Requires improvement

North East London 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)
RATY1	Sunflowers Court	Turner Ward	IG3 8XJ
RATY1	Sunflowers Court	Ogura Ward	IG3 8XJ
RATY1	Sunflowers Court	Monet Ward	IG3 8XJ
RATY1	Sunflowers Court	Hepworth Ward	IG3 8XJ
RATY1	Sunflowers Court	Kahlo Ward	IG3 8XJ
RATY1	Sunflowers Court	Titian Ward - Psychiatric Intensive Care Unit	IG3 8XJ

This report describes our judgement of the quality of care provided within this core service by North East London 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.

Summary of findings

Where applicable, we have reported on each core service provided by North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London 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	Requires improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Requires improvement**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- There were some environmental concerns that would compromise the safety of patients.Wards had blind spots which would prevent observation of patients. There were multiple ligature points in ward areas and patient bedrooms. Ligature assessments and action plans were brief and lacked detail. This made it difficult for staff to identify ligature points and to mitigate the risks to patients. There were a number of outstanding maintenance issues on some of the wards visited. For example Ogura ward had 40 issues outstanding.
- There were out of date medications in some of the clinic rooms. There was equipment that was past its review date.
- Risk assessments, risk formulations and care plans were not always being updated and reviewed. Patients' personal preferences were not always reflected in care plans. Not all patients had been given a copy of their care plan.
- Not all staff were receiving supervision on a regular basis. Not all staff had received an appraisal.
- Patients had mixed opinions about staff members. On two wards we were told that staff members entered patient bedrooms without knocking. We were also told staff members were not always responsive to patient needs. Staff sometimes cancelled patient leave and activities.

However:

- All wards visited complied with Department of Health guidance on same sex accommodation.
- Across all wards, 87% of staff were up to date with mandatory training..
- Staff were aware of safeguarding processes and had received training. The acute wards had a named safeguarding lead nurse who communicated with the local authority about issues on the wards
- Staff were knowledgeable about incidents and knew what was required to be reported.
- There was good medical cover to the wards during the day and night.Patients admitted to the wards were assessed by a doctor at the time of admission and by a consultant psychiatrist within 24 hours.
- There was regular physical health monitoring of patients on all wards. Staff followed NICE guidelines. For instance, there were psychological therapies available to patients.
- Multi-disciplinary teams on all the wards had a multi skilled staff team of mental health professionals. The teams met regularly.
- There was a good choice of food available, including foods for cultural and religious beliefs. A range of information was on display for patients including how to make a complaint, information about medications and advocacy services.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- There were blind spots on the wards that prevented adequate observation of patients by staff members. Staff had taken no steps to mitigate the risks this posed. Inspectors found a patient smoking in their bedroom on Ogura ward, staff had not identified this.Also, there were multiple ligature points in the wards communal areas and bedrooms. Ligature assessments and action plans varied in quality between the wards and management plans were brief and lacked detail. We found similar concerns during an inspection in October 2015 which the trust had failed to address to ensure risks to patients from ligature points were identified, assessed and appropriate action taken.
- Ogura ward had a number of outstanding maintenance issues that were still waiting to be addressed by the trust's estates department.
- There were out of date medications in some of the clinic rooms we reviewed. We found equipment that had passed its review date.
- There was high usage of bank and agency staff across all six wards.
- Patients told us activities and escorted leave could be cancelled on three of the wards due to staffing issues or pressures on the wards.
- Recording and monitoring of patients in seclusion on Titian ward were not sufficient.
- Risk assessments, risk formulations and care plans were not always being completed or reviewed. We found the same issue during an inspection in December 2014.
- There were blanket restrictions on the wards. For example all doors were locked on the wards and there was no access to hot drinks after 9:30pm.
- Although the average training rate for mandatory training was at 87%, some staff in some areas had very low rates of training.

However:

- The wards were generally clean and well maintained. Furniture was in good condition.
- The wards were compliant with Department of Health guidance on same sex accommodation.

Summary of findings

- Staff were adhering to infection control practices.
- There was good medical cover available to the wards both in and out of hours.
- Staff were aware of safeguarding processes and had undertaken training.
- Staff were knowledgeable about incidents and knew what should be reported on their electronic recording system. Staff were de-briefed following incidents and received feedback about lessons learned.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Care plans that we reviewed were not holistic and did not include individual patient needs.
- Bank and agency staff did not have access to electronic recording systems and relied on permanent staff members to complete entries on their behalf.
- Not all staff were receiving regular supervision and appraisal

However:

- Patients admitted to the wards were assessed by a doctor on admission and by a consultant psychiatrist within 24 hours.
- Staff monitored the physical health of patients weekly or more often if required.
- There was a good range of psychological therapies available to patients on all wards.
- There were regular team meetings on all of the wards we visited.
- The multidisciplinary teams on all wards visited had a range of mental health professionals. The multidisciplinary teams on each of the wards met regularly.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

- Patients we spoke to gave mixed opinions on staff members. On two wards, patient stold us that that staff members entered their bedrooms without knocking. Patients on Hepworth ward told us that patients were observed hourly through the night and that their bedroom lights were turned on to do this, waking the patient.

Summary of findings

- Patients told us some staff members were not always responsive to their needs.
- Not all patients had copies of their care plans, despite requesting them.
- Not all patients felt involved in their care plans development or that they captured there views.

