Good

Berkshire Healthcare NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWX51	Prospect Park Hospital	Bluebell Ward	RG30 4EJ
RWX51	Prospect Park Hospital	Snowdrop Ward	RG30 4EJ
RWX51	Prospect Park Hospital	Rose Ward	RG30 4EJ
RWX51	Prospect Park Hospital	Sorrel Ward	RG30 4EJ
RWX51	Prospect Park Hospital	Daisy Ward	RG30 4EJ

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

Summary of findings

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- Care plans were holistic, recovery focused and mostly person centred; there was evidence that patients were involved in their care planning. Physical health assessments took place on admission. A general practitioner (GP) attended the inpatient unit and provided sessions for those suffering from existing chronic conditions and for health promotion.
- There were a number of professionals working across the wards such as occupational therapists, psychologists, nurses and doctors.
- Regular team meetings occurred in which staff were updated of outcomes from complaints, lessons learned from incidents, outcomes of audits and new initiatives.
- The Mental Health Act documentation across all wards was generally good. Detention paperwork was up-to-date and available for scrutiny. There was evidence that the teams were endeavouring to adhere to the principles of the Code of Practice.
- Effective handovers were in place and digital dictation was piloted on one of the wards to reduce the length of time handovers were taking to enable this time to be spent with patients.
- Patients told us that the substantive staff were kind and caring, we also observed positive interactions with patients, and we found that staff were knowledgeable about their patients' care and treatment needs. Advocacy was widely available and publicised across all the wards.
- The carers we spoke to felt that they were involved in their relatives care, particularly in multi-disciplinary team meetings.
- Regular community meetings took place on the wards, patients were seen to be able to give their views, and staff gave feedback in a 'you said we did' format.
- Senior managers and the ward mangers monitored key performance indicators in relation to access and discharge to the acute wards. The ward reported no delayed discharges within a 6-month period. There were regular teleconferences to review the current inpatients and those who were clinically fit for discharge but had social issues that prevented this.
- The wards were able to cater for individual dietary and cultural needs. Information was displayed for patients' regarding how to complain, advocacy, ward information, and the mental health act.
- The inpatient unit had a multi faith room, gym and therapy centre which patients' could access seven days a week.
- Staff were aware of the visions and values of the trust, could describe what these were and told us that they were linked to their annual appraisals.
- The ward staff conducted regular clinical audits and provided feedback to other staff through email and the ward meetings to improve performance. Staff described good morale and team working on all the wards. All the staff said that they felt supported by their immediate line managers and could tell us who the senior managers were.
- All the adult acute wards and PICU were participating in the Safewards initiative, and Bluebell, Rose, Daisy and Snowdrop ward were accredited under the Accreditation for Inpatient Mental Health Services (AIMS) scheme.

However,

- The en suite privacy curtains in the double bedroom areas on Bluebell and Daisy ward did not provide adequate privacy to the patients occupying these rooms or dignity when they used the shower and toilet facilities.
- The high dependency unit (HDU) on Sorrell ward did not meet the same sex guidance or allow the patients their privacy and dignity whilst they were restricted to this area.
- Not all staff on Bluebell ward had been issued with keys. This meant that they did not have access to emergency equipment, or to activate the fire alarms.
- The wards were unable to increase their daytime establishments to staff the place of safety; this affected the staffing levels of the ward during the day when the place of safety was occupied.
- Risk assessments and risk management plans were inconsistent and not reflective of patients' risks in some areas.
- A patient was secluded without the appropriate safeguards and monitoring being out put in place and

patients' movements were being restricted in the HDU without any formal reviews of their care and treatment. These restrictions meant that the trust policy and the Mental Health Act code of practice was not followed

- There were blanket restrictions in place around the searching of patients on admission. These did not consider individual risks as to whether the search was necessary.
- Staff prevented an informal patient from leaving the ward without any formal review of their legal status.
- Staff did not conduct regular monitoring of the physical health of patients that were prescribed high dose antipsychotics.
- The wards used bank and agency staff to cover many shifts on the wards. Some patients reported that these staff could sometimes be dismissive and rude to them.
- Therapies as recommended by the National Institute for Health and Care Excellence (NICE) were not available for patients to access. There was not a clear strategy for managing those admitted with a personality disorder on the inpatient wards.

One to one supervision did not always occur in line with their trust policy of 4-6 weekly, nor was it always formally recorded when it did occur.

Summary of findings

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

Are services safe?

We rated safe requires improvement because:

- The en suite privacy curtains in the double bedroom areas on Bluebell and Daisy ward did not provide the patients occupying this room adequate privacy or dignity when using the shower and toilet facilities.
- The high dependency unit (HDU) on Sorrell ward did not meet the same sex guidance or allow the patients their privacy and dignity whilst they are restricted to this area. When we re-inspected the ward in February 2016 the trust had made the HDU a single sex unit to protect patients dignity and privacy.
- Not all staff had been issued with keys on Bluebell ward. This meant they did not have immediate access to emergency equipment, or to activate the fire alarms.
- The wards were unable to increase their daytime establishments to staff the place of safety; this affected the staffing levels of the ward during the day when the place of safety was occupied.
- Risk assessments and risk management plans were inconsistent and not reflective of some known patient's risks.
- A patient was secluded without the appropriate safeguards and monitoring being put in place. Patients' movements were being restricted in the HDU without any formal reviews of their care and treatment. These restrictions meant that the trust policy and the mental health act code of practice was not followed. When we re-inspected the ward in February 2016 the trust had delivered training in how to review patients in seclusion and what the documentation of this should look like.
- There were blanket restrictions in place around the searching of patients on admission; this did not take into consideration individual risks and whether a search was necessary.
- An informal patient was prevented from leaving the ward without any formal review of their legal status.
- The physical health of patients that were prescribed high dose antipsychotics was not monitored.

However,

- We found that the wards were clean and tidy.
- Ligature audits and environmental risk assessments were in place.
- The clinic rooms were well stocked, the medical devices were checked annually, and all emergency equipment was available and checked on a daily basis.

Requires improvement

Summary of findings

- On Rose ward, risk assessments were discussed and updated at the multi-disciplinary meeting. There was evidence of lessons learned shared with the staff through team meetings.

Are services effective?

Good

We rated effective as good because:

- Care plans were holistic, recovery focused and mostly person centred; there was evidence that patients were involved in their care planning.
- Physical health assessments took place on admission, and a general practitioner (GP) attended the inpatient unit and provided sessions for those suffering from existing chronic conditions and for health promotion.
- There were a range of professionals working across the wards such as occupational therapists, psychologists, nurses and doctors.
- All staff received a trust induction and a further local induction for their specific work area. Staff had completed their work place performance assessment (Appraisal)
- Regular team meetings occurred in which staff were updated on outcomes from complaints, lessons learned from incidents, outcomes of audits and new initiatives.
- Mental Health Act paperwork for those patients subject to detention was all correct and in place, patients also received a copy of their section 17 leave.
- Effective handovers were observed and digital dictation was being piloted on one of the wards to reduce the length of time handovers were taking.

However,

- Therapies as recommended by the National Institute for Health and Care Excellence (NICE) were not available for patients to access, and there was not a clear strategy for managing those admitted with a personality disorder on the inpatient wards.
- One to one supervision did not always occur in line with their trust policy of 4-6 weekly, nor was it always formally recorded when it did occur.

Are services caring?

Good

We rated caring as good because:

- Patients told us that the substantive staff were kind and caring; we also observed positive interactions with patients.
- Staff were knowledgeable about their patients' care and treatment needs.

