to make a written complaint about their care during a previous admission. Staff told us that information about complaints was fed back to them by senior staff which meant they were able to learn from these.

Melbury Lodge

Planning and delivery of services

The service provided individualised care to people and was responsive to their needs. Facilities and premises were generally appropriate to people's needs, although we received mixed feedback from people with physical disabilities about how well the facilities and premises catered to their particular needs. For example, one person, who used a wheelchair, told us they had struggled to use the shower whilst another person said this had not been difficult for them.

Diversity of needs

The service took account of the diverse needs of different people using the service. The spiritual needs of people were considered very important and the approach to care and treatment ensured these were integrated with people's other needs and recovery goals. The chaplain attended the ward on a part-time basis, two days every week, and took part in the weekly multi-disciplinary team meeting. The chaplain worked with new admissions to the wards to identify their faith and spiritual needs and collaborated with the person and nursing staff to develop an appropriate care plan. There was a multi-faith room available to people throughout the day. A monthly discussion group was held for people called 'mind and soul' which was an activity based group. Representatives of different faiths were accessible to people on the ward.

Right care at the right time

Staff told us there was a constant pressure to find beds for people who needed to come into hospital. It was sometimes not possible to provide a bed for people from the local area because the unit was full and people were placed elsewhere in the Trust or outside. This sometimes meant that people were admitted a long way from friends and family which did not aid their recovery.

Are services responsive to people's needs?

Requires Improvement

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

Learning from concerns and complaints

Information on the complaints procedure was provided to people using the service. People who wished to make a complaint were sometimes supported to do this by an independent advocate.

Staff understood the complaints procedure and how to respond. There was evidence of learning from complaints both those about care on the Kingsley wards and complaints about other services provided by the trust. The learning was shared and discussed with staff during team meetings.

Antelope House

Saxon and Trinity wards

Planning and delivery of services

The staff and environment on these two wards were responsive to people's needs. All patients had their own room with en-suite facilities.

Diversity of needs

People could use their rooms when they wished to. No blanket restrictions were in place. People had access to fresh fruit and hot drinks when they needed them. There was access to computers and the internet. Patients also had access to phones and were allowed their own mobile phones. There was a chaplaincy service available. One day a week the wards had access to chaplains who would see patients and offer spiritual guidance.

Learning from concerns and complaints

Staff were aware of the complaints procedure and felt that complaints were dealt with effectively. Staff were aware of how to report an incident and felt that incidents were learned from and this was shared through their multidisciplinary meetings. Information was available on the ward although we did not elicit any particular comments about complaints.

Hamtun

Planning and delivery of services

We had concerns regarding the seclusion facility on the ward. The Mental Health Act Code of Practice (2008) states that to be used as a seclusion room it must meet the following criteria: provide privacy from other patients; enable staff to observe the patient at all times; be safe and secure; not contain anything within it that could potentially cause harm to the patient or others; be adequately furnished and be appropriately heated, illuminated, ventilated and clean; be quiet but not soundproof and with some means of the patient calling for attention; and allow safe, observable access to toilet /washing facilities.

The seclusion room on Hamtun ward did not provide observable access to the toilet area. Staff acknowledged there was a "blind spot" in the toilet area. We also found that inside the seclusion room there was a large window which looked straight into the nursing station; this meant that people in seclusion could observe computer screens where confidential information was displayed. It was located in the middle of the ward and all other people on the ward could easily observe who was being placed into seclusion. The room itself was bare, with a plastic covered mattress on the floor. The observing nurse was stationed within a working office, full of distractions. The sole duty of the observing nurse was to provide continuous observation of the secluded patient and provide reassurance and verbal de-escalation. As there was no window in the door of the seclusion room this proved impossible to do.

We noted through examining the seclusion records that seclusion was used 57 times in a 10 month period. Although there is no benchmarking which helps us understand what is an acceptable number of seclusions, we do know that where best practice is followed, particularly in relation to de-escalation techniques and use of NICE guidance, that this has been effective in reducing the need for seclusion. It is significant therefore that this ward had no area designated for de-escalation.

Overall the Trust had a 97.7% completion of seven day follow up of a person following an in-patient admission. It was recognised that people could struggle post discharge, ensuring timely follow up reduced risk of suicide.

Diversity of needs

One day a week the wards had access to chaplains who would see people using the service and offer spiritual guidance.

