Good

Somerset Partnership NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH576	Rydon Wards One and Two	Acute wards for adults of working age	TA2 7AZ
RH576	Holford Ward	Psychiatric intensive care unit	TA2 7AZ
RH572	Rowan Ward	Acute ward for adults of working age	BA20 2BX
RH502	St Andrews Ward	Acute wards for adults of working age	BA5 1TH

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

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Overall summary

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

- By the time of this inspection, the services had taken the action we required it to take following the inspection in September 2015. The wards for adults of working age and psychiatric intensive care units were now meeting Regulations 11, 12, 13 and 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- Staff had a good understanding of how to keep patients safe. They understood how to make safeguarding referrals and did so when appropriate. Staff completed comprehensive risk assessments to enable them to identify issues of concern. Staff used observation levels to maintain patient safety and they reviewed these regularly. Staff on Holford ward worked with patients to identify effective ways for them to manage escalating behaviour.
- Staff completed comprehensive assessments at admission. The assessments identified areas of concern and staff formulated and used care plans to manage these. Staff used appropriate rating tools such as the malnutrition universal screening tool (MUST) to support the assessment process. They completed health of the nation outcome scores to assess the severity of the patient's condition and the treatment outcome at discharge.
- The trust provided a wide range of facilities to enable staff to support patients and help them to recover. Staff organised activities and ensured that patients had access to appropriate religious support and independent advocacy services.
- We saw evidence of effective multi-disciplinary working with staff focussed on helping patients recover from their illness. This included working with external agencies. Staff engaged in active discharge planning to ensure that they supported patients to return to the community.
- Most patients were positive about the care they received from staff. They reported that the food was good, activities were helpful and we observed warm and kind interactions between patients and staff. Patients had access to a weekly meeting to raise concerns and issues with staff.

However:

- Staff members had not followed the trust's seclusion policy. This meant that staff completed seclusion paperwork inconsistently including patient seclusion reviews. There was confusion about what incidents qualified as seclusion and needed appropriate recording.
- Staff did not manage medicines well. Staff had not signed when they had administered medicine and staff had given patients more medicine than had been prescribed. Managers were not able to act promptly on errors of this type, as there was no process in place to identify these problems regularly.
- Wards had a number of blanket restrictions in place. These were contradictory, unnecessarily restrictive and not routinely reviewed to assess if they were appropriate.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff had made errors in the administration of medicines, sometimes giving patients too much medication or not recording when they had administered medicines.
- Staff completed seclusion records inconsistently and were confused about when they should regard incidents as seclusion. There were also inconsistencies in staff understanding of restraint and when staff needed to record this.
- There were a number of blanket restrictions in place on wards that were contradictory or unnecessarily restrictive.

However:

- By the time of this inspection, the services had taken the action we required it to take following the inspection in September 2015.
- In September 2015, we found that staff did not regularly check and maintain the emergency resuscitation equipment and refrigerators on their wards. When we visited in March 2017, we found the trust had embedded processes for staff to check these items regularly. Staff checked refrigerators daily and emergency equipment weekly.
- In September 2015, we found that not all wards stocked drugs used to reverse the effects of benzodiazepines used for rapid tranquilisation. This put patients at risk of respiratory arrest. When we visited in March 2017, all wards carried a stock of medicine used to reverse the effects of benzodiazepines.
- In September 2015, we found that staff did not have sufficient knowledge of safeguarding procedures and could not identify situations that required a safeguarding referral. When we visited in March 2017, we found that staff had a greater understanding of safeguarding. They knew who to discuss issues with if concerns arose and how to make referrals. The wards had clear information and flow charts of how to proceed to support staff in this.

Are services effective?

Good

We rated effective as good because:

Summary of findings

- By the time of this inspection, the services had taken the action we required it to take following the inspection in September 2015.
- During our inspection in September 2015, we found that staff had not been gaining consent for treatment or clearly recording it in patients' notes. During our inspection in March 2017, we found staff had not recorded consent in the expected place in 11 out of 29 records. However, the trust produced additional evidence to confirm that staff had recorded consent elsewhere in the patients' notes.
- We observed effective handover meetings between staff that reviewed and managed patients' risks, ongoing issues and concerns.
- We saw evidence of effective multi-disciplinary and inter-agency working.
- Staff completed comprehensive admission assessments that covered physical health, mental health and social factors.

However:

- Staff did not complete and store paperwork relating to medication under the Mental Health Act in a manner that was consistent with effective and safe practice.
- Although staff could refer patients to psychologists for individual work, the wards did not have access to psychologists able to work on the wards with groups of patients to improve their psychological wellbeing.
- Some staff did not receive regular, formal supervision.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with kindness and respect. We observed interactions with good humour and warmth that were appropriate and professional.
- The majority of patients we spoke with told us that staff treated them well, with respect and were supportive. 24 out of 30 comment cards completed by patients were positive about the staff and their care.
- Wards held regular have your say meetings where patients could raise ideas, suggestions or concerns regarding the ward.
- Patients had access to independent advocacy from an outside organisation that visited the wards weekly.

Summary of findings

However:

- Care plans were individual and holistic but there was a lack of evidence of patient involvement in the writing of the plan.
- Six out of 30 comment cards completed by patients stated they did not like the care they received or the staff's attitude towards them.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There was a wide range of rooms and facilities that staff could use to support the patients' recovery.
- There were regular activities available supported by activities coordinators and occupational therapy staff.
- The wards had access to a chaplaincy service that was also their link to obtain support from leaders of other faiths.
- Patients reported that the food on the ward was of good quality.
- The wards participated in active discharge planning that was recovery focussed and aimed at supporting the patients in their move into the community.

However:

- None of the bedroom windows overlooked by public areas had privacy film or similar screening to protect patients' dignity. The trust took immediate action to rectify this when we raised it with them.
- The trust used CCTV on wards to monitor the ward environment with no signage visible to patients warning of this within the wards.

Are services well-led?

Good

We rated well-led as good because:

- The service had addressed the majority of the issues that had caused us to rate well-led as requires improvement in the September 2015 inspection.
- We found during our inspection in September 2015 that staff had a poor understanding of safeguarding. During our inspection in March 2017, we found staff had a greater understanding of safeguarding so that they could identify concerns and knew how to make appropriate referrals.

Summary of findings

- We found during our inspection in September 2015 that staff did not consistently check fridges or emergency equipment. During our inspection in March 2017, we found the trust had embedded processes for staff to check and maintain fridges and emergency equipment.
- We found during our inspection in September 2015 that some wards did not have a supply of drugs to reverse the effects of benzodiazepines. During our inspection in March 2017, we found all wards had access to flumazenil to reverse the effects of benzodiazepines.
- During our inspection in September 2015 we found that staff did not routinely gain or record consent from patients to receive treatment. During our inspection in March 2017, we found that staff recorded patient consent. However, staff use of the appropriate section of the notes to do this was inconsistent which meant that the information was potentially difficult to find.
- Staff reported having good morale, great mutual support from their team and that they felt supported by their managers.
- Three wards had been involved in a quality improvement process involving an outside organisation and teams of other professionals visiting to assess them.
- There was a robust process for reporting incidents and complaints and for ensuring lessons were learnt by staff on the ward.

