Oxford Health NHS Foundation Trust

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

## Quality Report

Trust Headquarters, Warneford Hospital Site,
Warneford Lane, Headington, Oxford, OX3 7JX
Tel: 01865 901000
Website:www.oxfordhealth.nhs.uk

Date of inspection visit: 18-19 July 2017
Date of publication: 13/10/2017

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| RNU09 | Buckinghamshire Health and Wellbeing Campus | Whiteleaf Centre, Ruby ward | HP20 1EG |

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

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

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

# Summary of findings

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

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

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

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

# Summary of findings

## Contents

# Summary of findings

## Overall summary

We inspected the safe, effective and well led key questions and found the following areas of good practice:

- The ward environment was in very good condition and kept clean.
- There was good medicine management in place with strong oversight by the pharmacy team. Emergency medicine and equipment was checked and in date.
- The ward had well-formulated and patient-centred care and treatment plans. Risk assessments and risk summaries were thorough and were updated regularly in response to incidents and changes.
- Ward rounds were inclusive, comprehensive and patient-centred. There was a focus on discharge planning from the start of admission and reviews included discussions with patients regarding their responsibility for their safety on discharge.
- Staff told us that despite the staffing challenges, they felt part of a very strong, supportive team. Patients and staff had positive comments about other staff members including senior managers.
- Patients and their carers had access to a range of information and support to encourage them to participate in their care.

However, we also found areas that the service provider could improve:

- Recruitment challenges and staff sickness meant that there was a high use of agency nurses on the ward. This meant that care was not always delivered to the highest standard. Staff members and patients told us they sometimes felt unsafe when there were mainly staff on duty who were unfamiliar with the ward and the patients.
- There has been a lack of consistency in the senior leadership of the ward over the previous 18-24 months due to locum posts and turnover of senior team members. However, the trust was taking action to improve recruitment and retention of staff.

# Summary of findings

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

**Are services safe?**

We found the following areas that the service provider could improve:

- Recruitment challenges and staff sickness meant that there was a high use of agency nurses on the ward. When we inspected, approximately 50% of the nursing staff were employed via an agency. A number of patients on the ward had a diagnosis of emotionally unstable personality disorder. Patients with this diagnosis significantly benefit from a stable and cohesive staffing team.
- Staff members and patients told us they felt unsafe when there were mainly staff on duty who were unfamiliar with the ward and the patients. This had resulted in increased pressure on other staff and a reduction of one-to-one time and escorted leave for patients. Information was not always communicated between staff and decisions made in the ward round were not always transferred to patient care records.
- There had been two deaths of in-patients under the care of the ward in the six months prior to our inspection. Staff and patients had been supported and senior management had begun to implement changes as a result of the deaths.
- There were blind spots from the nursing station that were not mitigated by mirrors and the view was further impeded by a large central room situated in between the nursing station and the bedroom corridors. All patients were checked under general observations every hour, in line with Trust policy, however some patients were observed every half an hour, in line with their care plans.

However, we also found areas the following areas of good practice:

- The ward environment was in very good condition and kept very clean. All of the bedrooms had ensuite bathrooms with anti-ligature fixtures and fittings, including taps, privacy curtains, anti-ligature beds and furniture.
- The ward demonstrated good medicine management in line with National Institute of Health and Care Excellence (NICE) guidelines, with strong oversight by the pharmacy team. All equipment and emergency medicines were checked and in date.

# Summary of findings

- All patients had a risk assessment completed on admission. Risk assessments and risk summaries were thorough and fed through to comprehensive risk management plans. For patients considered at high risk, staff could convene a risk panel meeting to discuss this further.
- Staff mandatory training levels were at 87% at the time of our inspection and 88% of staff had received safeguarding training. Staff felt confident about raising and escalating safeguarding concerns.

