Good

Berkshire Healthcare 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) |
|---|---|---|---|
| RWX51 | Prospect Park Hospital | Bluebell Ward | RG30 4EJ |
| RWX51 | Prospect Park Hospital | Snowdrop Ward | RG30 4EJ |
| RWX51 | Prospect Park Hospital | Rose Ward | RG30 4EJ |
| RWX51 | Prospect Park Hospital | Sorrell Ward (PICU) | RG30 4EJ |
| RWX51 | Prospect Park Hospital | Daisy Ward | RG30 4EJ |

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

# Summary of findings

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 Berkshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Berkshire Healthcare 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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# Summary of findings

## Overall summary

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

- Following our inspection in December 2015, we rated the service as good for effective, caring, responsive and well led. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.
- During this most recent inspection, we found that the services had addressed the issues that had caused us to rate safe as requires improvement following the December 2015 inspection.
- The acute ward for adults of working age and psychiatric intensive care units were consistently following their own policy and the Mental Health Act 1983 accompanying code of practice to ensure that the rights of those people subject to long-term segregation were being met.

However:

- Over the last 18 months the trust has had two very serious incidents which are still under investigation. We observed good evidence that the trust was taking the right steps to improve risk assessment and management plans however this requires further embedding.
- The risks associated with the garden access door on Daisy ward were not fully assessed and managed.
- There were hooks attached to the walls of the courtyard area outside Rose ward. Senior managers told us the purpose for these were for securing ladders to the walls to allow maintenance work to take place. These hooks could be used as ligature points and the risks associated with them had not been assessed and managed.
- Not all emergency medication was stored together and not all wards had the same medication available.

# Summary of findings

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

**Are services safe?**

Requires improvement

We re-rated safe as requires improvement because:

- Over the last 18 months the trust has had 14 serious incidents including two very serious incidents which are still under investigation. We observed good evidence that the trust was taking the right steps to improve risk assessment and management plans however this required further embedding.
- The garden access door on Daisy ward was not fully assessed and managed.
- There were hooks attached to the walls of the courtyard area outside Rose ward. Senior managers told us the purpose for these were for securing ladders to the walls to allow maintenance work to take place. These hooks could be used as ligature points and the risks associated with them had not been assessed and managed.
- Not all emergency medication was stored together and not all wards had the same medication available.

However:

- The service had addressed the issues that had caused us to rate safe as requires improvement following the December 2015 inspection.
- The service had a strong action plan in place to address staff recruitment and retention issues.
- Over 86% of staff were up to date with mandatory training.
- All wards were clean and well maintained.
- All patients received detailed risk assessments and associated risk plans that were individualised and person centred.
- Advanced directives were available for all patients on Sorrell ward in regards to their preferences in dealing with incidents which may escalate into aggression or violence.
- Staff used many opportunities to learn from when things go wrong.
- Quality initiative projects were well embedded on all wards.

**Are services effective?**

Good

At the last inspection in December 2015 we rated effective as **good.**

Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

**Are services caring?**

Good

At the last inspection in December 2015 we rated caring as **good.**

# Summary of findings

| | |
|---|---|
| Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating. | |
| **Are services responsive to people's needs?**<br>At the last inspection in December 2015 we rated responsive as **good.**<br><br>Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating. | Good |
| **Are services well-led?**<br>At the last inspection in December 2015 we rated well led as **good.**<br><br>Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating. | Good |

# Summary of findings

## Information about the service

The adult acute wards and psychiatric intensive care unit (PICU) for Berkshire Healthcare NHS Foundation Trust are provided on a single site at Prospect Park Hospital, Reading.

There are four acute wards for adults who require a hospital admission due to their mental health needs, either for assessment or treatment, or under the Mental Health Act.

The acute wards are mixed sex wards:

- Bluebell ward, a 27-bedded acute ward covers the areas of Wokingham and West Berkshire.
- Snowdrop ward, a 22-bedded acute ward covers the areas of Windsor, Maidenhead and Bracknell
- Rose ward a 22-bedded acute ward covers the area of Slough
- Daisy ward, a 23-bedded acute ward covers the area of Reading.