However:

- Interactions that we observed between staff and patients was caring and compassionate. Staff were polite and respectful to patients.
- Staff were knowledgeable about each patient and aware of their needs and risks
- Patients had access to advocacy services on all wards.
- The wards held community meetings where patients could input to decisions about the ward and provide feedback on the wards.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because:

- Staff and patients on Kahlo ward told us there were not enough interview rooms on the ward or rooms for groups and activities.
- Some patients reported their possessions had gone missing from their bedrooms.
- Patients on Ogura ward and Monet ward told us they have experienced difficulties accessing an interpreter.

However:

- Patients were able to return to their bedrooms after returning from leave.
- Patients on wards other than Kahlo had access to a range of activity and therapy rooms.
- Patients on all wards had access to outside space.
- There was a choice of food available on all wards. Cultural and religious foods were available to patients.
- Patients had access to appropriate spiritual support.
- Information was displayed about how patients could make a complaint on all six wards. Staff were aware of the complaints management process.

Summary of findings

- Staff received feedback on lessons learned following complaints.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- There were a number of safety concerns that had not been addressed or dealt with adequately
- Although overall there were good rates of mandatory training, there were some areas which were very low. Staff were not receiving regular supervision or appraisals.
- There was an over reliance on bank and agency staff. They did not have access to electronic recording systems and had to rely on permanent staff to input information into the system.
- The trust was not always responsive to requests for maintenance work to be undertaken on all of the wards.

However:

- Staff were aware of and agreed with the trust's visions and values.
- Clinical staff participated in a range of clinical audits on all wards we visited.
- Staff we spoke to felt supported by local management.
- Learning from incidents was disseminated to staff in team meetings and lessons learned meetings.
- Staff told us morale was good in each of the teams and they enjoyed working for the trust.
- Staff were aware of the whistleblowing process and were confident to use it if required.

Summary of findings

Information about the service

Sunflowers court is part of Goodmayes Hospital in Essex. It has five acute wards for adults of working age and one psychiatric intensive care unit (PICU).

Hepworth ward is a 20 bedded inpatient mental health unit for females aged 18 years of age and over. The service cares for women who are experiencing acute mental health problems. Patients on the ward are in crisis and are unable to be cared for at home due to the level of risk they present to themselves and others.

Kahlo ward is a 20 bedded inpatient mental health ward for females ages 18 years of age and over. The ward cares for women experiencing acute mental health problems.

Monet ward is a 20 bedded inpatient mental health ward for males aged 18 years of age and over. The ward cares for men suffering from acute mental health problems who are experiencing crisis and cannot be cared for at home due to their level of acuity.

Turner ward is a 20 bedded inpatient mental health ward for males aged 18 years of age and over. The ward cares for men who are experiencing an acute mental health problem and are in crisis.

Ogura ward is a 20 bedded inpatient mental health ward for males aged 18 years of age and over. The ward cares for men who are experiencing acute mental health problems, are in crisis and cannot be cared for at home due to the level of risk they present to themselves and others.

Titian ward is a 15 bedded psychiatric intensive care unit (PICU) for males aged 18 years of age and over. Patients present a high risk to themselves and/or others. Patients may be at risk of absconding and their risks cannot be safely managed in an acute ward environment.

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Our inspection team

The inspection team was led by:

Chair: Helen McKenzie, Executive Director of Nursing, Berkshire Healthcare NHS Foundation Trust.

Head of Inspection: Natasha Sloman, Care Quality Commission (CQC).

Team leader: Louise Phillips, inspection manager, Care Quality Commission.

The acute wards for adults of working age and psychiatric intensive care unit were inspected by an inspector from the Care Quality Commission (CQC), an expert by experience and four specialist advisors consisting of a doctor, two nurses and a psychologist, with expertise in acute inpatient services. A Mental Health Act Reviewer and pharmacist from the Care Quality Commission also attended.

Why we carried out this inspection

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

How we carried out this inspection

To 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?

Summary of findings

- Is it well-led?

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

During the inspection visit, the inspection team:

- Visited the six wards and looked at the quality of the ward environments and observed how staff were caring for patients.
- Spoke with 26 patients who were using the service.
- Spoke with the ward managers.
- Spoke with 31 other staff members; including psychiatrists, nurses, health care assistants, psychologist and occupational therapist.
- Looked at 22 case notes looking at areas including risk assessments and care planning.
- Looked at other relevant records such as checks of resuscitation equipment, medicine records, staff rotas and trust policies.
- Observed a governance meetings, multi-disciplinary tram meetings, shift handovers observed CPA meetings, ward rounds and a community meeting
- Carried out a Mental Health Act review.

What people who use the provider's services say

Patients we spoke with gave mixed views on the wards. We were told that staff generally treated patients with dignity and respect and were compassionate. However, some patients told us that staff were not always responsive to their needs and entered their bedrooms without knocking the bedroom door.

Patients did not all feel safe on the wards. We were told the behaviour of other patients could often make patients feel unsafe. Some patients they told us they did not feel safe as illicit substances were sometimes brought onto the wards.

Patients told us they liked the food. However, portion sizes were reported to be small.

Patients reported they were happy with the range of therapies when available. Some patients told us they were often bored on the wards.

Patients knew how to make a complaint and were supported to do so by staff.

Patients we spoke to said that staff searched them when they returned to the ward. Patients also told us that they had access to drinks and snacks during the day. However, after 9:30pm hot drinks were not allowed.

Patients had a named worker who they saw for regular sessions.