**Are services effective?**

We found the following areas of good practice:

- The ward had thoughtful, well-formulated and patient-centred care and treatment plans.
- Discharge was considered soon after admission; named nurses on the ward spoke to patients about discharge and consultants spoke to patients about discharge plans early in their admission.
- Patients and their carers had access to a range of information and support to encourage them to participate in their care.
- Ward round reviews were inclusive, comprehensive and patient-centred. However, the ward round review we observed was not attended by ward staff other than doctors. We were told that this was due to the staffing issues on the ward.
- Staff carried out daily, weekly, monthly and yearly environmental audits.

**Are services caring?**

- At the last inspection in June 2016 we were satisfied that acute wards for adults of working age at this location were caring**.** Since that inspection we have received no information that would cause us to re-inspect this key question.

**Are services responsive to people's needs?**

- At the last inspection in June 2016 we were satisfied that acute wards for adults of working age at this location were responsive**.** Since that inspection we have received no information that would cause us to re-inspect this key question.

**Are services well-led?**

We found the following areas of good practice:

# Summary of findings

- Staff told us that despite the staffing challenges, they enjoyed their work and felt part of a very strong, supportive team. Staff valued the support from senior managers but felt that staff skills not being utilised in the best way.
- Patients and staff gave very positive feedback regarding individual staff members.
- The trust responded to concerns about patients on the ward sharing ideas of self-harm via social media. Personal mobile phone use was risk assessed and risk assessments were amended to include questions on the use of 'social media.' A group was set up to discuss how best to manage the group of people who shared self-harm ideas on social media within the ward environment.

However, we also found areas that the service provider could improve:

- Recruitment challenges and staff sickness meant that there was a high use of agency nurses on the ward. This had an impact on staff and patients and meant that care could not always be delivered to the highest standard. This meant that creating change could be challenging as the ward was required to deal with immediate crises without sufficient substantive staff.

# Summary of findings

## Information about the service

The acute wards for adults of working age and the psychiatric intensive care unit for Oxford Health NHS Foundation Trust are provided from different hospital sites across the county.

Ruby ward is a 20 bed unit for working age women who have acute mental health needs who require hospital admission due to their mental health needs, either for assessment or treatment.

Ruby ward covers admissions from the areas of Aylesbury and the Chilterns and is based at the Buckinghamshire Health and Well-Being Campus in Aylesbury, Buckinghamshire (formerly known as the Whiteleaf Centre).

## Our inspection team

The team that inspected the service was led by Care Quality Commission inspector Jane O'Connor. It comprised one Care Quality Commission inspector, one Care Quality Commission inspection manager and a nurse specialist advisor.

## Why we carried out this inspection

This unannounced inspection was prompted by information received from the provider regarding the deaths of two patients on Ruby ward that occurred in 2017.When we last inspected the trust in June 2016, we rated acute wards for adults of working age and psychiatric intensive care units as good overall. We rated the core service as good for all five domains.

Following the June 2016 inspection we told the trust that it should take the following actions to improve acute wards for adults of working age and psychiatric intensive care units:

- The service should consider a garden access policy to ensure patients have the same night access to gardens across all wards.
- The service should document where care plans are given to patients or reasons why they were not.
- The service should ensure consistent recording of clinic room temperatures across all wards.
- The service should review their use of leave beds for new admissions.

Prior to this inspection there were no outstanding requirement notices directly relating to Ruby ward.

## How we carried out this inspection

To fully understand the experience of people who use services, we asked the following questions of the provider:

- Is it safe?
- Is it effective?
- Is it well-led?

During the inspection visit, the inspection team:

- visited Ruby ward in Aylesbury and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service

# Summary of findings

- spoke with the senior management team with responsibility for this ward and the deputy ward manager
- spoke with seven other staff members; including doctors, nurses and healthcare assistants
- attended and observed one multi-disciplinary meeting, two hand-over meetings, one rapid review meeting and one patient planning meeting.
- looked at five patient treatment records and eight medicine charts
- 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 did not always feel safe on the ward due to the lack of permanent staff and that agency staff were sometimes unfamiliar with the ward and patients. They did not always have one-to-one time with their named nurse due to staff commitments. For example, if other patients were on high levels of observations. They felt that the ward could be disorganised due to staffing issues and sometimes their concerns and requests about their treatment were not passed on to the medical staff by nursing staff. They told us that staff were kind and respectful but that some staff were harder to engage than others.