Parklands Hospital

Planning and delivery of services

People had single rooms, which they could access throughout the day. There were separate male and female lounges on the acute ward. At the time of our inspection

Are services responsive to people's needs?

Requires Improvement

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

there were only men on the PICU. Staff showed us they could accommodate up to two women on the ward, and segregated it accordingly. They said they would only admit two women at a time, so it was usually all male.

There was a room on both wards for people to have physical health care checks, and this contained equipment such as an examination couch, blood pressure monitor and weighing scales.

There was a kitchenette area with tea and coffee facilities, which we saw people using throughout our inspection. The people we spoke with told us they were able to make drinks when they wished.

People using the service had access to the internet. This was in a glass room in the middle of the corridor, so that people had some privacy, but could still be monitored. Similarly there was a patients' phone, which was in an open but recessed area of the corridor to give some privacy, whilst maintaining observation. There was an activity room that included craft materials on the acute ward, and a games room on the PICU. There was a gym in the unit, but people told us that this was not always accessible because of a shortage of staff who were trained to supervise people to use the equipment, but this was being addressed.

Prior to the inspection we were told that Department of Health (DH) guidance about gender separation on mental health wards was met, as all rooms were single and were on male and female corridors. However, we found that some of the bathrooms and toilets at Parklands Hospital were labelled as unisex. There was a female corridor which contained 16 female beds and a "flexi" room. On this corridor there was one ensuite room, one bathroom and two toilets. This meant that there was one bathroom for 15 women. Staff told us that they had put a bid in for a further shower room. In the male corridor there were seven male beds and at the far end of the corridor six beds that were usually used by people employed by the Ministry of Defence (MoD). On this corridor there was one bathroom, two toilets and an ensuite room for the seven beds, with a bathroom and toilet for the MoD beds. The bathrooms and toilets were labelled as unisex, and during our inspection we saw that women used the bathrooms on the male corridor. This was contrary to DH guidance as women had to walk past male bedrooms to get to the bathroom. There was a female lounge on the ward, which we saw was in use by women. We fed back our concerns about the gender separation to the ward manager. They told us they were aware of these and had put in bids to have remedial work completed.

There was a seclusion room in the PICU, which was available for use by other wards in the hospital. The seclusion room was next to the front door of the ward for ease of access, but this may be disruptive to the person inside. The seclusion room had the necessary facilities as outlined in the Mental Health Act Code of Practice, which included clear observation, access to a toilet and washing facilities, a clock, ventilation and a means of communicating with staff. There was a de-escalation area next to the seclusion room which was used following, or as an alternative to seclusion.

Right care at the right time

Records showed that the trust monitored the number of beds used within the service. The manager told us that there had been a higher turnover of people on the ward since the introduction of the 'Hospital at Home' team. Crisis team services that aimed to prevent people being admitted to hospital were based in the community teams. The 'Hospital at Home' team focused on facilitating the early discharge of people from the acute ward. Staff told us there were times when people had to sleep in beds outside their catchment ward hospital, and similarly when people were admitted to the service from other areas.

Staff on the PICU told us that if the ward was full, people would be referred to the bed management team and a bed would be identified elsewhere. Staff told us that this occurred frequently.

Learning from concerns and complaints

There was information on display about how to complain. The staff we spoke with described the complaints process and how they would respond and provide further information to people who wanted to make a complaint. This included giving them information about the Patient Advice and Liaison Service and the trust's complaints process. We saw that the service monitored complaints.

Some of the people we spoke with knew how to make a complaint, but others did not. However, all the people we spoke with said they felt able to approach staff a make a complaint if they wanted to, and most said they would speak with the ward manager.

Are services well-led?

Requires Improvement

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

Summary of findings

Vision and strategy

There was a clear commitment amongst staff to the organisational vision and values. Most staff and managers were aware of the trust's strategy and said they felt connected to the mental health division in particular. Staff spoke positively about people using the service and were knowledgeable in respect of their needs. All staff had undergone 'values based' training. This training helped staff define their work in relation to a set of values that ensured that the organisation had staff who were committed to a shared vision.

Governance

Governance structures were in place and in most wards were effective. Staff understood their roles and responsibilities and lines of reporting on the wards.

Performance was monitored and presented in a monthly dashboard format. Key performance indicators included workforce, patient experience, operational measures and quality and safety measures. The number of restraints and incidents were also monitored. Performance was discussed at monthly divisional committee meetings.

