Sheffield Health and Social Care NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

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

Requires Improvement 

Sheffield Health and Social Care NHS Foundation Trust provides three acute inpatient wards for adults of working age and one psychiatric intensive care unit ward. Wards are located across two sites; The Longley Centre and The Michael Carlisle Centre.

The trust is registered to provide three regulated activities in relation to this core service;

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

We carried out this unannounced inspection because at our last inspection in May 2021 we rated the service as inadequate and issued the trust with a Section 29A warning notice indicating areas requiring significant improvement.

This was a full inspection of the service whereby we reviewed all the key lines of enquiry within all domains.

As part of this inspection we visited all four wards;

- Dovedale Two ward – a 12 bed female acute ward located at The Michael Carlisle Centre
- Stanage ward – a 16 bed male acute ward located at The Michael Carlisle Centre
- Maple ward – a 17 bed mixed-sex acute ward located at The Longley Centre
- Endcliffe ward – a 10 bed mixed-sex psychiatric intensive care unit ward located at The Longley Centre

Our rating of the service improved. We rated them as requires improvement because:

- Staff did not always assess and manage risks relating to patients' physical health. Checks were not consistently completed on, and during, admission when patients had known physical health concerns.
- Staff did not always ensure that the use of section 17 leave was safe and appropriate. We found occasions where staff did not record patient's use of leave and their whereabouts to maintain safety.
- Staff did not appropriately discharge their roles and responsibilities under the Mental Capacity Act 2005 and Mental Health Act 1983, as it was unclear how decisions were made regarding capacity and whether the principles of the Act were adhered to because it was not always appropriately documented.
- Managers did not ensure that all staff received training, as bank and agency staff did not have to engage in the trust's physical intervention training, and not all staff had received adequate levels of supervision.
- Managers did not ensure that blanket restrictions on the wards were individually risk assessed and proportionate, and that their use was consistently applied. We were concerned about the restrictive nature of the care provided to patients admitted to beds in the health based place of safety suite.

Our findings

- Managers lacked oversight of some risks and concerns we found during the inspection. Governance processes were not always followed to ensure the safe running of the service. We found that there was no procedure or policy in place to guide safe staffing in the use of physical interventions, and the procedure in place for the management of beds in the health based place of safety used for acute admissions did not take into account the restrictive nature of the care of these patients.
- Managers did not ensure that staff had access to shared learning in order to improve the service. Supervision rates were low, staff did not always have access to debrief following incidents and team meetings were not always planned, well attended and appropriately recorded.

However:

- There had been some areas of improvement since the time of the last inspection and the service was compliant with the warning notice previously submitted.
- The trust continued to make improvements to the ward environment, Burbage ward was closed for a full refurbishment and the temporary environment on Dovedale Two ward was an improvement. We found that the overall cleanliness and presentation of the wards was improved.
- Mandatory training levels in the management of aggression and violence had improved since the last inspection and the majority of mandatory training had an improving compliance trajectory.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- Staff followed good practice with respect to safeguarding, treated patients with compassion and kindness and understood the individual needs of patients.

How we carried out the inspection

During the inspection we visited all four wards, looked at the quality of the environment and observed how staff were caring for patients. We spoke to 28 members of staff including ward managers, senior service managers, registered nurses, healthcare assistants, doctors, occupational therapists and psychologists. We spoke to 11 patients and 11 carers and family members of patients using the service. We reviewed a range of patient documents including care records, medication and physical health charts, and restraint and seclusion records. We attended five clinical meetings and reviewed a range of policies and procedures relating to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Patients were largely positive in their feedback about the service. Patients told us they felt safe and that staff treated them well and were supportive and caring. Patients could attend weekly multi-disciplinary meetings where they were encouraged to ask questions and offered advice and support around their treatment. Patients were largely positive about the food and activities available on the wards.

Our findings

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were clean, well equipped, well furnished, well maintained and fit for purpose, but there were some concerns regarding environmental safety.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas, including ligature risk assessments, but did not remove or reduce all risks they identified.

Since our last inspection, patients on Burbage ward had moved to Dovedale Two ward whilst renovations were taking place. The environment on Dovedale Two ward was noted to contain a significantly reduced number of ligature anchor points compared to Burbage ward. However, ligature risks were not entirely mitigated on Dovedale Two ward. The ligature risk assessment stated that the assisted bathroom should be locked and used under supervision of staff due to ligature anchor points within the room, but we observed this room to be left open and patients to be using this freely without supervision during our inspection. Additionally, the assisted bedroom on the ward had detailed ligature anchor points on the ward ligature heat map, but these risks were not detailed within the ligature risk assessment, which made it unclear what mitigation, if any, was in place. The bathrooms on all four wards contained shower curtains, and whilst the shower rails were collapsible the curtains themselves were not detailed as potential ligature risks within ligature risk assessments.

Trust data showed there were a number of ligature related incidents on all of the wards between 1 June 2021 and 30 November 2021. There were 19 ligature related incidents on Dovedale Two ward, 22 on Endcliffe ward, 10 on Maple ward and one on Stanage ward. The trust told us that only one of these 52 ligature incidents involved a ligature from a fixed point. Ligature related incidents did appear to be reducing in number since our last inspection. However, these figures demonstrate that ligature related incidents were still a risk on all wards.

Environmental improvements were taking place on Stanage ward, and in the garden on Dovedale Two ward at the time of inspection. The trust had environmental risk assessments and protocols in place for external contractors working on-site to ensure the safety of patients during these works.

Staff had completed fire risk assessments for both buildings, although we were concerned that the risk assessment for The Longley Centre had not been reviewed since June 2020. There were fire evacuation plans specific to each ward. However, not all patients that needed them had personal emergency evacuation plans (PEEP) in place, and whilst managers told us that PEEP documents were stored on mobile devices which a staff member would have access to during an evacuation, not all staff we spoke with were sure whether PEEP documents were in place, or where to find them in an emergency. We were concerned that a patient on Endcliffe ward did not have a PEEP in place despite them being observed to be very unwell and staff conceding the patient would be unable to evacuate independently in an emergency.

Our findings

Staff could not observe patients in all parts of the wards due to some blind spots. However, these were mitigated through the use of mirrors, CCTV cameras and patient observations. On Stanage and Dovedale Two wards patients had to be supervised when using the garden due to safety concerns.

Two of the wards, Stanage and Dovedale Two, complied with guidance and there was no mixed sex accommodation, but the remaining two wards, Endcliffe and Maple, were mixed sex. One patient we spoke with told us they had been involved in a sexual safety incident on Maple ward and this was being investigated by the trust. On both mixed-sex wards the majority of patients had access to en-suite bathrooms apart from two female rooms on Maple ward that shared a bathroom. Both wards had a female-only lounge, although this was not labelled as such on Endcliffe ward.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were mostly clean, well maintained, well-furnished and fit for purpose. The clinic room on Stanage ward was small and there were a number of boxes and bags cluttering the space. However, all other ward areas were noted to be clean and well maintained. Dovedale Two was newly furnished throughout and Stanage ward was undergoing some refurbishment at the time of inspection to improve patient bedroom spaces.

Staff followed infection control policy, including handwashing. Hand sanitiser was available on entry/exit to wards and staff were wearing appropriate personal protective equipment.

Seclusion room

We were unable to view the seclusion rooms on Endcliffe ward as these were both in use at the time of inspection. However, staff told us all seclusion rooms allowed clear observation and two-way communication and contained a toilet and a clock. Dovedale Two ward did not contain a seclusion room. Staff told us they felt this was positive and reported only one occasion when a patient had to be transferred to a psychiatric intensive care unit because they could not be managed safely on the ward. There was a standard operating procedure on this ward for staff to follow to enable them to support patients without the use of seclusion.

Following inspection we raised concerns with managers that one of the seclusion rooms on Endcliffe ward was also being used a ‘green room’ (a designated room for the purpose of de-escalation). We were concerned that it was not always clear what the purpose of this room was, and whether patients were able to freely leave if using the space for de-escalation rather than seclusion. Managers told us that if being used as a green room patients would be free to leave this space at any time. However, the green room was located off the ward and staff told us that patients would only be allowed to re-enter the ward once calm, suggesting that patients were not in fact able to leave the area at any time they wished. Each ward had a standard operational procedure document for use of ‘green rooms’ but we found that these were either past their designated review by date or were not dated at all. A reducing restrictive practice paper from September 2021 highlighted that work was needed on Endcliffe ward to consider the design of the green room in order to differentiate it from seclusion, but there was no clear plan for what this would look like or when it should be completed by.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Our findings

However, staff were not consistently checking, maintaining, and cleaning equipment. On Maple ward we found two sets of blood bottles had expired and some cupboards were notably dusty. On Endcliffe ward a pot of urinalysis sticks had expired and the weighing scales were not working correctly. There was also one loose strip of medication within the medicines cupboard and one cream not labelled for a specific patient. On Stanage ward the sharps bin was beyond the fill line. Staff were not consistently using stickers to indicate when equipment had last been cleaned on all wards.

Safe staffing

The service had enough nursing and medical staff, who knew the patients. Most staff received basic training to keep people safe from avoidable harm however there were some areas of low compliance.

Nursing staff

The service had enough nursing and support staff to keep patients safe and managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service had an establishment matrix for each ward which stated minimum numbers of staff required to work each shift. The service regularly used bank and agency staff in order to meet establishment numbers. Where shifts could not be filled with bank and agency staff, managers would move staff between wards and if necessary matrons and ward managers would step into establishment numbers to maintain patient safety. Senior service managers were in the process of completing a clinical establishment review to look at current and proposed establishment levels as well as to consider how staff could be best utilised in their roles to support staffing on the wards.

The service were using high levels of bank and agency nurses and nursing assistants. In November 2021 there were 105 shifts covered by agency nurses, 21 shifts covered by bank nurses, 479 shifts covered by agency nursing assistants, and 593 shifts covered by bank nursing assistants. The trust requested staff familiar with the service and block-booked bank and agency staff where possible to ensure they were familiar with the ward and patients. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The ward manager could adjust staffing levels according to the needs of the patients.For example, managers told us they were able to request additional staff to manage increased patient observations when acuity on the wards increased.

As of 15 December 2021 the service had 7.98 whole time equivalent vacancies for nurses and 19.59 whole time equivalent vacancies for health care assistants/support workers. In order to address this the trust had a permanent advert out for band five nurses. Senior managers were also in the process of reviewing staffing levels and considering what the trust could offer in terms of additional training for support workers in order to increase retention and encourage recruitment.

The cumulative staff turnover rate for the service was 15% as of November 2021. This rate had remained relatively stable over the last 12 months. Managers were aware of concerns with regards to the recruitment and retention of staff and were conducting a review to discuss how staff could be supported to develop their skills internally as a means to retaining staff.

Levels of sickness were higher than the trust target of 5.1%. At November 2021 the sickness level was 8.2%. Managers told us this was due to a combination of factors largely related to the COVID-19 pandemic. Managers supported staff who needed time off for ill health. There was a sickness policy and absence procedure flow chart for managers to follow. Managers told us they were supported by the human resources department to manage staff sickness.

Our findings

Patients had regular one to one sessions with their named nurse but some patients we spoke with told us that it could be hard to speak with regular staff as there were a lot of agency staff on shifts.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The trust told us that there had not been any activities cancelled in the last 12 months due to staff shortages. However, there were 12 reported incidents of escorted leave being unable to be facilitated from 1 December 2020 and 30 November 2021, due to staff shortages. The majority of patients we spoke with did not raise concerns with accessing leave.

It was unclear if the service had enough staff on each shift to carry out any physical interventions safely. The trust told us there was an expectation for a minimum requirement of three staff trained in the trust's approved physical intervention training to be on each shift per ward. However, this was not outlined in the trust's 'use of force' policy. This meant that we could not be sure whether there were enough staff on duty appropriately trained in the use of restraint at all times. During inspection we reviewed three records of use of restraint and found that on one occasion seven different members of staff were involved in the restraint and on another occasion four different members of staff were involved. This indicates that three trained members of staff may regularly not be adequate to carry out physical interventions required without needing staff from other wards to attend, which could result in a delay for support.Further to this, staff told us they felt there were not enough staff trained in physical interventions which could leave staff feeling unsafe and also burnt-out, as the same members of staff were always involved in restraint due to them being trained. Between 1 July and 31 December 2021 there were 10 reported incidents where there were less than three trained staff on shift at a specific time.

Staff shared key information to keep patients safe when handing over their care to others. Staff attended huddles at the start of each shift to ensure they were aware of the current key information in relation to each patient on the relevant ward.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. However, during inspection we reviewed four seclusion records and within two records we found that medical reviews did not take place on time. The service had recently implemented an audit to review the timeliness of medical reviews to establish any areas of concern going forwards.

Managers could call locums when they needed additional medical cover and managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with the majority of their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff.

At 12 December 2021 data provided by the trust indicated that the overall compliance rate for mandatory training was 92%. However, compliance for some courses fell below the trust target of 80%. Training compliance in immediate life support was 75%, in safeguarding children was 77%, in care certificate was 66%, in NEWS2 (national early warning score - a system for scoring routinely recorded physiological measurements in order to identify acutely ill patients) was 72% and in MUST (malnutrition universal screening tool) was 68%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Where training was an issue for a ward this was detailed on their risk register with a plan of how to mitigate risks from low compliance.

Our findings

The trust also had a recovery plan in place to ensure immediate life support was above 80% compliance by the end of January 2022 and we noted improvement in compliance since our last inspection in May 2021. However, we were concerned that training compliance was low in courses including NEWS2 and MUST due to gaps and omissions found in physical health monitoring across the wards.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well and it was not always evident that staff 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 completed risk assessments for each patient on admission and reviewed this regularly, including after any incident.

Staff used a risk assessment tool developed by the trust called the 'Detailed Risk Assessment and Management Plan (DRAM)'. Individual patient risk was considered under multiple domains and levels of severity, imminence and likelihood of risk were rated.

Management of patient risk

Staff did not always know about risks to each patient concerning their physical health and as such did not always act to prevent or reduce risks. During inspection we reviewed 11 patient care records across the four wards. We found that of these 11 records, five contained concerns relating to physical health monitoring. Three patients had not received a physical health check on admission with records stating that the patients did not want to engage, but there was no evidence that staff had attempted to revisit and complete these checks at a later date. One patient's care record detailed that they required physical health checks completing daily due to physical health concerns, but documents showed that checks were only attempted on four out of nine days since this plan was initiated. Another patient's care record detailed that they needed both daily and twice daily physical health checks, and it was unclear which was accurate. We found multiple days on which no checks were attempted or recorded. For one of the patients who had not received a physical health check on admission their care plan detailed physical health concerns including sleep apnoea and high blood pressure but they had not received any physical health checks since admission a week prior to inspection. A further patient's care record stated they required twice daily physical health monitoring, weekly weighing and supplementary drinks in order to manage their physical health. There were multiple days were no checks were recorded, with the last recorded check or attempt being recorded nine days prior to review. The patient's weight had not been recorded for over seven weeks and there was no recorded evidence of supplementary drinks being offered.

Staff identified and responded to any changes in risks to, or posed by, patients. Known risks were discussed at shift handover meetings and daily safety huddles and changes to patient care were made where necessary, such as changing observation levels or referrals to safeguarding.

Staff could not observe patients in all areas of the wards but followed procedures to minimise risks where they could not easily observe patients, including through individually risk assessed patient observations and placement of mirrors.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff told us that they had 'walk through' metal detecting devices but were not currently using these as they were waiting for a policy to be developed.

Our findings

However, we were concerned that blanket restrictions were not identified and managed consistently on all wards. On Maple ward a bulletin had been sent to staff stating that as of Monday 25th October 2021 section 17 escorted leave from the ward would not be allowed after 6pm each day due to it being dark. However, this restriction was not detailed on the service's blanket restriction log and had not been individually risk assessed. Additionally, staff were not adhering to a blanket restriction with regards to smoking. The trust had a no-smoking policy which stated that e-cigarettes could be used in single occupancy bedrooms, or outside in gardens and grounds. This was detailed on the service's blanket restrictions log, but during inspection we observed patients using e-cigarettes in communal areas of the wards and this was not challenged by staff.

Use of restrictive interventions

Levels of restrictive interventions were variable across the six-month period prior to inspection. In the period June 2021 to November 2021 there was a total of 352 incidents of restraint across the four wards. Numbers of restraints were slightly less in this six-month period than the previous six-month period where there had been 433 incidents of restraint. The highest number of restraints was on Endcliffe ward, the psychiatric intensive care unit. The trust told us that the variability was due to acuity on the wards.

In the period June 2021 to November 2021 there was one incident of prone restraint which took place on Stanage ward. Managers told us that restraints could occasionally result in prone restraint being used unintentionally, for example if a patient manoeuvred into this position, but that staff were not trained in, and did not use prone restraint intentionally. If prone restraint did happen during the course of a restraint staff were required to record this as part of an incident so it could be reviewed.

It was not consistently evident that 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 five incident reports on Endcliffe ward and within all the reports it was unclear whether staff had tried to use de-escalation techniques prior to using physical interventions with patients. We discussed this with managers and staff who confirmed that de-escalation always took place but conceded that the incident reports lacked in detail.

Staff participated in the provider's restrictive interventions reduction programme. Wards were beginning to engage with 'safewards', an evidence-based approach designed to reduce conflict and containment (coerced medications, restraint and seclusion) in acute adult mental health inpatient units. Staff on Dovedale Two ward had also recently contributed to a paper on reducing restrictive practice which they were presenting to other areas of the trust. Dovedale Two ward did not contain a seclusion room, unlike the previous ward from which patients moved. Staff we spoke with were positive about this and told us that they now felt more confident in using de-escalation techniques. All wards had access to 'green rooms'; calm spaces for de-escalation, as well as access to a range of sensory items to use as part of de-escalation.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff did not consistently keep clear records or follow best practice guidelines. We reviewed four episodes of seclusion and found that within two records nursing and medical reviews were missed or not completed on time. Within one of these records it was also not clear that seclusion was ended as soon as the decision was made to do so, in that the decision was agreed but seclusion did not end until 50 minutes later.

