Northamptonshire 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)
RP1V4	St Mary's Hospital	Kingfisher Sandpiper Avocet	NN15 7PW
RP1V4	Berrywood Hospital	Bay Cove Harbour Marina PICU	NN5 6UD

This report describes our judgement of the quality of care provided within this core service by Northamptonshire 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 Northamptonshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Northamptonshire 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	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?	**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 gave an overall rating for acute wards for adults of working age and the psychiatric intensive care unit (PICU) of **requires improvement** because:

- There were blind spots on all wards that meant that staff could not ensure patients' safety.
- Seclusion rooms were not fully compliant with the Mental Health Act 1983 Code of Practice (2015).
- There were ligature risks in the gardens on wards at St Mary's Hospital.
- Harbour and Kingfisher wards did not comply with the guidance on same sex accommodation.
- Some staff had a limited awareness of safeguarding procedures.
- Staff did not demonstrate a good understanding of the Mental Health Act (MHA) and Mental Capacity Act (MCA). It was not clear how patient's capacity to consent to their treatment had been assessed.
- Staff on Harbour ward had other tasks such as bed management and managing the 136 suite which meant that staffing levels did not always ensure patients safety.
- Blanket restrictions of locking bedroom, lounge, kitchen and garden doors had been applied on some wards. There were also restrictions on patients having access to hot drinks on some wards.
- Action had not been taken as a result of an incident that resulted in a patient's death.
- The records system was cumbersome and meant that staff could not always access all the information they needed about a patient.
- Information was available in a range of formats to meet patient's needs.
- Some patients were not clear about how to make a complaint.

Staff were caring. The occupational therapy service was very good and the model used helped patients to engage and develop their skills and abilities.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Seclusion facilities were not fully compliant with the Mental Health Act 1983 Code of Practice (2015).
- In Harbour ward unfamiliar bank staff were used and nursing staff had to spend more time working on bed management across the service than working with patients.
- There were ligature risks in the gardens at Kingfisher, Sandpiper and Avocet.
- There were blind spots on all wards.
- Harbour, Marina and Kingfisher wards did not comply with the guidance on same sex accommodation.
- Some staff had a limited awareness of safeguarding procedures.
- A serious incident where a patient died had not been learnt from as there was not a photograph of each patient on their medicine chart.

Emergency equipment was checked regularly and all staff were trained in how to use it. Environmental risk assessments were done regularly. Ward managers were able to adjust staffing levels to ensure safe staffing. Each patient had a risk assessment completed on admission that was updated regularly. There were clear records kept when a patient was secluded.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The records system was cumbersome and it was difficult to find all the information about a patient.
- Staff did not always use the Mental Health Act and the accompanying Code of Practice correctly.
- Staff did not show that they had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). The assessment of patient's mental capacity lacked detail in the cases reviewed. This meant that decisions could be made that were not in the patients' best interests.
- There was limited psychology input which resulted in the assessment process being delayed for one patient.

Patients physical health needs were monitored. Staff received training and supervision to ensure they had the skills to deliver care

Summary of findings

and treatment. Staff received an annual appraisal. Multi-disciplinary teams and inter agency working were effective in supporting patients. There were effective handovers between shifts. Inpatient and community consultant psychiatrists worked well together.

Are services caring?

We rated caring as good because:

Staff were caring. Patients' skills and knowledge were valued. Staff generally had a good understanding of patients' needs. Staff were sensitive to patients' needs. Patients' families and carers were involved in their care. Advocacy services were involved.

Good

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- In Harbour, Cove and Bay wards there were restrictions on all patients and these were not based on individual risk. For example, hot drinks were limited and the kitchen, lounges and bedrooms were locked. Patient's access to the gardens were restricted in the wards at St Mary's Hospital due to the ligature risks.
- Patients were able to personalise their bedrooms.
- In some wards patients did not have space to store their possessions. However, new furniture had been ordered in Marina ward to enable patients to do this. This would also be adapted to meet patient's needs.
- Information was available in a range of formats to meet patients' needs.
- Some patients were not clear about how to make a complaint

The model of occupational therapy used was very good. Patients had access to a range of activities. A range of rooms were provided on each ward. Patients were supported to meet their religious and cultural needs. Interpreters were available.

Requires improvement

Are services well-led?

We rated well-led as good because:

Staff had good opportunities for professional development The occupational therapy service was very well led. The 'Safe wards' initiative had led to improvements in patient safety and care. Staff knew the vision and values of the trust and agreed with these. Systems were in place to ensure staff received mandatory training and regular supervision.

Good

Summary of findings

- There was evidence that incidents were learnt from. However, action had not been taken to provide a photograph of each patient on their medicine chart following an incident which resulted in a patient's death.

Summary of findings

Background to the service

The acute wards for adults of working age and the psychiatric intensive care unit (PICU) provided by Northamptonshire Healthcare Foundation Trust are based on two hospital sites at St Mary's in Kettering and Berrywood in Northampton.

St Mary's Hospital has two acute recovery wards: Avocet and Sandpiper and one assessment admission ward: Kingfisher. Avocet has 15 beds for men and Sandpiper has 15 beds for women. Kingfisher has 10 beds for men and women.

Berrywood Hospital has two acute recovery wards: Bay and Cove, one assessment admission ward: Harbour and one PICU: Marina. Bay has 17 beds for women and Cove has 17 beds for men. Harbour has 12 beds for men and women. Marina has seven beds for men and women.

We inspected the services provided by Northamptonshire Healthcare Foundation Trust at St Mary's Hospital twice on 25 September 2013 and 1 April 2014. The outstanding compliance action for Regulation 10 of 2010 related to the monitoring of seclusion and whether seclusion was in line with their own seclusion policy. However, on this inspection, the service was now compliant with Regulation 17 of 2014 as seclusion monitoring and audit processes have improved in line with the required standards.

Our inspection team

The team that inspected the acute wards for adults of working age and the psychiatric intensive care unit consisted of eight people: two experts by experience, one inspector, one social worker, two Mental Health Act Reviewers, an occupational therapist and a psychiatrist.

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 these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited all seven of the wards at the two hospital sites (Berrywood and St Mary's) and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 34 patients who were using the service

Summary of findings

- spoke with the managers or acting managers for each of the wards
- spoke with 37 other staff members; including doctors, nurses and social workers
- interviewed the senior matron at Berrywood Hospital
- attended and observed three hand-over meetings and four multi-disciplinary meetings.

We also:

- collected feedback from patients using comment cards.
- looked at 14 treatment records of patients.
- looked at 92 patients prescription charts
- carried out a specific check of the medication management on Harbour ward.
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

Most patients said they felt safe.

Most patients told us that the food was okay and they had a choice.

Patients said they had regular physical health checks.

Patients told us they had their rights under the Mental Health Act explained to them. However, some informal patients were unsure if they could go out of the ward or not and what their rights were.

Patients told us that staff were caring, respectful and polite.

Some patients said that staff did not always have the time to speak with them and they did not have one to one time with staff enough.

Some patients told us they were involved in their care plans, however, some patients were unsure what a care plan was and how they were being supported to meet their needs.

Some patients said there were restricted times for hot drinks and on Harbour and Marina wards they were unable to take drinks out of the dining room.

Most patients said that the activities provided were good and helped to keep them busy.

Patients said that the ward was comfortable.

Patients told us they had information about advocacy and knew how to contact them.

Good practice

The model of occupational therapy used in the service is Model of Creative Ability (MOCA). All patients had an occupational therapy assessment and then through using this model were engaged with individually to develop their skills and abilities. We saw that this was used throughout the service. Patients were encouraged to share their skills and knowledge with other patients which helped to promote their self-esteem.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Seclusion rooms must be fully compliant with the Mental Health Act 1983 Code of Practice (2015).
- Action must be taken to minimise the blind spots in the wards so that staff can observe patients in all parts of the ward.
- All wards must comply with the guidance on same sex accommodation.
- There must be sufficient staff in Harbour ward to safely meet patients' needs.
- Learning from incidents must be implemented to reduce risks to patients.
- There must be systems in place to ensure that patients' capacity to consent is assessed and their human rights are respected in all cases.

Summary of findings

- Staff must receive the training they need to have an understanding of the Mental Capacity Act 2005.

Action the provider SHOULD take to improve

- All staff should be aware of the safeguarding procedures and how to report.
- The environment in Marina should be improved to ensure it is safe for all patients, staff and visitors.
- Patients' advance wishes should be considered.
- All staff in Marina ward should have training in how to support patients who have autism and Asperger's.
- Patients care plans should be in formats that they are able to understand.
- All staff should be able to access all records about a patient to ensure that they can support the patient safely to meet their needs.
- Restrictions should only be made on patients based on their individual risks.
- Consideration should be given to the environment on all wards to ensure that patients who have a physical disability can be safely accommodated there.
- Staff should receive the training they need so that they can meet the needs of all patients.

Northamptonshire 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
Kingfisher, Sandpiper, Avocet wards	St Mary's Hospital
Bay, Cove, Harbour wards Marina PICU	Berrywood Hospital

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.

Staff were trained in the MHA, the Code of Practice and the guiding principles. However, staff did not always demonstrate that they knew how this related to the individual care and treatment of patients.

The checklist used for assessing a patient's capacity to consent to their treatment was not completed. The records stated whether the patient had capacity or not but it was not clear how this decision had been reached.

The documentation in respect of the MHA was generally good. Two patient's records did not include consent to treatment forms.

Staff explained to patients their rights under the MHA when they were admitted. However, some patients did not have this explained routinely following admission to ensure they understood them. Information was provided to patients about their rights in leaflets which were produced in other languages where needed.

Patients were referred to the Independent Mental Health Advocate (IMHA) service where appropriate.

Detailed findings

Administrative support and legal advice on the implementation of the MHA and its Code of Practice was available from a central team.

Records showed discussions with the Second Opinion Appointed Doctor (SOAD) and patients were informed of the outcome of these.

