Bradford District Care 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)
TAD54	Airedale Centre for Mental Health	Fern Ward	BD20 6TA
TAD54	Airedale Centre for Mental Health	Heather Ward	BD20 6TA
TAD17	Lynfield Mount Hospital	Ashbrook Ward	BD9 6DP
TAD17	Lynfield Mount Hospital	Clover Ward	BD9 6DP
TAD17	Lynfield Mount Hospital	Maplebeck Ward	BD9 6DP
TAD17	Lynfield Mount Hospital	Oakburn Ward	BD9 6DP

This report describes our judgement of the quality of care provided within this core service by Bradford District Care 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 Bradford District Care NHS Foundation Trust. and these are brought together to inform our overall judgement of Bradford District Care NHS Foundation Trust..

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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Overall summary

We did not re-rate the service following this inspection:

- Whilst there had been significant improvements in ensuring that patients were safe, systems and processes were still embedding and there remained some areas of concern including staff not always completing environmental checks, ligature risk assessments not always identifying all the ligature risks or being updated, risk management plans were not always personalised or specific to the risks identified in the risk assessment, controlled drugs were not always managed appropriately, and patient leave documentation and the allocation of a risk rating for incidents was not always completed in line with the trust's policies.

However:

- The safety of the service had improved.
- Wards were safer, clean, well equipped, well furnished, mostly well-maintained and fit for purpose.
- Most staff had completed and kept up to date with their mandatory training, which was comprehensive and met the needs of patients and staff.
- Staff assessed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- The governance framework and processes had improved and ensured that ward procedures ran more smoothly and ensured that senior leaders within the service had better oversight.
- Staff spoke of a change in the culture of the organisation and that there was a collective responsibility. Senior leaders within the organisation were accessible and managers and staff felt supported.
- Most patients reported they had a positive experience and that most staff were nice. They told us staff kept them safe and they rarely used physical restraint.

Summary of findings

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

Are services safe?

We did not re-rate the safe key question following this inspection:

- Staff did not always complete local environmental checks or take action to reduce all risks they identified.
- Whilst staff had a comprehensive knowledge of ligature risks on all the wards, the assessment of ligature risk on all wards had improved but did not always reflect the current ligature risks on the ward.
- Risk management plans did not always tell staff how to respond to risks identified in patient risk assessments. Risk management plans were not always personalised or specific to the risks identified in the risk assessment.
- Staff did not always record patient leave from the ward in line with the trust policy.
- On one ward there were three bottles of controlled drugs that had not been disposed of and on another ward, there was a bottle of controlled drugs with no date of opening.
- The risk rating allocated to incidents was not always in line with trust policy.

However:

- Wards were safer, clean, well equipped, well furnished, mostly well-maintained and fit for purpose.
- Most staff had completed and kept up to date with their mandatory training, which was comprehensive and met the needs of patients and staff.
- Staff assessed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Systems and processes to safely prescribe, administer, record and store medicines had improved. Staff regularly reviewed the effects of medications on each patient's physical health.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services well-led?

We did not re-rate the well-led key question following this inspection:

Summary of findings

- Whilst there had been significant improvements in ensuring that patients were safe, systems and processes were still embedding and there remained some areas of concern. These included staff not always completing environmental checks, ligature risk assessments not always identifying all the ligature risks or being updated, risk management plans were not always personalised or specific to the risks identified in the risk assessment, controlled drugs were not always managed appropriately, and patient leave documentation and the allocation of a risk rating for incidents was not always completed in line with the trust's policies.

However:

- Governance processes at ward level had improved and performance and risk were better managed.
- The trust had made significant changes to the governance framework and processes since our last inspection, which had a positive impact on patient safety and the quality of care.
- Staff spoke of a change in the culture of the organisation and that there was a collective responsibility. Senior leaders within the organisation were accessible and managers and staff felt supported.

Summary of findings

Information about the service

Bradford District Care NHS Foundation Trust provides six inpatient wards for adults of working age who require acute and psychiatric intensive care. The trust is registered to provide two regulated activities in relation to this service:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

The trust provides the service from wards located at two sites. The Airedale Centre for Mental Health provides two acute inpatient wards. These are:

- Heather ward, a 19 bed female acute admission ward
- Fern ward, a 15 bed male acute admission ward.