There were no incidents of long-term segregation in the 12-months prior to inspection.

Our findings

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. At the time of inspection staff compliance with safeguarding children level two and safeguarding adults level two training was 93% and 96% respectively.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Since our last inspection the service had introduced safety huddles which took place each morning on the wards. Staff discussed any incidents in the previous 24-hours to ensure all safeguarding concerns were captured and reported. In the 6-months prior to inspection staff had made 129 safeguarding referrals across the four wards. This was higher than in the previous 6-months prior to our last inspection where we raised concerns that staff had not always made safeguarding referrals when patients had come to harm.

Staff followed clear procedures to keep children visiting the ward safe. Each ward had access to a visiting room off the ward where children could visit if deemed appropriate for the individual patient.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Teams included staff who acted as links between the ward and trust safeguarding team. Staff told us they felt confident to raise and report concerns and could give us examples of where they had done so.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. All wards were using bank and agency staff and managers told us they attempted to use regular bank and agency staff where possible. Managers told us these regular bank and agency staff would be provided with access to the client record system.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely either electronically or in locked clinic rooms.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not consistently review the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Pharmacy ward checks took place every two weeks on each ward which identified any errors, such as medications not stored securely or issues with room or fridge temperatures. Errors were incident reported where necessary and feedback given to ward managers to disseminate to their teams.

Our findings

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients were able to discuss medicines and ask any questions during weekly multidisciplinary meetings and staff told us they would also answer any patient questions about medication when they were providing it.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff did not consistently review the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. A patient on Endcliffe ward was regularly given medication intramuscularly as they refused to take this orally. We reviewed this patient's physical health records and found that whilst their care record stated they should have twice daily physical health monitoring, the last recorded attempt or check had not taken place for nine days. Prior to this there were numerous gaps in physical health checks for this patient, for example there was one attempt on 28 November 2021 with no observations recorded, two checks completed on 27 November 2021 and nothing at all recorded on 25 or 26 November 2021. It was unclear how staff were assured that this medication was not having any detrimental effects on the patient's physical health due to regular missing important physical health checks.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service but did not always provide staff with debriefs following serious incidents. 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 and raised concerns and reported incidents and near misses in line with trust/provider policy. Since our last inspection the service had introduced daily safety huddles on the wards. Incidents and safety concerns were discussed to ensure incidents were reported appropriately.

Staff reported serious incidents clearly and in line with trust policy. The service had no never events on any wards.

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.

Managers did not consistently debrief and support staff after any serious incident. Feedback from staff was mixed with some telling us they regularly received debriefs and others telling us they were unable to attend feedback and support sessions due to ward acuity. Ward managers told us they were aware this was an area requiring improvement.

Our findings

Managers had made improvements to ensure they investigated incidents in a timely manner. Following our last inspection we were concerned that there was a backlog of incidents requiring review and sign off by managers, with 66 incidents outstanding. Trust data provided showed that as of 20 December 2021 this situation was much improved with only six incident reports outstanding for review which had occurred between June and November 2021.

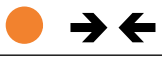
Patients and their families were involved in serious incident investigations.

Staff received feedback from investigation of incidents, both internal and external to the service and there was evidence that changes had been made as a result of feedback. Staff received copies of 'blue light' bulletins via email which alerted them to incidents and changes made as a result. For example, a recent bulletin had been sent to staff regarding an incident with an aerosol within the trust, which as a result meant that aerosol deodorants became a banned item on all inpatient wards and alternatives were detailed.

Staff met to discuss the feedback and look at improvements to patient care.

We saw evidence that managers shared learning with their staff about never events and serious incidents that happened elsewhere via 'blue light' rapid learning notices that were emailed to all staff.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the mental health of all patients on admission but did not always ensure physical health checks were completed. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

However, patients did not consistently have their physical health assessed soon after admission or regularly reviewed during their time on the ward. Of the 11 care records we reviewed during inspection, three related to patients who had not received a physical health assessment on admission. Documents stated that this had been attempted but that the patients had refused. There was no evidence that staff had attempted to re-visit the assessment. We also found gaps with ongoing physical health checks within four of the 11 records reviewed. Physical health checks were not being carried out as prescribed within the patients' care records for these patients who all had documented physical health concerns.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. However, plans were not always enacted by staff.

Staff regularly reviewed and updated care plans when patients' needs changed.

Our findings

Care plans were personalised, holistic and recovery-orientated. Information was separated into 'goals', some of which were more generic such as goals around improving mental health, but others were more personalised, such as goals around occupational therapy and independence in different areas of daily living.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans. However, we were concerned that some patients had not received a physical health check on admission and staff were not following plans regarding physical health needs as stated within records.

Staff made sure patients had access to physical health care, including specialists as required. We saw within care records that patients were being supported by specialists external to the service including dietetics. However, staff on Dovedale Two ward did tell us they were having difficulties with referring a patient for support from the tissue viability service as the referral process was not straightforward.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. However, we were concerned that one patient prescribed supplementary drinks to maintain their physical health was not receiving these as there was nothing documented to indicate this.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, the trust had a no-smoking policy and as such staff supported patients with nicotine replacement products and gave advice and support to those wanting to quit smoking.

Staff used some recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included the national early warning score (NEWS2) a system for scoring routinely recorded physiological measurements in order to identify acutely ill patients, and the malnutrition universal screening tool (MUST). However, we were concerned that staff training in these areas was below the trust compliance level, and NEWS2 scores were not being regularly recorded or undertaken by staff as prescribed within patient care records.

Staff used technology to support patients, such as through the use of phones and video calling facilities to contact family, especially when they were unable to visit in person.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Local audits took place such as audits of clinic room fridge temperatures, compliance with malnutrition screening, and infection control. Staff were also involved in trust-wide audits in areas such as care planning and record keeping.

Managers used results from audits to make improvements. We saw evidence of audit discussion and actions recorded in governance meeting minutes. However, we were concerned that governance meetings were not taking place monthly on all wards as they should, meaning that staff may miss opportunities to learn about and discuss issues and areas for improvement on the wards.