Although this information was actively used to address shortfalls and bring about improvements in some wards at Elmleigh it was not clear how the information from performance reports was being used to improve the service. The monthly performance dashboards for Elmleigh PICU and acute wards for July, August and September showed little discernible improvement on a range of measures, including training and appraisal, and in some areas performance was worse. It was not clear how shortfalls in performance were being addressed at a ward level at Elmleigh.

In other wards, such as the Kingsley wards at Melbury Lodge performance reports were used to identify areas of concern and plans were put in place to address any shortfalls.

Staff told us that the trust had a central audit schedule, which all the services followed. Where audits were carried out these were often helpful in bringing about service improvement. For example, at Parklands Hospital on the acute ward the night staff carried out a daily care plan audit, where they checked that records had been completed correctly during the day. They checked whether all people using the service had a care plan meeting date, a risk assessment review date, and the expected care plans in place. The audit report showed that there had been some gaps, which were addressed and subsequently followed up by an audit which showed improvements had been made. We saw also saw that audits were carried out into the use of high dose antipsychotics, and these were reviewed by medical staff and used to inform their practice.

Leadership and culture

Some wards were very well led. For example, at Melbury Lodge there was strong leadership on the wards and senior staff on the unit had been proactive in pushing through plans for ward improvements, including those aimed at reducing ligatures in the environment. There was evidence that plans and actions were reviewed to ensure appropriate changes were made. Most ward managers we spoke with had taken part in the trust's leadership programme.

Most staff spoke positively about their line managers and reported feeling able to raise any concerns they had about standards of care. Staff at Melbury Lodge described a positive ward culture with supportive relationships between staff and different disciplines. At Parklands Hospital managers and staff told us that the focus of the service was on reinforcing a culture that was patient centred.

At Elmleigh acute wards staff told us that managers were not particularly visible on the wards. Managers described the ward culture as a learning, no-blame environment. However, several staff we spoke with on the acute wards disagreed with this portrayal of the service which they saw as unsupportive and blaming. Most staff we spoke with were unhappy with the way they and the wards were being managed. Staff told us they had raised concerns about poor staffing levels and safety concerns but they had not felt listened to by managers and very little had been done to address the concerns.

Hamtun ward, at Antelope House, had undergone significant challenges in relation to ward management over the last two years, with a significant turnover of staff resulting in six managers over the past four years.

Are services well-led?

Requires Improvement

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

Current managers of the service recognised the importance of a stable and consistent management and workforce. Recruitment of staff remained a priority for the ward.

Engagement with people and staff

People were asked for feedback on the service and their experience on the wards. Patient experience surveys were given to people on discharge. Results showed that people's responses were generally positive.

We noted that changes had been made to some wards based on feedback from people. For example, at Parklands Hospital the design of the ward lounges had been based on people's suggestions and activities provided in the activities room, such as board games, had been chosen by people using the service.

Records showed that there were regular community meetings for people using the service on all wards. These meetings were an opportunity for people to engage in the service and make suggestions for improvements. There was some evidence that changes were made in response to feedback from the meetings. For example, there had been changes to the menu and the availability of activities, and repairs had been carried out at Parklands Hospital.

Hawthorns 2 at Parklands Hospital employed a peer support worker, who worked with staff and people using the service to support them to input into the service and its development. There was an action plan in place for developments on the ward.

The staff survey showed that the Trust was in the top 20% of trusts in terms of findings relating to staff appraisals, staff work related stress and staff having equal opportunities. Staff on most wards at Melbury Lodge, Parklands Hospital and Antelope House felt positive about their managers, team and the service they provided. For example, at Melbury Lodge staff felt engaged in the development of the ward and service provided. They felt able to raise any concerns they had about the quality of care provided to people and were confident their concerns would be taken seriously. At Elmleigh, however, the majority of staff did not feel engaged in ward improvements and were disappointed in the lack of support they received from managers.

Consultant psychiatrists met together regularly and a consultant we spoke with was very positive about local arrangements for influencing trust service planning and decision making.

Continuous Improvement

Most wards used performance data and feedback from people using the service to identify areas for improvement and bring about changes in the service. For example, the acute wards at Melbury Lodge encouraged innovation, development and continuous improvement of the service. The model of care used on the ward had been reviewed and changed to make it more recovery oriented. The service used a recovery focussed narrative as a framework for delivering responsive and effective care and treatment to people.