There is also a psychiatric intensive care unit (PICU) which provides intensive care services for both men and women who require more intensive support and increased levels of observation:

- Sorrell ward, a 14-bedded PICU and covers all of Berkshire.

An announced comprehensive inspection of Prospect Park hospital took place in early December 2015 and a follow up unannounced visit took place to Daisy Ward on 17 December 2015.

We also undertook an unannounced inspection on the 11 February 2016 to follow up a Warning Notice that we issued in regard to the High Dependency Unit (Sorrell Ward).

## Our inspection team

Team leader: Serena Allen, Inspection Manager, Care Quality Commission

The team that inspected acute wards for adults of working age and the psychiatric intensive care unit comprised one CQC inspector, a consultant psychiatrist specialising in inpatient mental health services, a social worker, a mental health nurse specialising in inpatient mental health services and a CQC inspection planner for three days. In addition, for the second and third days, the team was joined by an occupational therapist specialising in community and inpatient mental health services. After the inspection visit an expert by experience made telephone calls to carers. An expert by experience is a person who has experience of using care services.

## Why we carried out this inspection

We undertook this inspection to find out whether Berkshire Healthcare 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 of the trust in December 2015.

When we last inspected the trust in December 2015, we rated acute wards for adults of working age and psychiatric intensive care units as good overall with effective, caring, responsive and well led all rated good. However, we rated the domain of safe as requires improvement.

Since our inspection in December 2015 there had been 14 serious incidents requiring investigation and the trust commissioned an external review of all of these

# Summary of findings

investigations as they had significant concerns about the frequency, number and severity of the incidents. The report of the thematic review was due to be reported on in January 2017.

Following the December 2015 inspection, we told the trust it must make the following actions to improve adult acute inpatient wards and psychiatric intensive care unit:

We issued the trust with a warning notice in respect of the high dependency unit at Prospect Park Hospital. This was because the trust had failed to ensure that the rights of those people subject to long-term segregation were being met. This breached their own policy and the Mental Health Act 1983 code of practice. In addition the high dependency unit on Sorrell ward did not meet the Department of Health same sex guidance or allow the patients their privacy and dignity whilst they were restricted to this area. We returned to the high dependency unit at Prospect Park on the 11th of February 2016 and were pleased to report that the trust had resolved the concerns raised in the warning notice and were fully compliant with the law.

## 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, we reviewed information that we held about acute wards for adults of working age and psychiatric intensive care units, requested information from the trust, and asked a range of other organisations for information. This information suggested that the ratings of good for effective, caring and well led, that we made following our December 2015 inspection, were still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as requires improvement for safe. We also made a few recommendations at the last inspection which will be followed up at the next comprehensive inspection.

During the inspection visit, the inspection team:

- Visited five wards on the one hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 21 patients who were using the service and 12 carers and collected feedback from 37 patients using comment cards
- spoke with the managers or acting managers for each of the wards and the senior management team of the hospital
- spoke with 39 other staff members including doctors, nurses, occupational therapists, psychologists, heath care assistants, social workers and a pharmacist
- spoke with two visiting external health care professionals and two advocates.
- attended and observed two hand-over meetings and two multi-disciplinary meetings
- looked at 26 treatment records of patients
- carried out a specific check of the medication management on all wards
- looked at a range of policies, procedures and other documents relating to the running of the service
- observed three patient care review meetings.

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

- We spoke to 12 carers who all said they felt their relatives were safe on the wards, that the ward environments were clean and that in the main there were sufficient staff to deliver a good quality of care and treatment.
- We spoke with 21 patients who were positive about their experiences of feeling safe on the wards and extremely positive about the relationships they had with the ward staff in assisting them to feel safe.

# Summary of findings

- We received 37 comment cards from the adult acute and PICU wards. 84% of these comment cards were positive about the staff and environments of the wards.

## Good practice

- Advanced directives were available for all patients on Sorrell ward in regards to their preferences in dealing with incidents which may escalate into aggression or violence.
- Quality initiative projects were fully embedded on all of the wards. Examples of these projects included reducing the numbers of patients who failed to return to the ward from leave, improving the quality of risk assessments and ensuring physical health monitoring took place following rapid tranquilisation administration.

## Areas for improvement

### Action the provider MUST take to improve

- The risks associated with the garden access door on Daisy ward must be assessed and managed.

### Action the provider SHOULD take to improve

- The trust should ensure that the risks associated with the hooks on the walls of the courtyard of Rose ward are assessed and mitigated as they could be used as ligature points.
- The trust should ensure all emergency medication is stored together and that each ward has the same medication available.
- The trust should develop a written protocol for the use of the de-escalation rooms.
- The trust should review the blanket restriction of searching all patients coming into the wards as this was put in place following a specific serious incident which occurred over one year ago.

Berkshire Healthcare NHS Foundation Trust

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

**Detailed findings**

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Bluebell Ward | Prospect Park Hospital |
| Snowdrop Ward | Prospect Park Hospital |
| Rose Ward | Prospect Park Hospital |
| Sorrell Ward | Prospect Park Hospital |
| Daisy Ward | Prospect Park Hospital |

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

The design and layout of all of the wards did not allow staff to observe all parts of the ward easily. There were blind spots where staff could not always view patients. These risks were managed well, for example, each newly admitted patient received a welfare check 4 times an hour for the first 72 hours following admission. The design of all the wards meant there were challenges for staff to effectively observe patients and this could result in unwitnessed incidents occurring. However, we saw there was a high level of staff presence on all of the wards, and increased staff supervision was provided for patients with an increased level of risk. When required observation levels were increased and carried out more frequently for patients at risk of harming themselves. In addition to this all wards had parabolic mirrors to assist staff in observing all areas of the wards.

Staff on each ward had completed a detailed ligature point risk assessment. These had identified a number of high risk areas across the wards. The trust had put in place action plans to either manage or eradicate these risks. Where ligature risks remained, the ward staff were able to confidently tell us during the inspection how these were managed locally. The staff did this by managing areas through observation or through individual patient risk assessment and increased levels of observation of patients who may be at risk of harm to themselves. This reduced the risk of patients using ligature points. However, we found one high risk area on Daisy ward which did not have a managed plan. The door leading into the garden was unlocked and had a fence which could be climbed with comparative ease and it had at least a 12 foot drop on the other side. A patient could have scaled the fence and injured themselves falling over the top. We raised our concerns about this area and the service manager took action immediately to lock the door and agreed that staff would supervise all access into the garden area. In addition we had concerns about the courtyard area accessed by patients on Rose ward. The courtyard had hooks attached to the walls. These were high up and staff told us these were to provide stability for ladders used for cleaning, maintenance work, or by fire service. The hooks could have been used as ligature points and staff could not locate a risk assessment or management plan which addressed these risks. We raised our concerns about these unmitigated risks to the senior management team. The senior management team assured us a risk assessment would take place immediately.

All of the wards complied with the guidance on same-sex accommodation. The guidance states that all sleeping and bathroom areas should be segregated and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. All of the wards were mixed sex wards, bedroom areas were separated with designated male or female corridors. On all wards (except Daisy and Bluebell) patients sleeping accommodation were single rooms, with toilet and washing facilities that were either en-suite. Where these were not en-suite single sex bathrooms, designated male and female were located close by. Patients did not have to walk through an area designated for a patient of a different sex to reach either bedroom or bathroom facilities.

Each ward with the exception of Sorrell ward had an area adjoined to both male and female bedroom corridors, which could be used to extend the respective bedroom corridor dependent on the number of male or female patients, with a locked door separating the areas. All wards within the unit had a designated male and female lounge area.

Bluebell ward had two bedrooms that accommodated two bed spaces. Each of these twin rooms were located in the male and female areas of the ward, one in the male area and one in the female area. Daisy Ward had one room in the male area that accommodated two bed spaces. We had concerns at our previous inspection in December 2015, that the en-suite facilities did not have a door and the privacy curtain provided did not ensure patients sharing this room had adequate privacy, dignity or security when using the bathroom. By the time of the 2016 inspection the en-suite facilities in shared bedrooms on Bluebell and Daisy ward had doors fitted in addition to the privacy curtains.

Sorrell ward had a high dependency unit (HDU) which contained two sleeping areas, a seclusion room, a lounge area and a single bathroom that contained a shower and toilet facilities. The area was due for a full refurbishment in

Requires improvement

# Are services safe?

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

January 2017. We raised concerns in the December 2015 inspection as we observed that both men and women were using the HDU at the same time, they were not provided with segregated facilities. In response, when we re-inspected the ward in February 2016 the trust had made the HDU a single sex unit to protect patients dignity and privacy. During this inspection the HDU was being used as either a female or male area but not both at the same time. We checked records of usage of the facilities to confirm this was the case.

All of the wards had clinic rooms which were in good order and kept clean, with appropriate records showing regular checks taking place to monitor the fridge temperatures for the storage of medicines. Emergency equipment was stored on the wards in the nursing offices. An automated external defibrillator and anaphylaxis pack were in place. The staff carried out checks regularly to check the equipment was in order, fit for purpose and we saw evidence of these checks. The ward managers told us that equipment such as weighing scales and the blood pressure machines were regularly calibrated and that the equipment was checked on a regular basis. The wards clinic rooms were fully equipped and all had an examination couch. Ligature cutters were available in the clinic rooms and in the nursing offices. We did however have some concerns on Rose ward that the emergency medicines were not stored together; some were in the clinic room and others in the nursing office. We felt this could cause confusion in a medical emergency and lead to a delay in getting the medicine to a patient in good time. In addition there were different emergency medications available on each of the wards which could lead to delays in knowing what medication was available on the wards and getting the right medicine to the patient in the quickest time possible. We raised this with senior managers and they undertook to resolve the inconsistencies immediately.

Sorrell ward housed the seclusion room for the hospital and all patients requiring seclusion were transferred to the care of the staff of Sorrell ward. The acute wards had de-escalation rooms available. We had some concerns that the de-escalation rooms did not have written protocols, however, staff were able to confidently describe the use of these rooms.

The seclusion room on Sorrell ward was located in the high dependency unit (HDU) area of the ward. The trust showed us the agreed plans for extensive refurbishment works due to start on Sorrell ward in early January 2017. The plans included the new build of the seclusion facilities on Sorrell ward.

All the ward environments were in the main clean, tidy and had a good standard of furnishings and fixtures. However there were one or two exceptions such as broken window blinds on Bluebell ward and some wear and tear to the environment on Snowdrop ward. Cleaning records were complete and up to date. Cleaning schedules were available and followed.

We saw staff following good infection control practice including hand washing.

Environmental risk assessments were undertaken regularly and we saw evidence of work carried out as a result.

Access keys and alarms were available throughout the wards and all staff carried alarms. All staff had access to keys. We were told by all staff that alarms were responded to quickly. Security processes had been reviewed on Sorrell ward following a serious incident. The airlock area was now staffed at all times with additional locks and an alarm installed.

### Safe staffing

The adult acute wards and PICU had their staffing establishments estimated by the senior management team and had recently undergone a full review. The planned daily establishment for each ward was five staff in the morning, five staff in the afternoon and four staff at night. (5-5-4). Bluebell ward was an exception. Here, the planned daily establishment was 6-6-5, due to the increased number of beds on this ward. On the days of inspection, we found that the complement of staff matched or exceeded this planned daily amount.

The establishment levels for qualified nurses whole time equivalent (WTE) were:

- Sorrell ward 15
- Bluebell ward 19
- Snowdrop ward 15
- Rose ward 15
- Daisy ward 15

The establishment levels for health care assistants (WTE) were:

- Sorrell ward 15

Requires improvement

# Are services safe?

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

- Bluebell ward 17
- Snowdrop ward 15
- Rose ward 15
- Daisy ward 15

The number of WTE vacancies for qualified nurses were:

- Sorrell ward 6 (40%) (One new recruit offered position)
- Bluebell ward 9 (47%)
- Snowdrop ward 5 (30%) (One new recruit due to start in December 2016)
- Rose ward 2 (13%) (One new recruit due to start in January 2017)
- Daisy ward 3 (20%) (Two new recruits due to start in January 2017)

The number of WTE vacancies for health care assistants were:

- Sorrell ward 4 (27%) (Two new recruits offered position)
- Bluebell ward 5 (29%)
- Snowdrop ward 7 (47%) (Four new recruits offered positions)
- Rose ward 4 (27%) (One new recruit due to start in January 2017)
- Daisy ward 5 (33%)

Number of shifts filled and not filled by bank and agency staff:

- Sorrell ward – 1,116 shifts filled and 37 shifts not filled
- Bluebell ward – 730 shifts filled and 36 shifts not filled
- Snowdrop ward - 895 shifts filled and 28 shifts not filled
- Rose ward – 853 shifts filled and 40 shifts not filled
- Daisy ward _ 630 shifts filled and 35 shifts not filled

Ward managers offered bank shifts to regular ward staff in the first instance. Following this, bank staff and then agency staff would be sourced. The ward managers were able to authorise shifts to be covered by agency staff should they not be filled with bank staff. In some instances where the vacancies for qualified staff nurses were high, the trust had given agreement for agency workers to be given short-term contracts until the vacancies were filled. We saw that this worked well, for example on Sorrell ward where four nurses were employed on a long term contract. This ensured that, where possible, cover was provided by staff that had knowledge of the ward and the patients. This minimised risks to staff and patients. The trust ensured that bank and agency staff received a local induction on all the wards, which included the specific safety requirements for each ward.

Ward staff were deployed from their ward duties to support patients admitted into the trust's place of safety. Ward managers told us that they could book additional staff to cover their wards when staff were diverted to covering the place of safety service. Supernumerary staff were available on the wards to cover the place of safety service from midday through to 07.00. Following a review the trust had taken a decision to create a dedicated staffing team to cover work in the place of safety service. Recruitment was due to commence in January 2017.

Senior ward staff told us they were confident that their staffing levels could be increased should there be a clinical need.

We met the senior management team for the hospital and staff told us that the support and input offered by this team enabled them to focus primarily on the direct care provision for their patients. The senior management team included a dedicated clinical governance nurse, a risk management lead, a nurse consultant, a senior nurse, two clinical nurse specialists and a therapy manager,. In addition to this there was also an administration manager, a service manager, clinical director and inpatient locality director. Plans had also been agreed to appoint a discharge co-ordinator and a bed manager.

The trust reported that for the period from September 2016 to November 2016 the average staff sickness rate was 5% and staff turnover over the same period was 21%.

The trust reported it had difficulty in recruiting suitably qualified and skilled nurses, but they were in a process of ongoing recruitment to fill these posts. We looked at a range of initiatives put in place to recruit staff. These included the introduction of more senior posts for qualified staff nurses and non- qualified staff to provide development and promotion opportunities for staff. For example the trust had introduced a more senior non-qualified post to enable career progression for staff in more junior posts.

Staff were available to offer regular one to one support to their patients. There were enough staff on each shift to facilitate patients to have leave and for activities to be delivered. Staff and patients told us that activities were

Requires improvement

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rarely cancelled due to staffing issues but were at times deferred to a different time. Patients told us they were offered and received a one to one session with a member of staff at least three times each week. We saw that this was the case as it was reported daily in the patients' daily records. The clinical governance nurse audited and monitored how often patients received an individual session with staff.

Overall, staff and patients told us that activities were provided across a seven-day working week. Staff told us about a quality initiative project which had been introduced in 2015 to ensure a seven day week occupational therapy service across all wards. Following a patient satisfaction survey in September 2016, there was a 118% increase in satisfaction by patients with the amount and quality of activities available at weekends and 100% increase in staff offering to engage patients in activities.

We saw medical staff rotas and were satisfied there was adequate medical cover day and night. A minimum of two doctors were available on the hospital site at any given time of the day or night with a consultant available on call at night time.

A snapshot of mandatory and statutory training compliance for the date of our inspection showed that over 86% of staff had up to date training on managing clinical risk, The Deprivation of Liberty Safeguards, infection Control, information governance, The Mental Capacity Act, preventing and managing violence awareness, safeguarding adults and safeguarding children.

### Assessing and managing risk to patients and staff

We reviewed 26 care records of patients across the acute wards and PICU. There were comprehensive risk assessments completed for patients on admission to hospital, which were updated regularly including after any incidents. The wards used a recognised risk assessment tool embedded in the electronic care record system. The clinical governance nurse carried out daily checks to ensure that new admissions had risk assessments which were of a good quality and that risk management plans were pulled through into updated care plans.

Staff told us, where they identified particular risks, they safely managed these by putting in place relevant measures. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments we reviewed took account of patients' previous risk history as well as their current mental state.

A quality initiative project was introduced in March 2016 to improve the quality of the risk assessment process and documentation section of the electronic care records. Patients, their carers and staff were asked how the risk assessment process could be made more effective. Feedback included that there was too much information required, too much jargon used, too many tick boxes and information was spread over too many different sections of the care records. As a result changes were made and a new risk summary template was due to be rolled out across all wards in January 2017. Prospect Park hospital had a dedicated risk management lead who oversaw this work programme.

Risk sessions were provided by the nurse consultant on each ward where individual patients were discussed with both staff and the patients and their risk assessments and associated risk management care plans were reviewed collaboratively. Patients were encouraged to develop a personal safety plan which included information about coping mechanisms to use and contact details of professionals, family and friends who could be called on in times of crisis.

All the wards were compliant with staff training on clinical risk assessment and were able to confidently discuss managing risk. 86% of staff had received up to date risk management training.

A quality initiative project was piloted on Bluebell ward during 2016 to reduce the amount of patients who failed to return to the ward following agreed leave or spending time away from the ward. An audit tool was developed and practice included spending time with patients before they left the ward and asking all patients where they would be going, what their expected time of return would be and noting what clothes the patient was wearing. On every shift a 'security person' was identified from the staff team to ensure time was spent with each patient leaving the ward to discuss mutual expectations of the planned leave. All wards had business cards that had been designed to give information to help and support patients to keep to their leave time period and return at an agreed time. Additionally, it provided opportunity for those patients who were on leave to contact the ward when they were in crisis

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or equally patients had the opportunity to inform the wards about a possible delayed return to the ward (the ward contact number was available on the business card). All qualified staff had been given an anti-absconding work book to inform their practice and understand the reasons why people may abscond. Bluebell ward reduced the incidents of their patients failing to return to the ward by 90% within a 12 month period. The initiative was being rolled out across all wards at the time of our inspection visit with a trust set target to reduce the incidents of patients failing to return to the ward by 50% before March 2017. Staff working on this project published a paper in partnership with two other NHS trusts. This was published in October 2016, in the British Medical Journal as a quality improvement good practice example.

In the preceding three months before our inspection visit there had been 83 incidents of restraint across the wards. Of these restraint incidents, 34 involved use of the prone position, 29 were accompanied by the use of rapid tranquilisation and 20 involved seclusion on Sorrell ward. There were no incidents of long term segregation. All seclusion episodes took place on Sorrell ward only as per the hospital policy. The average monthly seclusion episodes in the preceding year were 11 seclusion incidents per month. Staff we spoke to regarding restraint and prone restraint in particular said that the training they received discussed the risks of prone restraint, and alternatives to using prone restraint. All staff commented on the usefulness and high quality of this training provided. Staff told us that the electronic incident recording system they used asked for each position that a patient was placed in during a restraint and the duration they were in that position. Staff told us if patients placed themselves into the prone position initially during a restraint that this would be recorded but patients would be turned as soon as it was safe to manoeuvre them.

The trust commissioned an advocacy organisation to interview every patient, following every episode of restraint to gain their feedback on the experience.

All the acute wards had de-escalation rooms which were equipped with furniture to ensure safe sitting restraint techniques, if this was required, for a short period of time only. Whilst patients were in the de-escalation room staff would remain with them. Patients remained in the room until they had calmed down, and interventions that were used in the de-escalation room ranged from using 'calm boxes', one to one time with staff, medication and sitting restraint and did not stray into secluding a patient in that room. The doors to the de-escalation rooms were not locked while being used by patients. Although staff were able to confidently describe the safe use of these rooms we had some concern that staff were unable to tell us which policy set out the protocol for their use. When we queried this with the trust they confirmed the use of deescalation is covered within the 'Time out and other restrictions of patients' movements' policy.

The 'Safe ward' initiative was well embedded on all wards. This nationally recognised good practice initiative proposes 10 interventions are used on a ward to reduce conflict and distress for patients and make wards safer places for patients and staff. For example using methods to calm down other than medication such as listening to music, soft lighting and distraction techniques.

A good practice example on Sorrell ward was all patients had advanced directives in place in regards to dealing with incidents which may escalate into violence or aggression. For example patients had identified their preferred methods for calming down and where appropriate their preferred medication to be prescribed.

A practice quality improvement project had been implemented across the wards to ensure physical health monitoring was carried out for all patients receiving rapid tranquilisation medicines. "Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need." (NICE, 2015). All incidents of rapid tranquilisation were reported and audited and in the latest audit 100% of patients had received physical health care monitoring as per the trust's policy.

There were a number of blanket restrictions on the wards. However, each had been thought through with staff and patients before implementation and had a clear rationale. For example, on admission, all patients underwent searches to ensure no contraband was brought into the wards. In addition all patients were searched on returning from leave. Staff told us that this was to ensure a safe environment for patients and staff and this had been put in place following a serious incident of a fire when a patient had brought a lighter onto the ward. Contraband is an item which is banned from the wards such as weapons, drugs or

Requires improvement

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alcohol. Staff told us that patient searches were done in a supportive and dignified way, ensuring it was conducted in a private area of the ward and by the appropriate gender of staff. We asked patients about this practice and none commented negatively about it. Blanket restrictions were under ongoing review.

All staff we spoke to said that if patients were informal they were able to leave the ward. All informal patients we spoke with said they knew they could leave the ward should they wish to do so.

All of the staff we spoke to knew how to raise a safeguarding issue or concern. Staff said that an electronic incident form should be completed and that they would inform the nurse in charge or the ward manager. All staff were aware of who the trust safeguarding lead was and how to contact them. Laminated safeguarding team contact details and flow charts of the safeguarding procedure were placed in all wards both in the nurse's office and also on the patients' notice boards. 93% of staff had up to date safeguarding adults and children training. During the seven clinical review and multidisciplinary meetings we attended safeguarding was raised and discussed for all patients.

We checked the management of medicines on each ward and looked at 24 medication administration records (MARs). There were no errors or omissions in recording. The medicines were stored securely in the clinic rooms. Daily checks were made of room and refrigerator temperatures to ensure that the medicines remained suitable for use. All medicines needed were available. We looked at the ordering process and saw the process for giving patients their regular medicines and we heard from patients about the information they were given. All medications checked were in date. There were good processes and procedures in place on the wards in relation to medication reconciliation. This is where the ward staff would contact general practitioners on admission, to confirm what medication and dosages the patient was taking so that these medicines could continue while the patient was on the ward. This meant patients were provided with their prescribed medicines promptly. Staff gave patients information about medicines. Staff discussed medicines in a multidisciplinary care review. Staff discussed changes to the patients' medicines with them and provided leaflets with more information. We saw this happening during our inspection. Where patients were receiving high doses of medication we saw that their physical health was checked and monitored.

Staff used clear protocols for patients to see children from their family. Each request was risk assessed thoroughly to ensure a visit was in the child's best interest. There were meeting rooms available for visitors outside of the ward areas.

### Track record on safety

The trust reported 14 serious incidents requiring investigation from October 2015 to September 2016. Each incident was investigated at the time of the incident. In addition, the trust commissioned an external and independent expert to review the incidents to identify common themes and trends arising from the 14 incidents. The investigation process should identify good practice and areas where improvements to services might be required. The overall aim as identified in the terms of reference was "to identify areas of good practice and systemic risks and opportunities to improve patient safety alongside making recommendations for organisational learning". The findings of the investigation were due to be reported back to the trust in January 2017.

During this inspection we found that whilst many positive changes in the safe domain had taken place, we still had concerns that these changes had not been fully or consistently embedded into practice.

The 14 incidents included three suspected suicides and one attempted suicide which did not take place on the wards. One of these incidents had been a serious incident on Sorrell ward which involved a patient who had absconded and died and a subsequent police investigation followed. Following this incident the trust had made the air lock at the ward entrance more secure to prevent a re-occurrence. There were three incidents of assault, including one where the patient was charged with attempting to cause grievous bodily harm. Four incidents were when patients failed to return to the ward at the agreed time (Two patients were away for longer than 72 hours). There were two unexpected deaths on the wards (one has been confirmed as accidental death at inquest and the second has not yet been reported on by a coroner). Lastly there was a fire in a bedroom on one ward where a patient died.

Requires improvement

# Are services safe?

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

### Reporting incidents and learning from when things go wrong

Staff knew how to recognise and report incidents. All incidents were reviewed by the senior management team, on a daily basis. The senior management team discussed all incidents and analysed recommendations from all serious incidents and reported these back to staff. Staff investigated all incidents to try to establish the root cause. We looked in detail at other recent incidents and tracked them back to the patients' care records. We saw in all cases that patients and staff involved had received a de-brief session following the incidents to immediately address any lessons to be learnt.

Staff received feedback from investigations in regular team meetings and they learnt key themes and lessons and developed action plans if they needed to make changes. Staff said there was always a debrief session arranged after a serious incident, and that a facilitated, reflective session would take place to ensure, as well as learning lessons, that staff felt adequately supported. A weekly meeting called the 'space group' facilitated by the nurse consultant and a psychologist was provided on each ward to enable staff to reflect on their practice and in addition learn any lessons from incidents or events. We looked at minutes of these meetings on all of the wards and saw that learning was discussed regularly. For example, we saw where restraint had been used, care plans had been adjusted to avoid the need for restraint in the future. In addition patients were encouraged to develop advanced directives about how they would like staff to intervene if they became distressed or agitated. At least two serious incidents occurred with patients who were inappropriately placed on acute wards or the PICU. We saw that staff had put contingency risk plans in place for current patients who were awaiting transfer to more suitable placements such as specialist learning disability placements, more secure facilities or in another case a specialist placement for a patient with a degenerative brain disorder.

# 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

At the last inspection in December 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Good

# Are services caring?

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

## Our findings

At the last inspection in December 2015 we rated caring as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

# 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

At the last inspection in December 2015 we rated responsive as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

# 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

At the last inspection in December 2015 we rated well led as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>There was no ligature risk assessment or a management plan for the garden door on Daisy ward. The door leading into the garden was unlocked and had a fence which could be climbed with comparative ease and it had at least a 12 foot drop on the other side. A patient could have scaled the fence and injured themselves falling over the top.<br><br>This is a breach of Regulation 12(2)(b) |