Our findings

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills but they did not provide all staff with regular supervision. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. All wards teams included occupational therapists and psychologists, and we saw examples of involvement from dieticians and physiotherapists.

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Not all bank and agency staff had undertaken the trust's approved restraint training. This training could be undertaken at level two or level three. The trust policy was for at least three members of staff trained to level three to be on-duty on each ward at all times. However, bank staff were only required to train at level two, meaning they could not consistently be included in numbers of restraint trained staff. Additionally, agency staff would only receive this training if they worked in the service regularly and agreed to take part in the training. Some staff told us they felt unsafe at times due to the lack of restraint trained staff. Staff told us that staff from other wards who were trained would respond to alarms, but that this response could take some time and leave staff struggling to manage a restraint incident.

Managers gave each new member of staff a full induction to the service before they started work. Bank and agency staff would be given pertinent information prior to working on the wards and would be supported by a staff nurse to review electronic systems before being given access to patient notes.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. At the time of inspection 91% of non-medical staff had received an appraisal within the last 12 months which was in-line with the trust target of 90%.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. At the time of inspection only one member of medical staff had not received an appraisal in the last 12 months.

Managers did not support non-medical staff through regular, constructive clinical supervision of their work. The trust compliance target was at least eight supervisions in 12 months per eligible staff member. As of 28 November 2021, the compliance rate for this amount of supervision was between 46% and 57% across the four wards. This has worsened since our last inspection in May 2021. The trust were aware performance in this area was of concern and had a recovery plan in place to drive improvement. Staff told us that due to staffing levels and ward acuity it was often difficult to find time for supervision. However, staff told us they felt supported and were able to engage in weekly group supervision led by the psychology team which they found beneficial.

Managers supported medical staff through regular, constructive clinical supervision of their work. At the time of inspection only one member of medical staff was non-compliant with the supervision target but they were currently on maternity leave.

Managers did not make sure staff on all wards attended regular team meetings. Managers told us staff could attend weekly business meetings as well as monthly governance meetings. However, between June 2021 and November 2021 we found that meetings varied in regularity across the wards. Staff told us that they would attend meetings where

possible, but it would depend on whether it was their working day or whether the acuity of the ward allowed it. However, notes from most meetings were electronic and accessible to those who could not attend, except for Maple ward who did not record minutes from weekly meetings but instead released a monthly newsletter. Staff could also attend daily safety huddles where they could discuss any ward concerns.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We spoke with staff who were being supported to undertake additional training such as nurse prescribing. Senior managers acknowledged the current difficulties with staff recruitment and retention and discussed plans to support those already working within the trust to access additional training, such as support workers undertaking training to become qualified nurses.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held weekly multidisciplinary meetings to discuss patients and improve their care. Those involved in the patient's care both internal and external to the service were invited to attend as well as the patients themselves. Carers and family members on some wards told us that they were also invited to meetings, where the patient agreed to this, but this was not the case across all four wards.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings which were held at the start of each shift.

Ward teams had effective working relationships with other teams both internal and external to the organisation.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and generally discharged these well with the exception of patient section 17 leave. Managers made sure that staff could explain patients' rights to them but this was not done consistently.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. As of 12 December 2021 83% of staff were complaint with this training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice via the trust's mental health act administrators. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Our findings

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. One patient we spoke with on Stanage ward told us that they did not have an advocate or know what an advocate was.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, and recorded it clearly in the patient's notes each time. However, it was not clear that staff always repeated rights as necessary when a patient refused or was unable to engage. We were concerned that within one record we reviewed we could not find that a patient's rights were repeated by the date stated on the appropriate form. The trust Mental Health Act Compliance audit for the week 25 November 2021 supported our concern as it highlighted that only 67% of patients had their rights explained within the review date and that staff were not consistently recording when attempts were made to read patients their rights or when the next attempt will be made.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice, but we were concerned that leave was not being managed appropriately in order to reduce risk to patients. On Dovedale Two ward paperwork for one patient stated they had one hour local area escorted leave per day, but within their care record from the same day it was stated they also had three hours escorted leave to their home address and the shops, which was not documented within the section 17 leave paperwork. It was unclear if the patient had taken this leave. On Endcliffe ward we reviewed section 17 leave taken by three patients between 7 and 8 December 2021. We found that staff had not made any record of when patients had returned to the ward and had not detailed in notes the time they were due back. Managers told us they would know if the patients hadn't returned because they were escorted by staff but it was unclear how staff would know if a patient hadn't returned on time. Finally, on Maple ward one patient took leave on 8 December 2021 and when we checked they did not have an approved section 17 leave form in place. Additionally, another patient was observed to take section 17 leave but there was no record of this on the system.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely but the service did not display posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits. However, it was unclear how findings were disseminated to staff as we could not see evidence of this in team meeting minutes.

Good practice in applying the Mental Capacity Act

Staff did not always support patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 but did not assess and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At 12 December 2021, trust-wide data indicated that 87% of staff were compliant with their level one training and 93% were compliant with level two.

Our findings

There were no deprivations of liberty safeguards applications made in the last 12 months.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Some staff were unsure who they should speak to in order to receive accurate advice on the Mental Capacity Act and deprivation of liberty safeguards but told us they would speak to a manager if they were unsure.

It was not clear if staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so, as staff did not assess and record capacity to consent clearly each time a patient needed to make an important decision. We reviewed the care records of 11 patients and found concerns relating to capacity within four of these records. We found that despite decisions around capacity being made, only one of the four records contained a detailed capacity assessment. Within the remaining three records we found reference to capacity assessments within patients' daily notes but these were not detailed, did not refer to the domains of lacking capacity including understanding, retaining, weighing and/or communicating, and did not include detail of how staff had attempted to maximise capacity.

When staff assessed patients as not having capacity, it was not clear that they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Within three of the records detailed above we could find limited information relating to best interests' decisions following a decision that a patient lacked capacity. Information with daily notes included some plans of what to do but these lacked in detail and included plans such as using restraint to carry out personal care. It was unclear who had been involved in the decision making and it was not evident that staff had considered the needs and wants of the patients.

The service only monitored some minor aspects with regards to how well it followed the Mental Capacity Act. These were in relation to capacity to consent to treatment and referral to advocacy. However, other aspects of the Mental Capacity Act were not monitored or reviewed, such as in relation to carrying out capacity assessments for things other than medical treatment.

Is the service caring?

Requires Improvement 

Our rating of caring stayed the same. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness, did not always respect patients' privacy and dignity and did not consistently support patients to understand and manage their care, treatment or condition.

During inspection we spoke with 11 patients across the four wards.

Staff were not always discreet, respectful, and responsive when caring for patients. On Endcliffe ward one patient's care record stated that a low-profile bed was in place, but during inspection we observed this was not being implemented as

the patient was using a mattress on the floor. We also observed that this patient's en-suite was locked, meaning they could not access it, but there was no rationale given for this restriction within the patient's care record. The two patients we spoke with from Endcliffe ward told us staff did not knock before entering their bedrooms and did not always seem interested in their wellbeing.

Staff did not consistently support patients to understand and manage their own care treatment or condition. We were concerned that patient's capacity to make decisions for themselves was not always considered or recorded adequately and as such it was not evident that patients were involved in this process. We saw evidence of best interests decisions being made but documentation did not make it clear that the patient's wishes, feelings, culture and history had always been considered. Wording used to describe actions to be taken was not always supportive, especially when in relation to using physical restraint if required.

Staff directed patients to other services and supported them to access those services if they needed help. Patients could use multi-faith rooms across both sites which were observed to be comfortable, well-lit rooms with a variety of religious texts and materials for patients to access. A chaplain attended some patient community meetings to offer support and feedback.

Patients said staff treated them well and behaved kindly. Patients we spoke to were largely positive about staff. However, one patient from Endcliffe ward told us that they felt staff were not present on the ward.

Staff understood and respected the individual needs of each patient. Patients told us staff were supportive and took the time to get to know them. A patient on Dovedale Two ward told us they felt staff had really taken the time to get to know them and find out how best to support them to avoid incidents and improve their time on the ward.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments. Some patients told us they did not want a copy of their care plan but confirmed this had been offered to them. We observed within care records that staff had noted when a copy of a plan had been given or offered to the patient.

Staff made sure patients understood their care and treatment. Patients could attend weekly multidisciplinary meetings where they were supported to ask questions. Staff told us they would also discuss medications regularly with patients and could signpost them or provide information around medications if needed.

Our findings

Staff involved patients in decisions about the service, when appropriate. Community meetings took place on all wards on a weekly or bi-weekly schedule and we saw examples of patients being asked to give feedback on what they would like to see on the ward and changes being made as a result. For example patients on Stanage ward asking for a fish tank and this was facilitated, and patients on Endcliffe ward were supporting the design of a sensory room. Patients on Dovedale Two ward were invited to contribute to a presentation on reducing restrictive practice.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could give feedback via community meetings and in addition, Dovedale Two ward also had a patient feedback box. Examples seen were patients requesting and being given access to a wider choice of drinks and sports equipment on the wards.

We did not see any example where staff had supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. One patient on Stanage ward told us they did not know what an advocate was but the majority of patients we spoke with told us they either had an advocate or had been offered one.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

We spoke with 11 carers and family members across the four wards.

Staff supported, informed and involved families or carers on most wards. Feedback from families and carers was largely positive. They described good care, staff being respectful and polite, and staff taking the time to talk with families and involve them in the patient's care. Most families and carers told us they were invited to patient multidisciplinary meetings, where the patient agreed to this, and were encouraged to keep in touch via telephone and internet communications such as Zoom. One family member told us they were able to access the ward psychologist for additional individual support. However, the two family members we spoke to from Maple ward told us that they found it difficult to obtain information from staff as the phone regularly went unanswered and when staff did answer they were not forthcoming with information. They also told us they had not been invited to meetings and had not been involved in the patient's care planning.

Staff did not consistently help families to give feedback on the service. Of the 11 family members and carers we spoke with the majority told us they could only give feedback via multidisciplinary meetings if the patient wanted them to attend. Four family members told us they had not been given any opportunity to feedback and were unsure how they could give feedback.

Staff did not routinely give carers information on how to find the carer's assessment. None of the families and carers we spoke with had received advice or been referred by staff for a carer's assessment.

Is the service responsive?

Requires Improvement 

Our rating of responsive improved. We rated it as requires improvement.

Our findings

Access and discharge

Staff did not manage beds well and a bed was not always available when needed. However, patients were not moved between wards unless this was for their benefit.

Bed management

Bed occupancy often exceeded 85% and when patients went on leave there was not always a bed available when they returned. In the six months prior to inspection occupancy varied between 90.1% and 103.3% including patients who were on leave. Managers told us that they would admit patients to leave beds if that patient was on extended leave pending discharge. The number of beds available was lower on Dovedale Two ward than it had been on Burbage ward and the trust had also removed dormitory style rooms which were previously in place on some of the wards. This placed increased pressure on bed occupancy. However, the trust had procured eight female and six male out of area beds in order to support admissions in the meantime until occupancy could be increased again once refurbishment work was complete.

On Maple ward patients could be admitted to one of two beds on the health-based place of safety (HBPOS) suite, which was next to the ward, if Maple ward was fully occupied. Between June and November 2021 there were 25 patients admitted to Maple ward via a HBPOS bed and the length of stay varied from 0.2 days to 23.7 days. Managers told us that staff on Maple ward would be responsible for the care of these patients and observation levels were set at 1:1 as patients would need to exit into a clinical area to access Maple ward. However, there was no policy or protocol in place regarding this operating procedure and we were concerned about the restrictive environment patients were placed in on the HBPOS suite whilst awaiting an appropriate bed.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Managers took part in weekly bed management meetings where length of stay and discharge was discussed.

The service did have out-of-area placements which meant a bed was not always available for the local patient population. Between April 2021 and December 2021 there were 69 inappropriate out-of-area placements for acute patients and 26 inappropriate out-of-area placements for psychiatric intensive care unit patients. This was despite the procurement of additional beds in other areas which the trust detailed separately as ‘appropriate’ placements. Out-of-area placements were discussed at weekly bed management meetings and managers told us patients were brought back to a bed in their local area as soon as this was possible.

Managers and staff worked to make sure they did not discharge patients before they were ready.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had low numbers of delayed discharges due to non-clinical reasons. Between, 01 June 2021 and 01 December 2021 the service reported six delayed patient discharges. These ranged in length of delay from 21 days to 238 days with the reason mainly being trying to find suitable onward accommodation.

Our findings

Managers monitored the number of delayed discharges through weekly bed management meetings. However, some wards had a discharge coordinator and others did not due to vacancies. Those without a discharge coordinator told us the process could become more difficult to monitor due to it being a time-consuming process and it becoming the responsibility of another member of staff.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Those involved in patient care and discharge were invited to weekly multidisciplinary meetings to support transitions of care.

Staff supported patients when they were referred or transferred between services. The psychology team on Endcliffe ward were able to offer ongoing therapy elsewhere if this was not completed at the time a patient was discharged or transferred.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients on most wards could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw examples of patient bedrooms containing personal items including pictures and sensory lights and patients told us staff supported them to make their rooms more homely. Patients were allocated electronic fobs so that they could access their bedroom at all times.

Patients had a secure place to store personal possessions. On Dovedale Two ward staff were awaiting provision of lockable safes for patient bedrooms so in the meantime patient possessions were kept in the ward office.

Staff used a full range of rooms and equipment to support treatment and care. Each ward had access to a clinic and treatment room, a 'green room' designated for de-escalation, as well as space to conduct activities on the ward. At the Michael Carlisle Centre patients could access an occupational therapy corridor off the ward where they could engage in art, pottery, gym sessions and cooking. At the Longley Centre, Maple ward and Endcliffe ward both had occupational therapy kitchens and gym rooms on the ward. Ward activity timetables were clearly displayed, and patients had access to a variety of activities including gardening, exercise, cooking, reading and singing.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could make phone calls in private. The majority of patients had access to their own mobile phones but for those that didn't a ward telephone was available.

The service had an outside space that patients could access. However, on Stanage ward patients had to be supervised when using the garden due to risks in the environment and at the time of inspection the garden on Dovedale Two ward was closed due to building works in the garden. The ward manager on Stanage ward told us that they allocated a member of staff to supervise patients in the garden, but that if there were admissions to the ward that needed support, this member of staff would be reallocated to that, meaning in such circumstances it could be difficult for patients to access outdoor space.

Patients could make their own hot drinks on all wards and were not dependent on staff. Patients on three of the four wards could also access snacks throughout the day, but on Endcliffe ward we did not see any snacks available and staff told us patients would have to ask to access food outside of mealtimes.

Our findings

The service offered a variety of good quality food. Some patients told us the choice was limited to either meat or vegetarian, but the majority of patient's told us the food was good.

Patients' engagement with the wider community

Staff supported patients with activities outside the service on most wards, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients on the acute wards said that discharge coordinators would support with this. However, two patients we spoke with on Endcliffe ward told us they had not been supported in this, and managers did identify a gap with a discharge coordinator on this ward.

Staff helped patients to stay in contact with families and carers. Patients we spoke with told us they were able to use phones and computers to maintain contact with their families, and that their families were invited to attend their weekly multi-disciplinary meetings if this was something the patient wanted.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Each ward had access to adapted bedrooms and bathrooms to support those with mobility needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service did not have information leaflets readily available in languages spoken by the patients and local community. However, staff told us they could easily access these if required and no patients raised any concerns around this.

Managers made sure staff and patients could get help from interpreters or signers when needed. We observed an interpreter being requested to attend a patient multidisciplinary meeting to support the patient's understanding.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. Patients could access on-site multi-faith facilities which were located off the wards in quiet areas.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. In the last 12 months there had been 20 complaints made across the service. Of these, three were subsequently withdrawn, four were fully or partially upheld and five were not upheld or were closed, with the remainder still ongoing. In the same time period the service received 30 compliments.

Our findings

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes and shared feedback from complaints with staff. Complaints were discussed and reviewed by managers at governance meetings and at weekly all staff business meetings.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

We did not see that the service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills and knowledge to perform their roles but most of the managers at ward level did not have lengthy experience to perform their role as they were new or seconded. For example, the ward managers on Dovedale Two and Stanage wards were new to the role within the last eight months, and the ward manager on Endcliffe ward was seconded to the psychiatric intensive care unit from another acute ward. However, most leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Most staff told us that they felt well supported by their immediate managers as well as by senior leaders within the trust. Following a recent serious incident on one of the wards, members of the senior executive team had visited the ward to offer support. Staff also told us they could email members of the senior executive team directly with concerns and had received feedback as a result.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team. The staff on Dovedale Two ward were looking to design their own specific vision to complement the trust overarching one. Staff recruitment and interview questions for all wards were based around the trust vision and values.

Culture

Staff felt respected, supported and valued. Staff told us that teams had gone through challenges due to low morale and staffing but felt that things were much improved in the last year and that teams worked well together and supported one another. Staff told us they felt valued in their roles and were confident that if they raised concerns they would be addressed. Results from the 2021 staff survey were not yet compiled.

Staff said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. Following our last inspection, we raised concerns regarding the high level of racist incidents aimed

at staff by patients. Staff told us they felt this was much improved, with staff being supported to report all incidents, and racism being discussed regularly at team meetings to ensure staff felt supported. The trust was in the process of developing a 'zero tolerance' pilot to address racism in the trust and staff within the service were taking a lead on this work.

Managers were aware that sickness levels were higher than trust averages and acknowledged that some of this was due to stress. The trust supported staff with a range of health and wellbeing support structures including access to online applications, self-referrals to psychological support, and membership of staff networks and health and wellbeing policies were available via the staff intranet, including those relating to sickness and agile working. Staff were aware of wellbeing support available within the trust and confirmed they would know how to access this, and managers were aware of how to signpost staff to support networks.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Managers did not ensure that important physical health checks were undertaken for patients consistently on, and during, admission. This meant staff were potentially unaware of physical health concerns relating to patients and as such did not take appropriate actions to maintain their health and safety. Additionally, managers did not ensure staff were up to date with training around physical health monitoring, meaning they could not be assured that staff understood how and when to undertake important patient checks.