However:

- We found evidence that the auditing of the administration of medicines to patients was not effective and managers had not identified this. We raised this at the time of inspection and the trust took immediate action to strengthen the audit process.

Summary of findings

Information about the service

Somerset Partnership NHS foundation Trust delivers mental health services across the whole of the county of Somerset.

There are four acute wards for adults of working age that provide assessment and treatment for people experiencing mental health difficulties. The wards support patients with a wide range of conditions, including depression, anxiety, psychosis and personality disorders. Patients are either detained under the Mental Health Act (MHA) 1983 or can be treated as a voluntary patient. Each of the wards is mixed gender and is responsible for a different geographical area of the county:

Rowan Ward is an 18-bedded ward which provides services for people who live in the South Somerset area.

Rydon Ward One has 15 beds and provides treatment for people from the Taunton area.

Rydon Ward Two also has 15 beds and provides services for people in the Bridgwater, Minehead and Somerset coast area.

St Andrews ward has 14 beds and cares for people who live in the Mendip area.

The trust has one ten bedded psychiatric intensive care unit called Holford Ward. This provides assessment and treatment for patients detained under the Mental Health Act (MHA) 1983 that staff could not manage safely or therapeutically on an acute ward. The ward is mixed gender. Facilities include a seclusion room and safe care area.

CQC had previously inspected Holford and Rydon wards on four occasions (September 2015, 26 November 2013, 22 June 2011 and 21 October 2010). Rowan Ward has been inspected on four previous occasions (September 2015, 29 April 2013, 16 January 2012 and 15 November 2011). St Andrews has been inspected twice previously (September 2015 and 03 December 2012).

Our inspection team

Our inspection team was led by:

Team leader: Gary Risdale, Inspection Manager (Mental Health), Care Quality Commission

The team that inspected these services comprised: a head of hospital inspection, an inspection manager, two CQC inspectors and a Mental Health Act reviewer. The team also included two specialist advisors who were senior nurses with experience of working in mental health services.

Why we carried out this inspection

We undertook this inspection to find out whether Somerset Partnership NHS Foundation Trust had made improvements to their acute wards for adults of working age and psychiatric intensive care units since our last comprehensive inspection in September 2015.

When we last inspected the trust in September 2015, we rated acute wards for adults of working age and psychiatric intensive care units as **requires improvement** overall.

We rated the core service as requires improvement for safe, effective and well-led and good for caring and responsive.

Following the September 2015 inspection, we told the trust it must make the following actions to improve acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that staff have sufficient knowledge of safeguarding procedures and that all safeguarding incidents are correctly identified and

Summary of findings

raised. Safeguarding alerts and concerns were not always being made when they should and some staff were not aware of their responsibilities with regard to alerting safeguarding authorities.

- The trust must ensure that consent for treatment is gained and that this is clearly documented.
- The trust must ensure that all sites where rapid tranquilisation is used hold the appropriate medicines to reverse the effects of benzodiazepine medication.
- The trust must ensure resuscitation equipment and refrigerators are checked and maintained.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 11 Need for consent

Regulation 12 Safe care and treatment

Regulation 13 Safeguarding patients from abuse and improper treatment

Regulation 15 Safety and suitability of premises.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about acute wards for adults of working age and psychiatric intensive care units and requested information from the trust.

During the inspection visit, the inspection team:

- visited each of the five wards that made up this core service
- spoke with 12 patients and collected feedback from 30 patients using comment cards
- spoke with the managers or acting managers for each of the wards
- spoke with 24 other staff members including doctors, nurses and occupational therapists
- met with three senior trust managers
- attended and observed four hand-over meetings and two multi-disciplinary meetings.
- looked at 29 treatment records of patients and 53 patient medicine record charts
- carried out a specific check of the medication management on five wards
- attended three patient "have your say" meetings
- facilitated a staff focus group that seven staff attended

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

What people who use the provider's services say

Patients provided mixed feedback regarding their treatment by staff. A large majority were positive regarding the care they received and their interactions with the staff, stating that they felt safe and well supported. However, some were negative and did not appreciate some of the blanket rules in place. They felt unsafe at times and that some of the staff were disrespectful in their attitudes or behaviour towards them.

Good practice

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that managers monitor the administration of medication and act on any errors found. The monitoring should include ensuring documents regarding consent to taking medicines under the Mental Health Act are easily accessible to staff and completed correctly.

Action the provider SHOULD take to improve

- The trust should ensure that staff understand what a restraint or seclusion incident is and document the incident thoroughly and contemporaneously as per trust policy.
- The trust should ensure there is clear signage to indicate where emergency equipment and medicines are stored and that CCTV is being used to monitor the environment.
- The trust should review current blanket restrictions in place on all wards to ensure they are working within least restrictive principles.
- The trust should ensure that staff record consent consistently in the appropriate section within patients' notes to ensure that this information is easily accessible to all staff.
- The trust should ensure that staff supervision is completed and recorded consistently.

Somerset Partnership 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
Acute wards for adults of working age	Rydon Wards One and Two
Psychiatric intensive care unit	Holford Ward
Acute ward for adults of working age	Rowan Ward
Acute wards for adults of working age	St Andrews Ward

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.

Eighty-one percent of staff had received training in the Mental Health Act (MHA) 1983. The trust's target for completion was 95%. Staff told us this only applied to qualified nurses. Staff demonstrated an understanding of the Act. However, they did not consistently apply some aspects. For example, none of the consent to treatment forms completed by doctors (T2 or T3) were kept in the clinic room on four of the five wards.

We saw evidence that staff attempted to read patients their rights at admission. If patients did not understand then staff revisited them later until patients understood. Staff also read patients their rights again when circumstances changed. For example, a section being changed or a tribunal upholding the need for detention.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Seventy-seven percent of staff had received training in the Mental Capacity Act (MCA) 2005 at the time of inspection. The trust's target for completion was 95%. This was an ongoing training package made up of online learning.

At the previous inspection in September 2015, we had raised concerns that staff had not gained or recorded consent to treatment or admission. We found during our inspection that staff had completed this information but where staff recorded it was inconsistent. We checked 29 and found that in 11 staff had not recorded consent to treatment or admission onto the ward in the appropriate section of the patients' notes. We found that consent had been recorded when it had been requested by outside agencies.

Staff we spoke with had some understanding of the MCA. However, when they were unsure they contacted someone for clarification they needed with the Act.

Staff had not made any applications under Deprivation of Liberty Safeguards during the 12 months prior to this inspection.