Areas for improvement

Action the provider MUST take to improve

Action the trust MUST take to improve

- The trust must ensure that risk assessments are completed and consider all patient risks.
- The trust must ensure that ligature assessments and action plans identify all ligature points and how to mitigate the risk to patients.
- The trust must ensure that care plans are recovery orientated and reflect the personal views and preferences of patients.
- The trust must ensure that out of date medications are not being used and are destroyed and recorded appropriately.
- The trust must ensure that medical equipment is calibrated and within review dates.
- The trust must ensure that maintenance issues are rectified on all wards.
- The trust must ensure that all staff are up to date with mandatory training.

Action the provider SHOULD take to improve

Action the trust SHOULD take to improve

Summary of findings

- The trust should ensure that staff receive regular supervision and appraisals

North East London 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
Hepworth Ward	North East London Foundation NHS Trust
Kahlo Ward	North East London Foundation NHS Trust
Monet Ward	North East London Foundation NHS Trust
Turner Ward	North East London Foundation NHS Trust
Ogura Ward	North East London Foundation NHS Trust
Titian PICU	North East London Foundation NHS Trust

Mental Health Act responsibilities

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

Most staff had received training in the Mental Health Act. This stood at 87%.

In the records scrutinised, there was evidence that patients were informed of their rights under section 132 on admission. However, some records had no further explanation recorded when patients had not understood their rights at the time.

Documents relating to detention were not available on the ward. We were told that records were saved in a recording system called 'Windip', but staff could not access this

during our visit. We were concerned that it would not be possible to transfer a patient to another hospital outside working hours without copies of the detention documentation readily available.

Patients had a poster in their room informing them of their detention status, who their responsible clinician and primary nurse were.

Patients had access to Independent Mental Health Advocacy (IMHA) services. There were posters on the wards about how to contact the service and also information leaflets.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of staff across the six wards had received Mental Capacity Act and Deprivation of Liberty Safeguards training. The compliance rate was 93%.
- Staff we spoke with had a good understanding of the Mental Capacity Act and the guiding principles.
- The regularity of reviewing capacity assessments were variable across the wards visited.
- Staff were able to access guidance and support about the Mental Capacity Act from a central team within the Trust.

Inadequate

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 six wards were located in Sunflowers court on the Goodmayes Hospital site. Hepworth ward was a 20 bedded all female acute unit. The ward had blind spots and were not using convex mirrors in corridors to assist with observations. The ward was clean and well decorated. The furniture was in good condition. Kahlo ward was a 20 bedded female acute ward. The ward was well maintained and well decorated. Ogura ward was a 20 bedded adult male acute ward. The ward had a number of outstanding maintenance issues that were awaiting rectification. We reviewed the maintenance log for the ward and found 40 outstanding issues that had been reported to the estates department. Issues included problems with the plumbing on the ward. Monet ward was a 20 bedded adult male acute ward. The ward was clean and the furniture in good condition. The ward had a number of maintenance issues, two bathrooms were still in the process of being renovated. There were no viewing panels on bedroom doors to assist with observations. Turner ward was a 20 bedded male acute ward. The furniture was in good condition and the ward was well maintained. Titian ward was a 15 bedded psychiatric intensive care unit (PICU) for adult males. The ward was very clean and well maintained. There were blind spots in the ward and bedrooms. All bedrooms had nurse call alarm systems and the doors had vision panels. The furniture was in a good state of repair. Patients had access to an outside garden which had plants, benches and basketball nets. The bedroom areas were not fully anti-ligature and there were ligature risks including hand towel holders and door hinges.
- We carried out detailed tours of each of the six ward environments. We found multiple ligature points throughout the wards, both in ward areas and bedrooms. The wards had completed 'environmental suicide and ligature point assessment action plans' which we reviewed. The assessments and action plans varied in quality and detail. For example, on Ogura ward the assessment was last completed on 2 September 2015. Where hazards and ligature risks had been identified they were not specific and were documented simply as 'door', 'window' and 'sink'. We spoke with staff and asked them to show us what the identified risk referred to. Staff were unable to identify the risk. There was also limited existing controls documented in the assessment. There were no controls documented for any of the patient bedrooms where there were multiple ligature points. Patients were able to access their bedrooms on their own. Actions had been identified and stated to 'replace' or 'management controls'. Management controls were not documented and there was no date by which works were to be completed or for the assessment and action plan to be reviewed.
- On Hepworth ward, the assessment and action plan was last completed on 15 March 2016. We requested a copy of the assessment and plan completed prior to this date but were informed by the ward manager that this was the only assessment and plan that had been undertaken. During an inspection in October 2015 the trust had failed to ensure the risks to patients from ligature anchor points were identified, assessed and appropriate works to address them scheduled. This was raised with the trust following the inspection in 2015. Despite this being raised to the trust previously by the CQC, little progress had been made. All of the existing controls documented refer back to 'individual patient risk assessments'. No actions or recommendations were documented. Staff we spoke with were unable to identify all the associated risks and were not safely mitigating and protecting patients from such risks. There had been five reported serious incidents relating to the acute wards. These were categorised as deaths, suicide and attempted suicide. Some of which were the result of ligatures on the wards and lack of risk management.
- There were no seclusion rooms on any of the wards apart from Titian ward. The seclusion room on Titian ward could be used by patients from the other wards if required. The seclusion room had a two way communication system between staff and patient, staff and patients were both able to control the lighting, blinds and air conditioning. There was a large digital clock on the wall. There was access to outside space for

fresh air. The seclusion room was monitored by CCTV, however, there was no clear observation or operating policy regarding observations for the en-suite bathroom area.