Managers did not ensure staff adhered to trust compliance levels for supervision. Whilst staff told us they were supported through group supervision sessions; levels of individual supervision were low. Following our last inspection in May 2021 we told the trust they should ensure that all staff receive supervision in line with the trust target, but data showed that compliance levels had dropped rather than improved at this current inspection. Additionally, staff were not following trust structures set out for team meeting timeframes. We found that meetings differed in type and regularity across wards and did not take place as regularly as they should. Staff told us they were not always able to attend meetings due to staffing levels and acuity. We raised this as a concern following our last inspection in May 2021 but could see no discernible improvement during this current inspection. Managers told us important feedback was given at these meetings, meaning that staff may miss out on important information if meetings were missed or did not take place.

The trust had not implemented a policy or standard operating procedure detailing how patients admitted to Maple ward via a bed in the health based place of safety suite should be cared for and we were concerned care was overly restrictive due to managers telling us patients required 1:1 support whilst in this area.

Managers did not have oversight of concerns relating to the use of, and documentation relating to, the Mental Capacity Act and we were concerned that the principles of the act were not always being followed. Additionally, managers did not have oversight of section 17 leave from wards meaning they were unaware that leave was not being managed appropriately for all patients.

Following our last inspection, we raised concerns that there were not enough restraint trained staff on duty at all times. Whilst we saw improvement in the monitoring and oversight of this it was unclear how the trust had come to the decision regarding the minimum number of restraint trained staff that were required.

Our findings

However, the trust had made improvements to the ward environments and there had been a reduction in ligature anchor points on the wards. We had some remaining concerns around risks not identified on ligature risk assessments, but overall ligature risks were managed well, and staff were aware of areas of higher risk and how these were mitigated.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care. We were concerned that patient physical health checks were not consistently completed on admission, or revisited if refused, and that ongoing physical health checks were not conducted for patients with physical health needs, meaning staff may not be aware of declining physical health at the earliest opportunity. We saw risk registers discussed at some team meetings, but this was not consistent, and staff were unclear whether they could contribute to risk registers or not.

However, known risk was discussed daily at staff safety huddles and handover meetings. Staff knew how to report incidents and incidents reported were largely reviewed by managers in a timely manner. Staff received emails known as 'blue light' notifications which alerted them to incidents elsewhere in the trust and any changes as a result.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. Staff engaged in audit at both team and trust-wide level and findings were discussed at governance meetings. However, we were concerned that governance meetings did not take place regularly on every ward and not all staff attended, meaning that staff may sometimes miss important information.

Engagement

The trust was engaged with several partner organisations to develop and improve the service. The trust worked closely with the local acute trust and engaged with the local authority to make improvements in safeguarding. The trust was an active participant at the accountable care partnership. Joining together the work of health and local authority commissioners with the three foundation Trusts, primary care Sheffield and the voluntary sector across the city.

Learning, continuous improvement and innovation

The trust was in the process of making changes on the wards in order to better support patients during admission. This included the introduction of 'Safewards' (an evidence-based approach designed to reduce conflict and containment in acute adult mental health inpatient units) and the 'PIPA' process (purposeful admissions to inpatient care); a model by which staff and patients plan the patients' admission on a daily basis with the aim of minimising duration of admission. Both approaches were in their infancy on the wards, but staff spoke positively on their implementation.

The service was engaged in research including studies on 'The prevalence of social communication problems in adult psychiatric inpatients' and 'The prevalence of neuronal cell surface antibodies in patients with psychotic illness'. On a more local level members of the psychology team on Endcliffe ward were also undertaking research into levels of burnout, fatigue and experiences of trauma amongst ward staff to understand what support needs they may have.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with five legal requirements in relation to this service.

- The trust must ensure that staff assess and monitor patient's physical health throughout admission as required and following the use of intra-muscular medication (Regulation 12)
- The trust must ensure that staff carry out and document capacity assessments and subsequent best interests decisions in line with the principles of the Mental Capacity Act 2005 (Regulation 11)
- The trust must ensure that staff manage section 17 leave appropriately to maintain the safety of patients and staff (Regulation 12)
- The trust must ensure that there are not blanket restrictions in place which restrict patient's freedoms that are not individually risk assessed including for patients residing in the health based place of safety (Regulation 13)
- The trust must ensure that leaders have oversight of, and act upon issues relating to risk and performance (Regulation 17)
- The trust must ensure that staff have access to shared learning via documented supervision, debrief and access to team meetings to improve performance (Regulation 17)
- The trust must ensure that there are procedures in place for the care and management of patients admitted to the acute wards but residing in beds in the health based place of safety suite (Regulation 17)
- The trust must ensure that there are procedures in place which outline the number of staff trained in physical intervention required to be on shift to maintain safety (Regulation 17)
- The trust must ensure that there are sufficient numbers of suitably trained staff on duty at any one time to care for patients, provide de-escalation, and if necessary physical interventions (Regulation 18)

Action the trust SHOULD take to improve:

- The trust should ensure that all potential ligature points are detailed on relevant risk assessments and that staff follow these management plans consistently to mitigate risk.
- The trust should ensure that all clinic rooms are clean and free of clutter
- The trust should ensure that seclusion is managed in line with the Mental Health Act Code of Practice in that medical and nursing reviews take place on time and it is ended at the earliest opportunity.
- The trust should ensure all staff are up to date with mandatory training
- The trust should ensure staff use and clearly document the use of de-escalation prior to physical restraint

Our findings

- The trust should ensure that staff clearly document and act in accordance with decisions in relation to individual patient care
- The trust should ensure that carers and family members are involved in patient care and that access to carers assessments is facilitated by staff.
- The trust should ensure that patients rights under the Mental Health Act 1983 are read in a timely manner when required
- The trust should ensure that all patients that require them have personal emergency evacuation plans in place and that staff know how to locate them in an emergency
- The trust should ensure building risk assessments are reviewed regularly
- The trust should ensure that staff do not use the green room on Endcliffe ward to inadvertently seclude patients

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 11 HSCA (RA) Regulations 2014 Need for consent

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

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury