

Requires improvement



Sussex Partnership NHS Foundation Trust

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

Quality Report

Trust Headquarters

Swandean

Arundel Road

Worthing

West Sussex

BN13 3EP

Tel: 01903 843000

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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)
RX213	Millview Hospital	Regency Ward Caburn Ward Pavilion Ward	BN3 7HZ
RX2E7	Department of Psychiatry	Amberly Ward Bodiam Ward	BN21 2UD
RX2P0	Langley Green Hospital	Coral Ward Jade Ward Amber Ward	RH11 7EJ
RX277	Meadowfield Hospital	Maple Ward Rowan Ward	BN13 3EF

Summary of findings

RX2L6	Woodlands Centre for Acute Care	Woodlands Ward	TN37 7PT
RX26N	Oaklands Centre for Acute Care	Oaklands Ward	PO19 6GS

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- On some wards, staff did not always ensure that paperwork to obtain patients' consent to treatment was complete and accurate. There was also missing information in some Mental Health Act paperwork on all wards except for Maple, Rowan and Oaklands wards. Out of the 126 medicine records we viewed on the initial inspection, 13 of these were incomplete or missing. For example, one patient was prescribed medicine for five months using a treatment authorisation appropriate only for the administration of emergency medicine. We reviewed mental capacity assessments on all the wards. On Jade ward, we reviewed two patient records where staff assessed patients' capacity. However, the forms did not indicate if patients with capacity consented to receiving treatment. One informal patient on Jade ward was assessed as not having capacity to consent to treatment and was administered medicine on two occasions without appropriate authorisation under the Mental Health Act or Mental Capacity Act. This was also identified at the previous inspection of the trust in January 2015. We took enforcement action and served a Warning Notice to the trust to take action on this.
- Patients were put at risk following the administration of high dose medicines and/or intramuscular rapid tranquillisation. This was because staff were not monitoring or recording patients' physical observations at regular intervals in accordance to ensure that patients were kept safe. We took enforcement action and served a Warning Notice to the trust to take action on this to keep patients safe (included in same Warning Notice as above).
- On four wards there were pieces of clinical equipment either missing, not working or out of date.
- Patients routinely did not have a bed to return to on the same ward after a long period of leave from the ward. It was trust policy not to keep leave beds empty. This meant that patients did not want to have

leave for fear of not having a bed to return to. Also, when patients returned to the ward after leave, they were sometimes referred out of area or to other wards where there was bed availability.

- Staff did not always update risk assessments following incidents on the ward.
- There were areas of least restrictive practice on Maple, Rowan and Oaklands wards where staff operated open ward environments. However, there was a blanket restriction on Amber ward where patients were unable to use their mobile phones and were supervised when making calls using office telephones.
- Not all staff had mandatory training or supervision.

However:

- Across all wards, patients were generally happy with the care they received.
- From the 1 - 4 November 2016 we carried out a focussed inspection to follow up the Warning Notice. The trust had responded positively to the Warning Notice and made significant improvements. The trust had developed an action plan and staff were well aware of this and what they needed to do. The wards were being supported by senior managers, peer review and practice development nurses. The e-learning for physical health monitoring had been updated and all staff were receiving refresher training. The records we viewed showed that consent to treatment paperwork was recorded appropriately. The records relating to physical health monitoring for patients prescribed high dose antipsychotics and following intramuscular administration of rapid tranquillisation medicines demonstrated this was being carried out.
- The majority of staff were kind, caring and built positive relationships with patients, their families and carers.
- The psychologist on Caburn ward developed a 'therapeutic keyring' containing distraction activities and emergency contact numbers to support patients when they were distressed.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Emergency equipment was stored in well-equipped clinical rooms across the wards. However, three pieces of equipment were not in working order. There were six flu jabs and a box of syringes out of date on Amber ward and 20 syringes were out of date on Pavilion ward. Oropharyngeal airways in small and large sizes were missing from the resuscitation grab bag on Maple ward.
- Patients on Amberley, Jade, Coral, Caburn, and Pavilion told us that staff did not always provide activities because there were too few staff. Patients on Caburn told us there were no activities at weekends and patients on Oaklands said there were no activities in the evenings.
- Staff did not permit patients on Amber ward to have or use their mobile phones on the ward due to a blanket restriction on the ward. This meant they were unable to make calls in private.
- Staff searched patients, using hand patting over clothes, and their belongings where appropriate. However, staff were not trained in search techniques.
- Both seclusion rooms we inspected were suitable for their purpose. However, the intercom system was out of order in the room on Amber ward. The seclusion paperwork we reviewed on Pavilion ward was good. However, staff used the calm room inappropriately for seclusion purposes. The room did not meet the Mental Health Act seclusion room guidance.
- Prevention and management of violence and aggression training was part of the trust's mandatory training programme, however many agency and bank staff were not trained in this so could not assist trained members of staff during incidents of restraint if required.
- The trust had not taken sufficient action to support patients at risk of harm to themselves. A serious incident occurred on Woodlands ward prior to our follow up inspection, concerning a patient at risk of harm to themselves. Risk assessments for two patients on Woodlands ward were not updated following incidents (one involved self harm) on the ward which occurred prior to our inspection. On Bodiam ward three risk assessments out of five we reviewed were not updated since the patients were admitted.

However:

Requires improvement



Summary of findings

- All patients we spoke with told us they felt safe on the wards we inspected.
- All wards carried out daily environmental risk assessments which included checking for broken furniture or other items on the wards which could be used by patients to self-harm, such as plastic bags.
- Although consultants were concerned about the low numbers of junior doctors available to their wards, medical staff told us that there was adequate medical cover available over a 24 hour period, seven days each week which was available to respond quickly on the wards in an emergency.
- We found comprehensive risk assessments in place for all patients on admission in the care records we reviewed. We saw good evidence of patients' perspective on their risks in the risk assessments we reviewed on Maple and Rowan wards.
- Staff were trained in safeguarding and knew how to make safeguarding alerts.

Are services effective?

We rated effective as requires improvement because:

- The trust implemented a new electronic data recording system early in 2016. Many bank and agency staff across the wards we inspected did not have passwords to access or upload data onto the new system. This put pressure on substantive staff to update patient notes on behalf of temporary staff.
- Many care plans we reviewed, except for those on Maple, Rowan and Oaklands wards, were not recovery oriented and did not include patient strengths and goals.
- Staff told us that informal patients were allowed to leave at will. However, on Woodlands ward an informal patient was not permitted to leave the ward. This was because staff believed the patient was at risk of harming themselves. However staff had not sought appropriate authorisation to detain the patient.
- Appraisal levels, according to data provided from the trust in September 2016, were low across all of the wards we inspected, for example: Woodlands - 23%, Regency - 13%, Pavilion - 12%, Amber ward - 6%. All wards had appraisal completion levels below the trust's target of 80%.
- Seventy-four per cent of staff completed MHA training in this core service. This met the trust's 65% target. However, Maple (43%), Coral (50%), Amberley (57%), Woodlands (63%) all had MHA training completion levels which were below the trust's training target.
- Section 17 leave forms on Jade ward, for Sussex patients on Coral ward and Bodiam wards lacked detail about conditions of

Requires improvement



Summary of findings

leave. This meant that the forms were not compliant with the MHA Code of Practice. Section 17 leave is a section of the Mental Health Act (1983) which allows the responsible clinician to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave the hospital site.

- Staff had access to training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, training completion rates for Coral and Amber wards were 40% and 39% respectively, which were below the trust's completion target rate of 60%.

However:

- All care records contained comprehensive patient assessments which were completed on admission.
- In all but two of the care records inspected, a full physical health examination was carried out on admission.
- All wards had input from psychologists and offered a range of therapies recommended by the National Institute for Health and Care Excellence, for example art therapy, mindfulness and psychology.
- All wards had access to experienced and qualified multidisciplinary teams.
- The majority of staff received regular supervision and attended regular team meetings. Most wards had 100% supervision completion levels.
- All patients had access to independent mental health advocacy services which were based in the hospitals we inspected.

Are services caring?

We rated caring as good because:

- We observed a range of interactions between staff and patients on all of the wards we inspected. Staff generally interacted with patients in a caring and compassionate way.
- We spoke with 51 patients during our inspection and the majority said they found staff to be kind, polite and treated them with respect.
- Staff we spoke with on all wards were knowledgeable about individual patients' needs and risks.
- Patients attended care plan approach and review meetings to plan their care and prepare for discharge.
- Patients on all wards we visited had access to advocacy services.

