

Southern Health NHS Foundation Trust

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

## Quality Report

Headquarters  
Tatchbury Mount  
Calmore  
Southampton  
Hampshire  
SO40 2RZ  
Tel:023 8087 4036

Website:  
<http://www.southernhealth.nhs.uk>

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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)
RW1GE	Antelope House	Saxon Ward Trinity Ward Hamtnun Psychiatric intensive care unit	SO14 0YG
RW1AM	Elmleigh	Blue bay Green Bay Red Bay Yellow Bay	PO9 2JJ
RW119	Melbury Lodge	Kingsley ward	SO22 5DG

# Summary of findings

RW1AC

Parklands Hospital

Hawthorn1  
Hawthorn 2

RG24 9RH

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

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

#### **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 previously conducted a comprehensive inspection of acute wards for adults of working age inpatient and psychiatric intensive care (PICU) wards in October 2014; we published the report in February 2015. We found that the trust needed to make improvements. We carried out this inspection to check if it had made these. We found that the trust had made a number of the required improvements, which we have described in the report.

However, it had failed to make sufficient changes to environmental concerns, particularly in identifying and prioritising fixed ligature points (a point that a person could attach a cord, rope or other material for the purpose of hanging or strangulation). Governance arrangements did not facilitate effective assessment, recording or monitoring of actions taken or actions outstanding to mitigate risks. We have taken separate enforcement action against the trust in relation to this.

We had serious concerns about the security and safety of the garden used by patients on Kingsley ward, at Melbury Lodge. A low roof was easily accessible by patients, they could then leave the site or there was a danger that they could access the second storey part of the roof. A patient had sustained serious injury falling from the roof; the trust had taken very little action to effectively address this risk. We requested that the trust took urgent action to maintain patient safety while its estates department undertook an assessment of any required work to make the environment safe.

The trust had failed to make improvements in the following areas:

- while we found that there had been some work in relation to the management of ligature risks, we were concerned that the trust was unable to clearly identify what action it had taken and how it was prioritising additional anti-ligature works required. It had not addressed ligature risks and blind spots on Kingsley ward at Melbury Lodge
- no effective action had been taken to prevent patients climbing onto the roof of Kingsley ward even though there had been several incidents which could have resulted in potential harm and one incident when a patient fell, suffering serious harm

- it had not fitted blinds on bedroom doors on Kingsley ward at Melbury Lodge to protect patient privacy and dignity
- the sluice from the male laundry room on Kingsley ward at Melbury Lodge had not been removed
- The trust had not made sufficient changes to the seclusion room on Hamtun psychiatric intensive care unit at Antelope House, so it still did not comply with the Mental Health Act 1983: Code of Practice. The trust advised that work was due to commence March 2016. However, the trust had not put in place interim measures to mitigate the impact on privacy, dignity and confidentiality.
- while staff told us blanket restrictions on Hamtun ward at Antelope House had been removed, patients said they were still not allowed to have a bath after 9pm
- staff did not always fully record decisions about patients' capacity
- patients were not always able to take leave due to staff shortages
- not all wards provided sufficient patient activities and opportunities for physical exercise
- staff did not always fully explain to patients their rights under the Mental Health Act
- staff did not always complete observation records in line with trust policy.

However, the trust had made the following improvements:

- begun adding extra bathrooms to comply with guidance on mixed sex accommodation on Hawthorn 2 at Parkland Hospital
- informed patients about any closed circuit television (CCTV) in communal areas on Hawthorn 2 at Parkland Hospital, and on Kingsley ward at Melbury Lodge when it was highlighted to them on inspection
- removed the sluice sink and macerator from the patient laundry on Hawthorn 2 at Parklands Hospital

# Summary of findings

- ensured staff completed or booked a place on mandatory training and received regular supervision
- displayed smoking cessation information on all wards and prescribed smoking cessation aids such as nicotine replacement patches for patients
- improved staffing levels across all wards
- ensured staff mostly completed risk assessments before patients took section 17 leave

# Summary of findings

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

### Are services safe?

We found the following issues that need to improve:

- While the trust had undertaken some anti-ligature work, it had not linked the estates ligature works tracker to the service risk assessments. The trust was not able to provide detailed information that clearly identified what actions it had taken to reduce or remove ligature risks on the wards, or which were priorities for action. The estates services was undertaking a review of all of the trust`s ligature assessments to identify what work was required at the time of inspection.
- The trust had not taken steps on Kingsley ward at Melbury Lodge to ensure it protected the privacy and dignity of patients.
- Staff did not always check and record fridge temperatures that stored patients` medication at Elmleigh and on Kingsley ward at Melbury Lodge to ensure medicines were stored at the correct temperature.
- Staff did not always fully document physical health checks on patients who had received rapid tranquilisation (where staff gave medication to a person who was very agitated to help quickly calm them), or who were in seclusion (where staff had supervised a patient confined in a specific area away from other patients) at Elmleigh or Hamtun psychiatric intensive care unit at Antelope house.
- The trust had not made sufficient changes to the seclusion room on Hamtun psychiatric intensive care unit at Antelope House, so it still did not comply with the Mental Health Act 1983: Code of Practice. The trust advised that work was due to commence March 2016 but there were no interim measures in place to mitigate the privacy, dignity and confidentiality issues.
- However, we also found the following areas of good practice:
  - Building work had begun to address breaches in mixed sex accommodation on Hawthorn 2 at Parklands Hospital.
  - While there were still problems ensuring that wards had enough staff, the trust was actively trying to recruit more staff and re-establishing staffing levels.
  - Trinity and Saxon wards at Antelope House were anti-ligature environments. However, when staff identified potential ligature risks they took action to manage these.
  - We found good practice in incident reporting on Saxon ward at Antelope House. For example, when patients had taken legal highs.

# Summary of findings

## Are services effective?

We found the following areas of good practice:

- Staff at Elmleigh and Trinity ward at Antelope House reported they had access to regular supervision. The area manager had also introduced reflective practice sessions facilitated by the psychologist.
- The trust had combined the acute mental health team (which provided intense support for people experiencing acute mental in a crisis) with their acute inpatient wards in a single care pathway. Staff at Elmleigh told us that having the acute mental health team on the same site helped them to easily communicate and help the transfer of patients between the teams by attending multi-disciplinary team meetings. Staff at Hawthorn 2 at Parklands hospital also said that community psychiatric nurses attended their multidisciplinary team meetings.
- We reviewed the records of three patients who had epilepsy and their health needs were in their care plan. Staff were aware of the trust's epilepsy toolkit.

However, we also found areas that the trust needed to improve:

- Patients' access to leave was not always guaranteed due to low staffing levels.
- Staff across wards, with the exception of Trinity and Saxon wards (at Antelope House), did not consistently document the decision-making process used to determine if a patient had capacity to make a decision.

## Are services caring?

We found the following areas of good practice

- We spoke with 25 patients and carers across all the hospitals, 21 of them said staff treated patients well. Of the remaining four, a patient and a carer felt that staff were not available for patients, and two felt that some staff care but that there were other issues with the way that they were treated.
- Patients were involved in designing the care pathway at Elmleigh.
- Patients had access to spiritual support.

However, we also found the following issues that need to improve:

- Staff did not always document how or whether patients had been involved in developing their care plans.

## Are services responsive to people's needs?

We found the following issues that need to improve:

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- Activities across the wards were variable, with some patients having good access to a variety of activities, and others not.
- Patients on Hamtun psychiatric intensive care (at Antelope House) unit told us that there were still some blanket restrictions on them bathing after 9pm.