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

Our findings

Safe and clean environment

- All of the acute wards had layouts that meant staff could not observe patients from a central point. The Rydon wards had recently fitted new observation mirrors to reduce the impact of blind spots. The manager of St Andrews stated that they were investigating the fitting of these mirrors on the ward. Rowan ward had a number of blind spots in the main ward and ward garden. Staff completed regular environmental observations to mitigate the risk caused by staff not having clear lines of sight. However, an inspector observed that the staff on Rowan ward had not checked the garden. Holford ward was laid out around a central nursing office with clear views onto the ward. The staff used 5-minute observations and CCTV to support the observation of patients on the ward.
- All wards had potential ligature points (anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation). Ward managers completed ligature risk audits of their wards to identify potential issues with the environment. However, the ligature risk audit completed on Rowan ward had not identified the large tree and other potential ligature points within the ward's garden. We raised this with the trust at the time of inspection and they addressed this immediately. Ligature risk audits indicated how staff should manage ligature points that the trust had not removed. These actions included ensuring that doors for specific rooms remained locked when staff were not present, these included activity rooms and ward laundry rooms. Staff mitigated the risks posed to patients by individually assessing them and making the necessary adjustments to their levels of observation. Managers had escalated ligature points to local risk registers. For example, on Holford ward there were full size doors in the patients' bedrooms to preserve their privacy in their ensuite bathrooms. The manager had taken this decision following discussions with ward staff. Due to the risk this presented the manager had escalated the issue to the ward risk register.
- All wards were compliant with same sex accommodation guidelines. All the wards apart from St Andrews had ensuite bedrooms. On St Andrews ward, staff allocated patients rooms dependant on gender on the ward's male or female corridor. Communal bathrooms and toilets were on these corridors to ensure compliance with Department of Health guidelines. Holford ward also had specified male and female corridors. However, at times staff placed male patients on the female corridor due to bed requirements. Staff managed this situation using environmental features (the far end of the female corridor could be closed off behind fob accessed doors) or by using increased levels of patient observation. On the other wards, staff actively managed the patient bedrooms to ensure that they grouped patients by gender with female patients generally at the far end of the corridor. Rydon Wards one and two also had the option of closing the far end of the ward behind fob accessed doors to support vulnerable female patients. All wards had a female specific day lounge. The de-escalation room on St Andrews ward was located within the female corridor. This meant staff might place male patients here to reduce their levels of agitation. The nearest toilet facilities were for women only but all patients using the de-escalation room used these facilities. The manager on St Andrews ward confirmed that if patients wanted to access some activity areas that were within the opposite gender's corridor, this was only possible if staff escorted them. However, during the period between September 2016 and February 2017 no male patients had used the de-escalation room on St Andrews.
- During the last inspection, we found that wards had not been checking their resuscitation equipment regularly and inspectors found some out of date items in the Rowan ward equipment. At the current inspection, we found that staff on all wards had been consistently completing the resuscitation equipment checks with an occasional gap of one week only on St Andrews ward and Rydon ward one. However, we found only St Andrews had signage on the door of the room in which emergency equipment was kept. This could impact the

effectiveness of temporary staff finding the equipment in an emergency. There was also no sign on the clinic room door in Holford ward so staff may find it difficult to find in an emergency.

- Holford ward had a seclusion room. Staff accessed this through the extra care area on the ward. This was fit for purpose and complied with guidelines. It was ensuite and staff and patients communicated using an intercom. Staff monitored patients using CCTV. The other wards had access to purpose built de-escalation rooms to help reduce the levels of agitation or aggression displayed by the patients they managed.
- All wards were clean and well furnished with pictures on the walls. The atmosphere on all wards was calm, welcoming and relaxed.
- Environmental risk assessments were regularly completed. At St Andrews, staff raised concerns regarding the physical security of the building. There was no fencing, CCTV or exterior lighting provided. Staff told us that there had been weapons (2 hammers), items used for self-harm and drugs found on the ward in early 2016. They believed that patients had been able to push these items through their windows whilst out on leave. This meant that when staff conducted any searches on their return they would not find the items. In response to this, the manager had started a process of random searches of bedrooms every week to reduce the incidence of contraband or prohibited items being on the ward. These had been effective, as nothing had been found in recent months. The trust reviewed those processes at the time of our inspection.
- All wards had integrated personal alarm systems for staff to use. Patients used nurse call buttons placed in patient bedrooms and communal areas.

Safe staffing

- There was 170 staff working across the five wards. Eleven staff had left the service in the previous 12 months. The number of vacancies and the percentage levels of sickness varied across the wards. The Rydon wards had the highest level of vacancies at 23%. Holford ward had a vacancy rate of 16% followed by St Andrews ward at 14% and finally Rowan ward at 6%. St Andrews had the highest sickness rate of 7%, Rowan ward had the lowest rate at 2%. The trust's average sickness rate was 4.7%.
- All wards had an established staffing level. However, it was possible for managers to increase these numbers to meet any increase in their patients' needs. In particular, this referred to patients on increased levels of observation to manage any concerns their presentation raised.
- Staff told us that they used regular bank or agency staff that knew the ward to ensure consistency in approach to the patients. The trust had arranged block booking of agency nurses so that they could plan the staffing to minimise the potential impact to patient care.
- Staff occasionally cancelled Section 17 leave due to changes in a patient's presentation but not due to staffing issues. To manage patient access to leave, the wards in Taunton had a daily capacity meeting where they discussed the needs of the day. Managers used this meeting to ensure that the required numbers of staff were in the right place at the right time to manage the ward's requirements.
- Wards in Taunton and Yeovil had access to out of hours medical cover. However, St Andrews was in a more rural position that made it more difficult to access emergency health care. If required, the psychiatrist on call could respond to telephone calls to provide advice and support and a local on-call GP was used as well. A psychiatrist would visit the ward in an emergency. If emergency physical health care was required, staff called an emergency ambulance. At this point, they were reliant on the speed with which an ambulance could reach the ward. The average response time was approximately 45minutes, but it could take as long as 2 hours. The ward managed this risk with clear exclusion criteria regarding patients that had acute physical health problems that may require emergency medical care. These included patients with unmanaged epilepsy or patients suffering from chest pains. If a patient required out of hours admission, arrangements were made to transfer a settled patient from another ward (with their agreement) to St Andrews so that a bed could be created on a ward with out of hours medical access.
- The trust had set a target that 95% of all staff who should have had mandatory training in each subject had completed it. Over half of the mandatory training subjects (11 out of 20) had completion rates of over 95% of staff. The lowest completion of mandatory training was 22% for safeguarding level 3, which was a new

training and was mandatory for managers only. Next was safeguarding children level 3 at 67 %, again mandatory for managers. For ward-based staff, the lowest completion rate was in the Mental Capacity Act at 77%.