Good



Summary of findings

- The wards involved and supported carers around the care of their family members on the wards.

However:

- We observed one staff member being dismissive towards a patient.
- Patients in Langley Green Hospital told us about four members of staff who were verbally and, on one occasion, physically aggressive towards them. We raised this with the ward managers during our inspection, who managed these staff issues appropriately.
- The average Patient-Led Assessments of the Care Environment score for privacy, dignity and wellbeing for this core service was 88% which was slightly lower than the national average of 90%.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- There was a high level of bed occupancy across the service. The highest level of bed occupancy, which included patients on leave, was on Jade ward at 110%. Woodlands ward had 27 patients on a 23 bed ward and Pavilion had eleven patients on a 10 bed ward. This meant that while some patients were admitted to the wards, a number of them were discharged to the community on short term leave but were still under the care of the wards. All patients who needed to return urgently from leave would have a bed identified.
- Staff told us that patients were sometimes moved to other wards. This was in order to allow for new patients to be admitted due to pressures on beds and to prevent patients being referred out of area. Staff told us they routinely asked patients for their permission to move them.
- All wards had weekly activity schedules. However there were very few activities available at weekends particularly at Millview and Langley Green Hospitals.

However:

- Each ward had access to a family room where patients met visitors off the ward.
- All wards had access to outdoor space.
- Welcome packs were available for patients on all wards and included information on ward activities, observation procedures and ward managers' details.
- Patients had access to food and drinks day and night across all wards.

Requires improvement



Summary of findings

- Interpreters and information leaflets in different languages were available upon request.
- Staff regularly discussed learning from complaints and we saw evidence of changes made on wards following feedback from patients.

Are services well-led?

We rated well led as requires improvement because:

- The trust did not have effective systems in place to ensure Mental Health Act paperwork was in order across the ward.
- The trust did not have effective systems in place to ensure medicines management was robust.
- Ward managers managed absence in line with the trust sickness absence management policy. Staff absence due to sickness were covered by agency and bank staff.

However:

- Open ward environments on Maple, Rowan and Oaklands wards were examples of least restrictive practice. This meant ward doors were unlocked and patients worked collaboratively with staff to ensure their safety when leaving the ward. This approach was instigated following research into the benefits of open wards which indicates reduced suicidal rates and fewer patients leaving without returning.
- The trust had an effective recording system to accurately reflect training. At the time of our inspection, supervision records were maintained locally on wards and were audited periodically.
- Staff across all wards reported that their work was challenging. However they felt supported by their ward managers and peers and morale overall was good.
- Staff were open and transparent and explained to patients and their families if and when something went wrong while they were admitted to the wards.
- Staff were offered the opportunity to give feedback on services and input into service development.
- The psychologist on Caburn ward developed a 'therapeutic keyring' containing distraction activities and emergency contact numbers to support patients when they were distressed.
- The ward manager on Woodlands ward trialled a six month pilot to develop a band 3 role for health care assistants on the ward.

Requires improvement



Summary of findings

Information about the service

The acute wards for adults of working age and psychiatric intensive care units at Sussex Partnership NHS Foundation Trust provide 199 beds across six sites throughout Sussex. There are two psychiatric intensive care units: 12 male and female beds on Amber ward at Langley Green Hospital and 10 male beds on Pavilion ward at Mill View Hospital. The acute wards are outlined below:

Mill View Hospital:

Regency ward is a 20 bedded male adult mental health inpatient service.

Caburn ward is a 20 bedded female adult mental health inpatient service.

Pavilion ward is a 10 bedded male psychiatric intensive care unit.

Department of Psychiatry, Eastbourne General Hospital:

Bodiam ward is an 18 bedded male adult mental health inpatient service.

Amberley ward is an 18 bedded female adult mental health inpatient service.

Woodlands Conquest Hospital:

Woodlands ward is a 23 bedded mixed gender adult mental health inpatient service.

Oaklands Centre for Acute Care:

Oaklands ward is a 16 bedded mixed gender adult mental health inpatient service.

Meadowfield Hospital:

Maple Ward is a 17 bedded mixed gender adult mental health inpatient service.

Rowan Ward is a 17 bedded mixed gender adult mental health inpatient service.

Langley Green Hospital:

Amber Ward is a 12 bedded mixed gender psychiatric intensive care unit.

Coral Ward is a 19 bedded mixed gender adult mental health inpatient service.

Jade Ward is a 19 bedded mixed gender adult mental health inpatient service.

Following our previous inspection in January 2015, we rated this core service as requires improvement. Oaklands and Maple wards did not meet the fundamental standards related to the safe care and treatment of patients (Regulation 12). The wards did not meet the fundamental standards related to staffing (Regulation 18). Oaklands ward and Meadowfield Hospital did not meet the fundamental standards related to dignity and respect (Regulation 10). Langley Green Hospital did not meet the fundamental standards related to good governance (Regulation 17). We issued requirement notices in respect of these for the trust to take action.

Our inspection team

The inspection team was led by:

Chair: James Warner, Consultant Psychiatrist and National Professional Advisor for Old Age Psychiatry.

Head of inspection: Natasha Sloman, Head of Hospital Inspections, Care Quality Commission.

Team leader: Louise Phillips, Inspection Manager, Care Quality Commission.

The acute wards for adults of working age and psychiatric intensive care unit were inspected by one inspection manager from the Care Quality Commission (CQC), three inspectors from the CQC, a mental health act reviewer, two experts by experience and five specialist advisors consisting of a doctor, two nurses, a psychologist, an occupational therapist with expertise in acute inpatient services. Two pharmacists from the Care Quality Commission also attended.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Visited the 12 wards and looked at the quality of the ward environments and observed how staff were caring for patients.
- Spoke with 51 patients who were using the service.
- Spoke with seven carers of patients who were using the service.

- Spoke with the ward managers of the 12 wards we inspected. During the focused follow up inspection we spoke with 15 managers.
- Spoke with 64 other staff members (4 of these were spoken with during the focused follow up inspection); including psychiatrists, junior doctors, nurses, health care assistants, psychologists and occupational therapists.
- Looked at 78 care records (46 of these were looked at during the focused follow up inspection) looking at areas including risk assessments and care planning.
- Looked at other relevant records such as checks of resuscitation equipment, staff rotas and trust policies.
- Looked at 192 (46 of these were looked at during the focused follow up inspection) medicine records.
- Observed multidisciplinary team meetings, shift handovers, observed a care plan approach meetings, ward rounds, a medicines management group, and a patient community meeting.
- Read 26 comment cards completed by patients.

What people who use the provider's services say

Patients we spoke with told us that staff generally treated them with dignity and respect and were compassionate. However, some patients told us that some agency and bank staff were not always as responsive to their needs.

The majority of patients we spoke with said they felt safe on the wards. Where patients felt unsafe, they told us the behaviour of other patients often made them feel unsafe. Patients told us that staff did everything they could to calm distressed patients so that anxious patients felt safer.

Patients told us they liked the food, however they would like more variety including salads.

Patients with physical health issues told us that staff ensured they attended extra health appointments.

Patients reported they were happy with the range of therapies available. However, some patients told us they were often bored on the wards, especially at weekends when fewer activities were available.

Patients knew how to make a complaint and were supported to do so by staff. We heard from staff and patients how certain practices on the wards were

Summary of findings

changed following patient complaint, for example the main meal at lunch time was moved to the evening to enable patients on day leave to have a main meal on return.

Good practice

- Woodlands ward provided self-assessment forms for bank and agency to complete to request additional support or training they required.
- The psychologist on Caburn ward developed a 'therapeutic keyring' containing distraction activities and emergency contact numbers to support patients when they were distressed or experienced post traumatic flashbacks.
- The ward manager on Woodlands ward trialled a six month pilot to develop a band 3 role for health care assistants on the ward. They developed the role in collaboration with band 2 health care assistants. The aim of the pilot was to retain staff by offering a career development pathway for health care assistants who did not want to train as nurses. This initiative encouraged staff to stay longer on the ward and offered continuity of care for patients.
- Open ward environments on Maple, Rowan and Oaklands wards were an example of least restrictive practice. Ten out of the 13 wards we inspected were locked which meant that patients were unable to leave the ward regardless of the risk they posed of absconding. For some patients this way of nursing was an important symbol of recovery where they felt trusted to stay on an open ward.
- Patients on Woodlands ward were consulted about decorating new furnishings for the ward. We saw examples of art work patients created to decorate the ward walls and dining room.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that medicines and equipment are in date and in working order.
- The trust must ensure that medicines prescribed to people detained under the Mental Health Act are documented and include the route of administration and the maximum dose to be administered.
- The trust must ensure that mandatory training compliance across all subjects meets the trust's compliance targets. This was a requirement following our inspection in January 2015.
- The trust must ensure that all patient risk assessments are updated and patients at risk of harm to themselves are kept safe.
- The trust must ensure that patients on Amber ward have access to phones to make calls in private while on the ward.

- The trust must ensure that sufficient action is taken to manage ligature risks to patients.

Action the provider **SHOULD** take to improve

- The trust should resolve its staff shortages. This was a recommendation following our inspection in January 2015.
- The trust should ensure that all the required checks and tests are undertaken for patients taking high dose antipsychotic medicines and the monitoring forms are fully completed.
- The trust should continue to embed the recording of observations of patients' health following administration of intramuscular doses of medicines as rapid tranquilisation.

Summary of findings

- The trust should ensure that medicines prescribed to people detained under the Mental Health Act are documented and include the route of administration and the maximum dose to be administered.
- The trust should ensure that all Mental Health Act treatment authorisation certificates are attached to patients' prescription charts.
- The trust should ensure that all bank and agency staff have access to prevention and management of violence and aggression training.
- The trust should ensure that the mattress is fixed to the wall and the two way communication system is fixed in the seclusion room on Amber ward.
- The trust should ensure that staff are trained in search techniques.
- The trust should ensure that patients' care plans are recovery focused.
- The trust should ensure that all agency and bank staff, where appropriate, have training and access to the care notes electronic recording system.
- The trust should ensure that all patients receive a copy of their care plan.
- The trust should ensure there are a variety of activities available for patients including weekends.

Sussex Partnership NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Regency Ward Caburn Ward Pavilion Ward	Millview Hospital
Amberly Ward Bodiam Ward	Department of Psychiatry
Coral Ward Jade Ward Amber Ward	Langley Green Hospital
Maple Ward Rowan Ward	Meadowfield Hospital
Woodlands Ward	Woodlands Centre for Acute Care
Oaklands Ward	Oaklands Centre for Acute Care

Mental Health Act responsibilities

- We do not rate responsibilities under the Mental Health Act (MHA) 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.
- Training in the MHA was completed by 74% of staff which met the trust's 65% training target. Staff we spoke

Detailed findings

to had a good understanding of the act and its guiding principles. Maple (43%), Coral (50%), Amberley (57%), and Woodlands (63%) wards had training completion rates below the trust's training completion target.

- We found on some of the wards that the trust did not always ensure that paperwork to obtain patients' consent to treatment was complete and accurate and there was also missing information in some Mental Health Act paperwork on all wards except for Maple, Rowan and Oaklands wards. Out of the 126 medicine records we viewed on the comprehensive inspection, 13 of these were incomplete or missing. For example, on Jade ward one patient was prescribed medicine for five months using a treatment authorisation appropriate only for the administration of emergency medicine. We reviewed capacity assessments on all the wards. On Amberley ward we reviewed treatment authorisation paperwork for five patients. On three files we saw no evidence that patients had consented to treatment. On Jade ward we reviewed two patient records where staff assessed patients' capacity to consent to treatment, however the forms did not indicate if patients with capacity consented to receiving treatment. One informal patient on Jade ward was assessed as not having capacity and was given medication on two occasions without appropriate authorisation under the Mental Health Act or Mental Capacity Act.

On Amberley ward we reviewed treatment authorisation paperwork for five patients. On three files we saw no evidence that patients had consented to treatment. This meant the treatment authorisation forms were incomplete.

On Caburn ward treatment authorisation forms were not attached to seven out of 18 medicine charts we reviewed. The attaching of these to medicine charts is not required by the Mental Health Act Code of Practice, however as they were stored separately, nursing staff did not have quick reference to ensure that the medicine being administered was the same as listed on treatment authorisation form. They were uploaded onto the trust's electronic recording system. We raised this with the ward manager who told us arrangements had been made to attach the forms to the prescription charts, however this had not been done at the time of our inspection.

On Woodlands ward a patient was prescribed and administered medicine for five months using a treatment

authorisation form appropriate only for urgent cases. The Mental Health Act Code of Practice states that such urgent treatment should continue only for as long as it remains immediately necessary. The responsible clinician had not ensured that either they completed a normal (non-urgent) treatment authorisation form or that a second opinion appointed doctor had been requested to offer their opinion. When we raised this with the Mental Health Act office and the consultant they agreed to immediately rectify the paperwork following a visit from a second opinion appointed doctor. Three out of five treatment authorisation forms on Amberley ward did not have capacity assessments or a record of discussions between the doctor and the patient regarding the patients' consent to treatment.

These issues were identified at the previous inspection of the trust in January 2011, and so were ongoing. We took enforcement action and served a Warning Notice to the trust to take action and ensure patients only received treatment consented to. The trust developed an action plan in response to the Warning Notice. From the 1 - 4 November 2016 we carried out a focussed inspection to follow up this Warning Notice. At this inspection we identified that the trust had responded positively to the findings in the Warning Notice and significant improvements had been made. Staff were well aware of the action plans and the wards were being supported by senior managers, peer review and practice development nurses. The records we viewed showed that consent to treatment paperwork was recorded appropriately and appropriate consent to treatment obtained.

- Section 17 leave forms on Jade ward, Bodiam ward, and for Surrey patients on Coral ward lacked detail about conditions of leave.
- Patients had their rights under the Mental Health Act explained to them on admission and routinely thereafter during their treatment.
- Administrative support and legal advice on the implementation of the Mental Health Act 1983 and Code of Practice 2015 was available to the wards.
- All patients had access to independent mental health advocacy services which were situated in the hospitals we inspected.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff across the wards we inspected had access to Mental Capacity Act and Deprivation of Liberty Safeguards training. The overall training completion rate for this core service was 66% which met the trust's training target of 65%. Training completion rates for Maple (36%), Rowan (32%), Amber (39%), Coral (39%), and Woodlands (54%) wards were below the trust's completion target rate of 65%.
- Staff demonstrated a good understanding of the Mental Capacity Act and its guiding principles.
- Staff we spoke with were aware of the trust's Mental Capacity Act and Deprivation of Liberty Safeguards policy.
- The trust had central support available to staff relating to the Mental Capacity Act.
- All 12 capacity assessments we reviewed on Maple, Rowan and Oaklands wards were complete and in date. On Oaklands ward we saw evidence where patients' rights were given to them on admission and repeated to the patients regularly thereafter.

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

- Nine out of 12 wards we inspected had blind spots. The associated risks were mitigated by staff patrols and observation levels which were adjusted depending on patient and ward risk. However, these activities took staff away from duties such as engaging with patients. There were good lines of sight on Maple, Rowan and Oaklands wards which were monitored by staff stationed at central points on each ward.
- We carried out tours of each of the 12 ward environments. Staff carried out ligature risk assessments which detailed specific actions to mitigate the risks identified. For example, Staff assessed patients' clinical risks to determine the level of staff observation required to manage their safety on the wards. Staff displayed a ward ligature risk map in the Coral ward manager's office as a visual reminder of ward risk points. Staff we spoke with knew where risk points were and were confident in how to manage associated risks often by observation of patients. Staff at Langley Green Hospital told us that two recent self-harm incidents in patients' rooms were interrupted during routine room observation rounds. However, despite improvements, shortly prior to the focussed follow up inspection a serious incident occurred on Woodlands ward where a person died following the use of a ligature. This meant that further improvements were needed to ensure that patients were not put at risk.
- Patient bedrooms on all wards, except for Bodiam ward and Amberley wards, did not have call buttons. However, there were call buttons in the disabled bedrooms on Coral and Amber wards. All staff carried personal alarms. We observed staff responding to alarms in a timely manner during our inspection.
- The wards generally complied with the Department of Health's Eliminating Mixed Sex Accommodation guidance and all patient bedrooms were ensuite. There were no curtains on the female lounge window on Jade ward to protect the privacy of patients using the room. Two male patients were admitted to the female corridor on Woodlands ward as clinical emergencies. Both patients were risk assessed prior to being admitted to assess their suitability for being placed on a female corridor. Both patients were assessed as being low risk and their admission was approved by the ward manager. Staff risk managed the patients by placing one on 'within eyesight observation' and the other on intermittent and then general observation in line with the trust's observation policy. Female patients did not have to walk past the male patient to reach their bathing facilities as all bedrooms had ensuite bathrooms. One of the male patients was discharged shortly after our inspection and the other remained on the ward at the time of writing this report. The ward's multi-disciplinary team assessed the appropriateness of moving the remaining patient to the male corridor when a bed became available. The team clinically assessed that it would be too disorientating to move the patient to another corridor and continued with 'within eyesight observation' to risk manage him on the female corridor.
- All patients we spoke with told us they felt safe on the wards we inspected.
- Emergency equipment was stored in well-equipped clinical rooms across the wards. All emergency equipment was checked weekly to ensure it was fit for purpose in an emergency. The electrocardiogram machine on Amber ward was waiting to be fixed and the oxymeter required a new battery to work. We found only one pad was present for the defibrillator on Jade ward. This meant that these three pieces of equipment could not be used at the time of our inspection. Ward managers told us they would arrange for the equipment to be fixed. We found six flu jabs and a box of syringes were out of date on Amber ward and 20 syringes were out of date on Pavilion ward. The clinic fridge temperature on Woodlands ward had only been checked twice in July and twice in September and was recorded at its maximum temperature of 8 degrees. On Maple ward oropharyngeal airways (used to open a patient's airway in an emergency) in two sizes, three/medium and four/large, were missing from the resuscitation bag since September 2014 although they were listed on the bag's content checklist. Four pieces of patient jewellery were logged in the controlled drug log

Are services safe?

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

book and stored in the controlled drug cupboard with medication. We alerted staff to this issue. We found a sealed destruction jar containing two destroyed illegal drugs in the controlled drug cupboard which had been there since 25 August 2016.

- There was a seclusion room in each of the psychiatric intensive care units at Langley Green and Millview hospitals. The seclusion room on Pavilion ward allowed for clear observation, had closed circuit television monitoring, a window, safe bedding and a two-way communication system. The room was well ventilated and had an en-suite bathroom with toilet, sink and shower room which was locked when not in use and was risk assessed for each patient using it. Staff completed detailed recording forms which were uploaded to the electronic recording system for each patient while they were in seclusion. The room had a clock which patients could see. There was working physical health monitoring equipment outside the room at the staff desk for staff use with patients. A calm room where patients were provided with one to one observation was located next to the seclusion room. It had its own en-suite toilet which was risk assessed for each patient and was locked when not in use. The seclusion room on Amber ward did not allow clear observation. There were blind spots in the room and there was no closed circuit television monitoring. The mattress was not fixed to the wall and could be used to block the observation window. The two way communication intercom was broken. The room had a clock which also displayed the date. There was a bathroom with anti-ligature shower, sink and toilet adjacent to the seclusion room. A ligature point is a point which could be used to attach a cord, rope or other material for the purpose of strangulation. Staff had access to physical health monitoring equipment. Patients entered an extra care area with soft furnishings before entering the seclusion room. This area was used as a calm area to carry out nursing activities prior to seclusion where appropriate. Staff told us that the door to this area was never locked as it was not a seclusion room and patients were always accompanied by a member of staff.
- Eleven out of 12 wards we inspected were well maintained and clean throughout, with the exception of Woodlands ward where the clinic room and en-suite bathroom facilities were unclean. Furniture, fixtures and

fittings were provided to a good standard. All wards carried out regular infection control and prevention audits. The average Patient-Led Assessments of the Care Environment scores for cleanliness for the wards we inspected was 97% which was slightly below the national average of 98%. These assessments were undertaken by health care providers and the public focussing on different aspects of the hospital environment including cleanliness.

- Each ward had domestic staff responsible for cleaning communal areas and patient bedrooms. We reviewed the cleaning rotas and found these to be up to date.
- All wards carried out daily environmental risk assessments which included checking for broken furniture or other items on the wards which could be used by patients to self-harm, such as plastic bags. During our inspection Regency ward identified that a broken display screen posed a ligature risk and was removed immediately.

Safe staffing

- All wards used the National Institute of Health and Care Excellence guide for acute hospital staffing to estimate the number and grade of nurses required on each shift.
- Ward managers monitored staffing levels and reported this in a monthly safer staffing report to the trust board. Numbers of staff required for each shift on the wards were matched by the numbers on shift. Woodlands ward launched a recruitment campaign to attract appropriately experienced and qualified staff with financial incentives including a relocation package. The ward manager told us this was because the geographical location of the hospital made it less attractive for potential employees.
- Staff vacancies were high across many wards except for Bodiam and Amberley wards. Eight of the wards had qualified nursing vacancy rates and six had nursing assistant vacancy rates that were higher than the trust average. Coral ward had the highest qualified nurse vacancy rate of 53% and Amberley ward had the highest nursing assistant vacancy rate of 41%. Woodlands ward had 11.5 vacancies for full time staff at the time of our inspection. Staff vacancies and recruitment were listed on the trust risk register.

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- There was low staff turnover on Maple ward where we observed very good staff engagement with patients.
- Staff and patients told us that nurses were often occupied completing paperwork and were often unable to offer regular one to one time to patients on all wards except Rowan, Maple and Oaklands wards.
- There were low numbers of junior doctors in role across the wards. Caburn ward had five junior doctors each working one shift throughout the week. This did not offer consistency for patients. The consultant on Coral only received support from a junior doctor for one shift weekly which meant the consultant spent a lot of time completing general administrative tasks, such as completing blood forms rather than spending time with patients.
- All wards used bank and agency staff appropriately to ensure they met their establishment levels. Ward managers told us they were able to adjust staffing levels as required, for example, in the event of increased patient observations on the wards. All bank and agency staff were inducted to the wards before they undertook shifts. Where appropriate, ward managers block booked agency and bank staff to ensure consistency of staff across their wards.
- Patients said activities were not always provided because of the lack of available staff to deliver them.
- Staff discussed patients' leave arrangements daily with patients. However patients told us that sometimes leave was cancelled due to staff shortages.
- Although consultants were concerned about the low numbers of junior doctors available to their wards, medical staff told us that there was adequate medical cover available over a 24 hour period, seven days each week which was available to respond quickly on the wards in an emergency
- In the period March to May 2016 the wards we inspected filled 1,207 shifts with bank staff and 367 shifts with agency staff. The highest usage of bank staff was on Amber ward where 195 shifts were filled by bank staff. The highest usage of agency staff was on Coral ward where 77 shifts were filled by agency staff. In the same three month period there were 36 shifts across the 12 wards that had not been filled by bank or agency staff. Bodiam ward had the highest number of shifts (11) which had not been filled. Overall number of shifts to be filled on wards was not available from the trust in order to offer a comparison between those filled with substantive and agency or bank staff.
- All staff had access to mandatory training provided by the trust in face to face and computer based forms. All mandatory training had a trust agreed compliance level of 75% except for fire onsite (inpatient), fire onsite (non-inpatient), Mental Capacity Act, Deprivation of Liberties Safeguards and Mental Health Act training which was 65%. The core service overall met the trust's training targets for all mandatory training except for fire onsite inpatient training. Four out of 12 wards had compliance levels below the trust target for health and safety training (Maple: 63%, Amber: 50%, Pavilion: 69%, Woodlands: 57%). Six out of 12 wards had compliance levels below the trust target for onsite fire training (Oaklands: 64%, Maple: 26%, Rowan: 54%, Amberley: 46%, Bodiam: 63%, Woodlands: 37%) and one out of 12 wards had compliance levels below the trust target for adults safeguarding (Pavilion: 33%). Ward managers told us it was difficult to release staff for training as they were required on the wards to support high levels of agency and bank staff on shift. The wards did not meet the essential standards related to staffing with regards to training (Regulation 18) when we last inspected in January 2015.

Assessing and managing risk to patients and staff

- Between December 2015 and May 2016 there were 214 episodes of restraint involving 121 different patients across the wards. Of these, 35 restraints were in the prone position and 14 resulted in the use of rapid tranquilisation. There were 32 of the restraints took place on Pavilion and Caburn wards which were the highest levels across the wards we inspected. The highest use of prone restraint occurred on Amber and Oaklands wards with seven occurrences on each ward. The highest use of rapid tranquilisation occurred on Pavilion and Amber wards (three each). Staff across the wards told us they followed the trust's rapid tranquillisation policy guidance which states that staff should use de-escalation techniques to reduce the need for restraint wherever possible.
- In the risk assessments we reviewed there were comprehensive risk assessments in place. We found the risk formulations were good and most assessments

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were updated after every incident. However, risk assessments for two patients on Woodlands ward were not updated following incidents (one involving self-harm) on the ward which occurred prior to our inspection. Prior to our follow up inspection of Woodlands ward, a patient at risk of harm to themselves was not kept safe and a serious incident occurred. On Bodiam ward, three risk assessments out of five we reviewed were not updated since the patients were admitted.

- During our previous inspection in January 2015, the wards did not meet the essential standards related to dignity and respect (Regulation 10).

We found that blanket restrictions, such as wearing belts, contraband items and locked doors to access and exit the ward doors were justified by the trust in order to maintain safe environments for patients and staff. All blanket restrictions were explained in patient welcome pack. Patients on Amber ward were not permitted to have or use their mobile phones on the ward. This meant patients were unable to make private calls as they were supervised when using telephones in rooms usually used only by staff which contained potential ligature points such as electrical wires.

- Staff told us that informal patients were allowed to leave the wards at will. However, on Woodlands ward an informal patient was not permitted to leave the ward. Staff told us this was because they believed the patient was at risk of harm. Staff did not have appropriate authorisation in place to detain the patient. We raised this with the consultant and ward manager and they agreed to arrange for the appropriate assessment of the individual under the Mental Health Act. This was to ensure that the person was properly assessed and a decision taken as to whether to provide care and treatment formally until their mental health improved and their risk level reduced.
- Most wards, except for Woodlands ward, displayed signage on the locked ward doors explaining informal patients' rights to leave the ward. The manager on Woodlands displayed a sign before we left. Rowan, Maple and Oaklands wards had open ward policies which was least restrictive practice. These wards had completed a literature review which had considered national research and guidance on open ward environments. This was published in the The literature

review suggested that there was evidence of reduced complete suicides and absconsions without return to the ward for patients who were treated on open wards. The doors on the wards were open and patients requested to be risk assessed prior to leaving the ward. This was carefully managed by staff. For some patients this way of nursing was an important symbol of recovery where they felt trusted to stay on an open ward.

- All wards had good observation policies and procedures. Observation policies were available on the trust's intranet and the staff we spoke with knew how to access them.
- Staff searched patients, using hand patting over clothes, and their belongings where appropriate. Searches took place in private rooms with two members of staff present who were gender appropriate to the patient being searched. However, staff were not trained in search techniques.
- Pavilion and Amber psychiatric intensive care wards formally secluded patients. The trust completed a trust wide clinical audit of seclusion policy and procedures in June 2016. Overall compliance with the current seclusion policy was 84% in 2016/17 which was an increase from 59% in 2014/15. Areas for improvement following the 2016/17 audit included offering a de-brief to patients after seclusion ended, informing appropriate people about the seclusion episode, and documenting patients' views regarding their preference for support when their behaviour deteriorated.
- We reviewed five seclusion records on Pavilion ward. The seclusion paperwork was in good order. Patients received physical health monitoring, nursing and multidisciplinary team (MDT) reviews when appropriate. The seclusion records we reviewed included reintegration positive behaviour support plans for patients. This was a plan where staff discussed the need for seclusion with the patient and agreed a plan to help avoid further episodes of seclusion. This was a recommendation from the recent trust wide clinical audit of seclusion policy and procedures.
- We saw in one out of five calm room records that the calm room, next to the seclusion room, was used for seclusion in addition to de-escalation. However, it was not documented as seclusion. Some staff told us that patients were sometimes prevented from leaving the

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calm room physically by use of restraint or locking the door. The calm room records also demonstrated that patients had been prevented from leaving the calm room by use of restraint. The calm room did not meet the Mental Health Act Code of Practice guidance on seclusion room design because it did not allow for communication with the patient when the patient was in the room and the door was locked. Also the room had blind spots when viewed from the observation window and a clock was not visible to the patient. Patients were reviewed regularly when using the calm room and the calm room reviews met the seclusion requirements for nursing review and MDT review.

We reviewed five seclusion records for episodes of seclusion on Amber ward which took place since 1 August 2016. The seclusion records were in good order and the initial decisions to seclude were recorded appropriately. Fifteen minute nursing observations, two hourly nursing reviews and regular MDT reviews were fully recorded. Physical health monitoring was also recorded in the nursing and MDT reviews. This meant that patients received the appropriate safeguards when in seclusion. We reviewed examples of use of the calm room close to the seclusion room on Amber ward. It was used as a quiet room/de-escalation room with constant support from staff and not for seclusion.

- Staff were trained in safeguarding and knew how to make a safeguarding alert. All wards had adult safeguarding training compliance rates which were above the trust's compliance rate of 75%. The trust submitted 35 safeguarding referrals for the wards we inspected between April 2015 and March 2016. Thirty-seven per cent of these referrals were for neglect.
- Pharmacy staff visited all the wards we inspected with varying degrees of input. Staff on the wards we inspected told us that patients spoke with a pharmacist about their medicines if they had particular questions. Pharmacists in Millview Hospital began the 'mind the gap' audit to monitor missed doses of medicine. Daily pharmacist visits to Regency ward to carry out medicine checks reduced 24% of missed doses calculated last year to 2% calculated this year. Daily pharmacy visits to Caburn reduced missed doses from 55 in September 2015 to eight in May 2016.
- Medicines, including controlled drugs were stored securely and recorded accurately when received onto

the ward. However, wards did not always monitor controlled drug stock levels according to the trust policy. On Jade ward, there were gaps in administration records which meant it was not possible to tell if patients had received medicines at the times indicated.

- A range of oral and intramuscular medicines, to be given 'when required', were prescribed for patients. These medicines were often not reviewed for over 14 days to determine if they were still needed. Staff on Jade ward described how several 'when required' medicines were prescribed for patients. However the prescribing consultant did not indicate which medicine was to be administered in which instance. Staff we spoke to said it was confusing for new staff to know which medicine to administer to patients when consultants had not given this guidance.
- Medicines were delivered daily to the wards and an on-call pharmacy service was available at the weekends meaning patients were assured that their medicines were available.
- Medicines administered to patients detained under the Mental Health Act were documented on the appropriate forms, however the route of administration and the maximum dose to be given was not detailed. Forms were not always signed by the consultant overseeing the patient's treatment or by the patient, if they had capacity to do so.
- On Caburn ward we reviewed 18 prescription charts. We saw good recording of diabetes medicine. However, medicine noted on a section 63 (urgent treatment authorisation) form for a patient on Caburn ward did not match what they were being prescribed. One patient with diabetes was dependent on insulin, yet staff did not monitor their blood sugar levels at the required frequency. Nursing staff also did not adjust the insulin dose to reflect raised blood sugar levels caused by other medicines.
- On Pavilion ward prescribing was generally good. However, we reviewed one chart where the consultant prescribed an urgent treatment combination of medicines which were an inappropriate combination due to possible adverse effects. We raised this with the consultant who agreed not to use this medicine combination.

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- On Woodlands ward, one treatment authorisation form was incorrect and the wrong medicine category was noted. We noticed that the BNF books on the ward were quite out of date and raised this with the consultant and ward manager.
- During our previous inspection in January 2015, the wards did not meet the fundamental standards related to Regulation 12, with regard to safe care and treatment where the trust had not protected patients against risks associated with unsafe use and management of medicines. During this inspection we found that patients who received rapid tranquillisation were not kept safe. Staff did not monitor or record physical observations at regular intervals, according to guidance set out in the trust's rapid tranquilisation policy, and to ensure patients were not at risk. The trust's rapid tranquilisation policy stated that where possible, (and where it is safe to do so), temperature, pulse, respiration rate and blood pressure, level of hydration and level of consciousness should be recorded at least every 30 minutes for a minimum of two hours or until no further concerns about physical health following the parenteral administration of any drug. If a patient refused physical health monitoring, the policy stated that a refusal should be recorded on the chart and as a minimum respiration rate should be monitored and recorded every 30 minutes. However, we found that this was not taking place and the physical health of patients was not being monitored following rapid tranquillisation. An example of this was that one patient on Pavilion ward was administered an intra-muscular injection on 3 September 2016. An observation monitoring form (MEWS) was completed with a single entry for that date stating that observations were offered but refused by the patient. Another example was that on Bodiam ward the medicine administration records showed that one patient had been administered intramuscular rapid tranquillisation. The physical health monitoring form following this had only been completed for 45 minutes following administration of the medicine. On the same ward we found that one patient had been administered rapid tranquillisation on two consecutive days, yet there was no evidence that their physical health had been monitored on either occasion.
- We also identified patients at higher risk of experiencing adverse effects from taking high dose antipsychotic medicines, however, their physical health was not being monitored. For example, on Amber ward there was no evidence of physical health monitoring for two patients following separate administration of benzodiazepine and antipsychotic medicines. Another example was that on Coral ward four out of seven medicine charts detailed high doses of medicine for patients. This was due to medicines being prescribed for administration both via intramuscular injection and orally as required. The medicine administration record did not specify that the medicine should be administered either by injection or orally, which could lead to high dose administration via a single route. We also found that on Regency ward a patient was prescribed medicines four times higher than the British National Formulary recommended dose limit. The British National Formulary (BNF) is a pharmaceutical reference book used in the United Kingdom. We pointed this out to the consultant who immediately adjusted the dose level. The error occurred because the medication was prescribed for administration as needed and had been added to the prescription chart but the previous medication level prescribed had not been crossed off the chart. Another patient on Amber ward was prescribed a high dose of Haloperidol, which increases the risk of side effects and could have negative impact on patients' cardiac health. When we alerted the ward manager and junior doctor to our concerns they agreed with our comments and stopped the high dose medicine from being administered to the patient.
- For both of the areas identified above, in relation to the lack of physical health monitoring following rapid tranquillisation and where patients were prescribed high dose antipsychotics, we took enforcement action and served a Warning Notice to the trust to take action and ensure patients were kept safe. In response to the Warning Notice the trust developed an action plan.
- From the 1 - 4 November 2016 we carried out a focussed inspection to follow up this Warning Notice. At this inspection we viewed 133 medicine administration records and identified that the trust had responded positively to the findings in the Warning Notice and significant improvements had been made overall. Staff were well aware of the action plans and the wards were being supported by senior managers, peer review and practice development nurses. Weekly audits of medicines took place. The e-learning for physical health monitoring had been updated and all staff were

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receiving refresher training. Every patient we reviewed that was prescribed high dose anti-psychotic medicine above the recommended dose range, had a physical health monitoring chart attached their medicine administration record. There were still some improvements needed where some charts did not record the date of certain checks and it was not always clear if these checks had been attempted and refused by patients or not undertaken at all. For patients who had been administered rapid tranquillisation, all staff we spoke with had a good understanding of the requirement to monitor and record observations of patients' health following intramuscular rapid tranquillisation. Some wards were also recording observations following oral doses where they had risk assessed that this was necessary. However, we did find that staff on some wards, such as Woodlands and Jade did not always use the physical health monitoring forms to record observations, instead recording these on the computerised records or modified early warning score charts, which could lead to confusion for ward staff as to whether these had taken place. There was one occasion on Maple ward where there was a lack of evidence of physical health monitoring following rapid tranquillisation. In two cases across the wards it was not always evident that where a patient had refused physical monitoring checks these had been carried out discretely, such as observing respirations of the patient. We made the relevant staff aware of these findings at the time.

Track record on safety

- There were 43 serious incidents in the 12 months prior to the inspection. Twenty-seven of the incidents related to unexpected death or severe harm. Coral and Jade wards in Langley Green Hospital reported seven and six incidents respectively relating to patient self-harm. Both wards had increased ward observation levels and risk assessments for patients on escorted leave to mitigate against further incidents. We found that while patients were risk assessed there were gaps in risk assessment and management. For example, a patient who was assessed as a high risk of self-harm took cutlery from a dining room and self-harmed in their room. Action was not taken to mitigate the risk of the patient using cutlery to self-harm, however observations levels were increased around the patient following the incident.
- The trust demonstrated learning from incidents. Following a serious incident of patient self-harm involving a belt, the trust implemented a ban on the use of belts on the wards for patients. The ban on belts was not carried out on Jade ward. Belts were permitted on Jade ward and staff risk assessed patients individually and used observation to mitigate against risk. Prior to our inspection there was an incident on Coral ward where a patient ended their life following taking part in a ward activity. The patient was not risk assessed prior to undertaking that activity. As a result of this incident, staff risk assessed every patient before they left the ward. However, staff did not record details of the risk assessment to share with the activity leader, but just wrote 'risk assessed'.

Reporting incidents and learning from when things go wrong

- Substantive staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. Ward managers reviewed all incidents and forwarded them to the appropriate general manager and matron. All incidents were electronically forwarded to the patient safety team. The system ensured that senior managers within the trust were alerted to incidents in a timely manner and monitored the investigation and response.
- The ward managers told us that lessons learnt from incidents were shared at regular ward manager meetings which were facilitated by matrons and general managers. The trust also distributed a fortnightly incident learning bulletin to staff to share learning from incidents.
- There was good learning from incidents on all the wards we inspected. The ward manager on Regency ward told us that secondary dispensing had been banned on the ward following a patient being given the wrong medicine dosage. Caburn ward carried out a root cause analysis into a series of events on the ward which resulted in them cutting en-suite bathroom doors at an angle so they did not pose a ligature risk.
- All staff we spoke to told us that they were routinely debriefed after serious incidents.

Are services effective?

Requires improvement 

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

Our findings

Assessment of needs and planning of care

- We reviewed 43 care records on the wards we inspected. All care records contained comprehensive patient assessments, which were completed on admission.
- Forty-one out of 43 care records indicated that a full physical health examination was carried out on admission. Ongoing routine monitoring of physical health, for physical health conditions such as diabetes, was generally good across the wards. This monitoring did not include physical health monitoring post medicine administration. Patients told us that staff met their physical health needs, including supporting them to attend health appointments off the ward. We saw good monitoring of physical health on Maple, Rowan and Oaklands wards. On Woodlands ward a patient was admitted to the ward in February 2016 with a diagnosed health issue. An onward referral for specialist health care was not made until August. Another patient on Woodlands ward was admitted with a health condition on admission, however we did not see evidence of any monitoring of their condition throughout their notes or in their care plan.
- The care plans we reviewed were generally holistic and included patients' support needs. Many care plans we reviewed were not recovery oriented, including patient strengths and goals. Staff told us this was often due to lack of patient engagement. However, four out of five of the records we reviewed on Pavilion ward were recovery oriented. Care plans we reviewed on Amberley and Bodiam wards did not include patients' views. Many patients across the wards were either unclear whether they had a care plan or had not received a copy. Patients on Oaklands, Maple and Rowan wards had copies of their care plans and their care plans were personalised, recovery focused and current.
- Staff accessed information they required to deliver care. The trust implemented a new electronic clinical information system early in 2016 and staff uploaded historical information onto the new system. The majority of bank and agency staff across the wards did not have passwords to access or upload data onto the

new system which put pressure on substantive staff to update patient notes on behalf of temporary staff. Ward managers told us they were in the process of applying for passwords.

Best practice in treatment and care

- All wards had input from psychologists and offered a range of therapies recommended by National Institute of Health and Care Excellence, for example art therapy, mindfulness and psychology.
- Each of the wards had good access to physical healthcare. Doctors on the wards provided assistance with physical healthcare and if necessary patients were taken to the local hospital.
- Staff used Health of the Nation Outcome Scales to measure the health and social functioning of patients on the wards.
- There was good staff participation in clinical audits across all the wards we inspected, for example audits of modified early warning scores (MEWS) were undertaken. This was a guide used by staff to quickly determine the degree of illness of a patient.
- Patients on Maple and Rowan wards took part in staff training, for example explaining what helped a patient who has a diagnosed personality disorder.

Skilled staff to deliver care

- All wards had access to an experienced and qualified multidisciplinary team including psychiatrists, nurses, occupational therapists, support workers, psychologists, art therapists, and pharmacists.
- Prevention and management of violence and aggression (PMVA) training was part of the trust's mandatory training programme. Many bank and agency staff were not trained in the trust's PMVA approach. This meant that as the wards had high usage of bank and agency staff, they were unable to assist nursing staff during incidents of restraint. This could put patients and staff at risk. One substantive member of staff told us they waited 18 months after joining the ward to undertake training and were involved in an incident of restraint when untrained.
- All staff received appropriate induction.
- The majority of staff received regular supervision and attended regular team meetings. Most wards had 100%

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supervision completion levels, however, Amber ward was lowest with a level of 25%. The ward manager had a supervision schedule in place to ensure all staff were supervised within the coming weeks. Ward managers supported bank and agency staff to ensure they felt part of the team and had their development needs met. For example, Woodlands ward provided self-assessment forms for bank and agency to complete to request additional support or training. Staff on Maple ward had access to weekly reflective sessions on the ward.

- The trust appraisal target rate was 80% and the completion level at the time of our inspection was 64% with 20% not completed (4% were on maternity leave, 4% were suspended, 8% on long term sick). This level met the trust target. During our previous inspection in January 2015, the wards did not meet the essential standards related to staffing (Regulation 18) regarding low appraisal levels.
- Staff received necessary specialist training for their roles such as medicine awareness for nursing assistants, preceptorship training, smoking cessation in preparation for the trust's smoking ban in October 2016, approved mental health professional training, and mindfulness. We heard that ward managers struggled to release staff for training, however, they told us this was a priority for team development and staff retention so they tried wherever possible to release staff for training.
- Poor staff performance was addressed promptly. At the time of our inspection, some ward managers were working closely with the human resources department to manage sickness and performance issues.

Multidisciplinary and inter-agency team work

- Weekly multi-disciplinary meetings took place on all wards. The multi-disciplinary meetings were attended by doctors, nurses, ward managers, occupational therapists, pharmacists, and junior doctors. Patients attended if their care was reviewed and their care co-ordinator attended if discharge was planned. We saw two incidents where patients requested leave to prepare for discharge and staff discussed how this was to be arranged while managing risk.
- There were effective team handovers between shifts across all wards twice daily. During handover staff

discussed observations they made about patients' physical and mental wellbeing, historical and emerging patient risks, any planned patient leave and observation levels required for each patient for that shift.

- All wards had good working relationships with care co-ordinators, community mental health teams, crisis teams and social services.

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

- We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.
- Training in the Mental Health Act was completed by 74% of staff which met the trust's 65% target. Staff we spoke to had a good understanding of the act and its guiding principles. Maple (43%), Coral (50%), Amberley (57%), and Woodlands (63%) wards had training completion levels below the trust's completion target.
- We found on some of the wards that the trust did not always ensure that paperwork to obtain patients' consent to treatment was complete and accurate and there was missing information in some Mental Health Act paperwork on all wards except for Maple, Rowan and Oaklands wards. Out of the 126 medicine records we viewed on the comprehensive inspection, 13 of these were incomplete or missing. For example, on Woodlands ward one patient was prescribed medicine for five months using a treatment authorisation appropriate only for the administration of emergency medicine. We reviewed capacity assessments on all the wards. On Amberley ward we reviewed treatment authorisation paperwork for five patients. On three files we saw no evidence that patients had consented to treatment. On Jade ward we reviewed two patient records where staff assessed patients' capacity to consent to treatment, however the forms did not indicate if patients with capacity consented to receiving treatment. One informal patient on Jade ward was assessed as not having capacity and was given medication on two occasions without appropriate authorisation under the Mental Health Act or Mental Capacity Act.

Are services effective?

Requires improvement 

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On Amberley ward we reviewed treatment authorisation paperwork for five patients. On three files we saw no evidence that patients had consented to treatment. This meant the treatment authorisation forms were incomplete.

On Caburn ward treatment authorisation forms were not attached to seven out of 18 medicine charts we reviewed. The attaching of these to medicine charts is not required by the Mental Health Act Code of Practice, however as they were stored separately, nursing staff did not have quick reference to ensure that the medicine being administered was the same as listed on treatment authorisation form. They were uploaded onto the trust's electronic recording system. We raised this with the ward manager who told us arrangements had been made to attach the forms to the prescription charts, however this had not been done at the time of our inspection.

On Woodlands ward a patient was prescribed and administered medicine for five months using a treatment authorisation form appropriate only for urgent cases. The Mental Health Act Code of Practice states that such urgent treatment should continue only for as long as it remains immediately necessary. The responsible clinician had not ensured that either they completed a normal (non-urgent) treatment authorisation form or that a second opinion appointed doctor had been requested to offer their opinion. When we raised this with the Mental Health Act office and the consultant they agreed to immediately rectify the paperwork following a visit from a second opinion appointed doctor. Three out of five treatment authorisation forms on Amberley ward did not have capacity assessments or a record of discussions between the doctor and the patient regarding the patients' consent to treatment.

These issues were identified at the previous inspection of the trust in January 2011, and so were ongoing. We took enforcement action and served a Warning Notice to the trust to take action and ensure patients only received treatment consented to. The trust developed an action plan in response to the Warning Notice. From the 1 - 4 November 2016 we carried out a focussed inspection to follow up this Warning Notice. At this inspection we

identified that the trust had responded positively to the findings in the Warning Notice and significant improvements had been made. Staff were well aware of the action plans and the wards were being supported by senior managers, peer review and practice development nurses. The records we viewed showed that consent to treatment paperwork was recorded appropriately and appropriate consent to treatment obtained.

- Section 17 leave forms on Jade ward, Bodiam ward, and for Surrey patients on Coral ward lacked detail about conditions of leave.
- Patients had their rights under the Mental Health Act explained to them on admission and routinely thereafter during their treatment.
- Administrative support and legal advice on the implementation of the Mental Health Act 1983 and Code of Practice 2015 was available to the wards.
- All patients had access to independent mental health advocacy services which were situated in the hospitals we inspected.

Good practice in applying the Mental Capacity Act

- On Bodiam and Amberley wards, all five capacity assessments we reviewed on each ward were of poor quality or incorrectly completed.
- Staff across the wards we inspected had access to training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. Training completion rates for Coral and Amber wards were 40% and 39% respectively, which were below the trust's completion target rate of 60%.
- Staff we spoke with demonstrated a good understanding of the MCA and its guiding principles.
- The trust had a policy on the MCA and Deprivation of Liberty Safeguards which staff we spoke with were aware of.
- The trust had central support available to staff about the MCA.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

- We observed a range of interactions between staff and patients on all of the wards we inspected. Staff interacted with patients in a caring and compassionate way. However, we observed one staff member on a ward being dismissive towards a patient when the patient did not want to attend a ward appointment. We raised this with the ward manager. Staff generally responded appropriately to patients in a calm, polite and respectful manner and were interested in the well-being of patients on the wards.
- We spoke with 51 patients during our inspection and the majority said they found staff to be kind, polite and treated them with respect. Patients told us that staff knocked before entering their rooms. However, three patients told us that some substantive staff and agency staff at Langley Green Hospital were uncaring. We raised this with the ward managers who immediately took action with the staff concerned.
- Staff we spoke with on all wards were knowledgeable about individual patients. They were aware of their needs and risks. Some patients told us staff worked hard to keep them safe when they felt anxious at times on the wards due to noise or activity levels. Staff did this by taking time to calm aggressive patients who were making some patients anxious.
- The average Patient-Led Assessments of the Care Environment score for privacy, dignity and wellbeing for this core service was 88% which was slightly lower than the national average of 90%.

The involvement of people in the care they receive

- Patients told us they had some involvement and participation in care planning. Seven patients told us they did not have a copy of their care plan. Staff told us patients sometimes did not want have a care plan, but care plans were developed for them to comment on in their own time. Patients attended care plan approach and review meetings to plan their care and prepare for discharge.
- Patients on all wards we visited had access to advocacy services. There was information available on the wards and in welcome packs about how to access advocacy.
- The trust used the triangle of care model for carer involvement and engagement. This approach was developed by carers and staff to improve carer engagement in acute inpatient and home treatment services. It recommends better partnership working between patients, their carers and organisations. A range of carers' support groups were available. Maple, Amberley and Bodiam wards held a monthly carers' clinic where carers had one to one support from a carers' support worker.
- Patients gave feedback on the service through a variety of routes including suggestion boxes, community meetings, friends and family tests, and face to face with staff.
- Patients were involved in decision making about the service. For example, on Woodlands ward, patients were consulted about decorating new furnishings for the ward. We saw examples of art work patients created to decorate the ward walls and the dining room.

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Access and discharge

- The average bed occupancy (including numbers of patients on leave) across this core service for the past six months was 100%. The highest level of bed occupancy was seen on Jade ward at 110%. Woodlands ward had 27 patients on a 23 bed ward and Pavilion had eleven patients on a 10 bed ward.
- There were 28 out of area placements for this core service for period January 2016 to June 2016.
- Patients did not have a bed to return to on the same ward after a long period of leave from the ward. It was trust policy not to keep leave beds empty. Patients usually did have a bed to return to after a single night's leave. Staff routinely waited until patients were ready to be discharged before they allowed them to go on leave because they were unable to retain a bed for them. Staff also deliberately recorded the leave late at night. They did this to reduce the possibility of the bed being used for another patient and in an effort to retain a bed for the patient on short term leave when they came back.
- We heard that pressures on bed management meant that patients were sometimes moved to other wards to allow for new patients to be admitted. Staff told us they routinely asked patients' permission to move them and sometimes this was done to prevent patients from being referred out of area.
- Staff told us that patients were routinely discharged in the afternoon following a review meeting and preparation of their medicine for discharge.
- A bed was usually available in both of the psychiatric intensive care units we inspected.
- There were 35 delayed discharges for the wards we inspected over the past six months. Ward managers told us this was due to difficulty in finding appropriate placements and accommodation for patients. The trust liaised with the local authority and other relevant providers to secure appropriate placements for patients requiring ongoing care.
- All wards had a full range of rooms and equipment to support treatment and care including clinic rooms, activity rooms and one to one rooms. Each ward had access to a family room where patients met visitors off the ward.
- Patients had access to their own mobile phones to make private calls on all wards except for Amber and Pavilion wards. The pay phone on Amber ward was broken. Amber ward's policy prevented patients from having their mobile phones during admission. Patients were permitted to use phones in two offices on the ward. A staff member sat in with patients while they made their calls to manage patient safety around ligature risks in these rooms which were usually out of bounds for patients. A family member told us her family member only made calls when staff had time to supervise them and not on request or for as long as they wanted. The ward manager told us the ward pay phone was being replaced. On Pavilion ward patients used a cordless phone to make private calls.
- All wards had access to outdoor space.
- Patients had access to food and drinks day and night across all wards we inspected.
- Patients were able to personalise their bedrooms, however this was risk assessed to ensure the safety of patients. The trust banned the use of adhesives on walls so staff worked with patients to find new ways of decorating their rooms where permissible.
- Patients had keys to lock their bedrooms. Each ward had secure cabinets to store patients' valuables which were listed on inventories.
- All wards had weekly activity schedules, however, there were very few activities available at weekends particularly at Millview Hospital. Five patients told us they were bored and needed more activities. However, patients on Oaklands, Maple and Rowan wards told us they had a varied activity schedule including music groups, and chair exercise.

Meeting the needs of all people who use the service

- Training records for the wards we inspected showed that 83% of staff completed equality and diversity training within the last year. This was above the trust's compliance target of 75%

The facilities promote recovery, comfort, dignity and confidentiality

Are services responsive to people's needs?

Requires improvement 

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

- Although staff told us that patients were welcomed to their wards with a welcome pack on admission, most patients told us they were welcomed to the wards but did not receive a welcome pack. Welcome packs included information on ward activities, observation procedures and ward manager details. Maple and Rowan wards offered welcome packs in a range of nine languages and accessible versions, for example in braille and easy read.
- The ward pharmacists talked with patients and gave them information sheets before they were administered new medicine to help patients understand what to expect.
- Interpreters and information leaflets were available in different languages on request. Two care plans we reviewed were developed with input from translators for foreign language speaking patients.
- A range of information was available to patients on all wards including information on treatment and medications, their rights, local advocacy and the complaints procedure.
- A variety of meals was available on all wards we inspected. Patients we spoke to were generally happy with the food. However three patients told us they would like more variety including salads. Patients told us food was available to meet dietary requirements such as lactose intolerance.

- Patients we spoke to said they had access to appropriate spiritual support and multi faith rooms on the wards for quiet reflection time.

Listening to and learning from concerns and complaints

- In the twelve months prior to May 2016, the trust received 84 complaints for the wards we inspected. The highest number of complaints were categorised as 'inadequate overall care'.
- Copies of the complaints procedure were displayed on the wards and in the ward information leaflets. Staff knew the complaints process and patients knew how to raise complaints.
- Staff regularly discussed learning from complaints. Patients across the wards complained that when they were attending appointments or on leave at lunch time they missed their main meal at midday. In response to this feedback, staff rescheduled meal times to ensure the main meal was served in the evening. Staff across the wards trialled different methods to charge patients' mobile phones in response to feedback that staff were not always available to do this for patients. One ward piloted phone charging time slots to reduce pressure on staffing. Patients on Amber ward complained they were hungry in between meals so staff arranged for a wider range of snacks to be available in the kitchen for patient use.

Are services well-led?

Requires improvement 

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

Our findings

Vision and values

- Staff were aware of and agreed with the trust's visions and values. There were posters throughout the unit about the trust's values.
- Staff told us they were aware of who the senior managers in the trust were and that they visited the wards.

Good governance

- The trust had effective recording system to accurately reflect training, supervision or appraisal compliance rates across the wards. This meant some managers kept their own local supervision records which were audited regularly.
- The trust did not have effective systems in place to ensure Mental Health Act paperwork was in order across the wards.
- The trust did not have effective systems in place to ensure medicines management was robust, some paperwork was inaccurate and there was lack of physical health monitoring where medicine required this. However, following the Warning Notice were served on the trust, they responded positively to this and implemented robust plans to ensure that physical health monitoring was taking place following the administration of rapid tranquillisation and for patients prescribed high dose medicines.
- The ward managers told us they had sufficient authority in their roles and had administrative support.
- Staff had the ability to submit items to the trust's risk register, for example, availability of prevention and management of violence and aggression training, and lack of profiling beds for disabled patients on Maple ward.

Leadership, morale and staff engagement

- During our follow-up inspection in November, it was evident that new leadership had led to improved practice regarding medicines management and documentation of patient consent to treatment.

- Ten of the 12 wards we visited had higher sickness rates than the trust average of 7.9%. Absences due to sickness were covered by agency and bank staff. Ward managers managed absence in line with the trust sickness absence management policy.
- All staff we spoke with were familiar with the trust's whistleblowing policy and procedure.
- Staff felt able to raise concerns without fear of victimisation.
- Staff across all wards reported that their work was challenging, however they felt supported by their ward managers and peers and morale overall was strong. The ward manager on Jade ward reported that morale was low due to previous resignations of a number of nursing staff. However, staff motivation at work across the entire trust scored 3.8 out of 5 in the trust's staff survey in 2015.
- During our inspection we were not made aware of any ongoing grievance procedures, allegations of bullying or harassment.
- Staff told us there were opportunities available within the trust for leadership development.
- Staff were open and transparent and explained to patients if and when something went wrong. We saw evidence of family members being invited to reviews following incidents on wards. We saw a letter of apology to a family where a member of staff used a confrontational response when speaking to a patient.
- Staff were offered the opportunity to give feedback on services and input into service development. For example, the ward manager for Regency ward submitted a business case, which was approved, to have the bathrooms and toilets renovated. The ward manager at Woodlands piloted their idea to have band 3 staff on their ward. This was to ensure a development pathway for healthcare assistants and support staff retention. The interim ward manager at Amber ward gave feedback that they wanted the trust to remove the blanket restriction on patients using their mobile phones while admitted to the ward.

Commitment to quality improvement and innovation

- Staff on Caburn ward developed a 'therapeutic keyring' containing distraction activities and emergency contact numbers to support patients when they were distressed.

Are services well-led?

Requires improvement 

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

The clinical psychologist on Caburn ward recognised that A4 paper sheets used in cognitive behavioural and dialectical behaviour therapy were not always readily available when patients were distressed. They developed a pocket sized key ring with 17 strategies for staff and patients to carry for use. The strategies included grounding techniques, positive self-talk, distraction techniques and breathing exercises. The keyring was piloted for use within the multidisciplinary team and patients. At the time of our inspection funding had been applied for to ensure wider availability of the keyrings.

- The ward manager on Woodlands ward trialled a six month pilot to develop a band 3 role for health care assistants on the ward. They developed the role with band 2 health care assistants to retain staff by offering a development pathway for health care assistants who did not want to train as nurses. This initiative meant that staff stayed longer and offered continuity of care for patients on the ward.
- Open ward environments on Maple, Rowan and Oaklands ward were an example of least restrictive practice. The ward used research published in publications of the Journal of Psychiatric and Mental Health to underpin their open ward policy.

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

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

- Patients on Amber ward were not permitted to have or use their mobile phones on the ward. Patients used telephones in offices while supervised by staff, for patient safety.

This is a breach of Regulation 10(1)(2)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- A number of risk assessments were not updated following incidents.
- On Amber, Maple, Pavilion and Jade wards we found clinical equipment which was missing, broken and out of date.
- The trust did not ensure that medicines prescribed to people detained under the Mental Health Act were documented and include the route of administration and the maximum dose to be administered.

This section is primarily information for the provider

Requirement notices

- The trust had not taken sufficient action to keep patients at risk of harm to themselves safe at all times.
- The trust had not taken sufficient action to manage ligature risks to patients.

This is a breach of Regulation 12(1)(2)(a)(b)(d)(e)(f)(g)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- Not all wards had reached the trust's minimum mandatory training compliance levels. Not all staff had regular supervision and appraisals.

This is a breach of Regulation 18(2)(a)