Requires improvement

Derbyshire Healthcare NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXM02	Hartington Unit, Chesterfield and North Derbyshire Royal Hospital.	Morton ward Pleasley ward Tansley ward	S44 5BL
RXM03	Radbourne Unit, The Royal Derby Hospital	Enhanced Care ward Ward 33 Ward 34 Ward 35 Ward 36	DE22 3WQ

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

Summary of findings

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated acute wards for adults of working age as requires improvement because:

- The trust did not consistently ensure the safety of those using services. This was due to a combination of high levels of bank/agency staff, low levels of staff training and by not carrying out the action plans from environmental risk assessments.
- Staff did not always monitor and record care interventions in line with trust policies or national guidelines. The lack of integrated care notes made information less accessible and increased the risk of miscommunication between clinical staff.
- Staff understanding of the Mental Capacity Act varied, many staff relied on the doctors to assess. Staff did not always indicate reasons for capacity assessments or fully complete the forms. Staff did not always implement care and treatment in line with the Mental Health Act and Mental Health Act Code of practice.
- Most inpatient beds were on dormitory style wards. Three wards segregated beds by curtains. This compromised patients' privacy and dignity. The trust had no plans to phase out this style of ward.
- Governance systems in place were weak. Not all staff had the opportunity to discuss lessons learnt with each other; staff business meetings were irregular and time limited due to wards being short staffed. Ward managers were often unable to complete ward duties when on call, as they needed to manage the health-based place of safety and respond to incidents within the units. The trust did not always learn from lessons and systems to share information with staff were ineffective.

However,

- The Trust were part of the national 'Triangle of Care' scheme. The 'Triangle of Care' scheme encourages a therapeutic relationship between patient, staff member and carer that promotes safety, supports recovery and sustains wellbeing.
- Both units offered a wide range of therapeutic and recreational interventions across seven days and throughout the evenings.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Many staff were not up to date with mandatory training requirements. Attendance rates at compulsory and mandatory training were low across most of the wards that we inspected and below targets set by the trust for minimum compliance.
- There was not always the correct grade of staff on all shifts. Some shifts did not have enough staff trained in control and restraint and life support.
- Despite environmental risk assessments being in place, the trust had not taken action to reduce risks to patients following incidents at Hartington unit. This showed that learning from incidents did not always result in the trust making changes.
- Monitoring and maintenance of manual handling equipment, clinic room temperatures and oxygen cylinders was inconsistent. Ward 33 had an oxygen cylinder out of date, despite logs confirming daily checks. Pleasley ward had no log of manual handling equipment maintenance; we found a wheeled commode to have no footplates. Clinic room temperatures on Ward 33, Tansley and Pleasley wards were consistently recorded above 25 degrees.
- Staff did not always follow National Institute of Clinical Excellence (NICE) guidelines when prescribing rapid tranquilization. Monitoring of patients vital signs post rapid tranquilization was not consistently recorded.
- On Pleasley ward, the lighting in the lounges on was dim, this was emphasised by dark flooring. We were concerned this was hazardous to people with poor sight. We felt this was a particular issue on Pleasley as it admitted older patients with additional physical needs.

However,

- Wards were visibly clean and well maintained.
- All patients had comprehensive up-to-date risk assessments.
- Staff used de-escalation techniques effectively.
- Staff knew how and when to make safeguarding alerts.
- Mixed wards were compliant with the Department of Health guidelines on mixed gender accommodation.

Summary of findings

- We observed staff interacting with patients in a respectful manner and in ways that were appropriate to the needs of the person.
- Patients had access to advocacy services.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- National Institute of Clinical Excellence (NICE) guidelines when prescribing medicine were not always followed for rapid tranquilization. Post rapid tranquilization monitoring was inconsistent and not always recorded.
- We found some patients had been prescribed and administered medication without regard to the Mental Health Act (MHA) and the MHA Code of Practice.
- Staff used a number of systems to record patients' information. This meant that information was not easily accessible.
- Staff lacked understanding about who might not have capacity to make specific decisions. Records reviewed did not clearly indicate the rational for staff carrying out capacity assessments, staff recorded information inconsistently and inaccurately.
- Staff across all wards did not receive regular clinical and managerial supervision.

However

- Staff completed a comprehensive assessment of patients' needs on admission and patients' needs were reviewed regularly.
- Staff carried out physical health assessments on admission to wards and care records showed that staff monitored patient's healthcare needs.
- Multidisciplinary teams and inter-agency working were effective in supporting patients.
- There was a varied programme of group and individual therapeutic activities across both sites.

Are services caring?

Good

We rated caring as good because:

- Staff interaction with patients was respectful and appropriate to the needs of the patient.

Summary of findings

- The admission process orientated the patient to the ward and informed them of their rights.
- Staff offered patients a choice with respect to treatment options.
- Staff supported patients in keeping contact with friends and families.
- Wards had links with carers and were members of the Triangle of care scheme.

However

- We saw very limited evidence of patients' views being clearly documented in their care plans.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff were responsive to patients' individual needs. They were able to accommodate bariatric and disabled patients. Staff considered cultural and gender specific needs, in some instances completed specific personalised care plans to incorporate these needs.
- Staff were aware of the diverse needs of patients and provided a range of support.
- Staff knew how to support patients who wanted to make a complaint.
- Staff adhered to the trusts 'Leave bed' policy, which ensured that patients returning from leave would always have access to a bed.
- Both units had a 'hub'. This was as area separate from the wards, where patients could participate in social and therapeutic activities.

However

- The dormitory style bedrooms on the acute wards compromised patients privacy and dignity. The trust had no plans to phase out the use of dormitory style wards.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

Summary of findings

- Governance systems were not robust, particularly learning from incidents and monitoring of documentation. Specifically in relation to rapid tranquilisation and seclusion and long-term segregation.
- The majority of wards did not have regular business meetings to discuss and cascade important information. The trust relied on individuals reading alerts sent by email.
- Managers did not ensure rotas allowed time for staff supervision, appraisals and training, which had resulted in low staff compliance rates.

However

- Staff reported good support within the teams and there was a good team spirit.
- Staff followed duty of candour by being open and transparent and verbally apologising when something went wrong.
- The trust recognised good practice across the core site by presenting wards with awards.
- Staff were aware of the visions and values of the trust and in one case had built upon this with their own addition.

Summary of findings

Information about the service

The acute wards for adults of working age provided by Derbyshire Healthcare NHS Foundation Trust are based on two sites at Derby City and Chesterfield.

There are five wards at Radbourne Unit. All are mixed gender except Ward 34, which is male and Ward 33, which is female. We inspected all five wards:

- The Enhanced Care ward (ECW) provides local inpatient care at an enhanced level to Derby City and Derbyshire County residents. It is not a psychiatric intensive care unit (PICU). However, it provides a higher staff to patient ratio to support those patients with complex mental health needs. It has 10 beds.
- Wards 35 – 20 mixed gender beds.
- Ward 36 – 20 mixed gender beds.
- Ward 34 – 20 beds for men.
- Ward 33 – 20 beds for women.

Radbourne unit also has the Hope and Resilience Hub. This is a therapy and recreation area, which patients from all wards can access.

There are three wards at Hartington Unit, which is based in Chesterfield. We inspected all the three wards:

- Morton ward – mixed gender, 24 beds.
- Tansley ward - mixed gender, 24 beds.
- Pleasley ward - mixed gender, 20 beds. Pleasley ward also admitted patients above working age.

Hartington unit also has its own Hub. This provided inpatients with a therapy and recreation area.

CQC last inspected both units 2011 and 2012. At the time of the inspection, the units had met all the essential standards inspected against.

There were five, unannounced, Mental Health Act Reviewer visits between 1 April 2015 and 18 April 2016 within this core service. We identified 20 issues during these visits, seven of which were about consent to treatment.

Our inspection team

Our inspection team was led by:

Chair: Vanessa Ford, Director of Nursing and Quality, South West London and St George's Mental Health NHS Trust.

Head of Hospital Inspections, CQC: James Mullins.

The team that inspected the core service consisted of two CQC inspectors, specialist professional advisers in the form of; a psychiatrist, two registered mental health nurses, an occupational therapist, a mental health act reviewer and an expert by experience. Experts by experience are people who have direct experience of care services we regulate, or are caring for someone who have experience of using those services.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all eight of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 30 patients who were using the service and two carers
- spoke with the managers or acting managers for each of the wards
- spoke with 50 other staff members; including doctors, nurses, student nurses and social workers
- attended and observed four handover meetings and five multidisciplinary meetings.
- collected feedback from 15 patients using comment cards.
- looked at 40 treatment records of patients.
- carried out a specific check of the medication management on four wards.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients and carers told us overall they were satisfied with the care they received. They were complimentary of the staff in what they felt was a difficult environment to work within.

Good practice

Staff on Ward 33 had completed research into Metabolic Syndrome in women. Outcomes from this study had improved care. All patients identified at risk received lifestyle modification advice from a dietician and activity coordinators. Staff sent GP's patient discharge summaries highlighting specific physical health areas that needed continuous monitoring.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve:

- The trust must consistently maintain medication at correct temperatures in all areas.
- The trust must ensure all emergency equipment is within its expiry date and accurately checked.
- The trust must ensure that the prescribing, administration and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings.
- The trust must ensure that clinical staff have a consistent approach to the use of rapid tranquillisation, understand its risks and record its usage.

Summary of findings

- The trust must ensure that all equipment is well maintained and checked in accordance to manufacturers guidelines.
- The trust must ensure that staffing levels and grade on shift meet the agreed standard.
- The trust must ensure that mandatory training is completed for all staff to achieve the trust target of 85%.
- The trust must ensure that staff receive regular managerial and clinical supervision, as well as yearly appraisal.
- The trust must ensure all staff understands the application of the Mental Capacity Act in practice. Documentation should contain evidence of recording of any decisions made about a patient's capacity.
- The trust must ensure that all long-term segregation and seclusion is undertaken in line with trust policy and documented accordingly.
- The trust must ensure that environmental risk assessments are updated and reviewed.
- The trust should ensure that patients are prescribed medications in accordance with the Mental Health Act, Mental Capacity Act and revised Code of Practice.

Action the provider SHOULD take to improve

- The trust should review how care records are integrated
- The trust should bench mark the need for psychiatric intensive care units.
- The trust should review how dormitory wards affect patients' privacy and dignity.
- The trust should ensure that all staff have the opportunity to discuss and reflect on lessons learnt, feedback, complaints and compliments.
- The trust should review the impact poor lounge lighting on Pleasley ward.

Derbyshire Healthcare NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Morton ward Pleasley ward Tansley ward	Hartington Unit, Chesterfield and North Derbyshire Royal Hospital.
Enhanced Care ward Ward 33 Ward 34 Ward 35 Ward 36	Radbourne Unit, The Royal Derby Hospital

Mental Health Act responsibilities

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

- Staff had a good understanding of the Mental Health Act (MHA), the MHA Code of Practice and its guiding principles. At the time of inspection, completion rates for MHA training were 98%.
- Staff attached section 58 consent to treatment certificates to medicine charts. This meant that nurses knew the legal authority under which they were administering medicines.
- Staff completed section 17 leave paperwork correctly.
- Administrative support and legal advice on the implementation of the MHA and its code of practice was available for staff from the MHA office.

Detailed findings

- There was a clear process for scrutinising and checking the receipt of MHA paperwork. We found overall the MHA record keeping and scrutiny was satisfactory
- Staff did not consistently file MHA paperwork. MHA documentation could be in the nursing care records, doctors care record or scanned onto the electronic recording system. This meant it would take staff time to find the legal authority under which they were providing care and treatment.
- Staff obtained consent to treatment from patients in line with MHA requirements and was documented on the authorised treatment certificate accompanying prescription charts. This meant that nurses were able to check medicines had been legally authorised before administering any medicines.
- We saw evidence that patients had received their rights (under section 132 of the MHA) and staff re read patients at regular intervals. Care records recorded where patients had exercised their rights. For example, patients requesting support from an independent mental health advocate and the right to appeal against detention.
- Staff understood the role of the Independent Mental Health Advocate (IMHA) and patients had access to an IMHA if required. We saw this information on posters and in leaflet form.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training records showed that 88% of staff had undertaken Mental Capacity Act (MCA) training. The training was an e learning programme. The MCA training package contained inaccuracies and staff understanding of mental capacity was variable.
- When we spoke with staff, they had varying degrees of knowledge about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Care records we reviewed showed that assessing and recording of capacity across the core service was inconsistent. Records did not highlight why capacity was being assessed and the rationale.
- Between 1 August 2015 and 31 January 2106, five DoLs applications had been made for this core service. At the time of inspection, there were no patients subject to DoLs.
- We observed the multi-disciplinary team discussing capacity within ward rounds. However, staff reported it was for doctors to assess and record.
- The trust invited an external organisation to carry out an MCA audit in January 2014. In response to this an action plan was developed. However, there were no other arrangements in place for the trust to regularly monitor adherence to the MCA.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean ward environment

- The layout of the wards did not allow staff to observe all parts of the ward and as such had blind spots. Staff were aware of the risks to patients' safety caused by the layout. To reduce these risks, staff assessed patients' individual risks and increased observation in key areas as needed. Staff also conducted hourly environmental checks. In addition, some wards had a fixed open nursing station placed in front of the main lounge. However, on Ward 33 and Ward 34, staff had place a desk in a corner. This could be used to barricade a person against the wall. Staff had not identified this as a risk.
- All wards had an up-to-date ligature and environmental risk assessment. Control measures in place to minimise the risk to patients included patient risk assessments, use of observations and increased staff supervision of the environment. Staff also locked rooms during handover or when not in use. For example, bariatric and disabled bathrooms. Bariatric rooms are for clinically obese people. There were anti-ligature fixtures and fittings in use across all wards such as collapsible shower rails, anti-ligature taps, anti-ligature wardrobes and the use of anti-ligature sheets. However, staff had identified other ligature risks such as door hinges to a lounge area and bariatric bed cables. Staff had documented on the ligature risk assessment with an action plan for the estates department to review. We noted there was no time scale indicated for this. Staff knew where to access ligature cutters in an emergency.
- The activity and recreation areas at both Hartington and Radbourne units had their own ligature and environmental risk assessment. Assessments had identified risks and action plans to reduce risks. For example, individual patients were risk assessed to use gym or pottery equipment. Staff kept the gym and pottery rooms locked when not in use.
- The wards complied with Department of Health guidance on mixed gender accommodation. Male and female bedroom corridors and bathroom facilities were separate. Female only lounges were available. Staff on Morton ward shared good examples of considerations made when admitting a transgender patient.
- We found all clinic rooms to be visibly clean. They were well equipped with clinical observation equipment such as blood pressure monitors, pulse oximeter and blood glucometer. Clinic couches had disposable sheets available. Equipment in clinic rooms had up to date records for cleaning, maintenance and had been portable appliance tested (PAT). Staff had access to emergency resuscitation equipment and emergency drugs. Overall, staff kept these in good order. However, we found one oxygen cylinder on Ward 33 was still available for use and was past its expiry date of 09/05/2016. This was despite staff carrying out daily and weekly checks on the emergency equipment, including checking expiry dates.
- All wards were visibly clean, had good furnishing and well maintained. Domestic staff followed schedules for cleaning. We saw that domestic staff kept cleaning logs up to date. Staff monitored the wards kitchen fridge temperatures. We could see from the logbook monitoring was undertaken daily.
- Wards were bright except Pleasley ward. The lighting in the lounges on Pleasley was dim, this was emphasised by dark flooring. We were concerned this was hazardous to people with poor sight. We felt this was a particular issue on Pleasley as it admitted older patients with additional physical needs.
- In the 2015 Patient-Led Assessment of the Caring Environment (PLACE) annual assessment, the trust scored 99% for cleanliness (higher than the national average for trust sites of 97.6%). The Radbourne unit scored 99.3% and The Hartington Unit scored 99.1%.
- We observed good hand hygiene and infection control in practice. Staff completed infection control audits. There were laminated hand hygiene posters displayed in clinic and toilet areas. Hand gel dispensers were available to staff and patients.
- Staff kept equipment well maintained, except on Pleasley ward. The mobile hoist had a portable

appliance test (PAT) sticker indicating it had last been PAT tested in 2014. There was a mobile blood pressure monitor with a blank piece of paper attached. Staff were not sure whether this meant it was out of use. The ward manager later confirmed the blood pressure monitor was out of use and labelled it as such. The ward did not have a list of moving and handling equipment or anyway of monitoring maintenance. We found one mobile commode did not have footplates. This meant patients feet would be unsupported during transit.

- The trust had one purpose built seclusion suite based at the Radbourne unit. It had two separate seclusion rooms; both were compliant with the Code of Practice and ligature free. One of the rooms was suitably adapted to meet needs of people with limited mobility. They were fitted with intercoms, ligature free adjustable blinds and had access to secure outside space. Staff were able to provide sensory-based interventions to the secluded patient using for example with music and aromatherapy. Staff said this helped patients to relax by providing a calming environment.
- All staff had personal alarms issued at the beginning of each shift. There were nurse call buttons in bathrooms and toilets. However, there were no nurse call alarms in bedroom areas. On Ward 35, staff had provided a wheel chair dependent patient with a mobile nurse call alarm.

Safe staffing

- Staffing levels had been established in line with National Institute for Health and Clinical Effectiveness (NICE) guidelines; SG1: Safe staffing for nursing in adult inpatient wards in acute hospitals. Guidance from NICE identifies there is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. However, staffing should take into account the bed occupancy and acuity of the service.
- The core service had 165 whole time equivalent (WTE) qualified nurses and 70 WTE nursing assistants.
- Trust data from December 2015 to February 2016 showed Tansley ward had the highest nurse vacancy rate of 37%. This was higher than the trusts average vacancy rate of 16 %. This was followed by Ward 36 with 27%, Morton ward with 25%, Ward 34 with 21% and Pleasley ward at 18 %. The other wards were below the trust average.
- The Enhanced Care ward had the highest nursing assistant vacancy rate of 25%. Other wards were below the trust average of 16%.
- Permanent and bank staff covered vacancies. Data shared by the trust showed three months before inspection (December 2015 – February 2016) 2452 shifts were covered by bank or agency staff. This meant there was an over-reliance on the use of bank and agency staff and on occasion wards operated short of staff or the ward manager would undertake the shift. All staff we spoke to described the wards being short of permanent staff. They felt it affected upon the continuity of care for patients, staff wellbeing, staff sickness levels and turnover.
- Staff turnover rates were highest on Ward 36, Tansley ward and Morton ward. All were above the trust average of 10%. In the last 12 months before inspection five staff left Ward 36, four staff left Tansley ward and five staff left Morton ward.
- Sickness levels across the core service varied. The national average sickness rate is 4.2%. The highest sickness rate in the three months before inspection was for the Enhanced Care ward at 11%, followed by Ward 35 at 9.5%, Ward 33 at 6%, Tansley ward at 6.5%, Ward 36 at 5.6%. All other wards sickness rates in the core service were below the national average.
- The numbers of nurses identified in the staffing levels set by the trust, did not always match the number on all shifts. Data shared by the trust showed three months before inspection (December 2015 – February 2016) the total number of shifts across the core service that were not covered was 376. Data from the safer staffing levels return (between April 2015 and January 2016) showed the core services consistently operated below the lower fill rate of 90% for nurses during the day, nine out of the 12 months. Morton, Tansley and Ward 34 consistently operated below the lower fill rate of 90% for nurses during the night. For these wards, the fill rate for nursing assistants was above the upper rate of 125%. This meant in some instances, extra-unqualified staff were working nights to fill in for qualified nursing staff. Ward managers confirmed this happened when they struggled to cover the rota due to vacancy rates, unexpected leave and sickness. Staff on the Enhanced Care wards said they occasionally have less qualified nurses on day shifts to cover night shifts.

Requires improvement

Are services safe?

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

- Ward managers block booked bank staff where they could and used staff familiar with the wards.
- Ward managers could adjust staffing levels to meet increased clinical need. During inspection, we saw managers adjusted staffing levels to take into account changes in clinical need.
- Both units held safer staffing meetings every day to review staffing levels across all core service wards. Mangers reallocated staff to different wards if necessary.
- Patients and staff we spoke with said low staffing levels occasionally meant one to ones and patients leave was cancelled.
- During inspection, we observed a qualified nurse in the communal areas of the ward at all times.
- We found 129 of 200 (65%) eligible staff, were up to date with control and restraint training. Staff reported on some shifts there would not be enough staff on each ward trained in control and restraint. This was below trusts mandatory training target. This meant staff could not always maintain a safe ward environment. At these times, staff from other wards supported incidents.
- The content of the control and restraint training. was not compliant with the recommendations laid out in the Mental Health Act Code of Practice, Positive and Safe (2014) or National Institute of Clinical Excellence (NICE) NG10 (2015). For example, patient centred approaches to developing individualised care plans. The lead trainer recognised it was not fully compliant and was undertaking a review.
- The trust set its target rate for compulsory training at 95% and 85% for mandatory training. These services fell below the targets. The overall compliance rate for compulsory training was 92% and 64% for mandatory training. Examples of training courses that fell below 75% included; Intermediate life support across all wards except Ward 36 with 57%, control and restraint on all wards except enhanced care ward and Ward 34 with 65% and basic life support with 79%. Eight of 143 eligible staff across the core service had completed training in the use of medication in the management of violence and aggression. Managers reported staff had to wait to access courses due to high demands within the trust.
- All wards had access medical cover night and day. Each ward had a dedicated, consultant junior doctor, specialist registrar or staff grade. Junior doctors provided out of hours cover with support from an on call consultant.

Assessing and managing risk to patients and staff

- During the period of 1 August 2015 and 31 January 2016, staff reported 115 episodes of seclusion. The Enhanced care ward had the highest amount at 67, followed by Ward 34 with 20 and Ward 33 at 14.
- During the period of 1 August 2015 and 31 January 2016, there were 51 episodes of long-term segregation. The highest amount of long term segregation was on the Enhanced Care ward with 23 episodes. Whilst reviewing care records, we found an unreported episode of long-term segregation within a dormitory area of an acute ward. Staff had recorded the incident in the patients care records. The clinical reasons for the segregation were satisfactory. However, staff had not accurately reported it as an incident of segregation on the electronic incident reporting system. We informed the trust of this during inspection and the trust sought to address the issue.
- Huntington unit did not have a seclusion room. All wards had a de-escalation room. Staff told us they would encourage patients to spend time in these rooms if patients were agitated or needed a calming space. However, we were concerned not all staff was aware of restrictive practices and the difference between de-escalation and de facto seclusion. Most staff we spoke to said they would not stop a patient leaving these rooms if they remained agitated. However, one member of staff told us that sometimes they if the room was used for a short period of seclusion, for example 10 – 15 minutes, it was not always recorded as seclusion.
- Records showed during three weeks in February and March 2016, staff secluded an inpatient in the section 136 (s136) suite at the Radbourne Unit on four occasions. A s136 suite is a place of safety and should not be used for inpatient care. This was because the seclusion room was occupied or under repair. Records also showed one use of the s136 suite at the Hartington Unit for in patient seclusion in March 2015.
- In January 2016, a manager had agreed for an inpatient transfer from the Radbourne unit to the seclusion suite

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at Kedleston forensic unit. This was because there was no seclusion room available at the Radbourne unit. Managers at Kedleston refused to admit the patient into seclusion, as the unit is commissioned to take forensic patients. This lack of clear discussion between managers in a challenging crisis affected the safety, privacy and dignity of the patient and staff.

- The number of incidents of restraint in the six months before inspection was 202, nine of which were prone restraints. The highest number of restraints was on Ward 33 with 60 incidents, two of which were in prone (face down) position. The Enhanced Care ward had 52 with two in prone position.
- Staff undertook the functional analysis of care environments (FACE) risk assessment to document and assess historical and current risks of patients. Doctors and nurses completed the FACE assessment on the patients' admission. We reviewed some good examples of individualised risk assessments. One included the risk a bariatric bed may pose to a patient. Another risks identified to a transgender patient. This showed us staff considered the individual risks of each patient.
- We reviewed 40 care records across the core service, all had a completed and up to date risk assessment. Staff updated risk assessments at ward reviews and after any incidents. We found that risk assessments were fully completed and included risk management plans.
- During inspection, we found all the acute wards had open entrance doors. Staff said they only locked when there was a serious incident or increased risk of a detained patient absconding. Patients confirmed the majority of the time doors were unlocked. This meant informal patients could leave at will. Staff told us they would have a discussion with patients prior to them leaving to check their wellbeing. However, we found one blanket restriction in place on the Enhanced Care ward. Staff had locked the door to the outside area in order to prevent one patient going outside. This was not individually care planned.
- The trust had up to date policies on positive and safe management of violence and acute psychological distress.
- Wards were in the process of using and developing interventions from the Safewards initiative. This international project aims to reduce rates of behaviours that threaten safety and reduce restrictive containment practices on wards (such as special observations, seclusion).
- All staff we spoke to were aware of the different observational levels used. We observed a mixture of observation taking place. Some staff actively engaged with patients they were observing through talk or activity. We also observed other staff completing observations with no interactions with the patient.
- All staff we spoke with were knowledgeable about de-escalation techniques to use to reduce challenging behaviours. During inspection, we observed three incidents of challenging behaviour that staff successfully managed with de-escalation techniques. Staff prevented a potential absconsion from the open ward without locking the doors and preserved a patients' dignity in the process.
- Trust data showed that staff had not used rapid tranquilisation in the six months before inspection. However, staff informed us they had used rapid tranquilisation.
- We reviewed 55 prescription charts. They were all clear and well documented with pharmacist interventions documented on the chart.
- We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them.
- Staff recorded patient allergies to medication on patients' prescription charts.
- Access to medicines was good and medicines for discharge were readily available.
- Staff reported medicine errors using the incident reporting system and resulting information was cascaded to the nursing staff team in ward team meetings.
- Medication cupboards were tidy. However, the temperature in the clinic rooms on Ward 33, Tansley and

Requires improvement

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Pleasley where medication was stored were consistently above 25 degrees. Staff kept a record of this. Medicines should be stored in temperatures below 25 degrees in order to preserve their efficacy.

- Staff were aware of and addressed issues such as falls and pressure ulcers. This was particularly apparent on Pleasley ward, as they admitted patients over the age of 65. Staff completed fall and hip protector assessments when needed.
- Staff had training in both adult and childrens' safeguarding. They knew how and when to make a safeguarding alert.
- Both units had a family room, which was separate from the wards. The trust did not allow children to go on the wards, but had a family room to facilitate patient visits.

Track record on safety

- Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported 14 serious incidents between 1 January 2015 – 31 December 2015 in this core service. None of these were Never Events. The largest cluster of incidents related to 'apparent/actual/suspected self-inflicted harm meeting serious incident criteria' with six incidents recorded.
- The trust also recorded serious incidents requiring investigation (SIRI). In the period 1 January 2015 to 31 December 2015, the trust reported 18 serious incidents through its SIRI reporting system related to this core service. Nine of the incidents related to unexpected death or severe harm.
- Improvements to safety following incidents included swapping standard wardrobes to ligature free wardrobes. Another example was increasing the height of the Enhanced Care ward garden fence after a patient had climbed over.

Reporting incidents and learning from when things go wrong

- All staff we spoke to were able to describe the incident reporting process using the Trust's online incident reporting form. Staff were able to access the system to report incidents themselves.
- Incidents forms we looked at confirmed that managers reviewed incidents reports. All had an action plan.
- The trust became a non-smoking environment in May 2016. There had been an increase in smoking related incidents reported by staff. For example, patients had been smoking in bedroom and bathroom areas causing fire alarms to signal. Staff offered smoking cessation to support patients and discussed issues with patients to try to reduce the frequency of incidents.
- Staff told us they discussed incidents and lessons learnt from incidents in team business meetings. However, we noted team meetings were infrequent and on some wards had not happened for several months.
- Hartington unit had small empty cupboards recessed into walls throughout the unit. The cupboards had previously housed fire reels. Patients could use these as hiding places. Staff told us of a missing patient incident, where the person had been missing for a few hours and the police informed. The person had been hiding in one of these cupboards. Staff had not identified this risk on the environmental risk register. The trust had not learnt lessons from the incident. We informed the operational manager of the risk and they agreed to review.
- The trust have a 'blue lights' system on the staff intranet. It is a notification system to alert staff of concerns and action plans. Only four of the staff we spoke with mentioned this as a way in which they received feedback and information.
- All staff we spoke with said debriefing was available after serious incidents. Staff from across the service shared examples. Radbourne unit staff had additional debriefing support available from the staff support officer.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- We reviewed 40 care records and found assessment processes were comprehensive and carried out in a timely manner.
- Patients had an initial assessment completed on admission. Nurses and doctors completed this together where possible. This was to prevent repetition for the patient.
- Assessments included physical health examinations. All care records showed evidence of ongoing monitoring of physical health. The trust had a patient information booklet about the importance of physical health care. This was available to all patients.
- Each patient had two separate paper based, care record files. Staff kept these in an unlocked trolley in the staff office. Staff said they locked the office when not in use.
- One set of care records was for nursing and allied health professionals. The other set was medical care records, completed by psychiatrists. The latter set was used for inpatient admissions and community. We found this system a challenge as it was not always clear where staff kept what documentation. Although regular staff were able to find information speedily, we felt this might be a challenge for bank or new staff to locate important information in a timely manner. This was apparent when we asked to see a patients physical observations post rapid tranquilisation. The staff member was unable to find the information quickly. Locating mental health act paperwork was also an issue. We found it had three possible filing locations. Staff did not file paper work consistently. This could potentially lead to miscommunication and an error in carrying out care interventions.
- Of the 40 care records we reviewed, 38 were up to date. Twenty had recorded that staff had offered patients a copy of their care plan. The care plans had a clear space for recording patient involvement. This was not always filled in and so it was difficult to evidence consistent patient involvement in care planning.
- All care plans were holistic and recovery orientated.

Best practice in treatment and care

- Staff did not always follow National Institute of Clinical Excellence (NICE) guidelines when prescribing medicine. A policy covering rapid tranquilization which included the new NICE guidance dated March 2016 was available. This detailed how to treat patients to manage episodes of agitation when other calming or distraction techniques had failed to work. However, we found the policy was not always followed and five patients were prescribed medication not in line with the guidelines. We found the monitoring of patients vital signs post rapid tranquilization was not always documented.
- In addition, we found one staff had given one patient on Ward 33, 42 doses of oral medication for agitation over 49 days. There was only one documented entry in patient's notes over this time regarding physical monitoring of the patient post oral dose.
- Staff that worked within the hubs offered psychological therapies such as cognitive behavioural therapy, mindfulness and compassion-focused therapy.
- Patients had access to physical healthcare including access to specialists when needed.
- Care records showed other professionals contributed to physical health assessments where appropriate. For example, an obstetrician attended a ward round for a pregnant patient to contribute to the care plan.
- Occupational therapists (OT) assessed patients' occupational and functional needs. They had a clear clinical assessment pathway with standardised assessment measures including the Model of Human Occupation Screening Tool (MoHOST). Patients had OT care plans and OT support plans.
- All qualified nursing staff had completed training to support patients with smoking cessation.
- Clinical staff used the Health of the Nation Outcome Scales (HoNOS). This is a clinical outcome measure to help clinicians monitor progress and outcomes of clinical interventions. All care records we reviewed had completed HoNOS forms.
- Staff on Pleasley ward had completed a falls audit. Staff had found most falls were attributed to getting out of bed, footwear and medications. In response to this, they had increased awareness amongst staff and educated patients accordingly.

Are services effective?

Requires improvement

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Skilled staff to deliver care

- The staff working across the core service came from a range of professional backgrounds including nursing, medical, occupational therapy, and social work. Other staff from the trust provided support to the wards, such as the pharmacy team and physiotherapists. However, both psychology posts had been vacant for several months. The trust had not been successful into recruiting into the posts.
- Staff received appropriate induction programmes provided by the Trust. Bank staff had ward inductions from the nurse in charge at the beginning of shifts.
- Since the launch of the Care Certificate standards in 2015, 29 inpatient health care assistants had joined the trust. Of these, six had completed Care Certificate training and the remaining staff were undergoing training.
- The Trust had set a minimum standard for clinical supervision that was 10 - 12 hours per annum (depending on the number of WTE hours worked). Data shared by the trust showed between April 2015 and March 2016, 26% of staff from across the core service, complied with this target. Ward 36 achieved the lowest compliance target at 7 %, followed by the Enhanced Care ward at 9%. Staff told us it was difficult to make time for supervision because of staffing levels and clinical activity. Ward managers said the supervision data might not reflect accurately; as staff did not always log that supervision had happened.
- The trust reported, as at 31 January 2016, 100 out of 232 staff had received an appraisal. This was an appraisal rate of 43%, which was the lowest rate for a core service within the trust.
- As at 31 January 2016, 102 doctors have been revalidated across the trust which attributed to 92% overall. The trust had not provided details on how this splits across core service or team level.
- Ward managers told us they received support from line managers and human resources to manage poor staff performance.
- During February 2015 and January 2016 there were four cases where staff had been suspended or placed under supervision within this core service. Managers told us that human resource supported the processes.

Multi-disciplinary and inter-agency team work

- All wards had daily 'PIPPA' meetings. This stood for purposeful inpatient planned admission. All members of the multidisciplinary team (MDT) attended as well as staff from the In-reach team, which was part of the crisis team. Staff from the "In Reach" team support patients with early discharge from wards.
- We observed three of these meetings on different wards. All had a similar structure. Staff discussed each patient, identified risk issues, changes to care plan and treatment and carer needs. All staff contributed to the meetings. Within meetings, the chair allocated actions and tasks to staff. We observed the staff to be professional and courteous to each other within the PIPPA process. It promoted effective team working and communication.
- Nursing handovers were additional to the PIPPA meetings. We observed five handovers across the core service. We saw staff communicating effectively the needs of patients and treatment plans. Staff also used handover meetings to review and discuss changes in patient observation levels and risk.
- The trust board told us Schwartz rounds happened throughout the trust. These are monthly multidisciplinary meetings are intended to "provide an opportunity for staff to pause and reflect upon their work related experiences in a supportive environment''. However, there was no evidence of these happening and during the inspection; the trust later confirmed they were not happening.
- Huntington unit employed a housing officer and decision support tool worker (DST). They supported patients and staff with housing and long-term continuing health care needs.
- We observed staff communicating with colleagues from community teams to arrange discharges and care planning reviews. Relationships with community teams appeared supportive and there were no concerns raised.

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

Are services effective?

Requires improvement

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

- Staff had a good understanding of the Mental Health Act (MHA), the MHA Code of Practice and its guiding principles. At the time of inspection, staff compliance with MHA training was 98%.
- Administrative support and legal advice on the implementation of the MHA and its code of practice was available for staff from the MHA office.
- There was a clear process for scrutinising and checking the receipt of MHA paperwork. We found overall the MHA record keeping and scrutiny was satisfactory.
- Staff did not consistently file MHA paperwork. MHA documentation could be in the nursing care records, doctors care records or scanned onto the electronic recording system.
- We found evidence that a doctor had used section 5(2) MHA five times on the same patient in five weeks. Each time, the doctor took the patient off the section 5(2) MHA without a MHA assessment. A section 5(2) MHA allows doctors to detain a patient for up to 72 hours. Doctors should not use a section 5(2) MHA as an alternative to making an application for further assessment under the MHA, even if it they think the patient will only need to be detained for 72 hours or less. The patients care records did not evidence any crisis management plans or multi-disciplinary discussion about the least restrictive approach to take. Staff did not document the rationale for the repeated use of section 5(2) MHA.
- We saw evidence of consent to treatment and capacity requirements recorded within some care records, but this was not consistent.
- Staff obtained consent to treatment from patients in line with MHA requirements and was documented on the authorised treatment certificate accompanying prescription charts. This meant that nurses were able to check medicines had been legally authorised before administering any medicines.
- However, we found one patient being illegally administered medication under a treatment certificate (T2). The notes clearly documented the patient had fluctuating capacity due to their diagnosis, however, medication was being administered under a treatment certificate, meaning that the patient was deemed to be consenting fully to taking the medication. There was no evidence that staff reviewed the patients' capacity on medicine administration and no indication to justify why the medication was being administered under T2 due to fluctuating capacity.
- Staff understood the role of the Independent Mental Health Advocate (IMHA) and patients had access to an IMHA if required. We saw this information on posters and in leaflet form.
- We saw evidence that patients had received their rights (under section 132 of the MHA) and staff repeated these at regular intervals.

Good practice in applying the MCA

- MCA training was part of an e-learning programme and eighty-eight percent of staff had completed this. However, when we spoke with staff, there were varying degrees of knowledge about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- None of the patients receiving care and treatment during our inspection was under a DoLS.
- Between 1 August 2015 and 31 January 206, five DoLs applications had been made for this core service.
- We observed the multidisciplinary team discussing capacity within ward rounds. However, staff reported it was for doctors to assess and record.
- The trust invited an external organisation to carry out an MCA audit in January 2014. In response to this an action plan was developed. However, there were no other arrangements in place for the trust to regularly monitor adherence to the MCA.
- Staff knew where they could ask for help regarding the MCA within the team, but they did not know if the trust had a MCA lead.
- Recording of capacity assessments, when they had been undertaken, seemed to be a tick box exercise. For example, of the eight care records we reviewed on Pleasley ward, all had a capacity to treatment or assessment form. However, staff had not indicated what they were assessing. Staff had not fully completed the form; they had not given comments or ticked the outcome of the overall assessment. They were not person centred and lacked important information.

Are services effective?

Requires improvement

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- Since inspection, the trust has issued staff with a 'blue light alert' regarding correct use and recording of the MCA.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We spoke with 30 patients receiving care and treatment in the acute wards. We observed how staff interacted with patients throughout the three days of our inspection.
- Throughout our visit, we saw staff interacting with patients in a positive, friendly, polite and respectful manner. Most patients we spoke to were positive in their views of staff.
- Most patients we spoke with said staff were aware of their individual needs. However, five patients told us staff were often too busy with paperwork to spend time with them.
- We observed many examples of staff treating patients with care, compassion and communicating effectively.
- We saw staff engaging with patients in a kind and respectful manner on all of the wards. For example, we observed staff knock doors before entering bedrooms.
- We observed staff remaining calm and respectful whilst managing challenging behaviour. For example, during a seclusion review, staff stood an appropriate distance away and in a discreet manner while the consultant led the review. The patient was given time to discuss their point of view.
- We saw staff were calm and gave time to agitated patients. We observed staff explaining in detail the process of care and interventions the patient was receiving.
- In relation to privacy, dignity and wellbeing, the 2015 Patient-Led Assessment of the Caring Environment (PLACE) score for the Radbourne unit was 95.7% and for Huntington unit 95%. The national average is 90%.

The involvement of people in the care they receive

- The admission process informed and orientated the patient to the ward. Patients had access to booklets that shared information about the units and wards. Booklets were available explaining how patients can be in control of their care, recovery and physical health. These were freely available on the wards and hubs. A named nurse was allocated to each patient on admission.
- We received mixed feedback from patients about their involvement in the care they received. The majority of patients told us they had been involved in their care. However, 11 patients told us they had not been involved in their care and had not received a copy of their care plan.
- We observed patients were involved in their ward round, asked their opinions and given choices about treatments. However, staff did not document this consistently in care records.
- Written care plans varied in their level of patient involvement. Most appeared to be written in a generic format, whilst others were clearly written in collaboration with the patient and with the patient's unique circumstances in mind. All of the care plans had a section to show patient involvement, but this was not always completed.
- We did not see evidence of advanced decisions within the care records.
- Staff invited patients' carers to the multidisciplinary reviews where appropriate.
- All patients spoken with told us they had opportunities to keep in contact with their family where appropriate.
- Patients had access to advocacy services. The advocate attended patient review meetings where appropriate.
- On most wards, patients had opportunities to give feedback on the service they received in community meetings. Patient attendance at community meeting varied. We could see that from community meeting minutes from Ward 34, there were times when patients attended and times when no one wanted to attend. Staff had recorded no one had attended. Staff told us when this happened they would try to ascertain patient's views on one to one. However, the Enhanced Care ward did not have a community meeting. Staff said they focused on having one to ones with patients, as they were usually too unwell. Ward 33 patients chaired a weekly community meeting. Ward 34 had minutes but we could see no one attended the last four. Pleasley ward patients told us they had regular community meetings.
- Ward 33 used 'getting to know you' cards. Patients and staff completed the cards that they then left in a folder

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on the ward. Patients and staff could read them and use them as conversation starters. Staff said it was useful as these cues could sometimes help diffuse difficult situations.

- The Trust were part of the national 'Triangle of Care; Carers Included' scheme. The 'Triangle of Care' is a therapeutic relationship between patient, staff member and carer that promotes safety, supports recovery and sustains wellbeing. Both units had a carers' champion who attended local carers' groups and forums. Huntington unit were in the process of auditing their Triangle of Care work. They were hoping to develop new ways to increase carer participation.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The daily purposeful inpatient planned admission (PIPPA) meetings on the wards also reviewed bed numbers, focussed on admission and discharges.
- The average bed occupancy for this core service was over 85% between 1 August 2015 and 31 January 2016, the highest of which was Ward 35 with 111%.
- The number of out of area placements that attributed to this core service between April 2015 and March 2016 was 48. These patients required admission to a psychiatric intensive care unit (PICU).
- Patients had access to acute admission wards and the Enhanced Care ward. The Enhanced Care ward (ECW) had a higher staff to patient ratio and was able to work with patients with more complex needs than those who met the criteria for an acute ward. However, staff were clear that this was not a psychiatric intensive care unit (PICU) and the standard operating procedure for the ECW confirmed this. The ECW primary function was to offer assessment and treatment to patients that could not be safely managed on a general acute ward. They provided a 72-hour assessment to patients where it was thought there might be an indication for the requirement of a PICU bed.
- The trust admitted patients whose individual needs required PICU to out of area beds. PICU beds were accessed from a wide geographical area and often far away from the county. This would restrict visiting for some carers. At the time of our inspection, eight patients were in PICUs out of county.
- Staff on the Enhanced Care ward said stepping patients down to an acute ward could be difficult if there are no beds available on the acute wards. This would mean patients remain longer than they need on the Enhanced Care ward and this in turn may prevent admissions to the Enhanced Care ward.
- All patients we spoke with said they had a bed to return to after leave. Staff managed beds in line with the trusts bed leave policy. This ensured 50% of leave beds were kept free.
- Staff told us they only moved patients between wards on clinical grounds and they would always discuss it with the patient first.
- Staff told us they try to arrange transfer of patients between wards at an appropriate time of the day. However, on inspection we saw that the trust had transferred a patient back from an out of area PICU late at night.
- Staff said they arranged discharge with the patient to suit their individual needs.
- Between August 2015 and January 2106 there had been 11 delayed discharges across the core service. Ward 33 had six of these. Morton, Pleasley, Tansley and Ward 35 had no delayed discharges. Staff said delays happened because of those patients complex care packages.
- The trust provided average length of stay for discharged patients between February 2015 and January 2016, across the core service. The average length of stay was 51.1 days. Ward 35 had the highest average length of stay at 45.4 days and Tansley ward the lowest at 31.1.

The facilities promote recovery, comfort, dignity and confidentiality

- Wards were mixed gender apart from Ward 33 and Ward 34. Mixed wards had female only lounges.
- Across the core service, there was a variety of single ensuite, single and dormitory style bedrooms. The dormitory bedrooms at the Hartington unit, segregated beds by curtains. This compromised patients' privacy and dignity. The dormitories at the Radbourne unit divided bedded areas by solid partitions. The partitions did not reach which reach the ceiling, but provided a degree of privacy. Each bedroom provided a small key coded safe for storing valuable items. However, four patients told us they did not know how to use these and the staff had not known how.
- Staff told us patients could personalise their bedroom areas, but we did not see any evidence of this.
- All wards had an enough rooms for meetings, one to one sessions and quiet areas.

Are services responsive to people's needs?

Good

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

- Both units had access to separate recreational and therapy areas that were based in hubs off the wards. The patients at Radbourne unit had named the hub area the 'Hope and Resilience Hub'. The hubs were open seven days a week, and offered different activities throughout.
- The hubs had an internet café with access to free Wi-Fi. The hub areas were relaxing and welcoming. Other facilities within the hub included a shop, a gym, pool tables, art, pottery and therapy rooms. There was direct access to a private outside space.
- Discharged patients could volunteer to work at the café to gain work experience.
- Occupational therapy and recreation staff facilitated individual and therapeutic group sessions within the hub and on the wards.
- Morton ward had developed regular social activities in the evenings and at weekend. One example of this was 'Serena's salon'. Patients could access a blow dry, manicure or head massage.
- Ward 33 had converted a dormitory area in to a recreation area. Patients had helped decorate and create this space. It had a sensory room. Staff reported there had been fewer incidents of restraints since the development of the recreation area.
- Staff on Ward 34 had organised a regular pool club that they ran in evenings when staffing allowed. They had also made links with a local football club to access tickets for matches.
- Both units had separate visiting rooms off the wards. At Radbourne unit, this was in a conservatory. It also had access to outside space. The Enhanced Care ward had its own visiting room within the ward.
- Staff assessed patients access to mobile phones on an individual basis. Staff kept phone chargers in the office as they had identified these as a ligature risk. Patients needed to ask to charge their mobiles.
- Patients had access to pay phones on all wards. The phones were in corridors that limited privacy. However, staff told us if a patient needed to make phone call in private then they could arrange for the patient to use a hospital phone.
- Patients on the Enhanced Care ward told us staff provided hot drinks at specific times during the day. They had access to cold drinks throughout the day and night.
- On all the other wards, patients were able to make hot drinks and snacks. During this time, patients told us night staff would make them a hot drink if they needed one and it was not detrimental to their sleep pattern.
- There was no staff rest room at Radbourne unit. If staff needed time out from the ward, they had to leave the unit.

Meeting the needs of all people who use the service

- Patients with limited mobility had access to adapted bath, toilet and shower facilities on all wards.
- Ward 33 and Moreton ward had a single ensuite bariatric bedroom. Complete with bariatric fixtures and fittings.
- Staff had easy access to interpreters. We observed staff and a patient use a telephone interpreter service for a seclusion review. We reviewed care records that confirmed staff booked interpreters to attend ward rounds and weekly one to one sessions with a named nurse.
- A choice of foods was available to patients. Although some patients told us they did not like to order there food up to three days in advance. The trust provided special diets to meet different physical and cultural needs. However, one patient told us they do not always get the correct food for their lactose intolerance.
- Patients had access to multifaith rooms on both sites.
- Staff could arrange for spiritual support on the ward if requested. We observed an example of this on inspection. We saw that staff had completed a care plan with a patient to take in to account his needs during the Ramadan. The care plan had identified specific times staff would wake the patient so the patient could pray.
- During inspection, we saw various examples of staff considering the individual needs of patients. For example, staff on Morton ward had considered gender preference and accommodated in one single ensuite bedrooms.
- Information leaflets were available to patients and carers. These were available on wards, at the hub and in

Are services responsive to people's needs?

Good

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

waiting areas at the units. Information leaflets available covered advocacy, patients rights, how to make complaints, carers support, detained patients rights and community services.

- The trust were able to provide patient information leaflets in languages other than English.

Listening to and learning from concerns and complaints

- During the period of February 2015 to January 2106, the trust received 29 formal complaints that related to this core service. Twenty-one of these complaints related to Radbourne unit, with Ward 33 and Ward 36 receiving five complaints each.
- Of the 29 complaints, four were fully upheld and 12 were partially upheld. None were referred to the Parliamentary Health Service Ombudsman (PHSO).
- Eleven of the complaints raised issues around poor care. Six of the complaints raised issues around medication. Seven referred to poor staff attitude.
- We reviewed a sample of the complaints. We could see the trust had given complainants feedback after raising concerns. Staff had documented action plans to address issues raised. Examples of this included the development of a meet and greet system for visitors to wards and a review of secure transport.
- In the same period, the trust received 125 compliments received for this core service. The largest cluster of feedback related to the general gratitude of the patients (mentioned on 71 occasions).
- Patients we spoke to knew how to make a complaint and felt able to do so if needed.
- Staff were aware of the complaints procedure.
- Wards had 'you said we did' information to feedback to staff and patients. This was placed on notice boards throughout the wards.
- Staff said they did not always receive feedback on the outcome of investigations of complaints.
- Mangers told us they fed back outcomes of complaints to individuals and teams by emails and discussed at team meetings. However, the wards struggled to have regular team meetings, so we were unsure as to how effective this would be.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- Staff knew about the trust values and demonstrated these through the person centred support they offered to patients. Ward objectives followed these values. Wards had the visions and values displayed notice boards for patients and staff.
- Staff on Ward 33 had created additional visions and values. They told us they aimed to work together with patients and families. To create a safe space with a supportive environment that focused on recovery and wellbeing. A practical part of this was that they had converted an unused dormitory area in to a recreational space for patients.
- Staff could name senior managers and felt supported. They could contact senior managers involved within the service for support. The trusts senior executive team visited the wards at Radbourne and Hartington units.

Good governance

- Overall, governance was weak. Staff compliance rates with mandatory and supervision training fell below the trust targets. Ward managers told us that they cancelled training if shifts needed covering. Wards struggled to cover all shifts with sufficient numbers of staff at the right grade and experience.
- Supervision and appraisal rates across the core service were below the trusts compliance target.
- Staff reported incidents on the trusts electronic recording system. At a local level, we saw examples of where the recording was effective, through reviewing individual specific events and incidents. However, we saw little evidence of trust wide learning from incidents and complaints being shared with staff in order to change practice.
- We were not clear about the governance mechanisms in place. Most wards struggled to have regular business meetings to cascade and discuss governance. The trust provided blue light updates to all staff via email for individuals to read.
- All wards had set key performance indicators. These monitored length of patient stay, delayed discharges, readmission rates, GP discharge notifications, Health of the Nation Outcome scales (HoNOS) and Care Programme Approach reviews (CPA's).
- The ward managers had sufficient authority to manage their ward. They received administrative support.
- All ward staff had access to the risk register. Ward managers placed items on the register and had responsibility to review each one.

Leadership, morale and staff engagement

- Sickness levels across the core service varied. The national average sickness rate is 4.24%. The highest sickness rate three months before inspection was for the Enhanced Care ward at 11%, followed by Ward 35 at 9.5%, Ward 33 at 5.98%, Tansley ward at 6.49%, Ward 36 at 5.60%. All other wards sickness rates in the core service were below the national average.
- Managers did not ensure rotas allowed time for staff supervision, appraisals and training.
- Ward managers were additional to ward staff numbers. They also participated on a duty rota for each unit. Duty covered managing the 136 suite and assisting during or post ward incidents across the unit. We observed one bleep holder had spent the entire day at the 136 suite. They had been unable to respond to incidents on the wards because of this. Ward managers said this additional duty would take time away from ward management.
- There was one reported case of bullying or harassment. Managers were addressing the incident as per trust policy.
- Most staff felt there was an open culture where they could talk to managers to raise concerns.
- Staff knew how to use the whistleblowing policy but felt this would not be necessary. There has been one whistleblowing enquiry raised to the CQC between 22 March 2015 and 23 March 2016 that related to acute wards. The main theme of this had been inappropriate admissions and concerns that senior staff were not supportive to staff.
- Staff we spoke with told us they felt part of a team and received support from each other.

Are services well-led?

Requires improvement

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

- All staff we spoke with said they felt well supported by their immediate manager and felt their work was valued. Generally, we saw a positive working culture within the teams that we inspected. Two of the band two staff did not feel valued by the trust. They did not feel their banding reflected the responsibilities they held within their role.
- The Trust gave yearly awards. Staff from Morton ward were proud to share they had received gold standard three years in a row that had led to their latest platinum award. Staff on Morton ward had developed an in house award to recognise individual staff. This was called DEED (delivering excellence each day).
- Staff had a good understanding of duty of candour and the need to be open and transparent. Ward managers were able to share examples of how this was implemented. For example, staff informed all patients of an incident at a community meeting. Staff also sent letters explaining the incident and action plan to all current and discharged patients that may have been involved.

Commitment to quality improvement and innovation

- Staff on Ward 33 had completed research into Metabolic Syndrome in women. Outcomes from this study had improved care. All patients identified at risk received lifestyle modification advice from a dietician and activity coordinators. Staff sent GP's patient discharge summaries highlighting specific physical health areas that needed continuous monitoring.
- Since 2014, the trust has planned implementation of 'Safewards'. Safewards is an international initiative. It offers range interventions for staff to use in order to increase patient safety in a ward environment. We saw staff use some of the interventions. For example, mutual help meetings were being ran on some wards. These aim to provide a safe space on ward for both staff and patients to meet to share positive thoughts. Some wards were using 'getting to know you' folders. A group of staff had planned to attend the international conference in Denmark later this year.
- Ward 33 had won a trust innovation bid to provide dance and movement therapy on the ward.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment · The provider did not consistently maintain medication at correct temperatures in all areas. · The provider did not ensure that the prescribing, administration and monitoring of vital signs of patients were completed as detailed in the NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings. · The provider did not ensure that clinical staff had a consistent approach to the use of rapid tranquillisation, understand its risks and record its usage. This was a breach of Regulation 12(1) - 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 15 HSCA (RA) Regulations 2014 Premises and equipment · The trust did not ensure that staff used, stored and maintained all equipment in line with manufacturers' instructions. · The provider did not ensure all emergency equipment was within its expiry date and accurately checked. **Regulation 15(2)**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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 18 HSCA (RA) Regulations 2014 Staffing · The trust did not ensure that all shifts had the required amount of staffing at the correct grade. · There was an over-reliance on bank and agency staff across all of the acute wards. · The trust did support staff in ensuring completion of statutory and mandatory training. · The Trust did not ensure that staff had received regular supervision. · The trust did not ensure that all staff had yearly appraisals. Regulation 18 (1) (2)(a)
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 **Good governance** · Systems to identify and manage all environmental risks in the patient care areas. · Systems did not ensure that all long term segregation and seclusion was undertaken and documented in line with trust policy. · Patient's capacity and ability to consent in the planning, management and review of their care and treatment was not routinely documented. Regulation 17 (1) (2)(b)(d)

This section is primarily information for the provider

Enforcement actions

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.