Lynfield Mount Hospital provides three acute inpatient wards, and one psychiatric intensive care unit. These are:

- Ashbrook ward, a 26 bed female acute admission ward
- Oakburn ward, a 22 bed male acute admission ward
- Maplebeck ward, a 21 bed male acute admission ward
- Clover ward, a 10 bed mixed gender psychiatric intensive care unit.

Patients using the acute wards may be detained under the Mental Health Act or admitted informally. All patients admitted to the psychiatric intensive care unit on Clover ward are detained under the Mental Health Act.

We previously inspected this service between 5 March 2019 and 7 March 2019. We visited all six wards during this inspection as part of our planned inspection programme. We inspected using all our key questions; safe, effective, caring, responsive and well led. We rated the service as inadequate overall, with ratings of inadequate for safe and well-led and requires improvement for effective, caring and responsive. We found the trust to be in breach of the following regulations within the Health and Social Care Act (RA) Regulations 2014:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 17: Good governance
- Regulation 18: Staffing

Following the inspection, we issued the trust a warning notice under Section 29A of the Health and Social Care Act 2008. This told the trust that our findings indicated a need for significant improvement in the quality of healthcare. Issues identified that required significant improvement included assessing and mitigating risks to patients, recording patient's leave in line with the trust policy, managing, auditing and storing medicines, ensuring that admission processes supported staff in managing the risks presented by new patients arriving on the ward, ensuring patients had access to call alarms to summon help in an emergency, the review and recording following the use of restrictive interventions, ensuring that all incidents were investigated appropriately and that lessons were learned as a result, and ensuring that systems and processes were in place which were operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users in receipt of these services.

We also issued the trust six requirement notices in relation to this service which required the trust to make improvements.

This inspection looked at the actions taken by the trust to ensure there was significant improvement in safety on and off the wards and in the governance of this service.

The service will be inspected again in future to review the trust's improvements in relation to the requirement notices we served and to re-rate the service.

Our inspection team

The team was comprised of one CQC inspector, one CQC assistant inspector, and two specialist professional

Summary of findings

advisors. The specialist professional advisors were both mental health nurses with experience of working in acute mental health wards for working age adults and psychiatric intensive care units.

Why we carried out this inspection

We undertook this inspection to follow up on the Warning Notice we issued Bradford District Care NHS Foundation Trust under Section 29A of the Health and Social Care Act 2008. This Warning Notice included a timescale of 13 June 2019 by when improvements must have been achieved. We undertake focused inspections within three months of the date set in the Warning Notice in line with our enforcement policy.

Our inspection looked at whether the trust had made significant improvements in relation to the safety and governance of their acute mental health wards for working age adults and psychiatric intensive care unit since our last comprehensive inspection in March 2019.

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all six wards, looked at the quality and safety of the environments and observed how staff were caring for patients
- spoke with eight patients
- interviewed nine managers and senior managers responsible for the running of the service
- spoke with 15 other staff including nurses, healthcare support workers and members of the multidisciplinary team
- reviewed a sample of 65 medication records of patients on each ward
- reviewed a sample of 23 records of restrictive interventions including restraint, seclusion and rapid tranquilisation.
- reviewed a sample of 66 days of leave records
- reviewed observation charts for 17 patients on enhanced observations.

We also:

- looked at the care and treatment records of 13 patients
- looked at a range of policies, procedures and other documents relating to the running of the service.
- observed four safety huddles, two seclusion reviews and two call out meetings.

What people who use the provider's services say

We spoke with eight patients. Most reported they had a positive experience and that most staff were nice. They told us staff kept them safe and rarely used physical restraint.

Some patients knew what their discharge plans were, but others did not. Some patients told us they had received copies of their care plans the day before we visited, and these did not reflect the discussions they had had with staff.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure that staff complete documentation fully when patients go on leave from the ward. (Regulation 12)
- The trust must ensure that the ward environment is reviewed regularly, and action is taken in response to issues when identified. (Regulation 12)
- The trust must ensure that ligature risk assessments reflect all ligature risks in the environment. (Regulation 12)
- The trust must ensure that patients have a risk management plan that addresses the risks identified in their assessments and is person centred. (Regulation 12)
- The trust must ensure systems and processes that enable the registered person to assess, monitor and improve the quality and safety of the services continue to be embedded. (Regulation 17)

Action the provider SHOULD take to improve

- The trust should ensure that staff complete documentation fully when patients are on enhanced observations.
- The trust should ensure effective communication is in place between the wards and estates department and that staff are aware of the processes, so that maintenance work is carried out as required and in a timely way.
- The trust should ensure that staff are compliant with their outstanding training.
- The trust should ensure that controlled drugs are managed safely and disposed of when no longer needed.
- The trust should ensure incidents are correctly categorised.