Assessing and managing risk to patients and staff

- Between 01 January 2016 and 31 December 2016, staff recorded 64 incidents of seclusion. Sixty-two of these had occurred on the PICU, Holford ward, with one each on Rydon ward and St Andrews. With further clarification, the trust confirmed that staff had mistakenly documented the incidents on Rydon and St Andrews, as neither had included the use of seclusion.
- Not all staff understood the definition of what constituted seclusion. Staff recorded that "seclusion was opened" but staff did not allow the patient to leave the extra care area. In another patient's notes, staff admitted them to the extra care area but staff did not document this as seclusion. This indicated that the proactive care policy may need clarifying regarding the definition of seclusion and when staff need to complete the appropriate documentation.
- We found inaccurate recording of seclusion. Progress notes lacked detail and did not state that seclusion reviews had taken place. They did not document the designation of the staff at the reviews or the mental state or presentation of the secluded patient. We found that staff had not completed the seclusion record and termination form with the end time/date of seclusion. Doctors did not appear to be routinely completing the seclusion review form. Sometimes doctors documented in the progress notes that they had completed a review. Four hourly checks were not always completed. Trust policy states that if a multidisciplinary team (MDT) discussion has decided that four hourly checks are not necessary that this is acceptable. However, we could find no evidence of MDT discussions or details on what constituted a MDT. On one patient record, a doctor refused to attend for a four hourly review as nothing had changed in the previous four hours. This patient had an untreated head wound. Staff duplicated seclusion forms with conflicting information about who was present. Some of these forms also had the incorrect review time, documenting the time of the previous review.
- There had been 265 incidents of restraint with the same period. Holford had the most incidents with 99, followed by Rydon ward with 67. Rowan ward used restraint 55 times and St Andrews 39. There was no clear statistics as to whether certain patients had caused particular problems. However, Holford ward had identified one patient that had been particularly unwell for approximately three months that contributed to their high figures.
- There had been 93 prone restraint incidents between the same dates. Sixty had occurred on Holford ward. Rydon wards followed this with 19, Rowan ward were next with 10 and St Andrews staff had used prone restraint four times. The majority were for the particularly unwell patient on Holford and were due to the administration of medication. We reviewed this person's care and saw that the service had discussed and monitored their care appropriately and there had been a positive outcome.
- The trust's restraint policy was subject to a degree of confusion with staff being unsure as to what qualified as a restraint. Different staff we spoke with had differing ideas as to when an intervention was reportable as using restraint. The policy staff showed us on the wards when we asked about restraint had not been reviewed since October 2015. The trust advised that there was a newer version available and that they were reviewing it in light of their proactive care policy. We witnessed one incident of restraint where the manager described it as using "cursory holds" but the record completed did not reflect the use of holds to move the person to their room. The trust confirmed that a new version of the policy would clarify what constitutes restraint. The new policy had gone to the trust board for approval and was due to be rolled out.
- We looked at 29 care records and found that all of them contained a completed risk assessment that staff had reviewed and updated regularly. Staff had used the standard risk assessment form provided with the computer system that the trust supplied. Risks staff assessed and identified included violence and aggression, self-harm, concerns about physical health issues and patient use of illicit substances or alcohol. Case notes showed that risk management was active and changes were made to care plans following incidents and staff were updated on these changes in

daily handovers. Assessment scales that staff used to support the assessment process included the malnutrition universal screening tool (MUST). Risk assessments included observation levels and access to areas like gardens.

- Blanket restrictions (rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application) were in place across all the wards. There were appropriate ones such as items banned from the wards. For example, drugs, alcohol and weapons. However, other restrictions were in place. Staff did not allow patients to have electrical power leads in their room in case they used the cable as a ligature. This included telephone chargers. However, staff allowed patients to keep belts, cords in hoodies or tracksuit bottoms and shoelaces. These are all items that people can use to tie ligatures. On Rowan ward, staff did not allow patients to use the assisted bathroom unless they were disabled. This was the only bath on the ward. Patients on Rowan had to eat from plastic plates due to incidents of self-harm and aggression a few years before. The manager told us that it was not possible to reassess this due to how often the patient group changed. Patients told us and staff confirmed that they locked all communal areas at midnight, including patient lounges. Staff justification for this was to encourage good sleep hygiene. However, patients stated that sometimes they could not sleep and they wanted to sit elsewhere than in their room but staff would not always allow them to do so. The trust started reviewing these restrictions and the contradictions in them when we raised them at the time of our inspection.

- Staff ensured that they locked the entry doors to all wards. However, there was clear signage to advise patients that they could leave the ward if they were not detained under the Mental Health Act 1983.

- Patients were subject to varying levels of observation according to the level of risk assessed. Trust policy stated that observation levels varied from as infrequently as once an hour to one to one with a member of staff. All wards managed risk using observation and staff clearly documented this in patient records. Staff discussed levels of risk within ward handover meetings and staff made decisions to increase or decrease the level of observation as the health of the patient deteriorated or improved. Staff placed patients at high risk of harming themselves or others on higher levels of observation. The trust did not routinely search patients that had been out on leave. Staff only did this if there was a degree of suspicion or some intelligence that justified this intervention. Staff only routinely searched patients' property at admission. Following incidents on St Andrews ward with patients possibly smuggling contraband items in, the manager had decided to instigate a search of four random bedrooms every Sunday. This was to reduce the potential impact of the harm such items could cause.

- Staff used the principle of least restrictive practice when working with patients. Staff only observed closely, restrained or secluded patients when this was necessary for their welfare and/or the welfare of others. This was particularly evident on Holford ward where the ward manager had attended the South West Safety Consortium. They had subsequently introduced a rating tool called a safety tool. Staff used this to work with patients to identify triggers and behaviours that might lead to self-harming or aggressive behaviours. The tool detailed actions for staff to take to minimise the risks to patients and staff. Staff on the ward felt that this had led to a better understanding between patients and staff in regards to triggers. This reduced the use of restraint and seclusion as staff could divert patients from potentially harmful behaviours using the methods they had already agreed with staff. The ward managers on Rydon 1, Rydon 2 and St Andrews were keen to use this tool. However as it was being piloted it had not been officially shared with these locations.

- The use of rapid tranquilisation followed a flow chart that staff had created using National Institute of Health and Care Excellence (NICE) guidelines. At the previous inspection, we found that St Andrews ward did not have a stock of flumazenil (a drug to reverse the effect of benzodiazepines, which cause respiratory distress). This placed patients at risk if they received this type of medication to reduce their levels of agitation or aggression. At the current inspection, all the wards including St Andrews had a stock of flumazenil. However, as it is administered intravenously, a doctor would be required to attend any ward where a patient needed it. Staff at St Andrews stated that due to

Requires improvement

Are services safe?

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

concerns regarding medical cover, they would routinely only give patients haloperidol or lorazepam rather than both together to reduce the potential risks associated with giving rapid tranquilisation. Only St Andrews had appropriate signage to confirm which specific cupboard emergency drugs were kept in which could affect the effectiveness of temporary staff needing to find them in an emergency.