At Parklands Hospital a suicide prevention audit had been carried out in November 2014. Staff had developed their own actions plans which they saw as more relevant to their service than centrally generated plans.

We noted that Hamtun ward, at Antelope House, had begun the process of seeking accreditation for Accreditation for Inpatient Mental Health Services (AIMs). AIMS works to assure and improve the quality of care in psychiatric intensive care units. It engages staff and service users in a comprehensive process of review, through which good practice and high quality care are recognised and services are supported to identify and address areas for improvement.

However, on the Elmleigh acute wards and PICU there was little evidence of commitment to continuous service improvement on the acute wards and PICU. A range of performance data was collected but not always clearly acted upon. For example, the Elmleigh PICU and acute wards had consistently performed poorly in respect of staff appraisal compliance and in September 2014 they were ranked 24 and 25 respectively when compared with 23 other similar services in the Trust. Similarly the wards had consistently performed poorly in terms of completion of mandatory training over the previous three months. Managers were unable to provide evidence of improvement plans in respect of areas of performance that were consistently identified as poor in the performance dashboard.

Are services well-led?

Requires Improvement

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

Although systems were in place to assess risks to people using the service they were not always effective in bringing about continuous improvement. For example, no action had been taken to follow up on action needed to remove ligature risks from the acute wards and PICU at Elmleigh that had been identified in January 2014. As a result people using the service were not being protected against the risks of inappropriate or unsafe care and treatment. When we asked managers at Elmleigh about this they told us they were unaware of any planned improvements but immediately contacted senior managers to raise concerns.

Our findings

Elmleigh

Vision and strategy

Staff and managers were aware of the trust's strategy and said they felt connected to the mental health division in particular. Staff told us they were committed to the organisational vision and values.

Governance

Performance was monitored and presented in a monthly dashboard. Key performance indicators included workforce, patient experience, operational measures and quality and safety measures. The number of restraints and incidents were also monitored. Performance was discussed at monthly divisional committee meetings. However, it was not always clear how the information from performance reports was being used to improve the service. We reviewed the monthly performance dashboards for Elmleigh PICU and acute wards for July, August and September. On a range of measures there was little discernible improvement and in some areas performance was worse. It was not clear how shortfalls in performance were being addressed at a ward level.

Leadership and culture

Staff told us that managers were not particularly visible on the ward and they often felt unsupported by them. Managers described the ward culture as a learning, no-blame environment. However, several staff we spoke with on the acute wards disagreed with this portrayal of the service and said they did not feel supported in their role. Staff told us they had raised concerns about poor staffing levels and safety concerns but they had not felt listened to by managers and very little had changed to address the concerns. The ward manager acknowledged that ward staff morale had "deteriorated somewhat."

Engagement with people and staff

People were asked for feedback on the service. Changes had been made to the wards based on feedback from people. For example, the design of the ward lounges was based on people's suggestions and activities provided in the activities room, such as board games, had been chosen by people using the service.

Consultant psychiatrists met together regularly and a consultant we spoke with was very positive about local arrangements for influencing trust service planning and decision making.

Continuous Improvement

At Elmleigh there was little evidence of commitment to service improvement on the acute wards and PICU. A range of performance data was collected but not always clearly acted upon.

For example, the PICU and acute wards had consistently performed poorly in respect of staff appraisal compliance and in September they were ranked 24 and 25 respectively when compared with 23 other similar services in the trust. Similarly the wards had consistently performed poorly in terms of completion of mandatory training over the previous three months. Managers were unable to provide evidence of improvement plans in respect of areas of performance that were consistently identified as poor in the performance dashboard.

Although systems were in place to assess risks they were not always effective in bringing about continuous improvement. For example, no action had been taken to follow up on action needed to remove ligature risks from the acute wards and PICU that had been identified in January 2014. As a result people using the service were not being protected against the risks of inappropriate or unsafe care and treatment.

Melbury Lodge

Vision and strategy

There was a clear commitment amongst staff to the organisational vision and values.

Are services well-led?

Requires Improvement

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

Governance

There were effective governance arrangements in place and staff were clear about their roles and responsibilities. There were arrangements in place for identifying, recording and managing risks and managers had been proactive in raising concerns with senior management. Staff understood their roles and responsibilities and lines of reporting on the wards. Monthly performance dashboards were used to monitor performance against a range of measures including the patient experience, staff training and development and bed occupancy. Performance was discussed at monthly divisional committee meetings. Plans were put in place to address any shortfalls.

Leadership and culture

There was strong leadership on the wards and senior staff on the unit had been proactive in pushing through plans for ward improvements, including those aimed at reducing ligatures in the environment. There was evidence that plans and actions were reviewed to ensure appropriate changes were made.

Managers told us that they worked to a philosophy of "hope and optimism." There was a strong focus on psychological interventions for all people using the service including mindfulness training. The ethos of the ward was clearly recovery focussed and this was apparent in established collaborative working and use of recovery narratives.

Staff described a positive ward culture with supportive relationships between staff and different disciplines. Ward managers felt supported by the modern matron. Staff told us they were very well supported by their managers and were positive about their style of leadership.

Engagement with people and staff

People were asked for feedback on their experiences and action was taken to address any concerns or themes that were identified following analysis. Carers had been involved in the development of information for other carers based upon their experiences. Staff reported back to people on action taken to address issues they had raised in community meetings. People told us they felt involved in their care.

Staff felt engaged in the development of the ward and service provided. Staff told us they felt able to raise any concerns they had about the quality of care provided to people and were confident their concerns would be taken seriously.

Continuous Improvement

The service encouraged innovation, development and continuous improvement of the service. The model of care used on the ward had been reviewed and action taken to make it more recovery oriented. The service used a recovery focussed narrative as a framework for delivering responsive and effective care and treatment to people.

Antelope House

Saxon and Trinity wards

Vision and strategy

All staff had undergone 'values based' training, this training helped staff define their work in relation to a set of values that ensured that the organisation had staff who were committed to an appropriate set of values and behaviours.

Governance

We found both these wards to be well led. There were adequate governance arrangements in place, with clear reporting structures and relevant meetings in place, such as a bed management meeting which we observed.

All staff clearly reported feeling able to raise concerns. All staff spoke positively about their line managers. In addition they felt well supported by their immediate line managers and felt able to raise concerns and talk openly about concerns. All managers had undergone 'Going Viral' training which was a leadership development programme.

Leadership and culture.

There was good leadership on the ward, staff spoke very positively about their managers and staff felt free to raise concerns and highlight areas of concern. Staff said they had access to training and development opportunities.

Engagement with people and staff

Staff were overwhelmingly positive about their immediate line managers and managers recognised the importance of a stable and consistent workforce. A recruitment drive continued at a pace. The staff survey showed that the trust was in the top 20% on findings relating to staff appraisals, staff work related stress and staff having equal opportunities.

Are services well-led?

Requires Improvement

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

We interviewed people who used the service and carers who were overwhelmingly positive about the engagement from staff.

Continuous improvement

All wards were implementing 'safewards' which aims to ensure that inpatient environments are peaceful and safe. 'Safewards' also aim to reduce coercion, engage people and implement least restrictive options.

Hamtun

Governance

There were adequate governance arrangements in place, with clear reporting structures and relevant meetings, such as a bed management meeting which we observed**.** There was a good handover which we observed on our unannounced visit where each person using the service was discussed in detail. This meant that there was continuity of care and information shared in relation to care plans and risk.

Leadership and culture.

Hamtun ward had had significant challenges in relation to ward management over the last two years, with significant turnover of staff (six managers in the past four years).

Continuous improvement

Hamtun ward had begun the process of seeking accreditation for Accreditation for Inpatient Mental Health Services (AIMs). AIMS works to assure and improve the quality of care in psychiatric intensive care units. It engages staff and service users in a comprehensive process of review, through which good practice and high quality care are recognised and services are supported to identify and address areas for improvement. They had also begun to adopt some principles of 'safewards'.

Parklands Hospital

Vision and strategy

The welcome pack and service user information on the wards stated the service's philosophy and aims, which was consistent with what we were told by staff. The staff spoke about people using the service and the care they provided in a person-centred manner, and were positive about the service they provided.

Governance

Staff told us that the trust had a central audit schedule, which all the services followed. We saw examples of some of the audits, some included actions and others were not really pertinent to this part of the service. For example, we saw an example of a physical health assessment audit, but the outcomes from this were in the process of development. There was a falls audit with an action plan, which included mental health but was mainly focused on the older people's services.