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

- The acute mental health teams performed the bed gatekeeping role and managed most admissions and discharges from the local in-patient units, supported by the locality acute care transfer co-ordinator. Information provided by the trust showed that patients were rarely admitted to a bed outside of the area because trust beds were full.
- Staff on all wards were clear that if a patient wanted to make a complaint, they would help and direct them to the patient advice and liaison service

## **Are services well-led?**

We found the following issues that need to improve:

- Staff on the wards did not always have an effective system in place to ensure that environmental risk was effectively managed or action taken to assess and manage the risks. This was demonstrated by, for example, the ligature risks that remained across the sites and the access to the roof and low fence in the garden, on Kingsley ward at Melbury Lodge.
- Effective systems were not always in place to ensure medicines were stored safely at Elmleigh and Kingsley ward at Melbury Lodge.
- Some staff on two acute mental health wards expressed concerns during and after the January 2016 inspection, that they receive inadequate support from the senior management team, although local management was supportive. They reported they did not always feel listened to when they raised concerns with senior managers about the safety of services, including known environmental risks and admitting patients when there were concerns the staff or ward could meet their needs safely.
  - Insufficient action had been taken to manage the safety of patients at Kingsley ward, Melbury Lodge. Staff could not clearly observe patients to mitigate environmental risks. Patients could access the roof and climb out of the wards garden. There had been a number of incidents of patients absconding (including those detained under the Mental Health Act). There had been

# Summary of findings

two serious injuries to patients caused by falling from the roof and/or attempting to access the roof. We asked the trust to take urgent interim action while estate work is assessed and undertaken.

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

- All of the staff we spoke with felt supported by their immediate colleagues and local management team.
- We saw evidence of clinical audits being undertaken leading to learning at Elmleigh. We had told them they must do this at the last inspection. Staff at Hawthorn 1 and 2 at Parklands Hospital and Kingsley ward at Melbury Lodge also told us that they were involved in clinical audits.

# Summary of findings

## Information about the service

The trust provides acute mental health care inpatient units for adults of working age from four sites, Antelope House (in Southampton), Elmleigh (in Havant), Melbury Lodge (in Winchester), and Parklands Hospital (in Basingstoke). It also provides psychiatric intensive care (PICU) from Antelope House and Parklands Hospital.

Antelope House has two acute mental health inpatient wards. These are Trinity, a 21-bed female ward, and Saxon, a 21-bed male ward. It also has a 10-bedded mixed sex psychiatric intensive care unit (PICU) (Hamton). Hamton Ward has three beds for female patients, and seven beds for male patients.

Elmleigh has four wards. These include Red bay (11 bedded female ward), Blue bay (11 bedded male ward), Yellow bay (six bedded ward is located between Red and Blue bay to allow either male or female patients to occupy those beds) and Green bay (a six bedded, mixed sex, high dependency unit). Staff move patients between green bay and the rest of the bays dependent on their needs.

Kingsley ward at Melbury Lodge is a mixed sex acute admission ward with 13 beds on the male corridor and 12 on the female.

At Parkland Hospital, Hawthorn 1 is a PICU with 10 beds and Hawthorn 2 is a mixed sex acute ward with 24 beds for males and females. Two female beds on Hawthorn 2 were closed at the time of inspection due to construction work.

All the locations have been inspected previously, although there had been changes to the wards at Elmleigh. This included the closure of the PICU and replacement with a high dependency unit (Green bay).

The last inspection of acute wards for adults of working age and psychiatric intensive care units took place between the 7 and 10 of October 2014. At this inspection, the trust received six compliance actions (now requirement notices) as inspectors found a number of breaches of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2010 as detailed below:

- Regulation 22 Staffing
- Regulation 23 Supporting staff
- Regulation 9 Care and Welfare of people who use services (two breaches)
- Regulation 10 Assessing and monitoring the quality of service
- Regulation 15 Safety and suitability of premises.

We told the trust that it must take action to address the problems that we had identified.

## Our inspection team

The inspection team was led by:

Team Leader: Karen Bennett-Wilson, head of inspection for mental health, learning disabilities and substance misuse, Care Quality Commission

The team that inspected this core service comprised six Care Quality Commission (CQC) inspectors, a specialist advisor who was a mental health nurse, an assistant inspector and two Mental Health Act reviewers.

## Why we carried out this inspection

In January 2016, the Care Quality Commission carried out a short notice, focussed inspection of Southern health NHS Foundation Trust.

# Summary of findings

Following the publication of the Mazars report in December 2015 CQC announced that it would undertake an inspection of the Southern Health NHS Foundation Trust early in 2016.

The Mazars report, commissioned by NHS England, details the findings of an independent review of the deaths of people in contact with the trust between April 2011 and March 2015. The report described a number of serious concerns about the way the trust reported and investigated deaths, particularly of patients in older person's mental health and learning disabilities services. It also identified that the trust had failed consistently and properly to engage families in investigations into death of their loved ones.

In response to the publication of the Mazars report the Secretary of State requested that we:

- review the trust's governance arrangements and approach to identifying, reporting, monitoring, investigating and learning from incidents; with a particular focus on deaths, including ward to board assurance and
- review how the trust was implementing the action plan required by Monitor.

In addition, we wanted to check whether the trust had made the improvements that we had told it to make following the comprehensive inspection in October 2014 and the focussed inspection of the learning disability services at the Ridgeway Centre, High Wycombe and the forensic services, which we had carried out in August 2015. We had also received a number of complaints about some of the trust services, had contact from a number of whistle-blowers (people who expose activity or information of alleged wrong doing in a private or public organisation) and had identified a high suicide rate in the Southampton area.

As such, this inspection focussed on mental health and learning disability services delivered by the trust, in particular:

- mental health acute inpatient wards (all four units)
- learning disability services in Oxfordshire and Buckinghamshire
- crisis/community mental health teams in Southampton
- child and adolescent mental health in-patient and forensic services

We also reviewed how the trust managed and responded to complaints and how the trust complied with the Duty of Candour regulation. The Duty of Candour regulation requires organisations registered with CQC to be open and transparent and apologise when things go wrong.

We gave the trust several days notice of the date of the inspection as we could not conduct a meaningful inspection of the issues that were the focus of this inspection without gathering information from the trust in advance of the site visit and we needed to ensure that members of the senior team were available to meet with us.

We did not provide a rating for any of the core services we inspected or an overall rating for the trust.

## Acute mental health inpatient services

At the previous inspection in October 2014, we found six areas for improvement (breaches of regulations). We said that the trust must improve in three of the main hospital sites with acute inpatient wards for adults of working age (Parklands Hospital, Antelope House and Elmleigh). We also said that the trust should make improvement in 15 areas across all the four sites with acute inpatient wards for adults of a working age.

## 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 trust:

- Is it safe?
- Is it effective?

# Summary of findings

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

On this inspection, we mainly focused on actions we had required the trust make in our previous inspection report, and actions we had suggested they make. However, we have reported on issues that were outside of these areas when we saw them on this inspection. Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all 10 of the wards at the four hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with 21 patients and four carers of patients
- spoke with the managers or acting managers for each of the wards
- spoke with 68 other staff members; including doctors, occupational therapists, nurses and healthcare support workers
- looked at 34 treatment records of patients
- looked at 44 medication charts
- looked at four staff supervision records
- carried out a specific check of the medication management on four wards
- 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

Eighteen patients reported that staff treated them well, including that they were polite and treated them with respect. Three carers also said that staff treated the patients well. Two patients at Hawthorn 2 (at Parklands Hospital), one patient and a carer of a patient at Elmleigh said that there were not enough activities. One patient said there were not enough staff on Kingsley ward at Melbury Lodge and one said the same about staffing on Elmleigh. One patient at Elmleigh said that they did not

feel safe. Two patients and two carers said that staff at Elmleigh were too busy to talk with patients or not visible enough. One patient on Hawthorn 2 at Parklands Hospital said that the shower rooms were not cleaned and were slippery. Three carers said that they were unhappy about the discharge process at Elmleigh. They felt the person they cared for was discharged too quickly; one felt that they were not involved in the process.

## Good practice

## Areas for improvement

### Action the provider MUST take to improve

The trust must ensure the safety of their premises and the equipment within it. The trust must identify and prioritise action required to address environmental risks on the wards, such as management of ligature points.

- The trust must ensure that action is taken to reduce the environmental risks of patients absconding from Kingsley ward at Melbury Lodge via the roof and garden. We asked the trust to take urgent interim action while estate work is assessed and undertaken.

- The trust must ensure that patients' privacy and dignity is protected on Kingsley ward while allowing staff to maintain adequate visual observations.
- The trust must ensure that the works on the seclusion room on Hamtun psychiatric intensive care unit are completed so that the room is fit for purpose.
- The trust must ensure that staff check and record medicine fridge temperatures, at Elmleigh and on Kingsley ward at Melbury Lodge to ensure medicines are stored at the correct temperature.