- At the last inspection, we found that staff on Holford ward had not identified safeguarding concerns and made the appropriate referrals to the local authority. On the current inspection, we found that all staff we spoke with understood what constituted a safeguarding situation that would require them to raise a concern or an alert. Wards had safeguarding information on display in staff offices so staff understood what they had to do and how they made referrals. Case notes and handover meetings demonstrated that staff made safeguarding referrals and that staff could identify both child and adult safeguarding concerns.
- At the last inspection, the wards were not checking their medicines refrigerators regularly so they were unclear as to whether medicines were being safely stored. This had the potential to affect the efficacy of the drugs. On this inspection, we found that staff on all wards were regularly checking and recording the fridge temperatures for the medicines fridges in their clinics. A local pharmacy delivered medicines after staff had completed stock checks. All medicines were stored appropriately in locked cabinets or trolleys. Staff checked stock levels of controlled drugs and signed to confirm this. Staff disposed of medicines appropriately using agreed methods to do so.
- We found errors in 13 out of 53 patient medication charts. These included staff not signing to confirm that they had administered medicines. This meant that we were unsure if staff had administered medicines as prescribed. We also found six occasions where staff had given patients more “as required” medication than the doctor had indicated staff should administer. For example, lorazepam prescribed as twice daily given three times or paracetamol given five times in 24 hours when it should only be given four times.
- The trust policy was that young children were not allowed to enter the ward for their own safety. Each ward had a room that visitors could use to see their friends or relatives. These rooms contained toys for any child visitors.

Track record on safety

- There had been six serious incidents reported in the 12 months between 01 January 2016 and 31 December 2016.
- The incidents included self-harm, sexual assault and a fall. The trust had commenced or completed SIRI investigations to look into each of the incidents.
- Following the fall incident, the trust plans to make amendments to the ward environment. These include a call bell at the bottom of the stairs to attract assistance from staff and a larger size monitor to enable staff to monitor potentially risky areas of the ward environment more easily.

Reporting incidents and learning from when things go wrong

- Staff reported incidents on a shared database. The ward manager or their deputy reviewed these. Staff knew what an incident was and how to report it although there appears to be some confusion over what qualifies as a restraint incident. We reviewed the database on Rowan ward and saw that staff reported self-harm and violent behaviour in addition to patients not returning from approved leave at the appropriate time.
- The trust had introduced the ‘see something, say something’ initiative to encourage staff to speak out about any good practice or anypractice that they felt was not of an appropriate standard. Staff across all wards were aware of this initiative.
- Staff demonstrated knowledge and awareness of their responsibilities under duty of candour legislation. This requires that staff operating at all levels within the organisation operate within a culture of openness and transparency. They should understand their individual responsibilities in relation to the duty of candour, and be supported to be open and honest with patients and apologise when things go wrong. Staff were able to demonstrate an understanding of this responsibility.

Requires improvement

Are services safe?

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

- There was evidence that managers and staff applied learning from incidents at a local level on individual wards. Some wards had a learning board in their staff room where they highlighted lessons from incidents to raise staff awareness. There was no evidence that there was systematic sharing of learning across all wards.
- Both staff and patients were debriefed and supported following incidents, we saw that following a significant incident on Rowan ward staff and patients had been given the opportunity to talk about the incident and share their feelings in a supportive environment.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- All patient records we reviewed contained a comprehensive assessment that staff had completed promptly after admission. These included comprehensive risk assessments and care plans that reflected issues raised within the risk assessment.
- The records included a physical health examination and we saw evidence that there was ongoing monitoring and management of physical health risks. These included the completion and review malnutrition universal screening tool (MUST) and sepsis awareness and instigated interventions to monitor and increase body weight to a healthy level.
- Care plans were comprehensive, holistic, personalised in some cases and related to risks identified. They varied in style, with some completed in the first person with the majority completed in the third person. There was a lack of evidence of patient involvement within the document. Patients reported that staff presented them with the completed document rather than it being a collaborative effort. However, we saw evidence of patients being involved in their care, including discussions regarding medication.
- Care records were stored using an electronic record system. This stores all patient documents and staff across the trust can view the records. This enables staff to have full access to records when patients move between wards or teams.

Best practice in treatment and care

- We saw evidence that staff did not always follow National Institute for Health and Care Excellence guidelines on prescribing or trust policy prescribing guidelines. We found two records on one ward that showed doctors had prescribed patients high doses of antipsychotic medication without staff completing the required physical health checks before prescribing occurred. There was no documentation from the medical staff to explain why the prescribing of this medication was justified or appropriate. We discussed this at the time and the manager confirmed that this was outside of trust policy. We also found evidence on one file that a doctor had prescribed as required antipsychotics above British National Formulary (BNF) guidelines. The recorded guidance of the doctor did not account for differences of effect between the tablet and injectable version of the drug. The computerised prescribing system was unable to recognise this so staff nurses needed to have appropriate knowledge of the medicines they administered to ensure incidents did not happen. The computer system had the option to set review dates for medication. However, we saw no records that indicated this option was being used, especially in reference to the need to review hypnotic or as required medicines in line with guidance which suggests this should be done every 14 days. However, one record had information stored regarding NICE guidelines about safe prescribing in pregnancy. Staff had saved an extract from the British National Formulary (BNF) to support prescribing practice on the ward for this patient.
- None of the wards we visited had a psychologist on the multi-disciplinary team. Staff referred patients to a community-based psychologist as required for possible one to one support. Staff told us that this was sometimes detrimental to patients because they did not have the opportunity to build up a relationship with the psychologist. As a result they may not feel comfortable talking to someone they had never met. We saw an example of this in patient care notes where a psychologist had travelled to the ward to see a patient who did not feel able to meet with them. The psychologist agreed to make telephone contact with the patient but was not able to travel to the ward again. On the day of our inspection, the patient refused to talk to the psychologist on the telephone.
- Patient records showed that staff supported them to access physical healthcare as required. This included support to attend magnetic resonance imaging (MRI) scans and liaison with maternity services.
- Staff assessed patients using the malnutrition universal screening tool (MUST) to ensure that they could address any risk to patients from malnutrition.
- Staff used health of the nation outcome scales (HONOS) to assess the severity of patients' presentation when they admitted them. They then completed the same form at discharge to assess how the patient had improved.

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- We saw evidence of staff completing clinical audits. These included care plans and Mental Health Act paperwork. Wards had named leads responsible for completion of these documents. However, we found evidence that the auditing of medicines management was not effective. It had not captured the errors made by staff in administering medicines to enable managers to address individual performance concerns. We raised this at the time of inspection and the trust took action to strengthen the audit process to capture these concerns so managers could take appropriate action.

Skilled staff to deliver care

- The wards had psychiatrists, occupational therapists, nurses, activity co-ordinators and service assistants who completed domestic tasks such as cleaning and serving meals. Pharmacists visited the wards on a weekly basis. Pharmacy technicians also visited some wards weekly. They did not have social workers based on the wards. Psychological assessments could be organised for patients but there was not access to ongoing psychological input for patients on the wards in the form of groups or other interventions. Wards had identified specific members of staff to act as leads for specific issues, such as diabetes or eating disorders. The personality disorder locality lead provided support in the form of reflective practice meetings and had delivered training in the past. They also visited wards to offer support for staff working with people with this diagnosis.
- Staff received a two-day corporate induction that includes topics such as safeguarding, the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards. This also covered duty of candour.
- All staff had received annual appraisals. However, completion of supervision was inconsistent across the wards. Supervision levels over the six months between August 2016 and February 2017 fluctuated between 20% at its lowest on Rydon ward two during the period of September and October 2016 which has increased to 50% during January and February 2017. Although the rates of formal supervision were low, staff told us they felt supported by their manager and they could talk to them if concerns arose. The ward had recently introduced a system of management supervision to provide additional support to the staff. Group supervision was available but the trust was unable to provide attendance details from before January 2017. The highest level of supervision was 94% on Holford ward, Rowan Ward and Ash Ward. Wards told us that they had completed team meetings. All wards provided us with the minutes from these meetings.
- One ward manager told us that staff had previously had access to a psychologist for group supervision; staff had found this to be very beneficial to help them to identify news ways of managing challenging behaviours. The removal of this external support was felt to be detrimental to the learning and development of the team.
- Managers told us that staff could access a fund to enable them to complete specialist training. Heads of department had sent out details of potential opportunities available in the past.
- Managers addressed staff performance issues appropriately. Supervising staff felt that they were supported by their managers to address poor performance within their team.

Multi-disciplinary and inter-agency team work

- We attended staff handovers on four of five wards. Doctors, nurses, occupational therapy staff and activity co-ordinators attended. Staff maintained a holistic approach to patient care. Staff were knowledgeable about the individual needs of patients. They discussed referrals to outside agencies to meet patient needs. Staff voiced the views and wishes of the patient where they had discussed issues with the patient prior to the handover. Staff also presented carers' views and wishes during the handovers and all staff present contributed to the discussion. Risks were discussed during the handover and plans made to support the patient with clear roles and responsibilities agreed within the team to achieve the plans.
- We also attended a pharmacy liaison meeting that focussed on the care of a patient with specific needs that they had not worked with on the ward before. This meeting included nurses, the ward manager, pharmacist, pharmacy technician, support workers and occupational therapy staff. They discussed the medication staff would give, the potential impact and side effects. They discussed how to reduce the impact of side effects using specific medications. They also discussed the potential role in supporting the patient

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that occupational therapy staff would have. All staff seemed to appreciate the proactive approach the pharmacist had taken in this patient's care. There then followed a discussion on the subject of drug errors and the manager encouraged the staff to reflect on the issues a specific situation had raised. Staff engaged with this discussion well and were willing to be open and honest about their feelings if the same had happened to them.

- Staff reported good working relationships with the local crisis and community mental health teams. Staff said that occupational therapists had a professionals meeting to allow them to share good practice across the wards.
- Patients were referred to outside agencies as required to meet their needs. Handover discussions and patient care notes showed that the ward staff had regular contact with housing providers, social services teams and community mental health services. We saw evidence of cross border working with an out of county drug support team working with staff and a patient on the ward.

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

- Eighty-one percent of staff had received training in the Mental Health Act (MHA) 1983. Staff told us this only applied to qualified nurses. Staff demonstrated an understanding of the Act. However, they did not consistently apply some aspects. For example, none of the consent to treatment forms completed by doctors (T2 or T3) were kept in the clinic room on three of the five wards. All of these wards used electronic prescribing. We found one case where medicine prescribed was not present on the consent to treatment form. The doctor had prescribed this at the beginning of January. A consultant had incorrectly completed a second form so if staff had given the patient the prescribed medication it would have been a medicines error. The consultant had completed the form the day before and the patient had yet to take the medicine. Staff admitted that as the forms were not in the clinic, they would not necessarily check them to see that the prescriptions tallied with the medication allowed.
- Staff told us they are able to get support from the MHA administration office in Yeovil. This office stored all original documentation. The office staff supplied copies to each ward. The office was responsible for organising all tribunals, second opinion approved doctor reviews and manager's hearings.
- We saw evidence that staff attempted to read patients their rights at admission. If patients did not understand their rights, then staff revisited them later until patients understood. Staff also read patients their rights again when circumstances changed. For example, a section being changed or a tribunal upholding the need for detention.

Good practice in applying the Mental Capacity Act

- At the previous inspection in September 2015, we had raised concerns that staff had not gained or recorded consent to treatment. We found during our inspection that staff had completed this information but where staff recorded it was inconsistent. We checked 29 and found that in 11 staff had had not recorded consent to treatment or admission onto the ward in the appropriate section of the patients' notes. The trust provided us with evidence that in these files and eight others, staff had not recorded the information in the appropriate place but they had recorded it elsewhere in the notes. We found that consent had been recorded when it had been requested by outside agencies.
- Seventy-seven percent of staff had received training in the Mental Capacity Act (MCA) 2005 at the time of inspection. This was an ongoing training package made up of on line learning.
- Where there was evidence suggesting a patient had impaired capacity, staff had not been consistently completing capacity assessments for patients admitted on the wards.
- Staff we spoke with had some understanding of the MCA. However, when they were unsure they confirmed that they would contact someone for clarification they needed with the Act.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- All interactions that we observed between patients and staff were courteous and respectful. Staff engaged positively with patients and demonstrated the ability to engage patients in meaningful conversation and activity. All of the wards we inspected were calm, staff knew their roles and worked to ensure that the patients felt settled and supported on the wards.
- There was mixed feedback from patients regarding their treatment by staff. A large majority were positive regarding the care they received and their interactions with the staff, stating that they felt safe and well supported. However, some were negative and did not appreciate some of the blanket rules in place. They felt unsafe and that some of the staff were disrespectful in their attitudes or behaviour towards them.
- The staff we met were focussed on providing the best possible care for the patients on their ward. They discussed patients with respect during meetings and staff clearly had a good understanding of their needs. They identified the requirements of the patients and ensured they made contact with the necessary staff or agencies to provide the necessary support.