There was a discharge summary audit from July 2014, which staff told us was carried out twice a year, and looked at a minimum of five records per ward. We saw that it noted some areas of good practice, and some areas for improvement. However, we could not see the action that had been taken to follow-up and although 10 records were reviewed for the acute ward, the findings were for all the sites in the trust, so were not that relevant to this site.

On the acute ward the night staff carried out a daily care plan audit, where they checked that records had been completed correctly during the day. For example, this showed that all people using the service had a care plan meeting date, a risk assessment review date, and the expected care plans. There were some gaps, which the audit showed had subsequently been addressed. We saw that audits were carried out into the use of high dose antipsychotics, and these were reviewed by medical staff.

Leadership and culture

The staff we spoke with said they felt supported by their managers. Staff and people using the service told us that they knew who the managers of the service were and found them approachable. The managers we spoke with had taken part in the trust's leadership programme. Managers and staff told us that the focus of the service was on reinforcing a culture that focused on the people using the service.

Engagement with people and staff

Records showed that there were regular community meetings for people using the service on both wards, and they took place every one to two weeks. There were standing agenda items which included maintenance, food and activities, and people were invited to raise any other issues. There was some evidence that changes were made in response to feedback from the meeting. For example, there had been changes to the menu and the availability of activities, and repairs had been carried out.

The acute ward employed a peer support worker, who worked with staff and people using the service to support them and their input into the service and its development. There was an action plan for developments on the ward.

Are services well-led?

Requires Improvement

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

The trust's monitoring information included the outcomes of patient experience surveys. Staff told us that this was from a survey people were given on discharge. A summary of the surveys showed that people's responses were rated between three to five stars (where five is high, and one is low)

We saw that staff meetings occurred on both wards. The areas discussed included recruitment, training, reminders to take action such as updating records, and suggestions for improvement. For example, suggested improvements to the clinic room on the acute ward were discussed. Minutes of the meetings showed some evidence of change and improvement on the ward. For example, a member of staff had been appointed to carry out administrative duties and free up clinical time. The staff we spoke with were mostly positive about working on the wards, and found the team they worked with supportive.

Continuous Improvement

A suicide prevention audit had been carried out in November 2014. Staff told us that some of the action plans generated by the central audit system were not that pertinent to this service, so they had developed their own. This was confirmed by the action plans we saw.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered provider had not taken appropriate steps to ensure, that at all times, there were sufficient numbers of suitably qualified and skilled staff on duty at Elmleigh to safeguard the health, safety and welfare of people using the service. This is a breach of regulation 22

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered provider did not have suitable arrangements in place in order to ensure that staff were appropriately supported in relation to their responsibilities. Significant numbers of staff on the Elmleigh acute admissions wards and PICU had not received appropriate training or refresher training in how to restrain people using the service safely or basic or intermediate life support. As a result there was a risk that staff would not be able to provide care and treatment to people that was safe and of an appropriate standard. This is a breach of regulation 23(1)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that people were protected against the risk of receiving inappropriate or unsafe care.

Compliance actions

At Parklands Hospital women had to walk past male bedrooms to use bathrooms and toilets, this is contrary to established guidance from the Department of Health about gender separation on mental health wards. Staff were not effectively implementing and monitoring the use of gendered facilities.

The registered person had not ensured that there was sufficient emergency equipment available to ensure the safety of people on the acute admission wards at Elmleigh. There was one emergency 'grab' bag (equipment used for resuscitation and treating anaphylaxis) and one automated external defibrillator in the unit which was not easily accessible to the acute wards. Consequently there was a risk to people's health and safety in an emergency.

This is a breach of regulation 9(1)(b)(ii) and 9(2)

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 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had failed to take action to protect people against the risk of unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to the health, welfare and safety of people using the service. At Elmleigh although systems were in place to assess and identify poor performance and risks they were not always effective in bringing about improvements. This is a breach of regulation 10(1)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

Compliance actions

The registered provider had not ensured that people were protected against the risks associated with unsafe or unsuitable premises. At Elmleigh, essential work needed to remove ligature risks from people's bedrooms had not been carried out in a timely manner; and on Hamtum ward, at Antelope House, the design of the seclusion room did not allow continuous observation of the person inside by staff.

This is a breach of regulation 15 (1)(a)