Summary of findings

- Care plans were mostly person centred and holistic; patients' discussions with staff about their care plan were recorded in all care records.
- Advocacy was widely available and publicised across all the wards.
- The carers we spoke to felt that they were involved in their relatives care, particularly in multi-disciplinary team meetings.
- Regular community meetings took place on the wards, patients were able to give their views, and staff feedback in a 'you said we did' format.

However,

We were told that there was a high number of bank and agency staff within the wards, and their attitude could often be dismissive and rude with the patients.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Senior managers and the ward mangers monitored key performance indicators in relation to access and discharge to the acute wards.
- The ward reported no delayed discharges within a 6-month period. There were regular teleconferences to review the current inpatients and those who were clinically fit for discharge but had social issues that prevented this.
- Patients' views were taken into consideration if they were requested to move wards.
- Patient led assessment of the clinical environment scores were good
- The wards were able to cater for individual dietary and cultural needs.
- The wards had lot of information displayed for patients' regarding how to complain, advocacy, ward information, and the mental health act.
- The inpatient unit had a multi faith room, gym and also therapy centre which patients' could access

However,

- Patients that were waiting to go back to the acute wards from Sorrell ward (PICU), could have their transfer delayed as admissions to the acute wards from the community took priority.
- There were no private areas on the ward that those who did not have access to a mobile phone could use to make a call.
- Patients had mixed views about the 'cook chill' food they were served.

Summary of findings

Are services well-led?

Good

We rated well-led as good because:

- Staff were aware of the visions and values of the trust, could describe what these were and told us that they were linked to their annual appraisals.
- The ward staff conducted regular clinical audits and provided feedback to other staff through email and the ward meetings to improve performance.
- The ward staff described good morale and team working on all the wards. All the staff said that they felt supported by their immediate line managers and could tell us who the senior managers were.
- Ward managers had sight of their key performance indicators and discussed these within their meetings to put context and meaning to these.
- The NHS staff survey for mental health nurses feeling satisfied with their work was higher than the national average.
- All the wards were participating in the Safewards initiative, and Bluebell, Rose, Daisy and Snowdrop ward were all AIMS accredited.

However,

- Staff performance was not managed through one to one supervision on most wards, was not formally recorded contemporaneously or was not conducted in line with trust policy.
- We found that there was very little oversight and monitoring of the management of the seclusion room or the high dependency unit.

Summary of findings

Information about the service

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

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

The acute wards are mixed sex wards:

- Bluebell ward, a 27, bedded acute ward covers the areas of Wokingham and West Berkshire.
- Snowdrop ward, a 22 bedded acute ward covers the areas of Windsor, Maidenhead and Bracknell
- Rose ward a 22 bedded acute ward covers the area of Slough
- Daisy ward, a 23 bedded acute ward covers the area of Reading. Daisy ward has two beds that are commissioned for alcohol detox; these beds are currently being used for patients in the west of the county, Reading, Wokingham and Newbury.

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

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

During the announced inspection, we visited all wards apart from Daisy Ward, which was closed prior to our inspection due to an incident on the ward. However, a follow up unannounced visit took place to Daisy Ward on 17 December 2015.

We also undertook a follow up inspection on the 11 February 2016 to follow up a Warning Notice that we issued in regard to the High Dependency Unit (Sorrell Ward). Our findings from this have been added to the report.

Prospect Park Hospital has been inspected on six occasions since 2011, and is currently compliant with previous regulations under the Health and Social Care Act. This inspection is the first one for the trust under the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Our inspection team

The overall team that inspected the trust was led by:

Chair: Dr Ify Okocha, medical director, Oxleas NHS Foundation Trust

Head of Inspection: Natasha Sloman, Care Quality Commission

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

The team that inspected acute wards and psychiatric intensive care units comprised of two CQC inspectors, a consultant psychiatrist specialising in inpatient mental health services, a Mental Health Act reviewer, a mental health nurse specialising in inpatient mental health services, and a psychologist who specialises in community and inpatient mental health services.

Why we carried out this inspection

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

Summary of findings

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 these services, asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited five wards on one hospital site and looked at the quality of the ward environment and observed how staff were caring for patients.
- spoke with 13 patients who were using the service and two carers and collected feedback from 31 patients using comment cards.
- spoke with the managers or acting managers for each of the wards.
- spoke with 39 other staff members; including doctors, nurses and social workers.
- attended and observed four hand-over meetings and three multi-disciplinary meetings.
- looked at 29 treatment records of patients.
- carried out a specific check of the medication management on four wards.
- looked at a range of policies, procedures and other documents relating to the running of the service.
- observed three patient community meetings and one planning the day meeting.
- conducted two Mental Health Act reviews.

What people who use the provider's services say

- We spoke to two carers who both felt that they were involved with their relatives care and treatment, and felt that they were listened to especially in multi-disciplinary meetings.
- We spoke with 13 patients, most spoke positively about the substantive staff on the ward. They said that they were respectful, kind and supportive. However, they felt that the bank staff were often rude and dismissive of their needs.
- We received 31 comments card from the adult acute and PICU wards. Sixteen of these comment cards were positive about the staff and environments, three had negative comments, eight had mixed views about the wards and four were unsure. The negative comments made were around not feeling listened to, concerns around other patients behaviours on the ward and not being let off the ward for leave.

Good practice

The trust had access to two GP sessions. One surgery held was for monitoring existing chronic illnesses and treatment recommendations such as respiratory and metabolic disorders. The focus of the second clinic was health promotion such as smoking cessation, weight management and diabetes.

One ward had piloted digital dictation handovers to reduce the amount of time spent in protracted conversation during handovers; this time was released back to patient care.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that physical health monitoring for those patients taking high dose antipsychotics is in place.
- The trust should consider how it would increase the access to psychological therapies on the adult acute wards and PICU in line with NICE guidance.
- The trust should consider its strategy for managing those patients with a diagnosis of a personality disorder whilst on the adult acute wards and PICU.
- The trust should review their policy for searching all patients within 30 minutes admission.
- The trust should review how they staff the place of safety as this depletes the ward and increases the amount of bank and agency staff on the adult acute wards and PICU.
- The trust should ensure that risk to patients is identified accurately within risk assessments and appropriate management plans are put in place to manage those risks.

Berkshire Healthcare 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
Bluebell Ward	Prospect Park Hospital
Snowdrop Ward	Prospect Park Hospital
Rose Ward	Prospect Park Hospital
Sorrel Ward	Prospect Park Hospital
Daisy Ward	Prospect Park Hospital

Mental Health Act responsibilities

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

The Mental Health Act documentation across all wards was generally good. Detention paperwork was up-to-date and available for scrutiny. There was evidence that the teams were endeavouring to adhere to the principles of the Code of Practice.

There were some discrepancies in the recording of the explanation of patients' rights under section 132, and it was not clear whether revisiting rights with patients who had not fully understood or had a change of status was always happening in a timely way.

All the wards had good access to independent mental health advocates (IMHAs) who visited the wards regularly and attended reviews and tribunals if requested by

patients. There was also comprehensive information about the IMHA service and the Mental Health Act on noticeboards. Patients confirmed that they were aware of the IMHA service.

Section 17 leave of absence was appropriately recorded on documentation and many patients were given a copy of their forms that they also signed. Short verbal risk assessments were carried out prior to leave on the acute wards.

The only ward to have a seclusion room was the psychiatric intensive care unit (PICU), Sorrell. At times when the seclusion room was locked, the ward team were recording and reviewing this seclusion appropriately. However, there was evidence that the ward was secluding and segregating patients in the seclusion room and in the high dependency unit, without recording it as such. At these times, the team considered that patients were not secluded or segregated as the door to the seclusion room or the high dependency unit was not locked. There were therefore no reviews as described in the Code of Practice for those in seclusion or long-term segregation. This was raised with the trust at the time of inspection and will be raised as a point of action detailed later in the report. When we re-inspected the ward in February 2016 there was evidence that the patients admitted to the HDU were reviewed intermittently by ward doctors and the nursing team as per trust policy. The notes reflected regular reviews and documented times and rationale for patients that were secluded or placed in the HDU. Care plans were formulated and prompted staff on risks, observation levels and included an exit strategy for the patient. Staff had received recent training from management in how to review patients in seclusion and what the documentation of this should look like. The trust had prompted all staff to read the policy for use of the HDU and were able to show this with a sign off sheet

Mental Capacity Act and Deprivation of Liberty Safeguards

76% of staff had attended training in the Mental Capacity Act (MCA), There were no patients detained under a deprivation of liberty safeguards (DOLS) and there were no pending applications.

The trust had a lead for MCA who staff were able to go to for advice and guidance when needed. The trust did not have a specific policy on the MCA but staff told us that they had links on the intranet to the mental capacity act and other relevant legislation that they could access.

The staff we interviewed were aware of the basic MCA principles and that patients should be deemed to have capacity unless proven otherwise. However, we reviewed one set of case notes, which said that a patient did not have capacity but it did not demonstrate how this decision was made.

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

The design of the all the wards meant there were many blind spots, which hindered observation of patients. This could result in unwitnessed incidents occurring. However there was observed to be a high level of staff presence on the wards, and increased staff supervision was provided for patients with an increased level of risk which reduced the risk of incidents occurring.

Each ward had a completed ligature risk assessment. These had identified a number of high risk areas across the wards. The trust had put in place action plans to either manage or eradicate these risks. Where ligature risks remained, the ward staff were able to tell us during the inspection how these were managed locally. The staff did this by managing areas through observation or through individual patient risk assessment and increased levels of observation of patients who may be at risk of harm to themselves. This reduced the risk of patients using ligature points. However, the ligature risk assessment audit on Daisy Ward was a simple list with no narrative describing mitigation or action of risks.

All of the wards were mixed sex wards, bedroom areas were separated on designated male or female corridors. On all wards except Daisy and Bluebell patients sleeping accommodation were single rooms, with toilet and washing facilities that were either en-suite or had designated male and female bathrooms close by.

Bluebell ward had two bedrooms that accommodated two bed spaces. Each of these twin rooms were located in the male and female areas of the ward, one in the male area and one in the female area. Daisy Ward had one room in the male area that accommodated two bed spaces. Due to the recent incident, we were unable to inspect the female area of the ward. The bed spaces were separated by a privacy curtain and had en-suite facilities. However, the en-suite room did not have a door and the privacy curtain provided did not ensure patients sharing this room had adequate privacy, dignity or security when using the bathroom. All other rooms on Bluebell ward were single sex.

Each ward with the exception of Sorrell ward had areas of the ward that dependent on the population of the patient group could be either male or female. These areas were adjoined to both male and female bedroom corridors, and dependent on what gender the area had been designated the door would be locked on the opposite side. This ensured that the opposite gender could not gain access to this area. All wards within the unit had a designated male and female lounge area.

Sorrell ward had a high dependency unit (HDU) which contained two sleeping areas, a seclusion room, a lounge area and a single bathroom that contained a shower and toilet facilities. The bathroom had a door to its entrance with an observation window within it that was key controlled this allowed staff to observe patients through the observation window or to have the glass closed in a frosted position to allow privacy. However, there were no internal privacy curtains surrounding the shower area.

We observed that both men and women were using the HDU. They were not provided with segregated facilities. The Mental Health Act 1983: code of practice states that: (CoP P8.25-6) “All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilet or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women- only day rooms.”

We informed the service during the inspection of the concerns particularly around the female’s privacy and dignity. In response, the service put arrangements in place for the patient to use the toilet and shower facilities within the female bedroom area of the ward. When we re-inspected the ward in February 2016 the trust had made the HDU a single sex unit to protect patients dignity and privacy.

All of the clinic rooms were safe and clean, with appropriate records showing regular checks taking place to monitor the fridge temperatures for the storage of medicines. In addition, the controlled drugs book was in use and up to date. Emergency drugs were all within date. Staff regularly checked resuscitation equipment and records showed they were up to date. Sharps disposable boxes were labelled with the date and ward, and there was

Requires improvement

Are services safe?

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

clear information displayed on the walls to explain what to do in case of a needle stick injury. We found well maintained medical devices that were checked annually; all the devices we saw had a date for when this was completed and when this was next due again. This meant the clinic area, and the equipment available for staff was safe to use and in good working order, this reduced the risk of equipment failing when it was needed.

Sorrell ward housed the seclusion room for the unit, other areas all had de-escalation rooms available for them to use.

The seclusion room on Sorrell ward was located in the high dependency unit (HDU) area of the ward. The HDU and seclusion environment required some maintenance. A window was cracked in one sleeping area of the HDU and the television in the lounge area was not working. Staff told us that these had been reported and were awaiting repair.

The seclusion room itself had a blind spot within the room but this was seen to be managed by parabolic mirrors being placed in each corner of the room to enable lines of sight at all times. Patients were not provided with adequate privacy when using the en suite toilet and shower facilities in the seclusion room. The seclusion room had an en-suite bathroom area that had shower and toilet facilities. The bathroom area was visible from the corridor of the HDU area through a window; this window could not be turned into a frosted position to aid privacy and dignity. This window was covered by a sheet of paper to prevent the patients within the HDU from viewing this area. There was a clock on the wall opposite the seclusion room to orientate the patients in seclusion and the HDU. When we re-inspected the ward in February 2016 temporary measures had been put in place to protect patient dignity in the shower room through a collapsible rail and curtain, the use of this was individually risk assessed. Windows into the toilet and shower room had a temporary screen over them that staff could lift to enable timely observation. We saw a works order for permanent changes to these windows.

All the wards environments were clean, tidy and had a good standard of furnishings on the main areas of the ward; however, we found areas within Bluebell and Daisy ward that were untidy, such as the laundry room and the activity of daily living kitchen. Integrated service solutions provide all maintenance, laundry and cleaning services within the acute wards and psychiatric intensive care unit (PICU)

Staff had access to keys and alarms on all wards except Bluebell, and security systems were in place to monitor staff access to these. In particular, staff were given keys and alarms on entry to the ward in the airlock of the PICU. However, two staff on Bluebell ward were not given keys, as there were not enough keys for all the staff on duty that day. This meant that they did not have immediate access to locked areas of the ward such as the clinic room and would not be able to activate the key operated fire alarm system if required leaving both other staff and patients at risk.

Safe staffing

The adult acute wards and PICU had their staffing establishments estimated using national tools and agreed by the senior nurses, director of nursing and governance for the trust. The planned daily establishment for each ward was five staff in the morning, five staff in the afternoon and four staff at night. (5-5-4). Bluebell ward was an exception. Here, the planned daily establishment was 6-6-5, due to the increased number of beds on this ward. On the days of inspection, we found that the complement of staff matched or exceeded this planned daily amount.