The involvement of people in the care that they receive

- Wards had an admission checklist and provided an information pack to new patients. The admission checklist included orientating patients to the ward and ensured staff did not miss any information.
- Holford ward made effective use of the safety tool to manage personal risk in a person centred and holistic manner. By asking patients about their triggers and damaging behaviours and what methods they used to manage them, staff were able to respond to the individual in a personalised way. This reduced the risk of the behaviours escalating to cause harm to the patient or others.
- Care plans were holistic and demonstrated knowledge of the views and wishes of the patient. Staff had not written them consistently in the first person and some patients told us that staff had placed their care plan in their room and they had not been involved in writing it.
- There was access to advocacy on all wards with a local service visiting regularly every week. There were posters up on the wards to confirm the details of both standard advocacy and also independent mental health advocacy and independent mental capacity advocacy.
- There was active involvement with carers across all the wards we visited, there was evidence in case notes of family and carer consultation, carer wishes were considered in handovers and we witnessed contact with family members being made via the telephone during our inspection.
- We sat in on “you say, we did” meetings where patients could feedback on the service and care they received. Staff discussed issues that they or patients had raised in the previous week and told patients what actions staff had taken to address these. Staff at these meetings handled potential points of conflict positively and with respect. All wards held the meetings but they occurred at different frequencies. For example, on St Andrews they happened weekly. However, on other wards they were monthly.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Average bed occupancy for the period 1 January 2016 to 31 December 2017 was 104% across all five wards. This was due to wards using beds for patients on leave to enable them to provide support to patients that community staff needed admitting. However, there was large a difference between the lowest and highest. Holford ward had an occupancy rate of 79% over this period, Rowan ward had the highest occupancy rate of an average of 119% over the same time.
- There had been no out of area placements in the previous six months. This was a point of pride when talking to staff and managers on the wards. This meant patients were close to their local communities, which helped with contact with families and discharge planning.
- The wards actively manage beds for patients on leave. This ensured that staff did not place patients out of area to help them keep in contact with their families. If a patient needed to return from leave, staff attempted to place them on the same ward. However, this was not always possible so staff placed them in a bed on a different ward in the trust. Consultants attended an acute pathway meeting with the crisis team and ward managers. This was to manage beds. Managers had an on call rota out of hours and at weekends to help manage admissions.
- Staff tried not to move a patient during an admission unless clinically justified. However, due to the lack of medical cover, staff moved settled patients to St Andrews ward to make a bed available on a ward for a new admission where a doctor was available. For example, Rydon ward one or two. Staff confirmed that this only happened if the patient agreed to move. Staff would also move patients who they had admitted to a ward that did not cover their home geographical area back to their home team to ensure consistency of care.
- Staff told us that they tried to ensure that any planned discharges occurred at a reasonable time of day, and preferably not just before the weekend.
- The trust had one psychiatric intensive care unit. Access for family and friends could be challenging dependant on the area the patient resides, as the family may have to travel across the county. However, the trust had not made any out of county placements during the year prior to inspection in a commitment to reduce patients becoming estranged and isolated from their family and friends.
- We saw evidence of active discharge planning. Handover discussions were recovery focussed and staff adopted a considered approach to safe discharge planning. This included referral to community support services as required. One handover considered a long-term approach to meet a patient's needs in the community. This included the psychiatrist offering ongoing support to ensure the patient did not return to hospital due to a lack of consistency of care.
- Each of the wards had experienced delayed discharges. The highest level of delayed discharges was on Rydon wards with a cumulative total of 731 days, next was St Andrews with 574 days. Rowan ward was at 49 days and Holford ward had a total of seven days. The delayed discharges related to patients who had either lost their accommodation, their placement had broken down or they needed further levels of support not available at their current accommodation. They all presented with complex needs due to a number of factors and this made it more difficult to find appropriate placements. In a number of cases, accommodation was trialled and broke down necessitating the patient returning back to hospital from leave.

The facilities promote recovery, comfort, dignity and confidentiality

- All wards had access to a wide range of rooms and facilities to enable them to support the treatment and care of patients. These included activities rooms, visitor's rooms, activity of daily living (ADL) kitchens and gyms. Most of the clinic rooms were well maintained and fully equipped. However, the clinic on Holford ward was too small to accommodate an examination bench. Staff gave patients the option of where the doctor would examine them. Options included the patient's bedroom or if the patient did not want staff to examine them in the private space of their bedroom, the ward's seclusion room was available.
- Wards had access to occupational therapists that provided an activity programme, including arts and

Are services responsive to people's needs?

Good

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

crafts, access to the gym and other activities. The wards endeavoured to try to provide activities over the weekend to keep patients occupied. This was often using activities planned by the OTs. The ward manager on Holford ward spoke of creative use of rostering to generate extra working hours for her to allocate staff to act as activity coordinators at the weekend.

- On all wards, we found that rooms overlooked by public spaces did not have privacy film fitted to their windows to protect the privacy and dignity of their patients. We raised this at the time of inspection and the trust took immediate action to resolve this issue on all wards.
- Wards where the trust used CCTV to monitor patients' movements in communal areas had signs on the external entrance. However, there were no signs within the ward environment to remind patients that they were under observation, which is a potential infringement of their rights.
- Each ward had a communal lounge with wards also having a women only space. On St Andrews ward there was also a men only lounge. Each ward had access to a visitor's room for patients to meet friends and relatives. These included a range of items for children to play with.
- Patients had the option of using their own mobile phone to make calls in private. If the signal was poor or they did not have their own phone, they utilised the wards' cordless phone instead.
- Patients on the wards had access to outside space. Staff checked these regularly on all wards apart from Rowan. On St Andrews, inspectors noted an environmental issue in the garden that could aid a patient to go absent without leave. The manager confirmed that this had happened recently. By the end of the day, the trust had responded and the issue had been resolved. On Holford ward, patients using the extra care area also had access to fresh air and open space. Staff we spoke with stated that these were locked from midnight however they would open them at night if required. Patients we spoke with agreed this was the case.
- Patients told us that the food was of good quality. During patient meetings, we saw staff discussing patients' dietary requirements including the need for alternative options to dairy or a vegan diet. Patients confirmed ward staff catered for their dietary needs.
- Access to hot drinks and snacks was limited after midnight as staff locked all communal areas to encourage good sleep hygiene. Patients reported that they sometimes found this difficult. Staff would make drinks for them but they were unable to consume them in communal areas and had to return to bed.
- We saw limited evidence of personalisation as patients had chosen not to bring their possessions to hospital. However, we saw one bedroom in the PICU that the patient had clearly personalised and staff confirmed that patients could personalise their rooms if they wished.
- All patients had access to a lock box in their room to store personal valuables. Keys were available for a security deposit. Patients did not have access to keys to lock their room to prevent other patients from entering their space. Staff confirmed that they would lock or unlock doors at patient request. Staff also kept other valuables or contraband items in a property cupboard. Patients asked staff to access this when they required these items or needed their phone charged.
- All wards had access to activities through the week that activities coordinators or occupational therapists facilitated. At weekends ward staff were responsible for the delivery of activities, which could be reliant on how busy the ward was. On Holford ward, through some creative rostering, the manager had created capacity in their staffing levels for a member of ward staff to be solely responsible at the weekend for providing activities. Rowan ward had access to activity coordinators at weekends and for two evenings per week.