The outcomes of managers' hearings panel reports were available in patient files. The reports from the Approved Mental Health Professional (AMHP) were not available in some files.

Mental Capacity Act and Deprivation of Liberty Safeguards

Some staff told us they had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, many staff we spoke with lacked an understanding of this legislation.

Doctors had recorded that the patient lacked mental capacity but it was not clear how this decision had been reached.

Staff had a limited understanding that capacity was linked to specific decisions. Records showed that where it was assessed that the patient lacked mental capacity this was for all decisions the patient would make.

Staff lacked awareness of when and who might lack the mental capacity to make decisions about their care and treatment.

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

Summary of findings

We rated safe as requires improvement because:

- Seclusion facilities were not fully compliant with the Mental Health Act 1983 Code of Practice (2015).
- In Harbour ward unfamiliar bank staff were used and nursing staff had to spend more time working on bed management across the service than working with patients.
- There were ligature risks in the gardens at Kingfisher, Sandpiper and Avocet.
- There were blind spots on all wards.
- Harbour, Marina and Kingfisher wards did not comply with the guidance on same sex accommodation.
- Some staff had a limited awareness of safeguarding procedures.
- A serious incident where a patient died had not been learnt from as there was not a photograph of each patient on their medicine chart.

Emergency equipment was checked regularly and all staff were trained in how to use it. Environmental risk assessments were done regularly. Ward managers were able to adjust staffing levels to ensure safe staffing. Each patient had a risk assessment completed on admission that was updated regularly. There were clear records kept when a patient was secluded.

Our findings

Kingfisher, Sandpiper, Avocet, Bay, Cove, Harbour wards

Safe and clean ward environment

- There were blind spots on all wards so staff were not able to observe all parts of the ward.
- There were ligature risks in the gardens in Avocet, Sandpiper and Kingfisher wards.
- Harbour and Kingfisher wards did not comply with the guidance on same sex accommodation. The bedroom corridors had not been separated into male and female corridors.
- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that were checked regularly.
- Seclusion rooms at both hospitals were not fully compliant with the Mental Health Act 1983 Code of Practice (2015)For example, they did not allow clear observation, two- way communication and did not have a visible clock. There were toilet facilities. However, if a patient wanted to use the toilet staff would not be able to ensure their safety as there were blind spots.
- At St Mary's Hospital the seclusion room was situated on the ground floor. This meant that if a person on Avocet ward needed to be secluded they had to be moved from the first floor. Patients who need to be secluded are at risk to themselves or others so to move a patient to another floor could increase the safety risk to the patient and to staff.
- Ward areas were clean, had good furnishings and were well maintained.
- Environmental risk assessments were undertaken regularly.
- Staff had access to appropriate alarms on all wards.

Safe staffing

- The provider has estimated the number and grade of nurses required using a recognised tool.
- In Harbour ward staff were concerned about the number of staff as they were also responsible for managing the 136 suite when it was used and for managing beds across the acute service. We saw that qualified nursing staff spent several hours on the phone in the office doing tasks related to bed management. Patients said that nurses were often not on the ward but busy in the office.
- In Harbour ward bank staff who had not previously worked on the ward were used to cover shifts.
- Staff in Kingfisher ward also managed the 136 suite at St Mary's Hospital. Their staffing levels had been increased by one to cover this which reduced the risk. Some staff told us that they did not always feel safe when covering the 136 suite as patients were unknown and often would be drunk or under the influence of illicit substances. They said they would call the police if needed to mitigate this risk.

Requires improvement

Are services safe?

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

- Patients in Kingfisher ward said there was always at least one qualified nurse in the ward area and not in the office.
- Agency and bank staff were used on all wards however these were usually familiar with the ward.
- There were usually enough staff so that patients could have a regular one to one time with their named nurse. Some patients told us this was sometimes cancelled because the ward was short staffed.
- Escorted leave or ward activities were rarely cancelled because there were too few staff.
- There was adequate medical cover day and night and a doctor could attend the wards quickly in an emergency.

Assessing and managing risk to patients and staff

- Staff completed a risk assessment of every patient on admission and updated this regularly.
- Staff used a recognised risk assessment tool.
- The risk of the ligature points in the gardens at St Mary's Hospital were reduced by patients being restricted to using the garden only when supervised by staff. This is a blanket restriction on all patients regardless of their individual risk.
- Informal patients were not clear of their rights to leave at will. We saw that risk assessments were in place which stated why the patient could not go off the ward unescorted by staff. However, not all staff were aware on Avocet ward which meant that patients could be at risk.
- Restraint was only used after de-escalation had failed and staff used correct techniques. All staff received training on the use of restraint. If they failed to meet the training requirements they had to do the training again to ensure that patients and staff were safe.
- Use of rapid tranquilisation followed NICE guidance.
- Seclusion was used appropriately. However, staff were not able to safely observe patients when in the seclusion rooms. At St Mary's Hospital we found that police were regularly called to assist staff to take a patient to the seclusion room.
- The records for seclusion were kept in an appropriate manner.
- All staff were trained in safeguarding, however some unqualified staff had limited knowledge of what safeguarding meant and how to ensure this was reported to the relevant authorities.
- There was good medicine management practice in all the wards.
- There were safe procedures for children visiting the hospital. Separate rooms were provided off the wards.

Track record on safety

- An incident had occurred on another ward within the trust where a patient was given another patients medication and died as a result. The learning from this was to have photographs on each patient's medicine record. Cameras had been purchased but photographs had not been taken. This meant that improvements in patient safety had not been made as a result of this.

Reporting incidents and learning from when things go wrong

- Staff said that they learnt from incidents and had opportunities to discuss and reflect on incidents at their monthly team days.
- Most staff told us they received feedback from investigation of incidents and met to discuss this. Some staff told us that this was not done formally but was often referred to during staff handovers. They thought the support could be improved so that changes could be made as a result.
- Information was displayed around the wards on the 'Safe wards' initiative and staff told us about this. They said that this had helped to reduce the number of restraints and seclusion used. It also helped to promote a more equal relationship between staff and patients which helped to make the ward a safer place.

Marina PICU

Safe and clean ward environment

- There were blind spots which meant that staff were unable to observe patients in all parts of the ward. Staff were unable to see the corridors and bedrooms from the nursing office.
- The ward did not comply with guidance on same sex accommodation. Bedrooms were en suite however, women had to pass a man's bedroom to get to their bedroom and vice versa. There were two separate lounges but these were not designated as for men or women only so both men and women used both lounges. Staff were aware of the need to have separate male and female bedroom corridors but this was dependent on the patients admitted and the gender mix at the time.

Requires improvement

Are services safe?

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

- The clinic room was fully equipped and accessible with resuscitation equipment and emergency drugs that were checked regularly.
- The seclusion room was not fully compliant with the Mental Health Act 1983 Code of Practice (2015).We found that there were blind spots. There was a mirror to try and reduce these but this had been removed by a patient and not replaced. Staff said that CCTV cameras were to be installed to eliminate the blind spots but were unsure when these would be fitted. The clock was digital and the time was not visible. Staff used a high rise seat which was placed at the door of the seclusion room to reduce risks. The intercom had been removed by a patient and not replaced so had to communicate through the locked door. Staff said seclusion was used for a minimum time but if needed to enter to allow patient to use toilet or give food and drink would have a team of at least three staff to do this. This also allowed time to assess the patient.
- The ward was clean. Some of the furniture and decoration was worn. Staff told us that there were plans to redecorate and refurbish the ward. The lighting was bright and did not help to create a relaxed environment.
- Staff had access to appropriate alarms.

Safe staffing

- The provider had estimated the number and grade of nurses required using a recognised tool.
- Bank and agency staff covered shifts where there were vacancies and sickness and when a higher level of observation was needed to keep patients safe. These were usually staff who were familiar with the ward.
- The ward manager was able to adjust staffing levels daily to take account of case mix and patients' needs.
- A relative told us they did not feel safe when visiting the ward due to the behaviour of some patients. They did not feel that there were sufficient staff to reduce this risk.
- There were usually enough staff so that patients could have a regular one to one time with their named nurse. Some patients told us this was sometimes cancelled because the ward was short staffed.
- Escorted leave or ward activities were rarely cancelled because there were too few staff.
- There was adequate medical cover day and night and a doctor could attend the wards quickly in an emergency.

Assessing and managing risk to patients and staff

- Staff completed a risk assessment of every patient on admission and updated this regularly.
- Staff used a recognised risk assessment tool.
- Restraint was only used after de-escalation had failed and staff used correct techniques. All staff received training on the use of restraint. If they failed to meet the training requirements they had to do the training again to ensure that patients and staff were safe.
- Use of rapid tranquilisation followed NICE guidance.
- Seclusion was used appropriately. However, the seclusion room had blind spots which made observation from outside difficult.
- The records for seclusion were kept in an appropriate manner.
- All staff were trained in safeguarding, however some unqualified staff had limited knowledge of what safeguarding meant and how to ensure this was reported to the relevant authorities.
- There was good medicine management practice.
- There were safe procedures for children visiting the hospital. A separate room was provided off the ward.

Track record on safety

- An incident had occurred on another ward within the trust where a patient was given another patients medication and died as a result. The learning from this was to have photographs on each patient's medicine record. A camera had been purchased but photographs had not been taken.

Reporting incidents and learning from when things go wrong

- Staff said that they learnt from incidents and had opportunities to discuss and reflect on incidents at their monthly team days.
- Staff told us they received feedback from investigation of incidents and met to discuss this.
- Information was displayed around the ward on the 'Safe wards' initiative and staff told us about this. They said that this had helped to reduce the number of restraints and seclusion used. It also helped to promote a more equal relationship between staff and patients which helped to make the ward a safer place.

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.

Summary of findings

We rated effective as requires improvement because:

- The records system was cumbersome and it was difficult to find all the information about a patient.
- Staff did not always use the Mental Health Act and the accompanying Code of Practice correctly.
- Staff did not show that they had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). The assessment of patient's mental capacity lacked detail in the cases reviewed.
- There was limited psychology input which resulted in the assessment process being delayed for one patient.

Patients physical health needs were monitored. Staff received training and supervision to ensure they had the skills to deliver care and treatment. Staff received an annual appraisal. Multi-disciplinary teams and inter agency working were effective in supporting patients. There were effective handovers between shifts. Inpatient and community consultant psychiatrists worked well together.

Our findings

Kingfisher, Sandpiper, Avocet, Bay, Cove, Harbour wards

Assessment of needs and planning of care

- An assessment was completed of each patients needs soon after their admission.
- A physical examination of each patient had been done. There was ongoing monitoring of patients' physical health problems.
- Care records were up to date.
- The records system used was cumbersome which made it difficult to find all the information about a patient. Some staff were unable to find all the records relating to a patient. For example, on Avocet ward staff were unable to find one patient's physical health records.

Best practice in treatment and care

- There was evidence that staff followed NICE guidance when prescribing medication.
- The number of psychologists was limited. There were two part time clinical psychologists and a trainee psychologist. However, some of the occupational therapists were trained in Cognitive Behavioural Therapy (CBT) so this was offered to more patients. There were also groups on how it felt to be admitted which gave patients an opportunity to discuss this.
- There was good access to physical healthcare; including access to specialists when needed.
- Some patients were offered an alternative treatment to electro-convulsive therapy (ECT) which was now being used in the service.
- Clinical staff participated actively in clinical audits.

Skilled staff to deliver care

- The full range of mental health disciplines and workers provided input to the ward. These included occupational therapists, psychologists, social workers and pharmacists.
- Staff received mandatory training, supervisions and appraisals. Staff had access to a monthly team meeting day which included training and development.
- Staff received the necessary specialist training for their role.

Multi-disciplinary and inter-agency team work

- There were regular and effective multi-disciplinary meetings.
- There were effective handovers within the team between each shift.
- There were effective working relationships with other teams within the organisation including care co-ordinators and the community mental health teams.
- Inpatient and community consultant psychiatrists worked well together.
- There were effective working relationships with teams outside of the organisation, for example, social services.

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

- Staff were trained in the Mental Health Act, the Code of Practice and the guiding principles. However, they lacked an understanding of this particularly in regard to informal patients.

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.

- Informal patients in Avocet and Sandpiper wards were told that if they left the ward they would be detained under the Mental Health Act (MHA).
- Consent to treatment and capacity requirements were not always adhered to. We found that not all records included consent to treatment forms.
- The checklist used for assessing a patient's capacity to consent to their treatment was not completed. The records stated whether the patient had capacity or not but it was not clear how this decision had been reached.
- Patients had their rights under the MHA explained to them on admission however, some patients did not have these explained routinely following admission.
- Administrative support and legal advice on the implementation of the MHA and its Code of Practice was available from a central team.
- Detention paperwork was filled in correctly, up to date and stored appropriately.
- Patients had access to the Independent Mental Health Advocacy (IMHA) services and staff were clear on how to support patients to access this.

Good practice in applying the Mental Capacity Act (MCA)

- Staff were trained in the MCA 2005 however, not all staff had a good understanding of this.
- There was a policy on MCA including Deprivation of Liberty Safeguards which staff were aware of.
- Capacity to consent was not recorded appropriately. Staff lacked the understanding that this should be done on a decision specific basis with regards to significant decisions.
- The MHA was used when patients were informal and the use of the MCA was not considered. For example, if an informal patient who was unsafe leaving the ward unescorted by staff wanted to leave the ward, staff told us that the patient would be detained under the MHA to ensure their safety. They did not consider that the patient may lack capacity which impacted on their safety and that the MCA could be used as a least restrictive option.
- Staff lacked understanding about who might lack capacity to make specific decisions and thought this related more to older adult wards.

Marina PICU

Assessment of needs and planning of care

- An assessment was completed of each patients needs soon after their admission.
- A physical examination of each patient had been done. There was ongoing monitoring of patients' physical health problems.
- Care records were up to date.
- The records system used was cumbersome which made it difficult to find all the information about a patient. Some staff were unable to find all the records relating to a patient.

Best practice in treatment and care

- There was evidence that staff followed NICE guidance when prescribing medication.
- The number of psychologists was limited. There were two part time clinical psychologists and a trainee psychologist for the service. The limited psychology input delayed the assessment process for one patient.
- There was good access to physical healthcare; including access to specialists when needed.
- Clinical staff participated actively in clinical audits.

Skilled staff to deliver care

- The full range of mental health disciplines and workers provided input to the ward. These included occupational therapists, psychologists, social workers and pharmacists.
- Staff received mandatory training, supervisions and appraisals. Staff had access to a monthly team meeting day which included training and development.
- Staff received the necessary specialist training for their role.

Multi-disciplinary and inter-agency team work

- There were regular and effective multi-disciplinary meetings.
- There were effective handovers within the team between each shift.
- There were effective working relationships with other teams within the organisation including care co-ordinators and the community mental health teams.
- Inpatient and community consultant psychiatrists worked well together.
- There were effective working relationships with teams outside of the organisation, for example, social services.

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

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.

- Staff were trained in the Mental Health Act, the Code of Practice and the guiding principles. However, they lacked an understanding of this.
- Consent to treatment and capacity requirements were not always adhered to. Two patient's records did not include consent to treatment forms.
- The checklist used for assessing a patient's capacity to consent to their treatment was not completed. The records stated whether the patient had capacity or not but it was not clear how this decision had been reached.
- Patients had their rights under the MHA explained to them on admission however, some patients did not have these explained routinely following admission.
- Administrative support and legal advice on the implementation of the MHA and its Code of Practice was available from a central team.
- Detention paperwork was filled in correctly, up to date and stored appropriately.
- Patients had access to the Independent Mental Health Advocacy (IMHA) services and staff were clear on how to support patients to access this.

Good practice in applying the Mental Capacity Act (MCA)

- Staff were trained in the MCA 2005 however, not all staff had a good understanding of this.
- There was a policy on MCA including Deprivation of Liberty Safeguards which staff were aware of.
- Capacity to consent was not recorded appropriately. Staff lacked the understanding that this should be done on a decision specific basis with regards to significant decisions.
- Staff lacked understanding about who might lack capacity to make specific decisions.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

Staff were caring. Patients' skills and knowledge were valued. Staff generally had a good understanding of patients' needs. Staff were sensitive to patients' needs. Patients' families and carers were involved in their care. Advocacy services were involved.

Our findings

Kingfisher, Sandpiper, Avocet, Bay, Cove, Harbour wards

Kindness, dignity, respect and support

- We observed that staff were respectful to patients and responded to them in a caring manner.
- We observed during occupational therapy sessions that patients were given an opportunity to share their skills and knowledge with other patients.
- Patients told us that staff were respectful and polite. We asked 13 patients if staff knocked on their bedroom door before they entered. Nine patients told us that staff did knock however; four patients told us they did not do this which did not respect their privacy and dignity.
- Patients told us that staff were caring and were interested in their wellbeing.
- Three patients in Bay ward and one patient in each of Cove and Avocet wards said that staff did not always have the time to speak with them. They said that they did not have their one to one time with staff enough. All other patients spoken with told us that staff were always available to talk with when they needed.
- Staff understood patients' individual needs and how to support them. In Bay ward staff had received training in how to meet the specific needs of a patient who was fed through a tube in their stomach. They had recognised that this could be a training need across the service and had developed a training package with the dietician.

The involvement of patients in the care they receive

- The admission process informed and oriented the patient to the ward.
- Records did not always record the involvement of the patient in their care plan.
- We observed that patients were involved in their ward round and were treated by all staff with dignity and respect.
- Most patients said they felt involved in their care. Two patients each on Cove and Avocet wards and one patient each on Kingfisher and Sandpiper wards told us they were not involved in their care plan. One of the patients on Cove ward was unsure what a care plan was.
- Patients had access to advocacy services. Information about advocacy services were displayed on each ward.
- Patients' families and carers were involved where this was appropriate.
- Patients gave feedback on the service they received in community meetings. Action was taken that showed that staff listened to patients and improved the service where possible.
- Patients were able to give immediate feedback about the ward using the 'I want great care' forms that were either in Tablet or paper formats. On each ward we saw that the results of this were displayed and staff were keen to ensure that the score for their ward improved each month.

Marina PICU

Kindness, dignity, respect and support

- We observed that staff were respectful to patients and responded to them in a caring manner.
- Patients told us that staff were respectful and polite.
- Patients told us that staff were caring and were interested in their wellbeing.
- Staff generally understood patients' individual needs and how to support them. All staff had received specific training in how to meet one patient's needs. Staff had received basic training in supporting patients who have a learning disability. However, not all staff were trained in how to support patients who had Asperger's. The ward manager was to deliver some training to staff in this to help improve their knowledge.

The involvement of patients in the care they receive

- The admission process informed and oriented the patient to the ward.
- Records did not always record the involvement of the patient in their care plan.
- Staff said that patients were involved in their ward round if they were well enough.

Good

Are services caring?

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

- Patients had access to advocacy services. Information about advocacy services was displayed on the ward.
- Patients' families and carers were involved where this was appropriate.
- Patients were able to give immediate feedback about the ward using the 'I want great care' forms that were either in Tablet or paper formats. The results of this were displayed and staff were keen to ensure that the score improved each month.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

We rated responsive as requires improvement because:

- In some wards there were restrictions on all patients and these were not based on individual risk. For example, hot drinks were limited, the kitchen, lounges and bedrooms were locked and patient's access to the garden was restricted where there were ligature risks.
- Patients were able to personalise their bedrooms.
- In some wards patients did not have space to store their possessions. However, new furniture had been ordered in Marina ward to enable patients to do this. This would also be adapted to meet patient's needs.
- Information was available in a range of formats to meet patients' needs.
- Some patients were not clear about how to make a complaint.

The model of occupational therapy used was very good. Patients had access to a range of activities. A range of rooms were provided on each ward. Patients were supported to meet their religious and cultural needs. Interpreters were available.

Our findings

Kingfisher, Sandpiper, Avocet, Bay, Cove, Harbour wards

Access, discharge and bed management

- Beds were available on acute wards when needed to patients living in the 'catchment area.'
- There was not always access to a bed when a patient returned from leave.
- Patients were moved from the admission wards to acute recovery wards during an admission. However, if this was not in the patient's best interests this was avoided where possible.
- When patients were moved or discharged this happened at an appropriate time of day.
- Discharge was generally not delayed other than for clinical reasons. However, there were some difficulties in local commissioners and housing providers accessing suitable placements to meet some patient's needs.

The ward optimises recovery, comfort and dignity

- A range of rooms were provided on each ward to support treatment and care. The relaxation room on Bay ward had been adapted to meet the needs of the patients. Patients told us they liked using this room.
- There were quiet areas on each ward and a room where patients could meet visitors.
- Patients could make a phone call in private.
- In Bay ward patients were unable to access Wi-Fi as there was not a signal. Patients were frustrated about this and told us it limited their ability to communicate with others and access games and books on their devices.
- Patients had access to outside space. However, in Avocet, Kingfisher and Sandpiper wards this was limited due to the ligature risks in the gardens. The doors were locked and patients could not access the gardens without staff.
- There was unrestricted access to outside space in Harbour, Bay and Cove wards.
- Patients told us that the food was okay and they had a choice.
- Drink times were restricted in Harbour and Cove wards and drinks could not be taken out of the dining room. In Harbour ward the kitchen and lounges were locked and patients could only access the kitchen with staff supervision. These were rules for all patients and not based on individual risks.
- All rooms were locked in Bay ward and could only be accessed by patients with staff support. Staff told us that patients in Sandpiper ward had keys to their bedrooms. However, we saw and patients told us that they did not have these but had to ask staff when they wanted to go to their bedroom.
- There was limited space for patients to store their possessions in Kingfisher ward. Staff told us that there were plans to replace all the wardrobes to give patients more storage space.
- The model of occupational therapy used was very good. Patients had access to a range of activities that engaged with their individual skills and knowledge and helped them to develop new ones.
- The occupational therapy service was available on two evenings a week and at weekends.
- The activity programme was changed to accommodate what patients said they would like to do at community meetings.

Are services responsive to people's needs?

Requires improvement

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

- In Cove ward patients had access to a community work project outside the hospital. Patients told us that this helped them to feel that they contributed to the community. They also had work references to help them find work when they were discharged.

Meeting the needs of all people who use the service

- There were accessible toilets, bathrooms and bedroom on each ward. One patient who had mobility difficulties and used a frame to mobilise told us that the ward was accessible to them. However, in Avocet and Sandpiper wards we saw that if a patient used an electric wheelchair it would be difficult to use the accessible toilet as space was limited.
- Care plans were not in easy read formats which meant that some patients might not understand them.
- Information about treatments, local services, patient's rights and how to complain were provided in accessible formats.
- There was easy access to interpreters where needed. We saw that interpreters attended patients ward rounds and tribunal hearings where required.
- Patients could request food to meet their religious and cultural dietary requirements.
- Patients had access to appropriate spiritual support.

Listening to and learning from concerns and complaints

- Some patients were not clear about how to make a complaint. However, complaint information was provided in a range of formats.
- Staff knew how to support patients to make a complaint.
- Staff received feedback on the outcome of the investigation of complaints. Some staff told us that improvements had been made as a result of listening to complaints from patients.

Marina PICU

Access, discharge and bed management

- Marina was the only PICU within the trust and so covered the whole of Northamptonshire. This meant that a bed was not always available on a PICU if a patient required more intensive care. Some patients were placed in Marina from other parts of Northamptonshire so were not close to family and friends.
- When patients were moved or discharged this happened at an appropriate time of day.
- Discharge was not delayed for other than clinical reasons.

The ward optimises recovery, comfort and dignity

- A range of rooms were provided to support treatment and care.
- There were quiet areas and a room where patients could meet visitors.
- Patients could make a phone call in private.
- Patients had access to a large garden and access to a courtyard where they could play football and basketball.
- Patients had a choice of food. Food was available to meet individual's needs and wishes.
- Hot drinks were limited and patients could not access the kitchen which was locked. Lounges and bedrooms were locked. This was for all patients and not based on individual risks.
- Patients were able to personalise their bedroom.
- The ward manager told us that new bedroom furniture to meet the needs of the service was to be provided in March 2015. This would give patients more room to store their possessions.
- The model of occupational therapy used was very good. Patients had access to a range of activities that engaged with their individual skills and knowledge and helped them to develop new ones. Most activities in Marina were individual and adapted to meet individual needs.
- The occupational therapy service was available on two evenings a week and at weekends.

Meeting the needs of all people who use the service

- There was a bathroom adapted to meet the needs of patients with a physical disability at the end of each bedroom corridor.
- There were bright lights in the ward which might affect patients who had autism. The ward manager told us that there were three patients on the ward at the time of our inspection who had a diagnosis of autism, Asperger's or learning disability. The ward environment was not adapted to meet these patient's needs.
- Care plans were not in easy read formats which meant that some patients might not understand them.

Are services responsive to people's needs?

Requires improvement

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

- Information about treatments, local services, patient's rights and how to complain were provided in accessible formats.
- There was easy access to interpreters where needed.
- Patients could request food to meet their religious and cultural dietary requirements.
- Patients had access to appropriate spiritual support.

Listening to and learning from concerns and complaints

- Information was provided in a range of formats so that patients were informed about how to make a complaint.
- Staff knew how to support patients to make a complaint.
- Staff received feedback on the outcome of the investigation of complaints. Some staff told us that improvements had been made as a result of listening to complaints from patients.

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.

Summary of findings

We rated well-led as good because:

Staff had good opportunities for professional development. The occupational therapy service was very well led. The 'Safe wards' initiative had led to improvements in patient safety and care. Staff knew the vision and values of the trust and agreed with these. Systems were in place to ensure staff received mandatory training and regular supervision.

- There was evidence that incidents were learnt from. However, action had not been taken to provide a photograph of each patient on their medicine chart following an incident which resulted in a patient's death.

Our findings

Kingfisher, Sandpiper, Avocet, Bay, Cove, Harbour wards

Vision and values

- Most staff were able to tell us the trust's values and agreed with these.
- Team objectives reflected the values and objectives of the trust.
- Staff knew who the most senior managers in the trust were and told us that these managers had visited the ward.

Good governance

- Ward systems were effective in ensuring that staff received mandatory training, had an appraisal and regular supervision.
- In Harbour ward staff were not always able to maximise shift- time on direct care activities as they spent time on bed management for the service.
- Staff participated actively in clinical audits.
- Incidents were reported and there was evidence that some incidents were learnt from. However, action had not been taken to provide a photograph of each patient on their medicine chart following an incident which resulted in a patient's death.
- Staff learnt from patients' feedback and made changes as a result of this.
- Indicators to gauge the performance of the team were used to develop active plans where there were issues.
- Ward managers had sufficient authority and admin support.
- Staff had the ability to submit items to the trust risk register.

Leadership, morale and staff engagement

- Staff knew how to use the whistle-blowing process and said they would feel confident to use this.
- Staff felt able to raise concerns without fear of victimisation.
- Some staff told us how the morale had been low due to staffing issues but thought this was now improving.
- Staff had opportunities for leadership development.
- Staff worked as teams and supported each other.
- Staff were given the opportunity to give feedback on services and input into service development.
- We saw that the occupational therapy service was very well led and this had an impact on the quality of service as a whole.

Commitment to quality improvement and innovation

- The 'Safe wards' initiative was used and staff told us how this had improved the wards and reduced the amount of restraints and seclusion needed.
- The occupational therapy model used had been researched and was based on a model from South Africa. Therapists had travelled to South Africa to research this. This model was now embedded within the service and had improved the occupational therapy service to benefit patients.

Marina PICU

Vision and values

- Staff were able to tell us the trust's values and agreed with these.
- The team objectives reflected the values and objectives of the trust.
- Staff knew who the most senior managers in the trust were and told us that these managers had visited the ward.

Good governance

- Ward systems were effective in ensuring that staff received mandatory training, had an appraisal and regular supervision.

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.

- Staff participated actively in clinical audits.
- Incidents were reported and there was evidence that some incidents were learnt from. However, action had not been taken to provide a photograph of each patient on their medicine chart following an incident which resulted in a patient's death.
- Staff learnt from patients' feedback and made changes as a result of this.
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- The ward manager had sufficient authority and admin support.
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- Staff knew how to use the whistle-blowing process and said they would feel confident to use this.
- Staff felt able to raise concerns without fear of victimisation.
- Some staff told us how the morale had been low due to staffing issues but thought this was now improving. They told us how the ward manager had made improvements and improved staff morale.
- Staff had opportunities for leadership development.
- Staff worked as a team and supported each other.
- Staff were given the opportunity to give feedback on services and input into service development.
- We saw that the occupational therapy service was very well led and this had an impact on the quality of service as a whole.

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This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (b) (c) (d)** The trust must ensure that sufficient numbers of suitably qualified, skilled and experienced staff are employed to ensure the safety of patients on all wards. The trust must ensure that action is taken to make improvements as a result of serious incidents. The trust must ensure that the seclusion rooms are fully compliant with the Mental Health Act 1983 Code of Practice (2015) to ensure patient safety. The trust must ensure that staff are able to observe patients and ensure their safety.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 (1) (3)** The trust must ensure that arrangements are in place for assessing patient's mental capacity to consent to their care and treatment. The trust must ensure that all staff have an understanding of the Mental Capacity Act 2005.