## Good practice

## Areas for improvement

**Action the provider MUST take to improve**

- The trust must ensure that recruitment is a priority so that Ruby ward has a stable senior leadership team and nursing team.

**Action the provider SHOULD take to improve**

Oxford Health NHS Foundation Trust

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

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Ruby ward | Buckinghamshire Health and Wellbeing campus |

## 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.

- Staff were trained in the Mental Health Act and understood the key principles of the Act.
- The Mental Health Act documentation that we reviewed was in order and patients' rights under the Act were upheld.
- Patients were regularly informed of their rights as required by the Mental Health Act Code of Practice.
- Patients had access to an Independent Mental Health Advocate.
- The ward noticeboards contained information for patients regarding their rights, how to access the advocacy service, how to complain and how to contact the Care Quality Commission.
- The pharmacy technician checked each patient's MHA status weekly to ensure that the consent to treatment forms were present for all patients and attached to their medicine charts.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were trained in the Mental Capacity Act and understood the relevant consent and decision-making requirements of legislation and guidance.

# Detailed findings

- Staff members were involved in discussions about capacity to consent to treatment and to admission. Capacity issues were discussed at each multidisciplinary review/ward round.
- The patient care records we viewed showed that patients' capacity to consent to their care and treatment was assessed on their admission and on an on-going basis.

# 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 ward was very clean, tidy and organised. Furniture was comfortable and well-maintained. Housekeeping staff checked the food and drink kept in kitchen fridges for patient use and we found that this was all in date. A cleaning schedule was advertised on the notice board and this was checked and completed and audited by the housekeeping supervisor. There was good access for people with physical disabilities.
- There were two large lounges, two small lounges and a large activity room. The ward was busy and some patients were communicating their needs verbally in communal areas. However, there were several quiet areas for patients to access, including a large outdoor area that had a high fence for safety. There was no communal ward phone but patients could use the phone in the nursing office or they could use their own mobile phone once risk assessed to do so. Bedrooms could be personalised and patients were individually risk assessed to have a key to their bedrooms to access them during the day. Patients had access to a kitchenette and a tea station for 24 hour access to drinks and snacks. There was a family room with toys off the ward that could be used for family visits.
- There were blind spots from the nursing station that were not mitigated by mirrors. The layout of the patient lounge and games room resulted in reduced observation from the nursing station. All patients were checked under general observations every hour, in line with Trust policy, however some patients were observed every half an hour, in line with their care plans.
- All of the bedrooms had ensuite bathrooms with anti-ligature fixtures and fittings, including taps, privacy curtains, anti-ligature beds and furniture. Patients were individually assessed for risks and measures taken if necessary, such as locking doors to en-suite bathrooms if deemed necessary. The kitchen and laundry room that contained ligature risks were kept locked.
- Ruby ward had a seclusion room and a separate place of safety that was also used as a de-escalation room. Both rooms allowed for clear observation by means of closed circuit television (CCTV) with cameras placed inside the room and bathroom area with a monitor placed just outside. The seclusion room had anti-ligature fittings, two-way communication via an intercom, toilet facilities but not a visible clock. At the time of our inspection the CCTV was not working but arrangements were in place for this to be fixed the next day. The ensuite bathroom door in the seclusion room was unlocked as a contingency to give staff sight of the patient in the room. The de-escalation room also had anti-ligature fittings and a bathroom, plus a television with a choice of films, a games machine and heavy comfortable chairs. There was also access to weighted blankets which can provide sensory relief to patients undergoing a crisis.
- The ward utilised a pin point alarm system and all staff carried alarms. If an alarm was pressed there was one responder from each of the nearby wards with one person identified per shift on Ruby ward to respond.
- There was a large dispensing room and a separate large treatment room with a couch and equipment that included an electro-cardiogram machine, blood pressure machine and weighing scales. These were checked and had been calibrated. Both rooms were clean, tidy and well-organised. There was a resuscitation grab bag in the nurses' station, as well as a portable de-fibrillation machine that was checked daily and in date. Emergency medicines were kept in the clinic room. The fridge and clinic room temperatures were fed into a pharmacy electronic system to enable the temperatures to be checked and audited.
- Throughout the ward, information was easily visible on patient notice boards that were relevant, informative and up to date. This included information about specific mental health problems, treatments, local services, help-lines, how to complain, advocacy as well as a separate board with information and support for carers.

### Safe staffing

- 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. When we

inspected there were five vacancies for band 5 nurses, and one for a band 3 nursing assistant. Two of the four band 6 nurses were on sick leave and staff sickness was at approximately 6%. The qualified nurse vacancies had led to significant use of bank and agency staff to cover nursing shifts. When we inspected approximately 50% of nursing staff on the ward were made up of agency staff. A number of patients on the ward had a diagnosis of emotionally unstable personality disorder. Patients with this diagnosis significantly benefit from a stable and cohesive staffing team.

- Patients told us they felt unsafe and insecure when there were mainly staff on duty who were unfamiliar with the ward and the patients. Their one-to-one time with a named nurse and escorted leave had sometimes been cancelled. Patients reported that they could not speak with their named nurses because they were covering the observation levels and patients did not want to speak to nurses they were not familiar with. In meetings we observed, patients raised concerns about this and felt the non-permanent staff did not know them and were not as empathetic towards them.
- Some staff also told us that they felt unsafe and vulnerable at times and that there was extra pressure on them and less time for other tasks such as administration and attendance at meetings. The staff members not covering the high observation levels felt there were too few of them left to care for the rest of the patients and to manage the ward.
- The trust had booked some agency staff members on longer contracts to try to minimise the impact of the continued use of agency staff and the shift co-ordinator planned 24 hours ahead to manage staffing. However, the ward regularly had patients on high observation levels and sourcing staff to cover the additional observations had been difficult. During our inspection there were two new admissions to the ward and this meant that there were four patients on level three observations. The two new admissions were not expected, so the wards had not been able to increase staffing in advance. Support from the neighbouring ward was provided until the increase in staffing was achieved.
- The ward provided an induction for bank and agency staff at the beginning of each shift. Not all agency staff were familiar with the ward systems and processes and not all had access to the electronic patient care record system. Colleagues with access to the electronic care record system were expected to input the information on their behalf.
- The ward operated three shifts per day. There were six staff members on the early and late day shifts and four on the night shift. There was a minimum of two qualified staff on each shift. The ward manager had been in post for six months, was full-time and worked two clinical shifts per week. The ward had one full time equivalent consultant post, at the time of inspection this was covered by two part time consultants. Both Ruby and Sapphire wards also shared one full-time staff grade doctor.
- Staff mandatory training levels were at 87% at the time of our inspection. All staff had received conflict resolution training and equality and diversity training. The lowest uptake for mandatory training was infection control and prevention which was at 74%.

### Assessing and managing risk to patients and staff

- There was good medicine management in place in line with National Institute of Health and Care Excellence guidelines. 'As and when required' medicines had been reviewed within 14 days and where applicable, the medicine charts we viewed clearly recorded the percentage at which medicine had been prescribed over the limit recommended by the British National Formulary.
- There was strong oversight by the pharmacy team who visited the ward weekly. We looked at eight medicine charts and all were in good order and correct. A pharmacy technician visited the ward three times a week to check medicine charts including 'as and when' medicines, for all patients on the ward. The pharmacy technician completed weekly stock checks, met weekly with the consultant, attended team meetings and was responsible for medicine reconciliation. Risk of medicine errors was more likely due to high use of agency staff but these were picked up quickly by pharmacy staff with input from a trust based medication safety officer; a senior pharmacist for the trust. The pharmacy team checked on 'to take out' medicines on receipt and completed incident forms as appropriate.
- All patients had a risk assessment completed on admission. Risk assessments and risk summaries were

thorough and fed through to comprehensive risk management plans. Risk assessments were regularly updated in response to incidents, changes in patients' behaviours and improvements in patients' mental health. However one patient's falls risk assessment had not been updated after a fall occurred two weeks previously. For patients deemed at an elevated risk, multidisciplinary risk panel meetings could be convened to focus on key risk areas, while keeping planned discharge as a focus.

- Eighty-eight percent of staff had received safeguarding training and staff felt confident about raising and escalating safeguarding concerns. Staff told us that Buckinghamshire County Council was responsive to the ward raising safeguarding issues and they felt able to contact them for advice. The handover to ward staff was thorough and informative and incidents and safeguarding were clearly highlighted on the handover sheets so that staff on the incoming shift were fully alerted. Key risks were also highlighted in the observation folder for staff undertaking level three observations of patients.
- The observation policy was in place and staff felt that this was easy to use and robust. The ward's ligature risk assessment was thorough, detailed and comprehensive with mitigation strategies clearly stated. This had been reviewed just prior to our unannounced inspection.
- All staff, including agency staff were trained in the prevention and management of violence and aggression. Permanent staff received PEACE training and were required to undertake a five day course followed by a one day refresher course every year. The ward practiced the Safer Care initiative, a project that supports clinical teams with care pathway improvement and clinical practice improvement in mental health care.
- Restraint was only used after de-escalation had failed and was carried out using the correct techniques and recorded as an incident. The use of rapid tranquilisation followed guidance provided by the National Institute for Health and Care Excellence.
- In the 'have your say' meeting that we observed, patients commented that there were not enough searches carried out on visitors and patients returning to the ward and that more could be done to reduce patient access to potential items that could be used to self-harm.
- Patients on the ward were risk assessed prior to being able to use their own mobile phones. A 'contagion group' was set up to discuss how best to manage the group of people who share self-harm ideas on social media within the ward environment. Risk assessments were amended to include questions on the use of social media.

### Track record on safety

- The trust reported that there were five serious incidents on Ruby ward that were recorded in the 12 months prior to our inspection. Two of these were in-patient deaths that occurred on the ward within six months of our inspection. One patient was found by staff in her bedroom having attempted suicide; staff attempted resuscitation but the patient later died in the local acute hospital. Another patient was found in the hospital grounds having attempted suicide while on agreed unescorted leave from the ward. The patient later died in the local acute hospital.
- There was a total of 126 incidents recorded on the ward's incident reporting system over the six months prior to our inspection. These included violence or the threat of violence to staff and patient self-harm, the majority of these resulted in the use of restraint by staff. Medicine administration errors and falls were also recorded. One medicine administration error concerned a patient being wrongly given medicine for chemotherapy on discharge – the medicine packet did not have the patient's name on it and this was noticed by the care co-ordinator who visited the patient at home following discharge.

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

- Staff knew how to recognise and report incidents using the trust's electronic reporting system.
- Staff received a full debrief following incidents and they told us there was a good level of support and feedback on both a group and individual basis. The Chaplain

supported staff and patients following the two inpatient deaths with additional input from the trust suicide lead officer. Staff from another ward had been brought in at the time to support staff on the ward.

- We saw an initial action plan created in response to the two deaths on the ward. Several issues were included along with actions, dates and staff members identified to ensure the actions took place. Two issues identified were around inconsistencies with key information not being communicated or being reflected in patient care records. Actions for these were on-going at the time of our inspection.
- In response to the two deaths, senior management had begun to implement other changes. Senior staff had indentified additional training needs for staff, particularly in the understanding of emotionally unstable personality disorder, since the deaths. The ward changed the way it managed out of hours admissions in response as lessons learnt from the deaths, to ensure junior staff were not making key decisions on what observation levels to apply to patients. It was also decided that community mental health teams should be involved sooner, at the point of admission, to enable them to contribute to discharge plans for the patient under their care.

# Are services effective?

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

## Our findings

### Assessment of needs and planning of care

- The ward had thoughtful, well-formulated and patient-centred care and treatment plans. However, the clear care plans were not always followed through due to a lack of substantive staff on the ward.
- Discharge was considered soon after admission. Named nurses on the ward spoke to patients about discharge and consultants spoke to patients about discharge plans early in admission. The ward had started to involve community mental health teams earlier when patients were first admitted. This was a change that was put in place following the deaths of two patients on the ward.

### Best practice in treatment and care

- Patients chaired and led the weekly planning meeting and raised issues in the 'have your say meeting'. 'You said we did' boards demonstrated the changes made as a result of feedback from patients.
- There was good involvement of and information for carers. Carers were given packs with information, the ward had posters signposting support and there was access to support groups. Carers were invited to ward rounds and encouraged to participate as appropriate.
- Staff carried out daily, weekly, monthly and yearly environmental audits. A hand hygiene audit was carried out monthly, the last compliance score for the ward taken the month before our visit was 98%. Every three months the pharmacy team carried out a controlled medicine audit and an audit of medicine systems and processes on the ward. Annual POMH audits were carried out (the national Prescribing Observatory for Mental Health (POMH-UK) that aims to help specialist mental health trusts/healthcare organisations improve their prescribing practice). The pharmacy team met with patients to discuss medicine in a weekly open slot or on request and promoted National Institute for Health and Care Excellence and professional guidance via briefings with staff.

### Skilled staff to deliver care

- Staff had opportunities to access training in specialist areas such as managing people with suicidal thoughts and complex needs. However nurses were not trained in dialectical behaviour therapy, a recognised therapeutic intervention based on cognitive behavioural therapy that has been adapted to help people who experience emotions very intensely. Leadership training was available for ward managers.
- Consultants had mutual peer support from consultants on another ward.
- A clinical psychologist provided input to Ruby ward two days per week and offered weekly cognitive behavioural therapy based groups that focused on the emotions experienced by patients with a diagnosis of emotionally unstable personality disorder. They also offered mindfulness work and weekly reflective practice sessions for staff.

### Multi-disciplinary and inter-agency team work

- Ward round reviews were inclusive, comprehensive and patient-centred. There was a focus on discharge planning from the start of admission and included discussions with patients with an emotionally unstable personality disorder diagnosis regarding their motivation to take responsibility for their safety on discharge. However, due to staff commitments and the increase in patients on level three observations, there were no ward staff other than medical staff involved in the ward round review. The ward round we observed was attended by patients' community care co-ordinators who were able to input fully. In all meetings we observed, staff were professional, caring and respectful throughout.
- There had been two admissions to the ward during the time we inspected. We observed the handover meeting between nurses and doctors and saw that this was thorough and included detailed information, including historic and current risks and any physical health issues.
- We observed a rapid review meeting which encompassed a highly focused clinical discussion on the individual needs of each patient. This included a focus on social, physical and mental health needs.

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

- Staff were trained in the Mental Health Act and understood the key principles of the Act.

# Are services effective?

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

- The Mental Health Act documentation that we reviewed was in order and patients' rights under the Act were upheld.
- Patients were regularly informed of their rights as required by the Mental Health Act Code of Practice.
- Patients had access to an Independent Mental Health Advocate.
- The ward noticeboards contained information for patients regarding their rights, how to access the advocacy service, how to complain and how to contact the Care Quality Commission.
- The pharmacy technician checked each patient's Mental Health Act status weekly to ensure that the consent to treatment forms were present for all patients and attached to their medicine charts.

### Good practice in applying the Mental Capacity Act

- Staff were trained in the Mental Capacity Act and understood the relevant consent and decision-making requirements of legislation and guidance.
- Staff members were involved in discussions about capacity and capacity was discussed at each multidisciplinary team review/ward round.
- The patient care records we viewed showed that patients' capacity to consent to their care and treatment was assessed on their admission and on an on-going basis. There was good documentation of the assessment of mental capacity in all care records. However we did not see evidence that capacity to consent to specific areas (such as physical healthcare) was recorded in the care records.

# 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 June 2016 we were satisfied that acute wards for adults of working age at this location were caring**.** Since that inspection we have received no information that would cause us to re-inspect this key question.

# Are services responsive to people's needs?

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

## Our findings

- At the last inspection in June 2016 we were satisfied that acute wards for adults of working age at this location were responsive**.** Since that inspection we have received no information that would cause us to re-inspect this key question.

# Are services well-led?

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

### Good governance

- Recruitment challenges and staff sickness meant that there was a high use of agency nurses on the ward. This had an impact on staff and patients and meant that care could not always be delivered to the highest standard. This meant that creating change could be challenging as the ward was required to deal with immediate crises without sufficient substantive staff.
- There had been a lack of consistency in the senior leadership of the ward over the previous 18 to 24 months. This was due to one locum consultant post and turnover of a senior nursing team member. These changes meant that some staff felt that a more established leadership team would mean a greater sense of stability for staff. The trust had taken action to address this by asking the senior matron to temporarily base himself on Ruby ward and effectively carry out the matron role whilst recruitment to the post was completed. However staff had very positive comments about senior leadership in place at the time of the inspection.
- Staff felt that the number of admissions to Ruby ward and the longer length of patient stay was related to the perceived lack of community support and resources in the Buckinghamshire areas compared to Oxfordshire. Some felt that the lack of ward staff being trained in therapeutic skills like dialectical behaviour therapy was another. Senior management told us that they planned to develop community mental health care for patients with emotionally unstable personality disorder that would match that of Oxfordshire. This may include the use of 'Structured Clinical Management' (an intensive working style for patients with a personality disorder diagnosis) and to broaden relationships with third sector provision and resources in Buckinghamshire. Consultants on the ward were also working closely with community consultants.
- The trust was in the early stages of developing the personality disorder pathway with the creation of two panels; a complex case panel, chaired by the clinical director and a positive risk panel with senior clinicians formulating a way forward. The latter had been organised responsively to support clinicians working with patients to assist with decision making and involved inpatient and community staff. The personality disorder pathway project included senior clinical leads and field experts, commissioners, staff and had patient involvement. It met regularly to map out the project to reach an agreement on how the pathway will take shape and subsequent actions. Senior trust staff were also engaged in talks with other providers who were working innovatively with patients who had a diagnosis of emotionally unstable personality disorder.
- The trust responded to concerns about patients on the ward sharing ideas of self-harm via social media. Personal mobile phone use was risk assessed and risk assessments were amended to include questions on the use of social media. A 'contagion group' was set up to discuss how best to manage the group of people who share self-harm ideas on social media within the ward environment.

### Leadership, morale and staff engagement

- There were good links and a support system had developed with the adjoining male ward, Sapphire ward, with some cross-over working between the two. Staff told us that despite the staffing challenges, they felt part of a very strong, supportive team. Staff valued the support from senior managers and those based on Sapphire ward. Staff felt that, due to the staffing issues and the need to deal with immediate crises on the ward, staff skills were not being utilised in the best way.
- The staffing difficulties were on the trust risk register and had been there since January 2015. There were strategies in place to ensure more effective recruitment that included open days for prospective candidates, engagement with training schools and the establishment of a steering group.
- Patients and staff gave very positive feedback regarding individual staff members including the senior matron, the Sapphire ward manager, the activities co-ordinator and the pharmacy technician.
- Staff were aware of the trust whistleblowing policy. There was a whistleblowing investigation underway at the time of our inspection.

# Are services well-led?

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.

### Commitment to quality improvement and innovation

- Ruby ward had accreditation for inpatient mental health services (AIMS). AIMS sets out standards and national guidelines which staff on wards should be achieving. AIMS is an initiative of the Royal College of Psychiatrists' Centre for Quality Improvement.

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 | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>There was not sufficient numbers of substantive staff on the ward to maintain safe and consistently good quality care of patients. |

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.