Meeting the needs of all people who use the service

- All wards apart from Holford had rooms that had adjustments made to accommodate patients with needs for disabled access. Staff were conscious that these rooms had higher levels of ligature risk and had to assess and manage patient risks accordingly. Each ward had at least one assisted bathroom. However, staff advised us that the assisted bathroom on Rowan ward did not have a hoist so patients with restricted mobility could not have a bath. This meant the bath designated for assisted use was not used at all.

Are services responsive to people's needs?

Good

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

- We saw evidence on St Andrews ward where a patient had requested to be examined by a female doctor. However, there were no female doctors on the team and so had not acted on the request. Other staff stated that they did not know how they would proceed but could potentially ask another team if they had a female doctor free to come to the ward. Staff said that they could provide a chaperone but could not provide female doctors easily in that team as a female doctor was not easily accessible on site.
- Wide ranges of information leaflets were available. If required the staff printed items in foreign languages. Each ward had a poster in a number of languages to enable patients to indicate if they needed an interpreter. The ward then provided this service for patients.
- The information leaflets provided covered a wide range of subjects including patients' rights, advocacy, how to complain, and on different types of treatment. At St Andrews ward, they had a rack of information leaflets provided by the mental health charity MIND that covered a wide range of information regarding conditions and treatments.
- As part of the service, the catering department catered for patients' religious and ethnic dietary needs. However, staff told us of some difficulties in obtaining halal meat in the local area.
- The trust had a chaplaincy service to provide Christian spiritual support. We witnessed a faith service conducted for patients on the wards. If patients had different spiritual needs, the chaplaincy service was the contact point used to arrange visits by religious leaders of other faiths.

Listening to and learning from concerns and complaints

- The core service received 22 complaints between 1 January 2016 and 31 December 2016. Of those, the trust fully upheld three and partially upheld 14. No complaints had been referred to the Parliamentary Health Service Ombudsman.
- Patients had access to a have your say / you say, we did meeting to enable them to raise concerns regarding their care. We attended a number of these and found that patients were happy to raise complaints here. Staff fed back actions taken to resolve issues and were positive and supportive if points of conflict arose. There were also leaflets and posters on the wards that advised patients and carers of how to complain.
- Staff understood how to support patients making complaints. They attempted to resolve issues at ward level but if this was not possible then staff advised patients to contact the patient advice and liaison service (PALS). The PALS service was the responsible for managing the complaints process and providing information and support to the patients. We saw evidence that ward staff met with carers and / or patients to resolve issues.
- Once PALS had completed the complaints investigation, ward managers formulated letters explaining the circumstances and apologising for the situation that had occurred. We saw evidence of these letters and they were appropriate, supportive and apologetic.
- Staff told us managers ensured that they were aware of learning from complaints. They discussed them at team meetings. We saw evidence of this in team meeting minutes. Managers also sent out Information by email to ward staff.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff had a mixed understanding or awareness of the new trust values and vision. They had received emails asking them to contribute to the discussion about what they should be. Posters were visible on all wards confirming the values and the behaviours that they represent. Individual team managers had identified how these values translated into the work the staff did on the ward. They felt that the overarching ethos of the values matched the care and service they delivered to the patients on the wards.
- Staff knew that a new chief executive officer (CEO) was in post and some had met him. Staff said that he had visited their ward and these visits had been unannounced at times.

Good governance

- We found on the last inspection that there had been issues with the gaining and recording of consent. During this inspection, we found that staff were recording consent but not consistently in the appropriate place in patient records. This could make it difficult for others to find.
- There were policies in place that the trust regularly reviewed. Most worked well in practice. However, staff appeared to find the policy around proactive care confusing, especially about when they should record an intervention as a restraint. There also appeared to be confusion around elements of the trust's seclusion policy. We raised this at the time with the trust for them to clarify these issues so the staff better understood the expectations about recording these interventions.
- Staff received mandatory training and although in some subjects they had not reached the trust's own compliance level, completion rates were generally around 90-95%. In the last inspection concerns had been raised about the lack of training in the Mental Health Act (MHA) and Mental Capacity Act (MCA). The trust had responded to this and commenced a new training package. This was an ongoing process but the trust had made progress. Eighty one percent of staff had completed Mental Health Act training and 77% of staff had completed Mental Capacity Act Training. Staff had received annual appraisals. We found issues with MHA paperwork that we raised at the time of inspection. The trust resolved them.
- Staffing on wards was at safe levels. The managers had block-booking arrangements in place for agency staff to manage the issues caused by staff vacancies and to provide continuity of care.
- Staff completed audits. However, the medicines audit did not capture the errors found in the administration of medicines by nursing staff. We raised this at the time of inspection and the trust took immediate steps to resolve this issue by strengthening the audit process.
- There was a clear governance structure regarding the reporting of incidents, safeguarding and complaints. Managers shared lessons learnt from these with the ward teams to improve practice.
- Ward managers felt that they had sufficient authority to complete their role. They escalated issues of concern to their local risk register and they added items to the trust risk register. For example, the manager on Holford ward had submitted the mixed sex psychiatric intensive care unit (PICU) to the risk register. The trust had scheduled a meeting between the ward manager and the chief executive to discuss this.

Leadership, morale and staff engagement

- Sickness rates varied across all the wards. Overall, the average was 5.2 % against a trust average of 4.7%. However, sickness rates ranged from 2 % on Rowan ward to 7% on St Andrews ward.
- Staff felt confident that they could raise concerns. All staff we spoke with knew about the trust's "See it, say it" initiative and because of this they felt comfortable to raise concerns without fear of repercussions.
- All staff told us that they enjoyed their jobs. Some staff had been in post for many years and felt that this reflected how much they enjoyed their role. Staff described good morale on the wards and feeling supported by their immediate managers. Non-registered staff described training and development opportunities. However, qualified staff felt that development opportunities and career progression was lacking for them.

Are services well-led?

Good

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

- Staff described good team working and mutual support from their colleagues that made working in potentially difficult and challenging situations rewarding.
- Staff we spoke with understood the need to be honest and open with patients when things went wrong and described situations when this had occurred.
- Staff had the opportunity to feedback on the service through team meetings. Some staff expressed concern that there are ongoing discussions that may affect inpatient services but no decisions had been made at the time of this inspection. This may result in major changes and staff felt the future is uncertain and that they are not fully engaged in the process.

Commitment to quality improvement and innovation

- Three of the wards had participated in the Accreditation for Inpatient Mental Health Services (AIMS) quality improvement scheme. Managers felt that it had been a very worthwhile process and they were awaiting the final confirmation of their compliance with the scheme. The wards had made changes as part of the process and because of feedback from the visiting teams that completed the assessment of the wards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The completion of medicine administration records was inconsistent and managers did not act promptly on errors made by staff. Staff had given patients more as required medication than the doctor had prescribed. Regulation 12 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.