# Summary of findings

## **Action the provider SHOULD take to improve**

The trust should ensure that the decision-making behind judgements of a patient's capacity to make a decision is clearly documented.

- The trust should ensure that staff document clearly that patients have been involved in developing their care plans.

Southern Health NHS Foundation Trust

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

## Detailed findings

### Locations inspected

**Name of service (e.g. ward/unit/team)**

**Name of CQC registered location**

### 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 Trust.

- Access to Section 17 leave across some of the wards was dependant on staffing levels, on Hawthorn 2 at Parklands Hospital.

- Staff did not always document their decision-making relating to a patient's capacity to consent to treatment.

- Staff did not always inform patients who were detained under the Mental Health Act of their Section 132 rights.

- There were local Mental Health Act administration offices that staff could seek advice from on the Mental Health Act.

### Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always use the pro-forma in the electronic care records for assessing mental capacity. This could mean that information used in decisions about mental capacity may be overlooked.

- Staff did not always document the rationale for decisions made about whether a patient had the mental capacity to make a decision.

# 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

While there had been some improvements to the management of ligature risks, we were concerned that the trust was unable to clearly identify what action it had taken and how it was prioritising the required additional anti-ligature works.

- In the majority of the wards inspected, some changes to the environment had been made, or staff were trying to ensure they mitigated ligature risks in other ways. Across all units, staff individually assessed patients for risk, even if they were in an anti-ligature ward such as Trinity and Saxon at Antelope house. Staff managed these risks through observations and care plans. However, while we saw examples of comprehensive care plans, many of the care plans were generic and may not always set out how the risk of the environment influences the individual's risks. A recent investigation report into an incident on Kingsley ward at Melbury Lodge reflected that the use of generic care plans might have contributed to the lack of specific risks to the individual from the environment being identified. Delays in undertaking environmental work placed the responsibility for mitigating the risks on the ward staff, even where it was difficult for them to reduce risks. For example, areas that were difficult to observe, such as ligature points in the bathrooms and bedrooms, which were a particular risk as they were where people spent time alone.

- While some anti-ligature work had been undertaken, the trust had not linked the estates ligature works tracker with the service risk assessments. The trust identified some changes that they had made. However, it was not able to clearly identify what actions had been taken to reduce or remove ligature risks on the wards, or which were priorities for action. The estates services was undertaking a review of all of the trust's ligature assessments to identify what work was required at the time of inspection.

Antelope house

- Saxon and Trinity wards were anti-ligature environments. Staff had carried out a ligature assessment and put plans in place to manage any ligature risks they had identified. The

nurse carrying out observations on Trinity and Saxon had a set of ligature cutters attached to the clipboard holding the observation charts. This meant that staff had the equipment to hand when they were conducting scheduled checks of patients, as well as helping other staff to know where the equipment was.

- We informed the trust that the seclusion room on Hamtun was unfit for purpose at the time of the October 2014 inspection. This was because there was a blind spot that meant staff could not clearly observe patients in seclusion. The room also did not offer privacy to the patient in seclusion as they were visible from the ward and the observing nurse was unable to provide continuous observation of the patient and reassurance and de-escalation to the patient in seclusion. The trust had made some improvements, it had added mirrors for better observation of patients, and had improved the ventilation system. However, it remained unfit for purpose at the time of inspection. The area manager confirmed that a funding request and plan had been submitted in October 2015. The trust is working with a building contractor to agree the cost of the work and how long it will take.

- The observation panel for the seclusion room was a large window on the back wall of the nursing office. Measures were in place to keep the number of staff in the nursing office to a minimum to ensure the dignity of the person in seclusion. However, on the day of inspection there were several staff present in the office on many occasions. Staff kept the lights in the nursing office off to minimise the level of noise and activity. This meant that staff were working without adequate lighting. The patient who was in seclusion on the day of our visit was clearly visible to all other patients and visitors on the ward. The layout of the room made it possible for patients in seclusion to observe computers in the staff office. This affected the confidentiality of patients, as patients in seclusion may have been able to observe information about another patient. We observed this happen during the inspection. A member of staff left a computer displaying patient care records unattended and in full view of a patient inside the seclusion room. Staff turned the screen off when they realised they had left it displaying records. The trust had planned to keep the observation window in the new design for the room. We raised our concerns with the ward

# Are services safe?

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manager, the area manager and the chief executive officer. After the inspection, we received confirmation that those plans were being reconsidered and temporary measures have been put in place to protect patients' dignity.

- Service managers told us that the trust was working with another trust in relation to 'no force first' initiatives to reduce the amount of seclusion used, and, if used, that the amount of time patients spend in seclusion was kept to a minimum.
- Flumazenil (an emergency medication to reverse the effects of lorazepam) was on the ward and we asked five qualified staff (including the ward manager) if they knew what Flumazenil was and where it was located. Two members of staff knew what this medication was, and one of these two knew where it was kept.
- Staff had audited the emergency response bag. Staff had documented that the nasopharyngeal airways were checked to ensure that the bag contained both size six and seven airways on the 17 January 2016 and marked these as present and correct and in date. However, when we checked the bag, all three airways were size six and all were out of date. We brought this to the attention of the staff on duty, who replaced the airways immediately.

## Elmleigh

- Staff reported that 18 of the 34 actions on their environmental ligature risk assessment form had been completed. This included actions to remove environmental risks; for example, removing the payphone from reception and removing a door stop. Staff had written that 14 items on the risk assessment were 'managed on an individual basis', three were 'in progress' and one was identified as already being an anti-ligature fitting. This meant that staff were required to manage most risks through individual risk assessments and ward observations. We reviewed eight initial management reviews of incidents at Elmleigh; two of them involved a patient harming themselves or tying a ligature. In one, we found that staff had not clearly documented their observations of the patient and in the other where a patient had tied a ligature, it was unclear whether staff had reported the incident appropriately. In addition we reviewed two incident reports where a patient had ligatured using their bedroom door handle and on the back of the bedroom door. Neither incident was recorded on the trust incident data system as an incident involving ligature points. One incident had not been documented in

the individual daily records, despite a record in the ward round two days later stating it was a serious incident that required staff intervention to get the patient down from the ligature.

- Staff had tested their response times to ensure that they could bring emergency response equipment to the room furthest from where it was kept within acceptable time limits. We reviewed a simulation report that showed staff could respond in a timely manner in the event of an emergency across all the wards at Elmleigh.

## Parklands hospital

- At the time of inspection, the trust told us they had acted on 10% of the items identified on the environmental risk register at Hawthorn 2. When we asked staff what the plan was to address the environmental risks, they said that they were due to discuss that later in the week of inspection. Staff showed us an email from a member of staff in the estates department that stated that staff were due to hold a meeting during the inspection week to discuss how the trust would address items on the environmental risk assessment at Hawthorn 2. However, this did not specify what they would address in the meeting or offer assurances that the trust would act on items raised in that meeting, only that a meeting would take place. The trust later provided us with a list of improvements that they would complete over a two-week period following inspection. The schedule for improvements they provided did not have dates for when each individual improvement would be completed.

- Two of the four patients we spoke with on Hawthorn 2 felt that there were safety issues with smoking. One said that there was an issue with people smoking in the toilets on the ward.
- At the previous inspection in October 2014, we found that female patients had to use bathroom facilities in a male corridor and that toilets had been marked as unisex. We told the trust that this must be rectified. Work had begun to address this on the 4 January 2016. Staff had left one of the bedrooms with an ensuite on the female corridor unoccupied so that the ensuite could function as a shower for female patients. Building work had commenced to convert a bedroom on the female corridor into a room with

# Are services safe?

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showers, toilets and a bath. The construction was due to be completed on 19 February 2016. Staff were escorting female patients to use the bath on the male corridor whilst this work was completed.

- A fire evacuation bag (containing procedures, clipboard with a register a pen and a fluorescent jacket) was present in the staff office at Hawthorn 2, as were ligature cutters. Staff told us that they had recently started checking that the ligature cutter kit had a cutter of each specific type, and that they did this daily. We reviewed the records of checks and found that this had been done on the majority of days (checks on one day had been missed).
- Staff kept a resuscitation and medical response bag in the clinic room. Staff told us that they checked it weekly. We referred to the records and found that they had mostly done this in the month prior to inspection. However, the records showed staff had only checked it twice in December 2015. Staff said they were aware of where emergency medication was stored, should it be needed in an emergency following rapid tranquilisation of a patient.
- Staff at Hawthorn 2 had access to personal alarms. These were not routinely tested. Managers said they encouraged staff to test the alarm they would be using before beginning their shift.
- In the previous inspection, we had told the trust to remove the macerator and sluice sink from the laundry room on Hawthorn 1 because of potential cross contamination. We found that this had been removed.

## Melbury Lodge

- The trust had not taken adequate action to reduce or remove ligature risks at Kingsley Kingsley ward. For example, using mirrors to manage blind spots or replacing fittings to ensure they did not pose a ligature risk. However, the trust had replaced the taps and showers in the communal bathrooms and had replaced the bedside cabinets and wardrobes in patients' rooms.
- We saw that a ligature assessment carried out in June 2015, and revised in August 2015 had 557 risk items on it. Of these items, at the time of the inspection we found that only one change had been made. The old nurse call alarms had been removed. This accounted for just less than 3% of the items on the list. The trust had not acted on some ligature risks that it had assessed as high risk such as a door closer mechanism in the male utility room. Staff told

us that they discussed risks in handovers between shifts and that they tried to bear this in mind when allocating rooms. However, staff told us that there was no formal checking or process for allocating rooms based on risk.

- The environment at Kingsley ward (both male and female corridors) contained blind spots that were not mitigated by the placement of mirrors or staff observations. Staff told us that there was no formalised policy of observing these areas, but patients who were deemed to be at risk were placed on observation individually. This meant that staff might not have noted incidents as quickly as they could have done due to them not having an easy line of sight on the ward. Staff told us that they had raised concerns with the senior management about managing the safety of patients who are acutely unwell with the risks of the environment. Staff were not aware what the estates plan was for the ward. We were informed by the trust there was an estates meeting to discuss how the trust would address items on the environmental risk assessment following the inspection. We checked the updated action plan from the trust with the staff when we returned in March 2016, and they had not seen the plan and were not clear what actions were prioritised.
- Only two out of 25 patients on Kingsley ward had blinds on their bedroom doors that allowed safe observation by staff and provided the patient with privacy and dignity. Staff had given the other patients blankets to drape over the top of their door to help protect their dignity. Depending on the placement of the blanket, it could prevent staff from monitoring patients without opening the door. We saw an email suggesting that the work to install more of the blinds would most likely start mid to late February 2016. On the day of inspection, staff could not provide us with a specific date that the trust would definitely install these. We reviewed meeting minutes from the estates work stream that showed that the original requests for the blinds appeared to have been deferred on the estates work list in November 2014 even though we had raised it as an issue in our inspection in October 2014. In the emails we saw, we found no clear reasoning behind why the work had been delayed, and why staff requests for the work to be done had not been acted on.
- We had serious concerns about the security and safety of the garden used by patients on Kingsley ward. Patients could access a low roof easily. From that roof, they could then leave the site or access the second storey part of the

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roof. Patients had accessed, or attempted to access, the low roof of the building eight times since 2010. From the incident data provided, this included people detained under the Mental Health Act who had absconded from the premises via this route. People are detained under the Mental Health Act (MHA) when it is deemed that they may present a potential danger to themselves and others. Trusts have a legal responsibility to ensure security arrangements are in place to ensure that people are safe whilst receiving care, including, restrictive protection required in relation to the Mental Health Act 1983. In an incident in December 2015 a patient, detained under the MHA had sustained a serious injury following a fall from the roof.

- The trust had failed to learn from previous incidents and concerns identified in relation to inadequate security provision. We reviewed a security report produced on 19 August 2014 (by the local security management specialist employed by the trust) that highlighted security risks and recommended environmental alterations to reduce the chance of patients climbing onto the roof. The action plan with these recommendations stated the 'work should be completed on 30 September 2014'. The trust had not taken any action by the time of our inspection, or following the most recent incident in December 2015. The trust confirmed that the height of the roof in the patients' courtyard had been identified as a risk. At the time of inspection the trust told us that there were no current plans or specifications for the work to the roof. However, it stated that the estates department would be asked to submit plans to the board for consideration in next year's capital bids.

- Staff told us they had raised concerns about these and other environmental risks numerous times and did not feel listened to by the senior management. We raised our concern about these risks again when we met with the chief executive and the chief operating officer on 12 February 2016, and in an email sent by the head of hospital inspection on 18 February 2016. We subsequently returned to Kingsley ward on 8 March 2016 to check if any interim action had been taken, and confirm the specification of works to be undertaken had been submitted. We found that very little effective interim action had been taken and no confirmed plans submitted. Staff informed us that three more patients detained under the Mental Health Act had attempted to access and/or had accessed the roof in February 2016. As a result, one patient had absconded and

left the country and another had sustained an injury requiring hospital treatment. We requested that the trust take urgent action to maintain patient safety while estates undertook an assessment and any required work to make the environment safe.

- The low garden fence was also identified as a risk for patients who may want to abscond from the ward. Staff had also raised concern about the security of the keypad access doors. We reviewed the incident information provided by the trust. This showed 48 recorded incidents of actual or attempted absconion from the ward between January 2015 and December 2015. Most of these were listed as people who were detained under the Mental Health Act.

- The environment at Kingsley ward was mostly clean. However, we found that cleaning staff had not followed trust policy by not marking shower chairs as being clean. Cleaning staff had also not cleaned residue from underneath a hand care station outside the male corridor. One of the communal shower rooms on the female corridor had mould on the ceiling, indicating a lack of appropriate ventilation. Further, we found that there was a sluice sink in the male laundry room. This posed a risk of cross contamination and we had identified it as a concern on a different ward in the last inspection. Staff had put signage to warn patients not to place their clothing on the surfaces to reduce the risk of contamination.

- Closed circuit television monitoring was used in some communal areas such as the dining room and entrance hall. We found that there was no signage in the dining room. Staff corrected this at the time of inspection when we made them aware of it. The dining room, family room and resource room were all kept locked when not in use, due to identified ligature risks. These had been identified on the risk register since September 2014.

- One patient's room did not have a heater, and the patient told us that although it did not bother them, staff had commented that the room was cold. The dryer in the female laundry was not working and the patient was unable to dry clothes in their room. When we brought this to the attention of the trust, it replaced the clothes dryer in the female laundry and secured a portable heater for the patient.

# Are services safe?

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## Safe staffing

The trust provided us with figures for staffing levels for December 2015, these figures are listed below:

### Antelope House:-

- Registered nursing staff levels were 16.3 on Hamtun and Trinity wards and 17.3 on Saxon ward.
- All three wards had 17 nursing assistants
- Vacancy rates for qualified nurses were 4.2 on Hamtun, 2.4 on Trinity and none on Saxon.
- Vacancy rates for nursing assistants were 1.5 on Saxon, 1.8 on Hamtun and 1.7 on Trinity.
- Between September and December 2015, bank or agency staff covered 313 shifts on Hamtun, 334 shifts on Saxon and 218 shifts on Trinity.
- The number of shifts that could not be covered between these dates was 48 on Hamtun, 50 on Saxon and 36 on Trinity.
- Eleven staff had left Saxon and 4.6 staff on both Hamtun and Trinity.
- Sickness rates were 13% on Hamtun, 6% on Saxon and 4% on Trinity
- Recruitment and retention of staff was an issue on both Trinity and Saxon wards at Antelope House. The ward manager on Saxon told us that recently a number of registered nursing staff had left to work in the community whilst two health care assistants were being supported by the trust to undertake nurse training. Vacancies were covered by agency staff on contract, which ensured patients were cared for by staff they knew. One member of staff on Trinity told us that the agency staff were of good quality and felt like members of the team.

### Staffing rates at Elmleigh were set across all four of the bays:

- 30.1 registered nursing staff and 27.5 nursing assistants
- 9.1 WTE registered nursing vacancies and no vacancies for nursing assistants
- 392 shifts had been covered by bank and agency staff in between September and December 2015, of which bank staff covered 283.
- 65 shifts had not been filled with bank or agency staff

- 13.4 WTE staff had left in the previous 12 months
- The sickness rate was 7%.
- During the inspection, staff told us that recent recruitment had improved staffing levels. For example, at Elmleigh, staff told us that they had 0.2 WTE band 6 vacancies and 0.7 band 5 vacancies. Staff also told us they were now 1.2 WTE over staffed with band two staff. The set staffing levels per shift on Elmleigh was 10 members of staff, minimum three registered nurses (target was four) and the rest made up of healthcare support workers during the early and late shifts. In the evening shift, the total was eight staff with a minimum of three registered nurses and a target of four (with the other staff being healthcare support workers). Staff at Elmleigh said they felt safe coming to work and that they had never been in the position where they could not safely restrain a patient. However, three patients and two carers said that either there was not enough staff at Elmleigh, or staff were too busy to talk to them.

### Staffing rates at Kingsley ward at Melbury lodge were:-

- 20.5 registered nurses and 12.7 and 12.7 nursing assistants
- There were 2.3 vacancies for registered nurses and 1.1 vacancies for nursing assistants
- 130 shifts had been covered by bank or agency staff, with 117 of those being covered by bank staff
- 28 shifts had not been filled by bank or agency staff
- 7.2 staff had left in the past year
- the sickness rate was 4%
- Staff at Kingsley ward had requested to increase the staffing on shifts to six staff on the early and late shifts and five at night in order to safely manage patients. The trust had agreed this. Staff said that the mixture of registered nurses to healthcare assistants on each shift changed due to the availability of staff to fill the shift, but that they aimed to have at least two qualified nurses on each shift. Whilst this increase in staff helped in part to manage risk to patients, following the inspection, there had been three more incidents where patients had gained and/or attempted to gain access to the roof since our inspection.

### Parklands Hospital

- Established levels of nursing staff were 17.4 WTE (and 13 WTE nursing assistants) on Hawthorn 1

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- Established levels on Hawthorn 2 were 16 WTE (and 11 WTE nursing assistants)
- Hawthorn 2 had the higher vacancy rates with there being 7.4 WTE registered nurse vacancies and 0.4 WTE nursing assistant vacancies.
- Vacancy rates were lower on Hawthorn 1, with 3.2 WTE registered nurse vacancies and 1.2 WTE nursing assistant vacancies.
- The ward had filled 550 shifts with bank or agency staff on Hawthorn 1, and 207 shifts on Hawthorn 2. Bank staff filled the majority of these shifts.
- Both Hawthorn 1 and 2 had 23 shifts each that the ward had not managed to fill with bank or agency staff.
- Hawthorn 1 had 4.8 WTE staff leave (out of 21.2 WTE) and a sickness rate of 8%.
- Hawthorn 2 had six WTE staff leave (out of 29.25 WTE) and a sickness rate of 4 %.

## Across wards

- All wards told us that they used bank staff and agency staff that knew the ward and there were procedures in place to make these non-permanent staff aware of clinical risk issues.
- Some patients and staff felt that staffing levels were a problem in some wards. One patient said that there were not enough staff on each shift at Elmleigh. Another patient said that staff were too busy to talk to patients. One member of staff at Hawthorn 2 said that recent staffing issues had meant that it was difficult to update clinical records due to not having enough time to deliver care alongside updating records.
- We reviewed training records. Training rates for basic life support (BLS) and proactively reducing incidents for safer services (PRISS) were mixed. At Elmleigh, all relevant staff were either booked onto BLS and PRISS training or already up-to-date at the time of inspection. In the past inspection we had told the trust that it must improve these training rates at Elmleigh. On Kingsley ward, 66% of staff had up to date basic life support training, 69% had up to date intermediate life support training and 81% had been trained in PRISS. However, one member of staff was exempt from training in PRISS for health reasons and so only three

members of staff had not been trained in this. We were told that staff were booked onto training but this had not taken place at the time of inspection. This was a potential risk as all wards undertook rapid tranquilisation.

## Assessing and managing risk to patients and staff

Use of seclusion varied across the wards. There were 28 incidents of seclusion at Elmleigh between June and December 2015, 26 at Hamtun psychiatric intensive care unit (PICU), 12 at Hawthorn 1 PICU, two on Trinity and two on Saxon ward. The trust had no way, at the time of inspection, to differentiate between seclusion and long-term segregation on its incident reporting tool. The trust advised that it intends to look at modifying the reporting system in order to capture this information.

- Staff use of restraint varied across the wards. There were 64 incidents of restraint in the six months before inspection at Hamtun PICU, involving 20 different patients. Staff restrained patients in the prone position in 16 of these incidents, and in one of the prone restraints, rapid tranquilisation medication was administered.
- Staff recorded 35 incidents of restraint at Elmleigh on 28 patients. In eight of those incidents, staff held patients in a prone position and in one case; this led to the staff administering rapid tranquilisation medication.
- Staff had logged 29 incidents of restraint on Trinity ward, on 15 different patients. Of those restraints, there were four occasions where staff restrained the patient in a prone position and in all of those occasions, rapid tranquilisation medication was administered. There were eight incidents of restraint on Saxon ward involving five patients, two of those were in the prone position and one case resulted in the administration of rapid tranquilisation medication.
- Hawthorn 1 (PICU) had 24 incidents of restraint involving 13 different patients. Staff restrained the patient in the prone position in 16 of those restraints and staff administered rapid tranquilisation medication during eight of those prone restraints.
- Kingsley ward reported 20 restraints involving 14 patients, five of which were in the prone position and three resulted in rapid tranquilisation medication being administered.
- There were 18 incidents of restraint on Hawthorn 2 involving 15 patients, six of those were in the prone position and five resulted in rapid tranquilisation being administered.

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- In line with guidance from the National Institute of Health and Care Excellence (NICE), the trust was working with another mental health trust in order to reduce the number of incidents of restraint.
- There were inconsistencies where staff recorded patient information on the electronic care record system at Kingsley ward. We saw two discharge risk assessments recorded in the progress note section only, the risk assessment field on the system had not been used. Therefore, for a staff member to review and understand risk issues, they would need to search progress notes. This also meant that staff would not have access to a historical overview of risks or how they may impact on the person's current presentation.
- Staff in two of the wards that we inspected reported that when using the electronic risk assessment tool, there was a paragraph available to record information on risk for each category. However, if new information was added in this paragraph, older information was pushed out of the box. One member of staff on Hawthorns 2 explained in order to address this they would spend time editing the paragraph in order to keep key historical risk information available.
- On the PICU unit, Hawthorns 1, we looked at the records of a patient recalled under section 37/41 of the Mental Health Act. A section 37/41 is ordered by a Crown Court where people are detained in a hospital rather than a prison, due to their mental illness. This patient's most recent risk summary did not contain relevant information regarding their index offence in the risk summary; staff did not appear to be editing this box to keep relevant information in. The first reference to this index offence was found in a version from a couple of years earlier.
- Staff in the PICU explained that they did not use a violence risk assessment tool such as HCR20 for forensic patients. However, they said that they sought advice on a patient's management where indicated from a forensic psychiatrist. There was evidence in the patients' progress notes that historical risks were still being recorded in summary from the multi-disciplinary team review. This missing information could lead staff to overlook areas of a patient's risk.
- Risk assessments were in place and up to date for patients on Trinity ward. Staff had updated risk assessments and care plans following any incidents. Risk assessments on Saxon ward were not always comprehensive. For example, one patient with physical health needs did not have all the risks around their condition documented and care planned. However, staff we spoke with had good knowledge of individual patients' risks and how to manage these. The area manager told us about reflective practice undertaken by the team with the ward psychologist. Staff looked at risk as a whole for a patient and tried to concentrate on the individual rather than their behaviour. We were told that this helped the team understand patients' needs and to help the team take positive risks.
- Staff did not always store medicines in line with trust policy and national guidance. Staff had not always followed trust policy of labelling open bottles of medication with the opening date. We found this oversight at Elmleigh, and at Kingsley wards. Staff did not check medicines fridges at Elmleigh routinely.
- The medicines fridge at Kingsley ward had a recorded maximum temperature of 12 degrees since October 2015. The temperature should have been a maximum of eight degrees for medicines requiring refrigeration. We brought this to the attention of staff who immediately contacted the pharmacy department. The pharmacy advised on what medicines to destroy and re-order. Staff arranged to use a fridge from another ward at the Melbury Lodge site to store their medicines for patients on the Kingsley wards.
- Staff had mostly recorded fridge temperature checks on the medicines fridge on Hawthorn 2, and the temperatures were within recommended limits. On Saxon and Trinity wards, medicines were stored safely. Staff carried out fridge checks daily to ensure medicines were stored at the correct temperature. Staff checked all emergency medicines regularly and these were in date. Staff checked the resuscitation bag regularly and all equipment was in date.
- The wards had a clear procedure in place for the administration of rapid tranquilisation. Staff were able to describe this. Staff were able to tell us how they monitored patients after both oral and intramuscular rapid tranquilisation administration.
- Hamtun PICU did not record incidents of oral rapid tranquilisation. We saw that staff had given patients oral rapid tranquilisation medication. We reviewed the policy with the ward manager and agreed that it does describe how the use of oral medicines for the purpose of rapid tranquilisation was included and that staff should document this. Staff told us that the trust's rapid

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tranquillisation policy was currently under review. The policy that was currently in use had not been updated following the updated Mental Health Act 1983: Code of Practice that came into effect on 1 April 2015.

- We reviewed two episodes of rapid tranquillisation (RT) use at Hamtun PICU. Both were intramuscular injections on the same patient. In relation to the first incident, the monitoring sheet was missing and there was only one entry in the vital signs check stating the patient was asleep and breathing normally. On the second incident, the RT monitoring form could not be found on the day of inspection but was submitted afterwards. Records showed that staff had completed the physical health review at 5 hours and had not completed the post RT check. Due to this not being available at the time of inspection, the team could not find this in the patient's electronic care record.
- The trust had reviewed the observation policy in the summer of 2015. The new paperwork enabled staff to record contemporaneous notes at the point of observation (previously, regardless of whatever observations patients were on, the paperwork only allowed for an entry of observation every hour). We saw the new paperwork was correctly used at Hamtun. The trust had incorporated new observation training into the induction of new staff. All staff at Hamtun had to read the policy, signed to say they had and then completed a competency-based assessment on the policy and the practice of observations.
- All patients at Hamtun were on a minimum of 15 minutes observations and these were increased dependent on risk and need. We reviewed the live observation records and all were fully completed and up to date. However, on the day of inspection, there was one patient on one to one observations at Hamtun. A member of the inspection team observed the nurse who was in charge of observing a patient leaving the patient and moving out of sight of the patient. We brought this to the attention of the observing nurse and the ward manager.
- We reviewed records of seclusion at Hamtun psychiatric intensive care unit and found they were not always complete. Staff used a seclusion book to log details of a patient's time in seclusion and there was one occasion where staff had not put in the time that a patient's seclusion had ended. However, staff did complete entries on this person's care record that showed staff had observed them and patients had received medical checks

in line with the Mental Health Act 1983: Code of Practice. In another case, staff had not documented that they had advised the patient of their rights. This was contrary to the trust policy on seclusion.

- We accompanied staff undertaking observations on both Saxon and Trinity wards. We observed good practice. Staff were knowledgeable about individual patients and their risks. Staff engaged well with patients during observations and it was evident there were supportive relationships between the staff and patients.

## Track record on safety

There were eight serious incidents reported across the acute wards we inspected between January 2015 and the time of inspection. Staff reported two serious incidents at Hawthorn 2 in the year prior to inspection. One of these incidents involved a patient death from natural causes in August 2015, and the other involved a patient falling in November 2015.

- Staff had access to a critical incident stress management team who provided debrief sessions following a serious incident. Staff we spoke with said they felt supported after incidents.

## Reporting incidents and learning from when things go wrong

The trust distributed learning from incidents via a newsletter sent out monthly. The newsletters were sent to local managers, who then distributed the learning to their team. We saw some evidence of learning from incidents being discussed in team meetings across a number of different wards. On Saxon ward, we noted good practice in learning from incidents and the management of risk associated with patients taking 'legal highs'. Staff had worked as a team with the psychologist to develop a team approach to managing this risk. On Hawthorn 1 we saw examples of the staff bulletin that six lessons learned, including that staff should offer a joint handover between care co-ordinators where possible. However, we saw that despite multiple incidents occurring on Kingsley ward involving risks in the ward environment, the trust had not taken appropriate action on these.

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- We reviewed eight initial management reviews of incidents at Elmleigh. Staff had completed five of these appropriately. Two of these reports did not track any learning and its implementation. One initial management review was brief and had limited information in the review.
- Staff told us that any physical contact with a patient (for example, to restrain or hold them); this was reported as an incident. We concluded that staff on Saxon and Trinity wards reported incidents appropriately. Staff at Hawthorn 1 and 2 reported that incidents were reported to the nurse in charge, who then completed the incident form. They were able to describe appropriate incidents to report.
- The trust had identified that it monitored services against a number of key performance indicators of safety and quality. These were reviewed at divisional governance meetings. Mental health services for people in Southampton had a number of key performance indicators that reflected concerns with the quality and safety of services delivered, for example high numbers of complaints and serious incidents. To address this, an improvement plan started in October 2015, working with community mental health services and the in-patient service at Antelope House. The area manager had undertaken a review of serious incidents to help inform the improvement plan.

# 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

- Assessment procedures varied across the wards and units. The procedure on Elmleigh was for nursing staff to complete an initial nursing assessment after admission. This was a paper document completed together with the patient, which administrative staff then entered into the electronic records system. In one of the four records we reviewed, staff had not completed this on admission because they recorded that the patient had not engaged.

- In the four records reviewed at Elmleigh, a number of other care plans preceding the inpatient episode were also on the system. The ward manager explained that following a CQC Mental Health Act visit they had started to archive community care plans predating the inpatient episode. However, the community team had requested they stop doing this, hence there were some out of date care plans alongside the inpatient care plan, with care plans being "added to and added to". This could have caused confusion as to which was the most recent or applicable. Elmleigh also had a paper folder with patient reported outcome measures (PROM). Staff and patients used this to design care plans that were recovery orientated recorded in the patient's words.

- On Kingsley ward there was no nursing assessment on admission. The four records we reviewed had an initial medical clerking assessment and '24-hour narrative' recovery orientated discussion. This outlined the reason for their admission, what would help them, and the people that staff could share information with. A member of staff said that nursing assessment is 'ongoing' and that they conducted a 24-hour narrative and drew up care plans. They told us they did not use an assessment tool nor was there a requirement to complete a fuller assessment. Staff told us this was due to the number of admissions they had in a day, and the sometimes-short duration that patients were there. However, this meant that staff might miss important information about a patient. This could reduce the quality of their care.

- Staff we spoke with on Hamtun ward at Antelope House knew about the epilepsy tool kit and the serious incident resulting in the death of a patient in one of the trust learning disabilities units. Staff on other wards were also

aware of the tool kit and where it could be found. We also reviewed the care records of three patients that staff had identified as having epilepsy across the other wards, and all of them had appropriate care plans in place.

- We found that on some wards, patients had a large number of care plans that were out of date. We reviewed care plans in three electronic patient records on Hawthorn 1 and found staff had placed multiple care plan items on each individual patient's care record, ranging from 12 to 22 items.

### Best practice in treatment and care

- We reviewed 44 medication charts and found that in 36 medication was prescribed appropriately, in the remaining eight we found that some medications had not been reviewed and some doses had been missed. When we raised these issues with medication with staff, they took action to address them.

- Staff at Hawthorn 1 conducted clinical audits of care records weekly. These audits checked different aspects of the records, such as patient involvement in care plans and the presence of risk assessments. Staff at Hawthorn 2 at Parklands Hospital told us that there were audits of medication and staff at Kingsley ward at Melbury Lodge said they were involved in clinical audits. Some staff at Elmleigh carried out monthly audits of case notes. The results of these audits were discussed with staff in supervision to help improve the quality of care records.

- The care navigator role in Elmleigh Acute Mental Health Unit was a role developed to support safe transitions through the acute care pathway; for example, ensuring that community staff are aware of discharge plans and identifying actions required to support effective transition. Staff reported that it has been effective in increasing clinical time for patient care.

### Skilled staff to deliver care

- Staff at Elmleigh had access to regular supervision. We reviewed four supervision records and minutes of a business meeting that reflected this. During our last inspection, we had identified that the trust needed to ensure that high quality supervision should be provided to staff.

- Staff reported receiving extra training on emotional coping skills to help them to provide better quality care at

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Hawthorn 2. This enabled the staff to work more effectively with patients who had difficulty managing their emotions, for example to help manage thoughts and behaviours in relation to self-harm.

- The care pathway manager at Antelope House held workshops entitled 'policy to practice gaps'. This workshop looked at better use of resources, and how the environment and resources helped or hindered the practice of observations.

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

- On Kingsley ward, staff told us that they had discussed patients in daily meetings held to discuss the patient's risk, called 'zoning meetings'. However, staff had not fully documented these meetings in the care records. We found mention of staff discussing a patient in a zoning meeting in one record. A review into a serious incident on this ward had identified a lack of updates in a patient's safety plan.
- Staff at Elmleigh held three multi-disciplinary meetings a week, one each for the three different psychiatrists. Staff also held a meeting on Fridays to discuss all the patients on the bays.
- The trust had combined the acute mental health team (which provided intense support for those in a crisis) with their acute inpatient wards in a single care pathway. Staff at Elmleigh told us that having the acute mental health team on the same site helped them to easily communicate and help the transfer of patients between the teams by attending multi-disciplinary team meetings. Staff at Hawthorn 2 at Parklands hospital also said that community psychiatric nurses attended their multidisciplinary team meetings.

## **Adherence to the MHA and the MHA Code of Practice**

- Staff at Hawthorn 2 told us that sometimes, staff had to re-arrange or reduce patients' leave from the ward due to staffing levels. However, the ward manager of Hawthorn 1 told us that staff never cancelled leave on their ward.
- Under the Mental Health Act, the 'three-month rule' states that patients may be given treatment without their consent. After the three-month period, if the patient consents to treatment and has the capacity to do so, the approved clinician has to complete a form stating this (a T2 form). If the patient does not consent or does not have the capacity to consent, then a second opinion from a second opinion appointed doctor (SOAD) is required. The SOAD will

speaking with staff involved in the care of the patient and if they agree that the treatment is required, the SOAD will authorise it on a T3 form. One patient was detained under the Mental Health Act (MHA) and treated under the three-month rule in their first three months of admission to Kingsley ward at Melbury Lodge. Nursing entries stated this patient was treated under a T2 or a T3. This was not the case as they had not been in hospital long enough for consent to treatment to apply under the MHA.

- In all cases apart from one, in the records we reviewed on Hamtun ward at Antelope House, staff had completed risk assessments prior to patients taking leave under section 17 of the MHA. On Saxon and Trinity wards staff carried out risk assessments before patients took leave under Section 17 of the MHA. Staff recorded this in patients' electronic notes.
- In all three records reviewed at Hawthorn 1 at Parklands Hospital there was evidence that had staff had explained to patients what their rights were. A member of staff explained to us that if a patient lacked capacity they would ask the independent mental health advocate to make contact with the patient directly.
- Two of the three records reviewed at Hawthorn 2 were for patients detained under the MHA; one of these patients had been given their Section 132 rights, whilst the other, despite being on Section 3 for four and a half months had not had any Section 132 rights recorded as being explained to them.
- At Kingsley ward, staff told us that they read patient their rights under the MHA on admission, and on day 10 of their detention. After this, they advised patients of their rights at appropriate intervals. The Mental Health Act office tracked this. We reviewed two patient records of detained patients, for one patient their rights were repeated at regular intervals. For the other, there was no evidence in the patient's records of their rights being repeated to them after the first attempt on admission. The form provided by the Mental Health Act office did not prompt staff to consider this.

- Staff could receive advice on the MHA from the MHA administration office.

## **Good practice in applying the MCA**

- In five of the 13 records reviewed, capacity to consent to treatment was well recorded. In the other eight, recording was often limited to a statement that a patient did or did

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not have capacity without the rationale for this statement. A member of staff at Hawthorn 2 who was present at the meeting said full discussion did take place. They told us that sometimes just the statement that someone had or lacked capacity to consent to treatment was recorded rather than the discussion that took place.

- In one of the three records reviewed at Hawthorn 2 a patient was stated to 'lack capacity with decisions regarding treatment', with no rationale for this recorded. Staff at Elmleigh, Hawthorn 2, and Kingsley ward did not

use the MCA pro-forma on their electronic care record system. Mental capacity was commented on in the patient's care plan, the admission clerking by the doctor and the gatekeeping entry form prior to admission. Mental capacity was also referred to in the multi-disciplinary team ward review and the core assessment. In all three of the records reviewed at Hawthorn 1, there was evidence of an assessment of capacity to consent to treatment. Staff recorded assessments in the capacity pro-forma on the electronic patient care record.

# 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 spoke with 25 patients and carers across all the wards. Twenty-one patients and carers had compliments for the way that staff treated patients, including that they were polite, respectful and caring. Two patients on Kingsley ward at Melbury Lodge told us that there had been thefts on the ward, but two said their possessions were safe. In the majority, patients felt safe from aggression on the wards, although two patients said that there were incidents of aggression on Kingsley ward and one said they felt unsafe at Elmleigh. Three carers said that staff had not communicated well with them about the discharge of their relative. A patient and a carer felt that staff were not available for patients when they needed them at Elmleigh, and two patients felt that some staff cared for them but that they either told patients what to do rather than ask or that they were otherwise impolite.
- We observed good care on all the wards we visited. Staff interactions with patients were kind and caring. We overheard interactions that were respectful and supportive. While we were on the wards, we observed staff present in both the patient area of the ward and in the ward office.
- We saw feedback that patients had provided about staff on Trinity ward at Antelope House, which was very positive about the whole team. One patient had nominated the nursing team as well as an individual staff member team for a 'People's Choice' award. A peer review consultation took place at Antelope House on 15 September 2015. Trinity ward staff were commended by patients for 'going the extra mile'. All patients interviewed felt safe and cared for on the ward. Patients on Saxon were equally complimentary. The report stated that one thing the four patients interviewed on Saxon would not change was, 'the attitude and willingness of staff'. They described staff as, 'compassionate, understanding and caring'.

### The involvement of people in the care they receive

- Care plans we looked at were mixed in regard to evidence of active involvement from patients in the planning of their care. In most cases, care plans reflected the identified needs of the patient and their views and preferences were represented.

- All of the three records we reviewed at Hawthorn 1 at Parklands Hospital showed evidence of regular discussion with patients regarding their care. A structured recovery orientated discussion was recorded in the progress notes as a pre MDT meeting nursing summary. However, the client view column in the electronic care plans was inconsistently completed.
- Recording of the patient's view was inconsistent in the three records reviewed at Hawthorn 2. In one, half of the care plans stated a patient's view, in another, all care plans stated that the service user was aware of the care plan, and in the third, the patient view column was blank in all care plans. None of the three records reviewed had a pre MDT meeting discussion or nursing summary. Staff at Hawthorn 2 said that patients were also jointly involved in creating wellness recovery action plans. Staff on Hawthorn 2 at Parklands Hospital told us that that they did not always give patients their care plans. The staff told us they had decided to produce personalised folders for patients containing their care plan and a welcome pack. Staff had not fully implemented this at the time of our inspection.
- We reviewed five care records on Hamtun at Antelope House and most had client views contained with their care plans. Where they did not, it was reasonable to say that these patients were unwell and difficult to engage in that process.
- Staff at the Kingsley ward told us that care plans were drawn up with the patient. However, one patient said theirs had been created by staff and then brought to them to read and sign. The patient had wanted more involvement in their care plan.
- On Trinity ward, we looked at four electronic patient records and paper copies of care plans signed by patients. One patient had written comments all over their paper plan and showed that their views had been taken into account. Care plans were detailed and comprehensive. Staff recorded clear progress notes about patients, which were written respectfully and incorporated patients' views.
- On Saxon ward, electronic records did not reflect patients' views. One patient's care plan for support with diabetes stated that their view was, 'yet to be established'. This patient had been an inpatient for two months at the time of our inspection. A second patient's care plan stated, 'this care plan was created collaboratively' but did not contain any record of the patient's views.

# Are services caring?

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

- Patients had multiple care plan items on their care records and staff did not always fully complete patients' views in them at Elmleigh. In the four records we reviewed, the number of care plan items with a patients view recorded in the notes varied between only one of 10 having it recorded, to seven of 12 having a patients view entered.
- On Hawthorn 1 at Parklands Hospital, patients had community meetings weekly. These allowed them to feed back on the service they were receiving. We reviewed meeting notes that showed that staff followed up on the actions patients had raised in these meetings, for example

in obtaining clocks for patients. We also found that at Elmleigh there were daily morning meetings scheduled that patients could attend to raise concerns. Patients at Kingsley ward could access a community meeting every Sunday to discuss any feedback with staff. We saw the welcome booklet at Hawthorn 2, which stated patients could access a community meeting weekly to discuss any concerns they had.

- Staff had involved patients in the redesign of the care pathway at Elmleigh via a focus group.

# Are services responsive to people's needs?

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

## Our findings

### Access and discharge

- According to the trust, there were 1441 admissions to the four hospital sites between January and December 2015 and 45 patients who had been re-admitted within two weeks of discharge in that same time period. Furthermore, in December 2015, there were 134 eligible patients for a seven-day follow up from the trust and seven patients did not receive this. Between July 2015 and the end of December 2015, four of the serious incidents reported by the trust involved patients within a month of discharge. We reviewed January 2016 board meeting minutes; these showed that a non-executive director at the trust raised high re-admission rates as a potential concern and the board has acknowledged that this needs to be monitored. It was agreed at the meeting that further analysis of serious incidents and seven-day follow up data should be done via the quality & safety committee. The medical director advised they would provide a presentation to the quality and safety committee regarding the use of indicators to provide assurance on quality of services within mental health.

- The acute mental health teams performed the bed gatekeeping role and managed most admissions and discharges from the local in-patient units, supported by the locality acute care transfer co-ordinator. The acute care transfer co-ordinator had responsibility for bed management and supporting the gatekeeping function. They monitored in-patient progress by visiting the wards daily and used a risk rating system to highlight when patients may be ready for discharge. The acute care transfer co-ordinators kept a tracking spreadsheet to monitor bed usage and had daily telephone conferences to track bed availability across the trust. Information provided by the trust reflected that beds were rarely required outside of the trust. The process was for staff to admit patients to a ward within the trust, and then, if it would not be more disruptive to the patient, transfer them to a local ward when a bed became available.

### The facilities promote recovery, comfort, dignity and confidentiality

- On Hamtun at Antelope House, the trust had installed a wall-mounted hot water boiler in the large communal area,

to which patients had continuous access. There was a shutter overhead, which could be pulled down in an emergency or at any other times of increased risk. All four patients that spoke with us confirmed that they were allowed access to drinks and snacks without restriction. All bedrooms are ensuite and there are separate lounges for women. There is an internal courtyard central to the ward area. There is a well-used activity room, which was popular with the patients.

- The payphone at Hamtun was broken at the time of our visit. However, patients were allowed to have their mobile phone, subject to risk assessment. All four patients that spoke with us confirmed that this was the case. In addition, if they needed to they could use the ward office phone.

- The signs at Hamtun that advised patients they could not have baths after 10pm had been removed. The care pathway manager and the ward manager both said if patients wanted a bath, they could do so at any time. However, all four patients we spoke with said that this was not the case, and that staff were still informing them they could not have baths after 9pm.

- Two of the four patients we spoke with at Hawthorn 2 in Parklands Hospital said that there were not enough activities, and they were not varied enough. We checked the planned activities for the week, and found that there was one morning with no activities, and none had been scheduled for the weekend of that week. Staff told us there was no formalised plan of activities. They were based on the skills of the staff on shift and, should there be low staffing levels, these might be cancelled. Physical activities were available on Hawthorn 1 (also at Parklands Hospital); although staff said that, the access to psychological input was limited to two hours each week. A patient and a carer of a patient at Elmleigh said that there were limited activities available. However, staff provided us with an activity timetable that showed staff had planned activities Monday to Friday and we observed the planned activities occurring whilst we were on site. The three patients we spoke with on Kingsley ward at Melbury Lodge said they had attended groups and one said that the mindfulness group was particularly good.

- We noted that the trust had put up signs that informed patients there was closed circuit television (CCTV) in the corridor and stairwell. We had told the trust to do this during our previous inspection in October 2014.

# Are services responsive to people's needs?

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

## **Listening to and learning from concerns and complaints**

- Staff on all wards were clear that if a patient wanted to make a complaint, they would help and direct them to the patient advice and liaison service. The trust management of complaints is discussed in more detail in the trust report.

# 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

- Governance arrangements did not facilitate effective assessment, recording or monitoring of actions taken or actions outstanding to mitigate risks. We have taken separate enforcement action against the trust in relation to this.
- The trust had introduced new performance management software to help ward managers monitor key performance indicators. The trust was in the process of fully training the appropriate staff to use the software. We reviewed board meeting minutes that showed a range of key performance indicators were reported. For example, levels of restraint were reported at divisional level and to the board in the integrated performance report.
- Systems to ensure staff were up to date with mandatory training were not fully embedded. We found that some rates of mandatory training were low on Kingsley Ward at Melbury Lodge. However, the trust was aware of this and we saw that staff had been booked onto training to address this.
- Effective systems were not always in place to ensure that medicines were managed safely at Elmleigh and Kingsley wards, and that seclusion was recorded properly at Elmleigh or Hamtun PICU at Antelope House. Systems and processes did not effectively assess and manage risks in the ward environment.

### Leadership, morale and staff engagement

- Staff across all wards felt supported by their peers and local managers. They said that the teams worked well together. Ward managers had sufficient authority within their teams. However, some staff across the wards were unsure how supportive the senior management at a divisional level of the trust would be if there was a serious incident. Some staff on two acute mental health wards expressed concerns during and after the January 2016 inspection, that they receive inadequate support from senior managers and the executive team, although local management was supportive. They reported they did not always feel listened to when they raised concerns with senior managers about the safety of services, including known environmental risks and admitting patients when there were concerns the staff or ward could meet their needs safely. Staff described occasions when their views and concerns had been ignored and decisions overridden. Staff were clear that this was not the local ward manager, but senior management within the trust. We received eight whistleblowing contacts in the six months prior to, during and after our inspection, raising concerns about senior management culture within the trust, some of these related to mental health acute units.
- However, staff at Hawthorn 1 said that they felt they could raise concerns with senior staff comfortably. Staff on Trinity and Saxon wards (both at Antelope House) told us that they were confident they could raise issues and would be listened to. Staff on both wards said the major pressure was staff recruitment.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>Regulation 12 HSCA 2008 (Regulated activities)</b></p> <p><b>Regulations 2014</b></p> <p>The trust had not ensured the safety of their premises and the equipment within it.</p> <p>There has been insufficient action taken to identify and prioritise action required to address environmental ligatures on the wards.</p> <p>Insufficient action had been taken and to manage the safety of patients at Kingsley ward. Staff could not clearly observe patients and patients could access the roof and climb out of the ward's garden.</p> <p>The seclusion room on Hamtun psychiatric intensive care unit is not fit for purpose.</p> <p>Staff did not always check and record medicine fridge temperatures at Elmleigh and on Kingsley ward at Melbury Lodge to ensure medicines were stored at the correct temperature.</p> <p>This was a breach of Regulation 12 (2) (b) (d) (g)</p>

Regulated activity	Regulation
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This section is primarily information for the provider

## Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

**The trust had not ensured that patients' privacy and dignity is protected in a safe way on Kingsley ward.**

This is a breach of Regulation 10(2)(a)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

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
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 <b>The trust did not have effective governance arrangements that identified, prioritised and mitigated risks to patient safety, for example, ligature risks, fall from heights and risks from patients absconding</b>  The trust did not have effective governance arrangements to deliver robust incident investigation or respond to concerns raised by patients and staff  Key risks and actions to mitigate risks were not driving the senior management team or the board agenda  Please see provider quality report for detail.