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

Wards were safer, clean, well equipped, well furnished, mostly well-maintained and fit for purpose. We saw maintenance and repairs completed during our inspection.

However, staff did not always complete local environmental checks or take action to reduce risks identified. The service had a daily environmental check process. Two staff should check the ward environment and report any problems to the maintenance department. These checks were not always carried out and the records were poor. Staff did not always record who completed the check, repeat issues where not identified, it was unclear whether action was being completed, and action was not always completed in a timely way. Staff told us this in part was due to poor communication systems with the estates department. Managers told us they did not have access to the estates logs. Some managers told us they would chase up issues that had been reported and find that they had been closed by the estates department without being resolved.

For example, on five wards, problems had been identified on one day but they did not copy through onto the next day even though there was still a problem. There were several issues identified on Fern ward including a broken glass viewing panel in the interview room, recorded on 2 September 2019 as “glass already reported” with no job number and not identified on any other records in September. This was still broken during the inspection on 10 September 2019. Also, on 7 September Fern ward courtyard had a broken window and ventilation cover; there was no evidence of them being reported and they were not identified on the following days and were also still broken at the time of the inspection.

However, the trust was aware that the environmental checks were not being completed correctly and had recently introduced a safety cross to monitor the environmental checks.

At the factual accuracy stage of the inspection, the trust told us that the estates team utilise a Computer Aided Facilities Management (CAFM) system called Concept. The electronic reporting and feedback element of Concept (called 'Reach') is available to all trust members of staff via the 'Connect' intra-net page. Training on this system is available and is being rolled out across the trust routinely.

Staff had easy access to alarms and patients had easy access to nurse call systems. Since the last inspection the trust had installed nurse call alarms in all patient bedrooms and communal areas. Managers reported they did not have systems in place to test them.

Safety of the ward layout

Staff could not observe patients in all parts of the wards. However, staff acted to mitigate blind spots on wards where patients could cause harm to themselves or others outside the view of staff. For example, on Oakburn and Ashbrook wards a staff member was present in the central hub area of the ward as the telephone room was in a blind spot. Staff also used observation of patients to reduce risks in the ward environment such as blind spots and ligature points. Observation levels varied and depended on the risk presented by the patient.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. A ligature point is a fixed point which a patient may use to tie something to strangle themselves.

Staff had a good understanding of the ligature points on their wards. Since the last inspection staff had undertaken new ligature awareness training. Managers had used a combination of theory and practical sessions to support staff to understand potential ligature points. Staff spoke highly of this training and all staff we spoke with knew where the ligature points were on their ward.

Since the last inspection, the trust had reduced the number of potential ligature anchor points on all wards. The trust had undertaken maintenance work to address potential ligature risks including removing some fixtures and using anti-pick sealant to block spaces that could cause ligature risk.

The assessment of ligature risk on all wards had also improved. Since the last inspection, the trust had introduced a new format for the ligature risk assessment. All wards had an assessment completed in April 2019 and updated regularly. These assessments were more

comprehensive than at the last inspection and identified ligature risks in each room on the ward. Printed copies of the risk assessments were easily available in the ward office and each office contained a plan of the ward showing the areas of high risk. Each shift had a safety huddle and these included reference to where the ligature risk assessments were in the office and discussion of any patients with a specific risk.

However, the ligature risk assessments did not always reflect the current ligature risks on the ward. Risk assessments did not always accurately reflect the current level of risk following the maintenance work to remove the ligature points, for example the removal of the telephone on Oakburn ward. Clover, Oakburn, Ashbrook and Maplebeck wards all had rooms that were missing on the printed ligature risk assessment. Some ligature risk assessments had differences where the same fixture had been graded as a different level of risk in different rooms on the same ward, or the same fixture had been graded as a different level of risk on two different wards. In addition, ligature risks were identified on all wards that were not on the printed report. This was mainly on Ashbrook ward and included door closers, shelving, soap and towel dispensers in some rooms. On all occasions staff confidently identified the ligature risks present in the rooms and were surprised they were not on the assessment.