- The six wards complied with Department of Health guidance on same sex accommodation. All of the wards were single sex. A potential issue was the transportation of female patients to the seclusion room on Titian ward as they would be required to pass through male areas. This risk was mitigated by staff accompanying female patients to the seclusion area if required.
- We reviewed the clinic rooms on each of the wards we visited. The clinic room on Ogura was clean. The light in the entrance to the room was not working. Staff said this had been a regular issue. The room temperature was not being routinely recorded. The last entry was on 21/03/2016. The clinic room fridge had been broken between 21/03/2016 and 01/04/2016. The new fridge arrived the day before our inspection. There was a fully stocked grab bag available in the clinic room. The clinic room on Titian ward was large and clean. The room had a full range of equipment that had been checked, tested, calibrated and signed. All equipment was within the review dates. There was a grab bag available in the clinic room with ligature cutters. Medicines were stored at suitable temperatures to maintain their quality. The refrigerator on Turner ward was not working between 13 March 2016 and 1 April 2016 but records showed that alternative arrangements had been made for storage and that there was no risk to the quality of the medicines. On Monet ward there were issues with the fridge temperatures. A new fridge had been delivered to Monet ward but had not yet been installed. On Kahlo ward the blood pressure monitor review date had passed (it was due for review in November 2015), there was no calibration date on the weighing scales. The clinic room on Kahlo ward had been identified as being too hot and it had been reported to the estates department twice and was escalated again on the day of our inspection.
- Staff on all of the six wards visited adhered to infection control practices.
- Each of the six wards had domestic staff who were responsible for cleaning communal areas and patient bedrooms. We reviewed the cleaning rotas and found these to be up to date.
- There were alarms call systems throughout each of the six wards. Staff were issued with personal alarms, when activated they notified the psychiatric emergency (PET) team who would respond. We were told by staff there was good response by the PET team when alarms were pulled. The PET team was made up of one member of staff from each ward and was aimed at supporting patients and de-escalation of disturbed patients.

Safe staffing

- The six wards used a safer staffing tool to estimate the number and grade of nurses required on each shift.
- Titian ward had three qualified nurses on shift and two health care assistants (HCAs) by day and two qualified nurses and two HCAs at night. Turner ward, Kahlo ward, Ogura ward, Hepworth ward and Monet ward had a minimum of two qualified nurses and two HCAs on shift in the day and two qualified nurses and one HCA at night.
- Each of the six wards used bank and agency nurses when required. Staff told us new bank and agency staff were required to be inducted to a ward prior to undertaking a shift. Bank and agency staff were assigned to a permanent member of staff to complete their induction. In a three month period the six wards had filled 2553 shifts with bank or agency staff. The highest usage was on Turner ward where 571 shifts had been filled by bank and agency staff. In the same three month period there were 97 shifts across the six wards that had not been filled by bank or agency staff. Turner ward had the highest number of shifts that had not been filled with 50.
- Ward managers told us they were able to adjust staffing levels as required, for example in the event of increased patient observations on the wards. We were told there is generally no problem when requesting extra staffing.
- Each of the six wards always had a qualified nurse present at all times.
- On admission patients were allocated a named nurse and associate nurse. Staff and patients we spoke with told us patients were able to access regular 1:1 time with their named nurse.
- Staff and patients we spoke with on Turner, Ogura and Kahlo wards told us that ward activities and escorted leave were rarely cancelled. However, patients on Monet

ward, Hepworth ward and Titian ward told us leave and activities were sometimes cancelled. This was usually due to staffing issues on the wards or due to staff not having time due to other pressures on the ward. Leave arrangements were discussed on a daily basis with patients by staff members.

- There was good medical cover to all of the wards both day and night. Out of hours an on call doctor was available to the wards and attended quickly in the event of an emergency.
- Staff on all six wards received mandatory training which was provided by the trust in face to face and computer based forms. The average mandatory training rate for staff across all six wards was 87% in 14 mandatory training areas. Training rates in fire safety awareness were low on Titian ward (60%) and Turner ward (70%). There was also low compliance rates on Turner ward for infection prevention and control (70%) and safeguarding adults enhanced (67%).We found Prevent 1 and Prevent 2 overall training rates for staff across all six wards was below 75%, staff on Hepworth ward had completed 56% and 10% respectively and staff on Titian ward was 33% and 47%.

Assessing and managing risk to patients and staff

- Between 1 September 2015 and 29 February 2016 there had been 202 episodes of restraint across the six wards, 147 were in the prone position and 114 had resulted in the use of rapid tranquilisation. Fifty-five of the restraints had occurred Kahlo ward and 37 on Titian. The highest use of prone restraint occurred Kahlo ward (48). The highest use of rapid tranquilisation had occurred on Hepworth and Kahlo ward, 22 each. Staff we spoke with told us restraints were only used as a last resort after de-escalation techniques had failed.
- Between 1 September 2015 and 29 February 2016 there had been 15 uses of seclusion. These all occurred on Titian ward.
- Titian ward formally secluded patients. None of the other five wards secluded patients but they could be moved to the seclusion room on Titian ward if required. Review of seclusion records showed that the time spent in seclusion varied from 24 hours up to nine consecutive days. Staff did not record sufficient detail in the seclusion records and there was a need for better monitoring of seclusion, for example patient observations. The seclusion room had a two way communication system between staff and patient, staff and patients were both able to control the lighting, blinds and air conditioning. There was a large digital clock on the wall. There was access to outside space for fresh air. The seclusion room was monitored by CCTV, however, there was no clear observation into the en-suite bathroom area.
- We reviewed 22 care records across the six wards visited during our inspection. Risk assessments, risk formulations and care plans were not always being completed or reviewed. Care and treatment for patients was not always provided in a safe way. Risks to the health and safety of patients were not mitigated. For example a patient was admitted to Ogura ward from Accident and Emergency (A&E) following an overdose. A risk assessment was completed by the Psychiatric Liaison Team in A&E prior to admission to the ward. Following admission to Ogura ward no further review had taken place. The same patient had stolen another patient's bank card and allegedly purchased illicit substances. The risk assessment was not updated or reviewed following this incident. The risk assessment for the patient documented 'intent to end life by hanging'. We reviewed the patient's care plans and found there was one in place around substance misuse. The care plan stated the patient would be searched when leaving and returning to the ward. The care plan went on to state urine and drug screens may also be undertaken. However, there was no management plan or guidance in place for staff on what action should be taken should the patient return to the ward under the influence of, or test positive for, illicit substances. There was no care plan in place to support the patient's suicidal ideation about hanging.
- There had been several incidents reported on Hepworth ward concerning a patient accessing a lighter on the ward and smoking in their bedroom. Staff told us they suspected another patient's relative had brought the lighter onto the ward and gave it to the patient. However, the patient's risk assessments and care plans had not been reviewed or updated following the incidents. There was no management plan in place to support the patient or staff.
- A patient on Monet ward had a grade four pressure sore and was seen by the tissue viability nurse on 1 April

Inadequate

Are services safe?

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

2016. On 7 April 2016 the patient attended A&E due to pain from the pressure sore. The discharge summary from the hospital stated 'grade 4 sore not being irrigated and dressed regularly or appropriately'. We spoke with the patient who said staff did not regularly clean the wound or change the dressing even when requested. We reviewed the care plans and risk assessments and found no information about the management and delivery of safe care and treatment with regards to the pressure sore.

- We found similar issues relating to the lack of risk management planning during an inspection in December 2014. There was a lack of risk management planning that had put patients and others at risk of harm. This was raised as a concern with the trust following the inspection in 2014.
- There were some blanket restrictions on the wards. Doors were locked throughout the wards and patients were unable to access hot drinks after 9:30pm. Staff on the wards searched every patient's bags and pockets on their return from leave. This was to minimise the risk of contraband items such as illicit substances and sharp objects being brought into the wards. The trust had a search policy which we reviewed. Searches took place in private rooms with two members of staff present. Staff members of the same sex as the patient being searched undertook the searches. In recent months a number of contraband items, including lighters, had been brought into the wards.
- Staff we spoke to were aware of safeguarding processes and had received training. The acute wards had a named safeguarding lead nurse who communicated with the local authority about issues on the wards. In the absence of the lead nurse there was a safeguarding contact within the trust who could be contacted for advice and information.
- We reviewed the medicines management practice on each of the wards visited. On Kahlo ward there were some out of date medications were being used. We found some missing signatures on the prescription charts and controlled drugs ordering book on Ogura ward. There were good medications processes on Turner ward, Titian ward and Hepworth ward. Medicines, including controlled drugs, which stored securely. Controlled drugs (CDs) are medicines which are stored in a special cupboard and their use recorded in a special register. On Turner ward we saw requisitions in the CD order book had been partially completed and then not used. The ward pharmacist told us the external pharmacy who supplied the CDs would not accept orders which had been amended, so if staff made an error they would start a new form. The pharmacist said they would ensure partially completed orders were voided in future to prevent misuse.
- The pharmacy team provided a clinical service to ensure that people were safe from harm from medicines. The pharmacists were involved in ward handover meetings and provided advice to the ward staff. A consultant told us he found their input helpful.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them while in hospital.
- Pharmacy staff had made comprehensive records on the prescription charts to guide staff in the safe prescribing and administration of medicines, for example making sure that physical as well as health monitoring was carried out, noting when blood tests were due and advising nursing staff to make sure patients avoided foods which interacted with their medicines.
- Some patients were prescribed clozapine which requires regular monitoring to make sure the correct dose is prescribed. We saw that the trust had a process in place to make sure the blood tests were carried out as needed. We saw that the trust had a High Dose Antipsychotic Therapy monitoring form to check that prescribing was safe and in line with guidance from the Royal College of Psychiatrists.
- We looked at the prescription and medicine administration records for 10 patients. Staff had recorded patients' allergies and administered medicines as prescribed.

Track record on safety

- There had been five serious incidents in the 12 months prior to the inspection. Of the serious incidents three were unexpected deaths, one was a suicide and one was an attempted suicide. Both incidents had involved the use of ligatures. The trust had undertaken root cause analysis reports of each serious incident.

Inadequate

Are services safe?

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

- The trust demonstrated learning from incidents. One patient had used a plastic bag to commit suicide. The trust had implemented a ban on plastic bags on the wards, although we found that on some wards plastic bags were still in use.

Reporting incidents and learning from when things go wrong

- Staff we spoke to were knowledgeable about the incidents that should be reported. Staff were also aware of how to report them on the electronic record system, DATIX. Only permanent members of staff can access the DATIX system and bank and agency staff were required to record incidents in word documents. A permanent member of staff would then uploaded these into the system.
- Staff told us following incidents there was a de-brief for the staff and patients. Incidents were discussed in 'lessons learned' meetings and in team meetings. We reviewed minutes of meetings from all six wards and confirmed incidents were discussed and reflected on. Learning from incidents was also emailed to staff to ensure information was disseminated.
- Staff had made some changes as a result of feedback. However, there were some gaps in its implementation. For example, there had been an incident on Hepworth ward where a patient had committed suicide using a plastic sack. Plastic bags were made a prohibited item on the unit. There were notices of this rule on entry to the ward. However, during our inspection visit we saw several plastic bags being used on the ward.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- Patients admitted to the wards were assessed by a junior doctor at the time of admission and by a consultant psychiatrist within 24 hours of admission. When a patient was admitted on a weekend they would be assessed by a consultant psychiatrist the following Monday.
- Physical health was monitored weekly or as necessary. This was dependent on patient need. We saw evidence of the modified early warning score being completed on the wards at least weekly in patient records. Access to physical healthcare was through the ward doctors and if required patients would be escorted to the local hospital.
- Care plans that we reviewed during our inspection of the wards were generally recovery orientated and in most cases, reflected the patient's individual preferences, goals and views. However, three of the four care plans on Hepworth ward appeared to be copy and pasted from the ward round template, especially in relation to capacity and consent. Three care plans on Kahlo ward only partially considered the strengths and goals of patients. Patients on Turner ward told us they had a copy of their care plan but did not feel it represented their views. We also found care plans had not been formulated in relation to patients who had suicidal ideation. We also found a patient with pressure sores who had no information in their care plan about the management and delivery of safe care and treatment for a pressure sore.
- Staff stored care plans on an electronic system, RIO. Daily progress notes were completed within the RIO system. Only regular staff members had access to the RIO system. This placed additional pressure on regular qualified staff to make entries in the care notes. Staff told us that agency staff would write their notes in word documents and a regular staff member would then copy and paste the information into the relevant care records. Some information, such as Mental Health Act information, was also stored in a system called WinDip. At the time of our inspection WinDip was down and caused problems accessing information.

Best practice in treatment and care

- For people detained under the Mental Health Act (1983) the required documentation for treatment for mental disorder was in place.
- Staff on all wards followed NICE guidance when prescribing medication. The trust had an administration of rapid tranquilisation policy that was followed.
- Each of the wards had input from psychologist and offered a range of therapies recommended by NICE, for example behavioural therapy and mindfulness.
- Each of the wards had good access to physical healthcare. Doctors on the wards provided assistance with physical healthcare and if necessary patients were taken to the local hospital.
- Staff used recognised rating scales such as the health of the nation outcome scale. Psychology staff also used outcome measures to assess progress in therapies.
- Clinical staff participated in a range of clinical audits on all wards visited. For example there had been audits on the physical health monitoring of patients on lithium, a trust wide audit of therapeutic kitchens, missed dose of medication audit,pharmacy interventions audit and an audit on high dose antipsychotic prescribing.

Skilled staff to deliver care

- The multi-disciplinary teams on all six wards had a range of mental health professionals including nurses, psychologists, consultant psychiatrists and occupational therapists.
- Staff we spoke with said they were scheduled to receive supervision approximately every four weeks. However, some staff we spoke with had not received supervision that regularly. The supervision figures for the six wards showed 64% of staff across the six wards had received supervision. Compliance rates for Titian and Hepworth ward were high (100% and 93% respectively), however, Kahlo ward (65%), Monet ward (45%), Ogura ward (20% and Turner ward (60%) were below the trust target of 85% compliance.
- Information provided before the inspection showed that only 67% of staff across the six wards had received an appraisal.
- There were regular team meetings on all of the wards visited. Staff we spoke with felt supported by the local management structure and their colleagues. Staff spoke

Are services effective?

Requires improvement

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

highly of the ward managers and said they were visible and available on the wards. Staff told us morale was good generally. However, at times the pressures of the wards meant some staff felt stressed at times.

- Staff received a corporate induction from the trust. Staff were then inducted to the wards following the corporate trust induction.
- Staff performance issues were monitored and addressed using the trust policy. There were no staff performance issues reported during the inspection.

Multi-disciplinary and inter-agency team work

- The multidisciplinary teams on each ward met several times a week and on some wards on a daily basis. We observed a number of multidisciplinary team meetings on the wards visited. They were well attended by staff. We observed detailed and holistic discussions taking place. There was a patient centred and respectful approach to the meetings. Risks and safeguarding concerns were also discussed. All team members present were given the opportunity to contribute their views to the meetings and were listened to by all in attendance.
- There were shift to shift handovers on all of the wards we visited. Handovers contained a summary of patients presentation and risks. We observed a number of handovers during our visit to the wards and found them to be detailed.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- 87% of staff across the wards had received training in the Mental Health Act.
- Staff we spoke with had a good knowledge and understanding of the Mental Health Act, its accompanying Code of Practice and the guiding principles.
- Consent to Treatment and capacity requirements were adhered to. There were copies of the relevant consent to treatment forms attached to medication charts.
- In the files scrutinised, there was evidence that patients were informed of their rights under section 132 on admission but some files had no further explanation recorded if patients had not understood at that time.
- The trust had central administrative and legal advice available to staff.
- In the files scrutinised, detention paperwork was available in the mental health administration office and included all information required.
- No documents relating to detention were available on the wards. We were told that records were uploaded to 'Windip', but staff could not access this during our visit. We were concerned that it would not be possible to transfer a patient to another hospital outside working hours without copies of the detention documentation being available.
- Patients rooms had a poster informing them of their status of detention, who their responsible clinical and primary nurse were.
- Voiceability Advocacy Service and PoHwer provided the independent mental health advocates to the wards. Details of the service were available on the ward on posters and information leaflets were given to patients at the time of admission.

Good practice in applying the Mental Capacity Act

- 93% of staff across the six wards had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Staff demonstrated a good understanding of the Mental Capacity Act and its guiding principles.
- The trust had a policy on the Mental Capacity Act and Deprivation of Liberty Safeguards which staff we spoke with were aware of.
- We saw that capacity assessments were variable across the wards.
- The trust had central support available to staff about the Mental Capacity Act.

Requires improvement

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed a range of interactions between staff and patients on all six wards. Staff interacted with patients in a caring and compassionate way. Staff responded appropriately to patients in a calm, polite and respectful manner. Staff were interested in the well-being of patients on the wards.
- Patients we spoke with gave mixed views on staff across each of the wards. Most patients told us staff were kind and treated them with respect. However, patients on Monet ward and Ogura ward told us staff entered their bedrooms without knocking. Patients on Hepworth ward told us staff observed them hourly during night and would turn the main lights on in their bedrooms to undertake observations. Patients said this disrupted their sleep which they found distressing. Patients also told us at times staff on Monet and Ogura ward were not always responsive to their needs.
- Staff we spoke with on all wards were knowledgeable about each individual patient. They were aware of their needs and risks.
- Patients on some wards told us activities and leave could be cancelled due to staffing issues or incidents on the ward.
- On Titian ward we saw that one person preferred to be given their medicines by a particular nurse. Other staff moved away while the person took their medicines to facilitate their request.
- Patients were unable to personalise their bedrooms. Patients were unable to put anything on the walls in their rooms.There were no names on bedrooms doors. Staff were unable to identify the patient who resided in each room.

The involvement of people in the care they receive

- The admission process to the wards orientated patients to the ward and provided information about the services offered. Some patients visited the wards prior to admission to familiarise themselves to the wards, the ward routines, meal times and visiting. Patients were given a welcome pack on arrival to the ward which contained information about treatments, advocacy services and how to complain.
- Patients told us they had some involvement and participation in care planning. Patients could attend CPA meetings. Patients on Titian ward told us they had developed their care plans in collaboration with their named nurse. However, there were mixed views across the wards. Patients on Hepworth ward told us they did not have copies of their care plans despite asking for them. Patients on Turner ward told us they did have copies of their care plans, however, they did not feel involved in there development or that they represented their views.
- Patients on all wards we visited had access to advocacy services. There was information available on the wards about how to access advocacy. Patients also received information about advocacy services in their welcome packs.
- Most families and carers we spoke to felt involved in the care their relatives received. However, some families told us they had not been involved in care planning or given the opportunity to do so.
- The wards held community meetings where patients were able to input and help make decisions about the wards. Patients were also able to give staff feedback on the wards.
- Patients were able to give staff feedback in discharge surveys.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- The average bed occupancy levels across the acute service was 91% in the six months prior to the inspection. Bed occupancy levels are the rate of available bed capacity. It indicates the percentage of beds occupied by patients. The bed occupancy levels for the wards were as follows

  Hepworth ward - 95%

  Kahlo ward – 87%

  Monet ward – 97%

  Ogura ward – 92%

  Titian ward – 79%

  Turner ward – 94%

- There had been 16 delayed discharges in the six months prior to our inspection. Turner ward had had four (three due to public funding and one due to finding a care home placement), Hepworth ward had had three (two due to public funding and one due to further non-acute NHS care being sought), Ogura had had two (one due to public funding and one due to further non-acute NHS care being sought), Kahlo had had two (one due to public funding and one due to finding a care home placement) and Monet had had five (two due to public funding and three due to finding a care home placement).
- There had been no out of area placements in the acute service in the six months prior to the inspection.
- Staff told us that patients were able to return to the their bedrooms after returning from leave. The wards did not admit new patients to beds that were occupied by patients out on leave.
- Patients on all six wards were not moved between bedrooms unless there was a clinical needs or justified reason.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had access to a number of treatment and activity rooms including art rooms, therapy rooms and a gym. However, staff and patients on Kahlo ward told us there were not enough rooms available for groups and activities and interview rooms.
- The trust were not responsive to the wards requests for maintenance work. We saw on Ogura ward there were 40 items that had been submitted to the estates department that were still unfulfilled. The clinic room on Kahlo ward had been identified as being too hot and it had been reported to the estates department twice and was escalated again on the day of our inspection.
- Patients were able to make phone calls on the wards.However, arrangements for each varied. Patients on Hepworth ward were able to use their own sim cards in a ward mobile phone, without a camera or internet, to make phone calls. A phone for patients to make calls were available on other wards. Some patients told us they did not feel they were able to make private phone calls at all times.
- Patients on all of the wards had access to outside spaces.
- Patients were required to ask staff for hot drinks and snacks. On several wards hot drinks could not be accessed after 9:30pm at night. Patients complained about this restriction.
- Choices of meals were available to patients on all wards. Feedback from patients about food was generally positive, however some patients commented that portion sizes were not adequate. Cultural and religious foods, including halal, were available to patients on all wards.
- Patients we spoke to on some of the wards reported that their personal possessions had gone missing from their bedrooms. Staff had been responsive to investigate the missing items.
- There was access to activates for patients on all wards. However, some patients told us they felt bored and didn't have enough to do.
- Patient bedrooms were not personalised. There were no names on bedrooms doors. Staff were unable to identify the patient who resided in each room.Each bedroom had hospital grade bedding . Patients were unable to put anything on the walls in their rooms.

Are services responsive to people's needs?

Requires improvement

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

Meeting the needs of all people who use the service

- Staff on all six wards received training in equality and diversity as part of their mandatory training. Training records for the six wards showed that 94% of staff had completed the training within the last year.
- Staff told us that information leaflets were available in different languages on request. Staff told us interpreters were also available on request if required. However, patients on Ogura ward and Monet ward told us about difficulties assessing an interpreter.
- There was a range of information available to patients on each of the six wards including information on treatment and medications, their rights, local advocacy and how to complain.
- The ward pharmacists would talk to patients before they started a new medicine to help them understand what to expect, and provided information sheets on medicines.On Turner ward the pharmacist had started to offer drop in sessions to answer questions about medicines.
- We were told about a patient who preferred a particular staff member administered their medication on Titian ward. Staff facilitated this request.
- A patient with arthritis on Kahlo ward told us they had had difficulty showering so the ward had provided them with a shower chair to make it easier.
- There was a choice of meals available in each of the six wards. Patients we spoke to were generally happy with the food and told us vegetarian options were available and options applicable to religious and ethnic groups' dietary requirements, such as Halal.
- Patients we spoke to said they had access to appropriate spiritual support. A patient on Turner ward told us how they had been facilitated to access communion by the ward.

Listening to and learning from concerns and complaints

- Between 1 September 2015 and 29 February 2016 there had been 11 complaints across the six wards. Three complaints had been made on Monet ward, two of these were not upheld and one was still open. There had been three complaints made on Turner ward, one was not upheld and two were still open. There had been three complaints made on Kahlo ward, all of which were still open. There had been two complaints made on Hepworth ward, one was not upheld and one was still open.
- There had been no complaints had been referred to the Ombudsman in the last 12 months.
- Information about how patients could complain were clearly displayed in each of the six wards we visit. Patients were also given information about how to complain in there welcome packs when first admitted to the ward. Patients we spoke with felt able to raise a complaint. Staff we spoke with were aware of the complaints management process and assisted patients to raise complaints. In the first instance staff told us they would try to raise complaints locally but if this was not possible it would be escalated.
- Staff we spoke to received feedback on complaints through the 'lessons learned' group. Complaints and learning were discussed in these sessions and also disseminated to staff via email.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- Staff we spoke with were aware of and agreed with the trust's visions and values. There were posters throughout the unit about the Trust's values.
- Staff told us they were aware of who the senior managers in the trust were. Staff told us senior managers had attended barbeques in the garden area on Titian ward.

Good governance

- Staff were not all up to date with their mandatory training. However, there was an overall compliance rate of 87% across the six wards.
- Staff were not receiving regular supervision or appraisals.
- Shifts were generally covered with a sufficient number of staff with the relevant experience.
- Clinical staff participated in a range of clinical audits on all wards visited including. For example missed dose of medication audit,pharmacy interventions audit andan audit on high dose antipsychotic prescribing.
- Staff knew what incidents should be reported and did so on an electronic recording system. However, bank and agency staff members did not have access to this system and relied on permanent staff members inputting information on their behalf.
- Learning from incidents was shared among staff in team meetings, lessons learned meetings and by email.
- The trust were not always responsive to requests for maintenance to be completed on the wards. We saw several examples on the wards where issues had been raised but not yet rectified.
- Safeguarding processes were followed by staff. Staff were also aware of the Mental health Act and the Mental Capacity Act and the procedures that were required to be followed.

Leadership, morale and staff engagement

- Staff we spoke with across all six units had good morale and enjoyed working on the wards. They demonstrated they were motivated and dedicated to the patient group. Some staff reported at time pressure and stress could build but they were happy working for the trust overall.
- Staff on all wards told us there was good team working between all staff members and there was good mutual support available.
- At the time of our inspection we were not made aware of any ongoing grievance procedures, allegations of bullying or harassment on any of the wards we visited.
- Staff were familiar with the whistle blowing process and how to use it if required.
- Staff told us they were confident and able to raise any concerns they had about the wards without fear of victimisation.
- Staff told us there were opportunities available within the trust for leadership development.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment On Kahlo ward we found some out of date medications were being used. Medical equipment on some wards was not routinely calibrated or within review dates. This is a breach of Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found a number of maintenance issues across the wards that had not been rectified. For example there were 40 outstanding issues on one ward. This is a breach of Regulation 15 (1) (e)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Person Centred Care Care plans were not recovery orientated and in most cases did not reflect the patient's personal preferences, goals or views. Care plans we reviewed contained brief statements that were not holistic or recovery focused. We reviewed 12 care records. This is a breach of Regulation 9(1)(a)(c), 9(3)(a)(b)(d)(f).

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.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care • The quality of risk assessments varied across the wards. There was evidence that risk planning was not always being carried out. For example there was a patient with a high risk of suicide by hanging and drug overdose. There was only a risk assessment in place for a drug other dose. • We raised similar concerns in relation to a lack of risk planning during an inspection in 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The environmental risk assessments, ligature assessments and action plans were variable. It was unclear as to the concerns identified and staff were unable to identify risks from the assessments. There was limited information provided about the action to be taken to mitigate risks. We raised similar concerns in relation to ligature risks and assessments during an inspection in 2014. This is a breach of Regulation 12 (1) (2) (b)