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

- Sorrell ward 18.6
- Bluebell ward 23
- Snowdrop ward 16.2
- Rose ward 16.6
- Daisy ward 19.9

The establishment levels for unqualified nurses (WTE) were:

- Sorrell ward 13
- Bluebell ward 10.8
- Snowdrop ward 12.4
- Rose ward 12
- Daisy ward 9.7

The number of WTE vacancies for qualified nurses were:

- Sorrell ward 2
- Bluebell ward 8
- Snowdrop ward 4.6
- Rose ward 2.9
- Daisy ward 7.2

The number of WTE vacancies for unqualified nurses were:

- Sorrell ward 3.3
- Bluebell ward over established by 3.7

Requires improvement

Are services safe?

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

- Snowdrop ward 0.45
- Rose ward 1
- Daisy ward over established by 2

Number of shifts filled by bank and agency

- Sorrell ward – Qualified staff 84 shifts and unqualified 397 shifts
- Bluebell ward – Qualified 45 shifts and unqualified 274 shifts
- Snowdrop ward - Qualified 122 shifts and unqualified 266 shifts
- Rose ward – Qualified 74 shifts and unqualified 224 shifts.

Ward managers offered bank shifts to the substantive staff on the ward in the first instance. Following this, shifts would be placed on to the electronic system for the shifts to be sourced for bank workers. The ward manager was able to authorise these shifts to be covered by agency should they not be filled with bank staff. In some instances where the vacancies for qualified staff nurses were high, the trust had given agreement for agency workers to be on short-term contracts until the vacancies were filled. This ensured that, where possible, cover was provided by staff that had knowledge of the ward and the patients. This minimised risks to staff and patients. However, staff told us that when there were high levels of supportive observations, sickness and cover was required for the place of safety, this could be a challenge.

The trust ensured that bank and agency staff received a local induction on all the wards. During this, they were shown the specific safety requirements for each ward.

Ward staff were deployed from their ward duties to support patients admitted into the trust's place of safety. There was a rota whereby qualified and unqualified nurses would be released from the wards if a patient was admitted to a place of safety. Ward managers told us that at night time they could book additional staff to cover their wards when staff were diverted to covering the place of safety. However, during the daytime additional staff had to be found within the wards establishment numbers. This meant staff would be taken away from direct care of patients' on the ward to support the place of safety.

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

The Trust reported that for the period of August 2014- July 2015 Sorrell ward had six staff leaving, a 20% vacancy rate and a sickness and absence rate of 3.7%. Bluebell ward had seven staff leaving a 21% vacancy rate and a sickness and absence rate of 4.7%, Snowdrop ward had eight staff leaving, a 16% vacancy rate and a 4.6% sickness and absence rate. Rose ward had 4 staff leaving, a 13% vacancy rate and a 4.2% sickness and absence rate. Daisy ward had four staff leaving a 16% vacancy rate, and an 11.5% sickness and absence rate.

The sickness and absence rates across the acute wards and PICU for that period were higher than the trust overall target for the mental health inpatient wards at 3%. However, there was a high vacancy rate across all the wards. The trust reported it had difficulty in recruiting suitably qualified and skilled nurses, but were in a process of ongoing recruitment to fill these posts.

We spoke to 39 staff members and 8 service users who gave mixed views as to if the ward was short staffed if leave or one to one time was ever cancelled. Overall, staff told us that activities were provided across a seven-day working week. However, at the weekend, the activities provided were not as comprehensive and if there were increased pressures on staffing, occasionally these could be cancelled. Staff said that leave was not cancelled; but was 'postponed' or shortened. One patient we spoke with confirmed that their leave had been shortened to 15 minutes when they should have received 30. A number of other patients said they received their escorted leave as it was prescribed.

The lead governance nurse audited one to one time that staff spent with patients and information was fed back to the ward when compliance with this fell below the expected standards of 3 times weekly.

Mandatory and statutory training compliance for the 12 month period ending October 2015 for each ward was as follow:

Sorrell Ward

- Information Governance (IG) – 81%
- Prevention and management of violence and aggression (PMVA) – 100%
- Infection control (IC) – 100%
- Safeguarding children – 100%
- Safeguarding adults 86%
- Fire – 64%

Requires improvement

Are services safe?

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

- Health and safety – 84%
- Moving and handling – 84%

Bluebell ward

- IG – 90%
- PMVA – 100%
- Infection control – 97%
- Safeguarding children – 100%
- Safeguarding adults- 94%
- Fire – 87%
- Health and safety – 96%
- Moving and handling – 96%

Snowdrop ward

- IG – 100%
- PMVA – 95%
- Infection control 100%
- Safeguarding children 100%
- Safeguarding adults 95%
- Fire – 86%
- Health and safety – 95%
- Moving and handling 95%

Rose ward

- IG – 85%
- PMVA – 89%
- Infection control – 96%
- Safeguarding children – 96%
- Safeguarding adults – 96%
- Fire – 84%
- Health and safety – 92%
- Moving and handling 92%

Daisy Ward

- IG – 83%
- PMVA – 96%
- Infection control – 89%
- Safeguarding children – 96%
- Safeguarding adults – 96%
- Fire – 92%
- Health and safety – 92%
- Moving and handling – 92%

Overall, the staff teams across the acute wards and PICU had mostly completed mandatory training above the 85% target, the exceptions to this was Sorrell ward (PICU) where it fell just below 85% in information governance, health and safety, and moving and handling. However, this was down to 64% for compliance with fire training.

Assessing and managing risk to patients and staff

We reviewed 29 care records of patients across the acute wards and PICU. These looked at various aspects of patients care that covered MDT meetings, care plans and risk assessments. We found that for the 29 care records we reviewed all had an initial risk summary completed at the point of admission. However, we found the quality of the risk assessments varied across the wards. On Rose and Snowdrop ward, risk assessments reflected the patient's risks and were updated and reviewed regularly. On Rose ward in particular, we found that there were detailed multi-disciplinary team (MDT) discussions regarding risk and live updates to risk assessments to reflect the changes during the MDT.

However, we found there to be a number of inconsistencies and gaps in the risk assessments we reviewed on Bluebell, Daisy and Sorrell ward. In two risk assessments we reviewed there was a change to the risk level of a patient for example going from medium to low risk but there was no formulation or documentation to suggest why this had happened or how this affected the patients care or treatment. In another risk assessment we reviewed, the risk management plan was generic and not detailed, it included statements like for the persons 'mood to improve' and 'to maintain an adequate diet'. This did not give any detailed examples of how this was to be achieved or did not capture the person's risk of deliberate self-harm and how this was to be managed.

In one set of case notes, on Bluebell ward we found a risk overview that appeared to be very detailed with clear triggers to risks and protective factors outlined. However, we noted that the box was ticked to indicate the person was under multi-agency public protection arrangements (MAPPA) but there was no mention of this in the risk assessment or risk management plan, this was discussed with the nurse on duty who said that the person was not subject to MAPPA.

Staff told us, that one patient was known to make allegations against staff. We reviewed the patient risk assessment and did not find any mention of the risk or any plan of how the risk was to be managed to safeguard the patient and staff.

Requires improvement

Are services safe?

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

All the wards were complaint with staff training on clinical risk assessment training compliance figures provided by the trust ranged from 92% - 100%.

There were 80 episodes of seclusion in the six months up to August 2015; these episodes were all on Sorrell ward. Sorrell ward had the only seclusion room on the unit for the adult acute and PICU use. There were 215 episodes of restraint on 62 patients within the same six month period, again Sorrell ward having the highest number of restraints with 102 episodes on 19 patients.

There were 106 prone restraints within the same six month period, Sorrell ward having the highest number of prone restraints at 56.

The staff we spoke to regarding restraint and prone restraint in particular stated that the training that they received discussed the risks of prone restraint, and alternatives to using prone restraint. Staff told us that the electronic incident recording system they used (DATIX) asked for each position that a patient was placed in during a restraint and the duration they were in that position. Staff told us if patients placed themselves into the prone position initially during a restraint that this would be recorded but patients would be turned as soon as it was safe to manoeuvre them.

Staff on Snowdrop and Bluebell wards both had de-escalation rooms; The de-escalation rooms were equipped with furniture to ensure safe sitting restraint techniques. Whilst patients were in the de-escalation room staff would remain with them or at least outside of this room. Patients remained in the room until they had calmed down, and interventions that were used in the de-escalation room ranged from using 'calm boxes', one to one time with staff, medication and sitting restraint and did not stray into secluding a patient in that room.

Staff on Sorrel ward failed to follow the MHA Code of Practice (CoP). We observed a patient being nursed in the seclusion room although staff reported the patient was not formally secluded. The patient was prevented from leaving the seclusion room. The Mental Health Act 1983: Code of Practice (CoP) defines seclusion as (CoP p26.103) "Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving." Therefore, the patient was secluded and had not been afforded the rights of clinical review and monitoring as prescribed in the CoP. When we escalated our concerns with the service, senior staff acknowledged that the patient should be treated as secluded as per the CoP. The service agreed to review the patients care and treatment and either instigate seclusion or de-escalate this according to the patient's risks.

We spoke to and reviewed the records for both patients nursed in the HDU. We found that one patient had been in the HDU for 6 days and the other had been there for 18 days. Both patients were on level two supportive observations meaning that a staff member would remain in line of sight of the patient throughout the day. Every 15 minutes the staff member observing made a record of the patient's presentation and needs. We reviewed the policy for time out and restrictive movements of patients, which said that if patient's movements were to be restricted that the patient should be reviewed every shift and every 72 hours by the multi-disciplinary team.

The procedure for nursing a patient in an area away from others would meet the MHA Code of Practice definition for long-term segregation (LTS) monitoring.

(CoP26.155) "The patient's situation should be formally reviewed by an approved clinician who may or not be a doctor at least once in any 24-hour period and at least weekly by the full MDT."

However, on reviewing the case records for the two patients we found no evidence of any formal assessments by a clinician or an MDT for the specific purpose of reviewing the patients' time and continued stay in the HDU taking place, nor did they have specific care plans in place to support their care and treatment in the HDU. This meant the trust had no appropriate monitoring of patients within the HDU took place and did not meet the requirements of the mental health act 1983 code of practice. This had also previously been highlighted with the trust following a Mental Health Act review in September 2015; however, no action had been taken to ensure that the required safeguards were in place for those patients in the HDU.

One patient whom we interviewed said that a doctor had not seen them since entering the HDU 6 days ago, we reviewed the patients carer records and this was confirmed. The patient told us that they had not left the HDU other than on one occasion to use the courtyard area. The patient said that they were being kept in the HDU area as staff thought they had a lighter. We spoke to the nursing

team and the consultant who both agreed that the patient would need to hand in there lighter as part of their plan to be reintegrated back on to the ward. We spoke to one patient who had spent time in the HDU initially on admission; they told us that at no time were they given access to the courtyard, as these were the rules. Patients who spent time in the HDU were not given any rights or clear guidance as to what they needed to do to be reintegrated back on to the ward, which therefore did not meet the code of practice standards.

We spoke with the service and explained our concerns about the use of the HDU. On return to the ward the following day they had ensured that patients had care plans in place specifically for the HDU and had said that they would ensure that formal reviews would take place as per their policy. When we returned to inspect the ward in February 2016 we saw evidence that patients admitted to the HDU were reviewed intermittently by ward doctors and the nursing team in line with trust policy. The notes reflected regular reviews and documented times and rationale for patients that were secluded or placed in the HDU. Care plans were formulated and prompted staff on risks, observation levels and included an exit strategy for the patient.

Patients underwent proactive searches within 30 minutes of being admitted to the adult acute wards or the PICU. Staff told us that this was around maintaining a safe environment for patients and staff. All the ward managers told us that patient searches were done in a supportive and dignified way, ensuring it was conducted in a private area of the ward and by the appropriate gender. Staff said that they very rarely had a patient who refused to be searched, but should this occur a 'sensible' approach would be taken. This included thinking about what the staff members relationships are like with the patient, discussions and explanations were thorough, capacity issues were considered and other interventions such as observations could be used instead of enforcing a search.

During the month of June 2015, the trust conducted an audit of searches of patient on admission and the number of staff trained to conduct searches. It found that of the 42 admissions to the adult acute wards and PICU that 41 had been searched on admission. Twenty-five of these had appropriate documentation had been completed and uploaded to their electronic record system and the other 16 were waiting to be uploaded. On reviewing the policy for searching patients on the mental health in-patient area, the procedure that staff described showed that they were following trust policy. However, this was a restrictive practice for all patients to have to undergo a search on admission.

Each ward had outside areas where patients could have access to fresh air, in some areas we were told that this was open at all times for patients in others due to either risks associated with the courtyards or due to staffing this would be opened at intervals throughout the day. This created restrictions on patients' freedom.

The hospital went smoke free as of October 2015; this has placed restriction on patients who were admitted into hospital as they were asked to give their cigarettes and lighters in to ward staff on admission. Ward staff retained patients' cigarettes and lighters until they were able to leave the hospital at the point of discharge or had leave to exit the hospital grounds. Nicotine replacement therapy was offered to those who are unable to leave the hospital site.

All staff we spoke to said that if patients were informal they were able to leave the ward, unless there were concerns regarding the risks to themselves or others, if so a review about them leaving the ward would take place with the medical team. However, on reviewing one informal patient's notes on Bluebell ward we found they had been physically prevented from leaving the ward on 6 December 2015, the patient remained informal on the day of inspection on the 7 December. This meant that the ward staff did not ensure that the patient was afforded their right as an informal patient to leave the ward.

Fifteen out of the nineteen nursing staff we spoke to knew how to raise a safeguarding issue. Unqualified staff said that an electronic incident form (DATIX) should be completed and that they would inform the nurse in charge or the ward manager. The qualified staff were able to tell us that there was a safeguarding lead within the trust, that safeguarding concerns were reported on DATIX, and this would send an email to the safeguarding lead. Out of hours, staff would contact social services to report any safeguarding issues. Flow charts of the safeguarding procedure were placed around the ward offices for staff. All wards were within the trust target of 85% for safeguarding adults and children training.

Requires improvement

Are services safe?

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

We found one example where safeguarding procedures on Sorrell ward (PICU) had not been followed. There was a gap of nine days before the incident was reported on DATIX or to the safeguarding team. This did not protect the patient from potential harm or abuse during that period of nine days. However, the trust had put an action plan in place to ensure that the individual involved with the incident and also the team involved followed safeguarding procedures.

We reviewed 61 medication charts. Seven out of the 61 patients were being prescribed antipsychotic medication that was above British National Formulary (BNF) limit. The BNF is a pharmaceutical reference book of information and advice on prescribing and pharmacology, along with details of medicines available on the National Health Service (NHS) including indication(s), contraindications, side effects, and doses. When we find patients taking over the recommended BNF limit for antipsychotic medication, it is expected that physical health care monitoring would be in place for the patient and it would be highlighted on the patient's medicine chart. We did not find any evidence of physical health care monitoring for those patients who were on antipsychotic medication above BNF limits and only one patient had it highlighted on the medicine card.

Five out of the sixty one patients did not have an allergy status on the medicine chart, this put patients at risk of harm.

There were good processes and procedures in place on the adult acute wards and PICU in relation to medication reconciliation. This is where the ward staff or pharmacist will contact the patients GP on admission, this is to confirm what medication and the dosages the patient is taking; this is so that this can continue whilst they are in hospital. These meant patients were provided with their prescribed medications promptly.

The pharmacist and the staff we spoke to all stated that there was support on the wards from the pharmacy team, who would provide individual one to one time with patients around medication information and education.

One patient we spoke to said that they had had to wait a number of hours for medication for discharge. The pharmacist acknowledged that there had been some errors in the discharge processes, and that the procedure was under review.

Track record on safety

There had been 26 serious incidents in the period August 2014 – July 2015. Nineteen incidents were classed as admission of a minor to an adult acute ward or PICU. Four absent without leave over a period of 72 hours, two incidences involved allegations against staff (agency), and one incident involving a restraint of a patient.

The trust recognised that there was an issue relating to the admission of minors to the adult acute and PICU wards. During the 6-month period prior to the inspection, the adult acute ward had three minors admitted between the ages of 16-17, with an average length of stay of 9 days. The trust escalated this as a concern to NHS England, who agreed to fund nine tier 4 beds at the Berkshire adolescent unit (BAU) as of October 2015. However, this ward at the time of inspection was only open to three patients as the resources required to function at capacity were not in place.

The trust made us aware that there had been a serious incident the evening prior to the inspection on Daisy ward where there had been a fire and a patient had died. The investigation in to this incident had been commenced and had been referred to the coroner.

Reporting incidents and learning from when things go wrong

All 39 staff we interviewed were able to tell us that incidents should be reported through their electronic incident reporting system (DATIX) They were able to describe what types of incidents should be reported, and we saw evidence that incidents and lessons learned were discussed in team meeting minutes throughout the month of November. Staff told us that debriefs occurred following a serious incident. One change which staff told us had been made following a serious incident, was that the staffing had been increased at the place of safety, to ensure that incidents that occurred could be managed safely.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We reviewed 29 care records; we found that most of the care plans to be comprehensive, holistic and recovery focused. We found that 16 patients had been involved in their care planning and the care plans were written in a person centred way, in the 13 other care plans there was evidence of discussion of their care plan in one to ones with staff but plans were written from a staffs perspective. Three out of 29 care plans had not been reviewed or updated in line with trust standards and four of the records only partially reflected the needs of the patients, which meant that there was not an accurate record of the patients care, and treatment needs.

Staff completed physical health care assessments on admission and when patients had specific health care needs, this was evidenced in the patient's care plan.

All information relating to patients was stored on the electronic records system (RIO). Any paper work that was completed outside of RIO was later scanned into the patient's record on RIO. However, we found that this could mean there were delays in the paper records being scanned in to RIO as when reviewing care records some documents were found to be missing and were still waiting to be scanned which meant that patients' records were not easily accessible when staff needed them.

Best practice in treatment and care

National Institute for Health and Care Excellence (NICE) guidance CG123 "common mental health disorders: Identification and pathways to care" and CG178 "psychosis and schizophrenia in adults: treatment and management" recommends that the psychological therapies of cognitive behavioural therapy (CBT), interpersonal psychotherapy are available for patients. We found that although the acute wards and PICU had a number of sessions in which a psychologist was allocated to the wards, and an assessment of the patient's needs was completed, no therapy took place during a person's inpatient stay on the acute wards or PICU. If a patient was assessed as requiring therapy, a referral would be made to external services. We did find an exception on Rose ward, which ran a family psychosis group.

NICE guidance CG78 'borderline personality disorder: recognition and management' recommends that there is clear guidelines for admitting patients with a personality disorder to an inpatient setting. However, we found patients admitted to the adult acute wards and PICU did not have a clear plan in place for their admission. The psychologists we spoke with were not aware of any trust strategy in the management of patients admitted with a diagnosis of a personality disorder.

We did find a number of groups available within the inpatient service that looked at patient health and well-being such as hearing voices groups, mindfulness, staying well and social skills groups. The assistant psychologists, occupational therapists and assistant occupational therapists within the wards facilitated these groups.

All inpatients receive a physical examination on admission. In addition to the consultant and other medical staff on the wards, the trust had access to two GP sessions. One surgery held was for monitoring existing chronic illnesses and treatment recommendations such as respiratory and metabolic disorders. The focus of the second clinic was health promotion such as smoking cessation, weight management and diabetes.

In the care records we reviewed, all the patients were found to have a health of the nation outcome scales score (HoNOS). We found that other rating scales were being used to measure patient outcomes such as the Glasgow antipsychotic side effect scale (GASS).

Skilled staff to deliver care

There was a full multi-disciplinary team on each ward, such as occupational therapists, occupational therapy assistants, qualified and unqualified nurses, consultants, psychologists and psychology assistants. Some wards had vacancies for occupational therapists or psychologists.

Staff received additional training that was relevant to their role. Staff received a trust induction on beginning employment with the trust and a local induction when they commenced their role on the ward. One hundred percent of non-medical staff across the adult acute wards and PICU had completed their work performance appraisals, with the exception of Daisy ward that had a 79% completion rate.

All nursing staff told us that they received supervision. However, this was not always one to one supervision but mainly through group peer supervision. The ward managers we spoke with acknowledged this and said this was something they were working to improve. The ward managers said that when one to one supervision did

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happen this was not always recorded formally. The allied health professionals on the wards all told us that they received regular supervision in line with their own professional standards. Medical staff also told us that they received regular supervision from the medical director. However, we found that in all wards with the exception of Rose ward, one to one supervision was not regularly conducted or recorded. Therefore, there would be no formal discussions recorded in staff's' one to one supervision around performance issues and actions needed to improve performance.

Team meetings occurred across all of the adult acute wards and PICU. We saw that staff were given the opportunity to reflect on previous incidents, were given feedback from ward based audits such as blank box audit from medication cards and initiatives such as Safewards and the ward's progress regarding this. Feedback from the community meetings was also discussed during the meetings.

Audits were completed on patients' risk assessments, medication card blank boxes, care plans and one to ones with patients. Ward managers emailed the results of audits to staff and would discuss the findings in team meetings.

Multi-disciplinary and inter-agency team work

Multi–disciplinary team (MDT) meetings happened either weekly (a full day) of twice weekly (two half days) on the adult acute ward and PICU. We observed two MDT reviews and one care programme approach (CPA) 117 meeting; this is where a detained patient's care team meet with a patient prior to their discharge to ensure that all their needs are met and which services will be involved in their care after discharge. We also reviewed five care records and entries specifically relating to MDT meetings. MDT meetings were well attended by professionals such as doctors, nurses, occupational therapists, and psychologists. We were told that a patient's community worker (care co-ordinator) did not attend MDT meetings and saw their patients outside of this.

There was opportunity during the MDT's for staff members to give feedback on the patient's progress. Carers were invited and attended meetings, they were seen to be able to give feedback and their views listened to. The wards used a standard template with headings to ensure that all areas of the patients care and treatment were covered and discussed. However, we saw very little evidence of discharge discussions and planning happening during the MDT meetings. Outcomes and plans documented from the MDT were very brief and medication focused.

Nursing staff participated in handovers three times per day at the changeover of each shift and a further MDT handover occurred once per day. We observed four nursing handovers, where a patient's risk, section of the mental health act, level of observation and a summary of the patients' presentation were discussed.

Staff looked at innovative ways of increasing time with patients within their existing resources. On Bluebell ward, we observed a digital dictation handover, this is where a nurse from the previous shift recorded all of the relevant information from their shift and the next shift would listen to the recording. The staff present at the handover explained that prior to bringing in digital dictation at handover times, handovers took over one hour to complete, and the handover observed took 23 minutes. This released time back to staff to spend with patients.

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

61% of staff had attended training in the Mental Health Act (MHA) which is below the trust standard of 85% therefore they have put an action plan in place to increase compliance with the MHA training

The staff mostly adhered to the Code of Practice guiding principles. The MHA documentation we reviewed in the files of detained patients appeared to be in order. There were sound systems for the granting of section 17 leave of absence and brief verbal risk assessments were completed before leave was taken on the acute wards.

Patients generally told us they understood their rights under the MHA. However, recording of patients' rights was variable, therefore it was difficult to identify when rights had been revisited with patients on an ongoing basis.

Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medicine charts where required.

There were four independent mental health advocates (IMHA) attached to the five wards. The IMHAs visited the

Are services effective?

Good

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wards regularly, and patients confirmed that they knew what an IMHA was and how to access them. Information was available on noticeboards on each of the wards with IMHA and MHA information.

Good practice in applying the Mental Capacity Act

76% of staff had attended training in the Mental Capacity Act (MCA). There were no patients detained under a deprivation of liberty safeguards (DOLS) and there were no pending applications.

The trust had a lead for MCA who staff were able to go to for advice and guidance when needed. The trust did not have a specific policy on the MCA but staff told us that they had links on the intranet to the mental capacity act and other relevant legislation that they could access.

The staff we interviewed were aware of the basic MCA principles and that patients should be deemed to have capacity unless proven otherwise. However, we reviewed one set of case notes, which said that a patient did not have capacity but it did not demonstrate how this decision was made.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed staff treating patients with care, compassion and communicating effectively. Staff engaged with patients in a kind and respectful manner, and the staff we spoke to were knowledgeable about their patients' needs. We spoke with 13 patients, most spoke positively about the substantive staff on the ward, and said that they were respectful, kind and supportive, but one patient was unsure whether staff cared about them or patients' futures.

Three patients we spoke to commented on the number of agency staff on the wards and said that they were often rude and dismissive of their needs. We spoke to one carer who added further to this and said that there was a high number of agency staff and that often there were many new faces who did not appear to have enthusiasm or empathy for the patients they were caring for.

The involvement of people in the care that they receive

Patients received orientation to the wards on admission and the wards had dedicated welcome packs. Staff had placed information leaflets around the ward and in prominent positions in the communal areas of the ward. Notice boards contained various information including the care programme approach (CPA) process, access to advocacy, Mental Health Act, Mental Capacity Act, Key Nurse, names and photos of staff and guidance about the philosophy of the ward as well as information about spiritual and pastoral care.

In 29 of the care records we examined, 16 of the patients had been involved in their care planning and the care plans were written in a person centred way. In the 13 other care plans we reviewed there was evidence of discussions about care plans taking place in one to ones with staff but they were they written from a staff's perspective.

Weekly community meetings took place where patients were able to participate in feedback about what is and is not working well on the ward. We also saw evidence of feedback from the previous meetings in a 'you said we did'. These meetings took place during 'protected time' to ensure that staff were available for patients. The wards also operated a patient electronic feedback machine, which was a survey that asked questions about patient experience on the wards.

Advocacy was widely available and well advertised across all the wards. Independent mental health advocates attended each ward on a weekly basis to speak to patients and take referrals.

Carers felt that they were involved with their relatives care and treatment, and felt that they were listened to especially in multi-disciplinary meetings. We found that Rose ward ran a carers group that looked at supporting carers and signposting them to other organisations.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The beds are gate kept by the crisis response home treatment team (CRHTT) and the duty senior nurse. Twice weekly bed management meetings occurred through a teleconference. Patients that were clinically fit for discharge to the community were discussed and were there were hold ups due to funding or social care reasons such as accommodation. The frequency of this meeting would increase should the demand for beds increase. This assists the staff on the adult acute wards to move patients out of acute mental health beds if there was no clinical need for a patient to remain in hospital.

From February 2015 to July 2015, the average bed occupancy for each ward exceeded the trust target of 90% with the exception of Sorrell ward (PICU) whose bed occupancy was 63%. However, the ward manager and consultant for the ward both said this information was inaccurate as the ward had been full for at least the previous 6 months. They told us that discussions were taking place with senior managers to understand why their occupancy was under reported. The adult acute wards bed occupancy including leave beds were:

- Bluebell – 94%
- Snowdrop – 96%
- Rose ward – 99%
- Daisy Ward – 97%

In the same period, the trust did not report any formal delayed discharges across the adult acute ward and the PICU. However readmission rates within 90 days for this period were:

- Bluebell- 29
- Snowdrop – 27
- Rose – 19
- Daisy- 20
- Sorrell – 6

The trust target for readmissions within 90 days was 8% for the periods of August, September and October 2015 the trust achieved its target with the exception of August where their average rate was 10%.

The trust also has a target for the average length of stay for patients at the point of discharge this being 30 days or less.

The average lengths of stay for August, September and October 2015 were 44 days, 42 days and 35 days. The average length of stay for Minors under the age of 18 on the adult acute wards was 9 days.

The trust reviewed all its performance data at a senior manager level; this is disseminated to the ward managers for review and discussion during their ward mangers meetings. This shows that the ward mangers are aware of their targets and current positions to enable them to put context and meaning to these figures, and escalate concerns where there are delayed transfers of care or processes that are not working. All the ward managers we spoke to had access to their performance reports that detailed this information.

The staff on Sorrell ward (PICU) told us that they often had difficulties transferring patients back to the acute wards due to the shortage of beds and that admissions into hospital took priority over those transferring from the PICU. On the day of inspection, there was one patient awaiting transfer, and two patients who were informal on the PICU, one of the informal patients had been admitted directly due there being no bed available for them on the acute wards the other due to clinical need. Sorrell ward also had one person in an out of area bed that they were trying to repatriate back.

All adult acute beds at Prospect Park Hospital were for the Berkshire wide area. Although each adult acute ward is allocated locality areas which patients from that area should be admitted to, there was seen to be flexibility in this and patients were admitted to a ward that was not linked with their locality if a bed was not available for them in that ward. Patients were moved to their locality ward when a bed became available, but patient preference was also taken into account if they did not wish to be moved. Patients who had been moved from Daisy ward due to an incident were asked whether they wished to return or not following this being reopened, and staff were sensitive to patients' requests not to return.

The staff we spoke to said that discharge happened during the day so that staff could ensure that medication and support was in place for those going home, and that they tried to avoid evening and weekend discharges unless these were pre planned.

Are services responsive to people's needs?

Good

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

The facilities promote recovery, comfort, dignity and confidentiality

Each ward was similar in design, having male and female corridors for patient bedrooms, with activity rooms, dining areas and all had access to outside space and activity of daily living kitchen. The clinic areas also doubled as treatment rooms with examination couches and examination equipment in each. The unit also had a therapy centre where off the ward activities took place and a gym. The wards appeared to be comfortable and clean although in some areas of the wards storage and clutter were an issue.

There were designated male and female lounges on each of the wards where patients were able to go and spend quiet time away from others. There were a number of rooms on the wards that could be used for a dual purpose. For example, rooms could be used for one to one time with staff, MDT meetings or CPA meetings but could also be used for patients and their visitors. There was access to a family visiting room so that patients' could have visits with their children and maintain contact with them whilst they were an inpatient.

There was access to a payphone on each ward, the position of the payphones varied on the wards some were in the dining areas others were on the main body of the ward. All the pay phones we saw had a privacy hood however, this did not allow patients to make a phone call in private in these areas. If the risk assessment deemed it safe, staff allowed patients access to their mobile phones to enable them to communicate with their relatives and carers. This allowed other forms of private communication to take place such as text messaging and emails.

Each ward had outside areas where patients could have access to fresh air, in some areas we were told that this was open at all times for patients in others due to either risks associated with the courtyards or due to staffing this would be opened at intervals throughout the day.

Meals were brought to each ward and were 'cook chill', which is, where food is cooked then rapidly chilled to a certain temperature this can then be stored and reheated when ready to serve. We were told that there was a 4-week menu cycle that gave variety to the meals, and there was always an option for sandwiches. The patients gave mixed views about the food some saying that it was 'good food' others saying that they 'did not like it' or 'it could be worse'. The majority of the patients' told us that they had access to snacks and drinks as they wanted apart from Sorrell ward (PICU) which had specific times set for hot drinks.

Patients and staff on all wards except Daisy ward told us that they were able to personalise their bedroom areas, We observed patients to have posters and photographs on their doors and in their bed areas.

Place scores for the adult acute ward and PICU are all within and above the national averages with the exception of snowdrop for privacy at 84% and condition maintenance and appearance at 88%. However, we did not find any significant areas of concern during our tour of the ward in these areas.

Meeting the needs of all people who use the service

Patients' diversity and human rights were respected. Staff understood, promoted and supported patients and their differences. Staff working in the trust were aware of patients' individual needs and tried to ensure these were met. This included cultural, language and religious needs. Interpreters were available if required for people whose first language was not English.

The unit had an off the ward multi faith room called the sanctuary where patients were able to go for prayer or meditation. Patients told us that staff would escort them there if they wanted to go, or they could have access to a priest or imam on the ward.

All of the wards had welcome packs or introduction booklets, these were just being introduced to some areas but we were told that initial feedback was positive. There was information boards across all of the wards that included information about carers groups, advocacy services, complaints procedures, Safewards, staffing levels key nurse and ward round information.

The access into the building provided easy access for those requiring disabled access, the wards were all on the ground floor, entering the ward the doorframes allowed for wider access.

Staff told us that they were able to cater for different types of dietary and cultural needs. If the 'cook chill' could not provide this, the ward manager had a budget that they were able to purchase food from and use the activity kitchen to prepare food.

Are services responsive to people's needs?

Good

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

Listening to and learning from concerns and complaints

There had been 20 complaints received in total across the acute wards and PICU from August 2014 to July 2015. Bluebell received six complaints, three were not upheld, two were locally resolved and one was ongoing at the time the information was received from the trust. Snowdrop received two complaints both were not upheld. Rose ward received one complaint which was not upheld. Daisy ward received six complaints one was not up held, one was upheld, and four were partially upheld and Sorrell ward received four complaints, one was not upheld, and three were partially upheld.

Ten out of the 13 patients we spoke with told us they knew how to make a complaint. We found posters, and leaflets on the wards informing patients how to raise a concern, complaint or compliment. However three of the 13 patients' stated that they did not know how to make a complaint, but one of these stated that they would speak to staff and 12 of the 13, patients' all would feel confident in making a complaint if they needed to.

There was a clear complaints policy in place, the majority of staff we spoke to all understood the policy and that complaints should be directed to the nurse in charge or the ward manager and escalated if needed. The patient advice and liaison service (PALS) attended the wards. Staff were not able to tell us how they received feedback on complaints, unless this was directly about them.

Are services well-led?

Good

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

Our findings

Vision and values

We saw the visions and the values of the trust were displayed in each of the wards. Ward managers and staff told us that the core values were linked in to staff appraisals, and were able to tell us what these core values meant and stood for.

Staff we spoke to said they were aware of the leadership and management structures in the immediate service and they were able to tell us the names of the senior managers

Good governance

Appraisals and personal development plans were in place for the majority of staff. The trust policy for line management supervision states that supervision should take place a minimum of six to eight weekly. However, we found on all the wards with the exception of Rose ward that one to one supervision did not meet this standard; this was however supplemented by clinical group supervision that occurred on a more frequent basis for those staff who wished to attend. Ward managers told us that clinical group supervision and one to one supervision was not recorded or not recorded contemporaneously. This did not allow individual performance to be managed through one to one line management supervision.

On all the wards deputy ward managers and staff nurses participated in clinical audit, including audits of one to ones with patients, risk assessments, care plans, medication card blank boxes and Mental Health Act 132 rights. This information was gathered and where there were gaps, deficits, or good practice evidenced staff were notified by email. We saw that this information was used for discussion at the ward meetings.

Staff told us staff mix was appropriate and additional staff was sourced via the bank or through an agency when needed. However, this had to be requested through the senior nurse or senior manager by the ward manager or the nurse in charge in her absence.

Mandatory training was in place and up to date. Staff were positive about the additional training that was offered and available for them to access if they wished such as completing their nurse training or additional post registration courses.

The ward managers were aware of their key performance indicators such as, average length of stay, delayed discharges, absence without leave and absconcions. There were also commissioning for quality and innovation (CQUIN) targets for the wards specifically around assessment and treatment of cardio metabolic risk factors for patients with psychosis. We saw in the care records that patients were screened on admission where indicated, and the trust was on track for meeting this CQUIN target.

However, we found that there was very little oversight for the management of the seclusion or the high dependency unit against the trusts policies or the Mental Health Act Code of Practice.

The ward managers felt that they had sufficient authority to lead and manage their wards; all the wards had administration support that also supported the ward managers with their administration tasks.

Leadership, morale and staff engagement

The majority of staff we spoke to described morale on the wards as good. They said they felt supported to do their job, enjoyed working well with good teams, and received ward manager support. However there were a couple of instances of where occupational therapists had described difficulties fitting in with the teams due having to rotate on a yearly basis across the inpatient wards.

All the staff said they were aware of the whistleblowing policy and that they could whistle blow if they feel they were not listened to. The majority of the staff did say that they felt listened to by their immediate managers and should they raise concerns they would be taken seriously. However, there were issues raised about the medical input on Sorrell ward that the workload for one consultant was high without any junior doctor support, we were told that these issues had been raised and had not yet been addressed. Following the inspection the trust has since told us that they were aware of this issue and prior to the inspection and the recruitment process to appoint a new Staff Grade psychiatrist to the ward was under way.

The ward staff described many opportunities for professional development The ward managers spoke of being able to succession plan with their staff and look at opportunities to ‘home grow’ staff.

Are services well-led?

Good

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

Commitment to quality improvement and innovation

All the wards were participating in an initiative called safewards; this has a number of modules in which the patients' and the staff work together with the aim of making the ward a safer and calmer place. The modules look at things such as mutual expectations, calm down boxes, soft words and mutual help meetings. Each of the wards were at different stages and had completed some of the modules and not others.

Snowdrop, Bluebell, Daisy and Rose ward all had completed accreditation for inpatient mental health services (AIMS) this is accredited by the Royal College of Psychiatrists. AIMS is a standard based accreditation programme designed to improve the quality of care in inpatient mental health wards. Sorrell ward were working towards their AIMS accreditation at the time of inspection.