The trust had a monthly Ligature and Environment Risk Safety Group meeting. The governance arrangements around the ligature risk assessments had been discussed in the meeting in August 2019. An action had been identified for clinical managers to check the ligature risk assessments reflected the ward environment after work had been carried out to reduce the environmental risk. The trust had plans in place to move to an electronic system that reduced the administrative burden of the ligature risk assessments and would make updating the assessments easier.

Clinic room and equipment

Clinic rooms were equipped with most of the necessary resuscitation equipment and emergency drugs that staff checked regularly. Each ward had a dedicated clinic room. The rooms were clean and in good order; they contained examination couches and privacy screens for patients' physical examinations.

Each ward had an emergency grab bag stored in the clinic room. These were present on each ward and contained most of the correct equipment and emergency medicines. However, on Oakburn ward there was an empty oxygen cylinder.

Staff checked, maintained, and cleaned equipment. Each clinic room contained equipment to support patient care which had been serviced in the 12 months prior to inspection.

Safe Staffing

The service had nursing and medical staff, who received basic training to keep people safe from avoidable harm.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. The trust required all staff to complete four modules of mandatory training, regardless of their role or grade. These were information governance, fire safety, infection prevention and manual handling. The trust also had a list of required training for staff dependent on their role and grade.

The trust set a target of 80% for completion of mandatory and required training and a target completion rate of 95% for Information Governance and Fire Safety. The trust reports training on a month by month rolling basis.

The compliance for mandatory and required training courses at 10 September 2019 was 88%. Of the training courses listed, four failed to achieve the trust target and of those, three failed to score above 75%. The training compliance was higher than the 65% reported in March 2019

The training courses with the lowest levels of compliance were; care programme approach roles and responsibilities and care planning, food hygiene and moving and handling. The ward with the lowest compliance with training was Clover ward; Ashbrook ward had the highest level of compliance. All wards had an average training compliance above 80%. Since the last inspection, the trust had prioritised training on clinical risk formulation and had a plan in place for staff to complete the care programme approach training by December 2019. Staff were booked to complete Mental Capacity Act training by the end of September 2019 and food hygiene by the end of October 2019.

Are services safe?

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

The required training programme was comprehensive and met the needs of patients and staff. In addition to the new ligature awareness training, the CPA Clinical Risk, Formulation, Assessment and Management training had also been redesigned. Again, staff considered the best practice and the law related to clinical risk management, and then applied this within a role play scenario. Staff reflected on the experience and reviewed learning from recent serious incidents.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers had records in their office identifying which staff needed to attend training. Ward managers attended a weekly call out with the service manager where they discussed training compliance. During the inspection we observed this meeting and not enough training dates for moving and handling was escalated as a problem that stopped staff completing their mandatory training.

Assessment and management of patient risk

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff had access to risk information before a patient was admitted. At our last inspection in March 2019, we were concerned there was no process by which the clinical team were involved in admissions to consider individual patient needs against staffing or acuity difficulties on the ward. This had improved. The service had implemented a new acute mental health admission standard operating procedure (dated 4 April 2019). This detailed the procedure for admissions to all the wards and included the referrer contacting the ward and giving a verbal handover using a situation, background, assessment and recommendation (SBAR) template. This template identified essential information needed including the background of the patient and reasons for admission, the current risks that the person presented including any that would be present in a ward environment, and an agreement about when the person would be admitted to the ward. This process ensured that staff on the ward had the information necessary prior to a patient arriving to be admitted. Clover ward used a referral template that contained the same information as on the SBAR template.

We reviewed 11 care records across all wards. All records contained an SBAR template or referral form completed before admission. We observed an SBAR template being completed on one ward. The staff member noted the risk information necessary to understand the needs of the patient and agreed the time they would arrive on the ward. Staff spoke of feeling empowered by using this process and being able to challenge referrers if they did not provide enough information. The service managers were working with the local authority to ensure that staff who referred to the service were fully aware of the expectations and what type of information was required from them.

Staff completed a risk assessment for each patient when they were admitted and reviewed this regularly, including after any incident. We reviewed care records of 13 patients across all wards. All patients had a risk assessment completed within 24 hours of admission. Risk assessments had regularly been updated following incidents or when a patient's presentation changed. However, four patients had been absent from the ward without leave. Whilst all four risk assessments had been updated with a description following these incidents, only one risk assessment identified this as a risk.

Staff were prompted to ensure risk assessments were updated on incident forms and through the daily safety huddle and purposeful inpatient admission meeting where the multi-disciplinary team met together to review each patient. In the daily call out meeting, ward managers reported if any risk assessments or care plans needed to be updated.

Management of patient risk

Staff knew about risks to each patient and acted to prevent or reduce risks. In addition to the staff handover each ward had a safety huddle every day with all available members of staff attending it, including members of the multidisciplinary team and domestic staff. During the safety huddle staff discussed anything that could impact on patient safety including incidents, if patients had the same initials, patients with the highest level of risk, patients who needed physical health monitoring, patients that needed additional support in the event of a fire and any safeguarding or environmental risks.

Are services safe?

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

After the safety huddle staff conducted purposeful inpatient admission (PIPA) meetings every morning in which a visual control board was used to discuss each patient. We observed the discussion of two patients in a PIPA meeting. Staff held a comprehensive discussion of risk and incidents and identified actions to prevent or reduce the risk for each patient. Staff had detailed knowledge of the patients they worked with and what strategies helped individual patients. However, this was not always evident in care records.

Staff identified any changes in risks to, or posed by, patients and these were documented in their risk assessments. However, risk management plans did not always tell staff how to respond. Risk management plans were not always personalised or specific to the risks identified in the risk assessment, particularly on Clover and Oakburn wards. We saw good practice on Ashbrook and Heather wards where personalised, detailed risk management plans were in place. Patients on Maplebeck had detailed crisis plans in place, but these were not specific to the person. For example, they included the risk of arson for two patients with no known risk of arson.

Staff followed procedures to minimise risks where they could not easily observe patients. Each patient's risk level was assessed and if necessary, they were allocated enhanced levels of observation for risks such as suicide, self-harm and aggression. Observation levels were hourly checks or constant observation. Patients could have support from two staff if they needed it.

Most patients were on hourly observations. We reviewed 66 days of records across the service and found these were all complete with no gaps. We also reviewed patient observation charts for 17 patients who had received enhanced observations. Staff did not always complete all the necessary information on the charts such as how many staff were supporting the patient, when the enhanced observations had started or the date for the record being completed. Seven of these had at least one missing signature with 52 missed signatures in total. However, these had all been identified by the trust as missing and managers had sought assurance for example by reviewing closed circuit television footage to ensure the patient had been safe and the observations had been carried out.

Staff did not record patient leave from the ward in line with the trust procedure. This was a concern at the last inspection and was still a concern.

Staff completed a paper document and two electronic entries for each period of leave. Prior to accessing leave staff should complete several tasks which included; a risk assessment, a check of the patient's leave allocation, a contact number, time signing out and the destination of the leave, and a description of what the person was wearing. Staff were then required to record the time each patient returned to the ward.

We reviewed 66 days of leave records. Staff did not always document the full name of the patient, the destination of the leave or a description of what the patient was wearing. On some occasions the staff ticked that a patient had returned rather than recording the time of return. On occasions staff did not complete the electronic record of the leave period in a timely manner.

Patients who smoked took several short periods of leave during the day. The smoke free policy and procedure (dated 13/6/19) outlined the use of e-cigarettes which could be used outside in the grounds or in the ward courtyards. The policy stated that Section 17 leave for detained patients should be therapeutic and "not purely for the purpose of smoking." It also stated "Section 17 leave will be up to 2 periods per day and cannot be split or broken down further." However, we reviewed the leave allocations for three patients on Maplebeck who smoked. All had five or six short periods of leave allowed each day in addition to any longer periods of leave they were allowed. Heather ward and Fern ward had fewer periods of leave documented than the other wards.

The trust had completed regular audits on the leave documentation and had made some changes to the documentation in an attempt to improve the completion of this. They were also aware that the leave processes were time consuming and the impact of the smoke-free environment on leave allocation. As such, they had started a quality improvement project to improve these processes. This was not complete at the time of the inspection.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. This was also considered within the newly developed clinical risk training.

Use of restrictive interventions

Since the last inspection, the trust had improved processes to monitor the use of restrictive interventions. At the daily call out meeting, managers reported any incidents,

occasions when rapid tranquilisation or seclusion had been used. They also identified any actions that were needed, for example debriefs that needed to occur or gaps in documentation that needed to be followed up.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We reviewed eight restraint records, and on all occasions, staff had attempted to de-escalate the situation verbally. Patients told us that staff rarely used restraint and talked to them about ways they could manage their distress.

Between 01 April 2019 and 01 September 2019 there were 554 episodes of restraint. There were no prone restraints. Prone restraint is where a patient is restrained in the chest down position.

In this same time period, the trust reported there were no episodes of mechanical restraint by trust staff. There were three incidents involving mechanical restraint by the police. These were reported into the positive and proactive meeting and were escalated to Board if there were concerns raised through the quality and safety committee and the Mental Health Legislative Committee.

Staff followed National Institute of Health and Care Excellence guidance when using rapid tranquilisation.

Between 01 April 2019 and 01 September 2019 there were 107 episodes of rapid tranquilisation. Since the last inspection, the trust had updated the Procedure for the Pharmacological Management of Acutely Disturbed, Aggressive and Violent Behaviour (Including the use of Oral Medication and Rapid Tranquillisation) (Dated 04 April 2019) to reflect National Institute of Health and Care Excellence guidance, legislation and to provide updated procedural documents and templates. The new procedure also required staff to debrief patients within 72 hours and provided a useful visual assessment tool for when patients refused to have any physical observations taken.

We reviewed 12 rapid tranquilisation records. Ten of the 12 records were completely in order with required observations taken and the visual assessment tool used if a patient refused. One record on Clover ward did not contain the physical health monitoring documentation. However, the managers' review of the incident report clearly referred to the documentation being complete. One record on Fern ward was for a patient who had been given a medication that needed extended monitoring. This patient had monitoring initially, but then three four-hourly observations were missed. Two patients on Fern ward had not been offered a debrief.

During the inspection, we observed a daily call out at Lynfield Mount Hospital. Within this call out managers from Clover and Ashbrook both noted that debriefs following rapid tranquillisations in the last 24 hours had not been completed and plans were in place to complete them. The ward and clinical managers of the service were developing a local audit for the documentation to identify any gaps.

Between 01 April 2019 and 01 September 2019 there were no episodes of long-term segregation. There were 16 episodes of seclusion, which were all on Clover ward (psychiatric intensive care unit).

The five acute inpatient wards did not have a seclusion facility. If a patient required seclusion, they were transferred to the Clover ward, the psychiatric intensive care unit. When we visited the Airedale Centre for Mental Health, a patient had been placed in the Section 136 suite as their physical aggression could not be managed on the ward. They were then transferred to seclusion room at Lynfield Mount Hospital by the police and admitted to Clover Ward. Senior managers told us this rarely happened and there was no incident of this reported in the 3 months prior to the inspection.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. At the time of inspection, there were two patients admitted to Clover ward in seclusion. Both had been admitted directly to seclusion from other wards due to their presentation. One patient was in seclusion on a nearby forensic ward as the seclusion room on Clover was in use. We attended seclusion reviews for both these patients. Both patients were treated with kindness and dignity throughout the reviews and the decisions made were clinically appropriate.

Staff kept clear records when a patient was in seclusion. Since the last inspection, the seclusion record on the electronic record keeping system had been updated. We reviewed two seclusion records and these were in line with guidance and the trust policy. Observations were recorded correctly, patients were reviewed regularly and had a care plan in place. Since the last inspection, the ward manager had introduced a new seclusion audit to monitor for gaps

in seclusion records. We reviewed the audits for 17 episodes of seclusion. The audit reviewed seclusion documentation, required reviews, 15-minute observations, physical observations and debrief with the patient. Five episodes of seclusion had a missed signature and eight had a late review. These had been submitted as incident reports and new paperwork had been introduced to ensure reviews were on time. Any episode of seclusion was also reported in the daily call out meeting with the clinical manager.

Staff applied blanket restrictions on patients' freedom only when justified and reviewed these regularly. At our last inspection we were concerned that there were blanket restrictions in place with no review process. This had improved. Blanket restrictions were reviewed in the daily safety huddle and the daily purposeful inpatient admission meeting on each ward. Ward managers reported on the use of blanket restrictions in the daily call out meeting and completed an incident report every day which included details of the review. At the time of inspection Ashbrook and Heather ward had a blanket restriction in place regarding the use of plastic cups. Ashbrook had attempted to remove the restriction. However, due to further incidents it was reinstated. Ashbrook had clear signs explaining there was a blanket restriction in place in patient bedrooms and in the communal area of the ward. The incident reports showed a clear rationale for the blanket restriction being in place. A similar blanket restriction on Clover ward had been lifted as soon as possible. Staff explained that other blanket restrictions such as supervised bathing and drinks cans had been addressed since the last inspection.

Senior managers noted that good practice was shared with the forensic service through the positive and proactive care meeting and a number of blanket restrictions had been removed following the last inspection.

Medicines management

Systems and processes to safely prescribe, administer, record and store medicines had improved. At our last inspection we had concerns that medication management on each ward did not always follow best practice. We had concerns about gaps in medication administration records where staff had not signed for medication, checks of controlled drugs and the storage of medication.

Since the last inspection, the service had introduced a red tabard that nurses wore when administering medication. This clearly indicated that the nurse should not be interrupted and had reduced medication errors.

Staff checked medication administration records had been completed correctly in handovers. Ward managers reported any issues they had identified with medications not being signed for at the daily call out meeting. Any necessary actions were identified, and managers reported on these the next day.

Staff regularly reviewed the effects of medications on patients' physical and mental health in daily purposeful inpatient admission meetings.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored securely and were only accessible to authorised staff. All medicine was in date. However, on Heather ward we found an open bottle of medicine with no date of opening.

Medicines requiring refrigeration were stored appropriately and safely. At the last inspection in March 2019 we were concerned that the fridge and clinic room temperatures were not consistently monitored. The trust now had a digital system for fridge temperatures and these were monitored in the central pharmacy. The pharmacy team would contact wards if a fridge was too hot or cold to discuss actions to take, for example disposing of medication and ordering new stock.

There were arrangements for the management of controlled drugs and staff checked them weekly. Controlled drugs are managed under the misuse of drugs legislation; they are subject to rigorous checks and are classed (by law) based on their benefit when used in medical treatment and their harm if misused. On Heather ward, a discrepancy within the controlled drugs register had been identified and reported as an incident. This was reviewed by a senior manager. However, on Oakburn ward there were 3 bottles of a controlled drug that had not been disposed of. There were also 3 instances when there was no witness signature in the register. On Fern ward an open bottle of a controlled drug was not labelled with the date of opening. A nurse stated they had opened it on the morning of the inspection but had not labelled it.

Are services safe?

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

Staff followed current national practice to check patients had the correct medicines. Medication administration records were in good order with any allergies identified. Consent forms were stored with the records when necessary.

We reviewed the medication administration records of 63 patients. There were 28 occasions when patients had refused their medication and although this had been correctly coded on their medication administration record, the nurse had not signed the record. The medicines policy (dated 13 June 2018) did not offer staff any guidance about whether they should sign the record or not.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Health and Care Excellence guidance. Physical health monitoring was in place for the 16 patients who required it in the records we reviewed.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported most of them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff received training in risk awareness and the reporting of incidents and the service had 97% compliance with this training.

Staff reported most incidents that they should report. The trust used an electronic incident reporting system that was accessible to all staff. We reviewed the incidents reported in the three months prior to the inspection. Some referred to incidents that had not been reported previously for example environmental damage and a patient fall.

Staff reported incidents clearly. At out last inspection we were concerned that incidents where harm had occurred to patients were being signed off as 'no harm' or 'low harm'. This had improved. Incidents were assigned both an impact rating and a risk rating. Managers expressed frustration that only physical impact was considered within the impact rating. On Heather ward, the manager rated some ligature incidents as minor harm to recognise the psychological distress and impact the incident had on the individual. Senior managers were aware of this and the trust planned to review the incident guidance to better reflect psychological distress.

Managers had been provided with guidance about the risk rating of incidents, and further training was planned for the end of September 2019. However, we were concerned the trust did not currently have full oversight of the severity and type of incidents as at the time of inspection, incidents were not always rated in line with this. For example, on Maplebeck, Clover and Oakburn, incidents when a detained patient had escaped from the ward environment or absconded while on leave were rated as either 'near miss' or 'no harm'. The guidance said these should have been rated as 'moderate'. We saw some evidence that senior managers had fedback to managers when they felt an incident had been incorrectly graded.

The service had no never events on any wards in the last three months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if, and when, things went wrong. The provider had a duty of candour policy in place. Incident reports usually evidenced that staff had spoken to a patient when things had gone wrong.

Managers debriefed and supported staff after any serious incident. Staff told us they were offered debriefs after incidents, and they could also discuss these within supervision. Staff reported these were useful and that they felt supported, including when they had been off work following an incident. Some staff gave examples of when staff from other wards had covered a ward to ensure that all staff involved could attend a debrief.

Managers investigated incidents. Ward managers investigated incidents on their ward and senior managers reviewed the actions taken. They gave feedback to ward managers about other areas to consider when necessary.

Staff received feedback from the investigation of incidents, both internal and external to the service. Staff gave examples of incidents both within their ward and from other wards and the learning from these. For example, an incident on Oakburn ward had led to the ligature risk assessments being updated. The recently developed clinical risk training included discussion about recent serious incidents and staff spoke highly of this.

Are services safe?

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

Staff met to discuss the feedback and look at improvements to patient care. Feedback was shared through team meetings and minutes were circulated via email. Staff reflected on incidents and what their team would do in that situation. Incidents were also discussed in supervision, in handovers and within the daily safety huddle and purposeful inpatient admission meetings.

There was evidence that changes had been made as a result of feedback. For example, staff on Heather and Fern ward had recently started recording patients accessing the activity rooms at the Airedale centre for mental health on the register of movement to ensure they knew where all patients were. Staff also gave examples of ligature assessments being updated and seclusion paperwork being updated after incidents.

Are services well-led?

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

Our findings

Governance

Our findings from the safe key question demonstrated that governance processes at ward level had improved and that performance and risk were better managed. The trust had made significant changes to the governance processes since our last inspection and these had a positive impact on patient safety and the quality of care.

The trust had implemented a 'functional model' of care with one consultant psychiatrist on each ward. The multidisciplinary teams met every day to discuss patients within the purposeful inpatient admission meeting, which included discussion of patient risk, leave status, and any incidents that had occurred. Staff told us this meant that patients could have changes made to their treatment quickly and could progress faster. Staff commented that 'everything feels more organised and structured'.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The trust had introduced a series of 'call out' meetings across all levels of the trust. Ward managers attended a daily call out meeting with the clinical managers focusing on the immediate safety of the wards. Managers reported on a number of factors that impact on patient safety including bed occupancy, leave records, incidents, medicine omissions, seclusion, rapid tranquilisation, staffing levels, observations, risk assessments, blanket restrictions and any other significant issues. We observed two call out meetings and a weekly call out meeting with the service manager which included staff training compliance, vacancies, and serious incidents. This meant that ward managers were able to escalate any concerns such as training courses with not enough training dates to ensure staff compliance. These meetings were efficient, effective and any actions necessary were documented and revisited to ensure they had been completed the following day.

The chief operating officer also had a weekly call out meeting with general managers which included discussion of ligature risks, bank and agency shifts, staff training compliance, bed occupancy and readmission rates. This meant that throughout the organisation there was more oversight of areas of concern.

Staff spoke of a change in the culture of the organisation and that there was a collective responsibility. Senior leaders within the organisation were accessible and managers and staff felt supported.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Clinical service managers met with ward managers every week to review learning from serious incidents. Staff told us about times when changes had been made, for example ligature risk assessments were updated on all wards following an incident.

Staff undertook or participated in local clinical audits. Managers completed a daily audit and reported to the call out meeting. These audits were successful in identifying areas for concern that required improvement. Whilst there had been significant improvement, for example the seclusion audit on Clover ward resulted in the seclusion documentation changing, and reviews were now being completed in line with the Mental Health Act code of practice, in some areas there remained concerns. These included issues with environmental checks, ligature risk assessments, risk management plans, observations documents, leave documentation and oversight of incidents.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance