

Requires improvement 

Coventry and Warwickshire Partnership NHS Trust

Wards for older people with mental health problems

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)
RYG79	St Michael's Hospital	Ferndale Ward	CV34 5QW
RYGCW	Manor Hospital	Pembleton Ward Stanley Ward	CV11 5HX

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

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 Coventry and Warwickshire Partnership NHS Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire Partnership NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

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

Overall we rated wards for older people with mental health problems as requires improvement because:

- The ward environments were not safe or conducive to dignified care. They did not comply with the requirement to eliminate mixed sex accommodation in accordance with the Department of Health guidance and Mental Health Act 1983 Code of Practice. Female patients were sleeping in male areas of the ward. On all wards there were multiple ligature points (places to which patients intent on self-harm might tie something to harm themselves), these included window latches, taps and doors. Staff had completed annual ligature risk assessments. However they had not assessed the risk to individual patients. This meant that patients with a known risk of self-harm had not been adequately assessed. Staff kept ligature cutters in the clinic room which was locked. This meant that they were not easily accessible to staff. There were blind spots on all wards which meant staff could not observe all areas to maintain patient and staff safety. Some mirrors were in place on one ward. All bedroom doors were solid wood and did not have privacy panels to observe patients. None of the wards had a couch in the clinic room. Staff used a link corridor for de-escalation and the management of aggression. This meant that agitated and aggressive patients were cared for in an area that was not designed for seclusion.
- Some care plans were not personalised or holistic. Patients views recorded in the 'this is me' document were not included in the care plan. Not all patients had a copy of their care plan.
- Staff did not always comply with the requirements of the Mental Health Act. They did not always inform patients of their right to support from an Independent Mental Health Advocate in line with Mental Health Act code of practice. Some section 17 leave forms did not indicate to whom they had been given in addition to the patient. When staff confined patients in the link corridor they used seclusion policy documentation.

- There was a high bed occupancy rate and a high length of stay on all wards. When patients went on leave their bed was used for another admission. If the patient needed to come back to hospital a bed would be found on another ward. There were two delayed discharges, one patient was awaiting funding and another was awaiting a suitable community placement. Patients' full names were displayed on bedroom doors.

However:

- Wards were visibly clean and well maintained. Cleaning records were up to date and there were practices in place to ensure infection control. Clinic rooms were well equipped. There were wheelchairs and bathing facilities specific to the needs of older frail people with reduced physical ability.
- There were sufficient numbers of staff on all wards. Ward managers were able to adjust staffing levels daily to take into account increased clinical needs such as levels of observation or patient escort. Regular bank and agency staff were used to ensure that the correct number of staff were on duty.
- Staff identified patients physical health needs. Medical staff documented physical health examinations and assessments following admission to the wards. Physical health examinations and assessments were documented by medical staff following the patient's admission to the wards. They also undertook ongoing monitoring of physical care problems. Ongoing monitoring of physical health care problems was taking place.
- All wards used paper care records. These were stored securely and available to staff when they needed them.

Summary of findings

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

Are services safe?

We rated wards for older people with mental health problems as requires improvement for safe because:

- The Department of Health guidance and Mental Health Act 1983 Code of Practice in relation to the elimination of mixed sex accommodation were not met on all wards. Female patients were sleeping in the male area of the ward.
- There were blind spots on all wards; staff could not observe all areas to maintain patient and staff safety. All bedroom doors were solid wood and did not have privacy panels to observe patients.
- There were multiple ligature points (places to which patients intent on self-harm might tie something to harm them) on all wards, these included window latches, taps and doors. Ligature cutters were kept in the clinic room which was locked.
- A link corridor was used for de-escalation and the management of aggression. These incidents were recorded using the seclusion policy documentation but the area was not suitable for this purpose as it was cluttered with equipment and furniture.

However:

- The provider had calculated the number and grade of staff needed to care for patients on a normal day. There was always adequate numbers of staff on the ward at all times. When necessary, regular bank and agency staff were used who knew the ward and patient group.
- Ward equipment was well maintained and the wards were clean, bright and airy. Convex mirrors were in place in some areas.
- Staff used the 'Modified Early Warning Signs' (MEWS) tool on all wards. Staff recorded physical observations using the MEWS ratings to make a decision about further action they should take. Falls assessments had been completed and care plans were in place.

Requires improvement



Are services effective?

We rated wards for older people with mental health problems as requires improvement for effective because:

Requires improvement



Summary of findings

- Qualifying patients were not being told of their right to support from an Independent Mental Health Act Advocate (IMHA). Those patients lacking capacity were not referred to advocacy automatically in line with MHA code of practice.
- Section 17 leave forms did not record who else had been given a copy other than the patient.
- Some care plans were not personalised or holistic.

However:

- Patient physical health needs were identified. Medical staff documented physical health examinations and assessments following the patient's admission to the wards. On-going monitoring of physical health care problems was taking place.
- Patients accessed a range of physical healthcare services including podiatrists, district nurses, tissue viability nurses and opticians.
- Outcomes for patients using the services were monitored and audited. This included the monitoring of key performance indicators such as length of stay and readmissions within 30 days of discharge.

Are services caring?

We rated wards for older people with mental health problems as good for caring because:

- We saw that nursing staff treated patients with care and respect and communicated in ways patients understood. Staff knew of individual needs and concerns, and spoke respectfully about patients.
- We saw when staff helped patients with their personal care, this was done in private and patient dignity was maintained.
- Patients were invited to and supported to attend the multi-disciplinary reviews along with their family where appropriate.
- Visiting hours were in operation and there was a separate room for patients to see their visitors.

However:

- A member of catering staff became impatient when a patient was undecided in their choice of lunch.
- Patient's views recorded in the 'this is me' document were not included in the care plan. Not all patients had a copy of their care plan.
- One carer told us that they were discouraged from visiting more than once a day.

Good



Summary of findings

Are services responsive to people's needs?

We rated wards for older people with mental health problems as requires improvement for responsive because:

- There was a high bed occupancy rate and a high length of stay on all wards.
- When patients went on leave their bed was used for another admission. If the patient needed to come back to hospital, a bed would be found on another ward.
- Patients' full names were displayed on bedroom doors. This was a breach of confidentiality and was brought to the attention of the ward manager who immediately rectified it.

However:

- Wards had access to garden areas leading off from the lounge. They provided a spacious area for patients to be able to walk, share time with carers and to enjoy fresh air. There were a number of leaflets available telling patients how to make a complaint, how to get in touch with advocacy services, local carer groups and about individual treatments.
- Staff unlocked doors on the main entrances to allow informal patients to leave the ward on request. There was a poster on the door telling informal patients what to do if they wished to leave the ward.
- Wards were accessible for patients with disabilities. Each ward had a disabled toilet and bathroom.

Requires improvement



Are services well-led?

We rated wards for older people with mental health problems as requires improvement for well led because:

- Patients with a known risk of self-harm had not been adequately risk assessed and ligature cutters were kept in the locked clinic room.
- Three out of 12 staff interviewed knew how to raise a safeguard.
- Full patient names were displayed on bedroom doors.
- Male patients were placed on enhanced observations when sleeping in female areas that were not linked to individual risk assessments.
- Ward managers said they had sufficient authority and felt able to carry out their role effectively.
- Staff told us they were aware of the trust vision and values.
- Staff knew how to use whistle-blowing process and felt able to raise concerns without fear of victimisation.

Requires improvement



Summary of findings

- Ward managers said that they felt supported by senior managers, and they had sufficient authority to make changes to the ward staffing levels when needed.
- Staff said that there were opportunities for personal development and training.
- Staff sickness and absence rates were being managed by ward managers with human resource support.

Summary of findings

Information about the service

Coventry and Warwickshire Partnership NHS Trust has three wards for older people with mental health problems. The wards are situated in Nuneaton and Warwick.

Pembleton ward is a psychiatric physical complexity unity providing 12 beds for both male and female patients in Nuneaton.

Stanley ward has 12 beds for the assessment and treatment for men and women with a dementia related

illness in Nuneaton. The ward had been relocated from the Caludon Centre in Coventry in December 2015 owing to health and safety concerns about the building at the time.

Ferndale ward is a psychiatric physical complexity unity providing 16 beds for both male and female patients in Warwick. The ward had been relocated from the Caludon Centre in Coventry in February 2016 due to health and safety concerns at the time.

At the time of the inspection all wards were full.

None of these locations have been inspected previously.

Our inspection team

Our inspection team was led by:

Chair: Paul Jenkins, Chief Executive of Tavistock and Portman NHS Foundation Trust.

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals. CQC.

Inspection manager: Margaret Henderson, Inspection Manager, mental health hospitals CQC.

The team that inspected wards for older people with mental health problems comprised a CQC Inspector, a Mental Health Act reviewer and two specialist professional advisors. All of them had experience of providing these services.

The team would like to thank all those who met and spoke with inspectors during the inspection to share their experience and perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- Visited all three 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 six patients who were using the service.

Summary of findings

- Spoke with the managers for each of the wards.
 - Spoke with 12 other staff members; including doctors and nurses, ward clerk and student nurse.
 - Attended one multi-disciplinary meeting.
 - Spoke with five carers of people who were using the service
 - Reviewed 17 care and treatment records of patients.
 - Carried out a specific check of the medication management on three wards.
 - Examined 11 sets of Mental Health Act (1983) records.
- 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

We spoke with six patients and five carers.

- Five of the patients we spoke with were positive about their experience of care on the wards. The majority of patients said staff knocked before entering their bedrooms and were respectful and polite.
- Patients enjoyed activities on the ward and liked going into the garden. Patients enjoyed the food and some would like a better choice of food.
- Some patients said they were not involved in the planning of their care. Some patients could not remember receiving a copy of their care plan.
- Carers said that they were able to raise concerns to the ward manager. One carer said that she had been discouraged from visiting the ward more than once a day.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure adherence to the guidance on eliminating mixed sex accommodation.
- The trust must address environmental issues including poor lines of sight and ligature risks in patient areas.
- The trust must ensure that qualifying patients are referred to support from an Independent Mental Health Act Advocate, in line with MHA code of practice. Section 17 forms must indicate to whom they had been given in addition to the patient.
- The trust must ensure that seclusion is carried out in adherence to the MHA code of practice.

Action the provider **SHOULD** take to improve

- The trust should ensure that all care plans record capacity assessments where relevant.
- The trust should ensure that care plans are personalised and holistic and that a copy is given to the patient where appropriate.
- The trust should ensure patient confidentiality when putting names on patient doors.
- The trust should consider providing privacy panels in bedroom doors for staff to observe patients when required.

Coventry and Warwickshire Partnership NHS Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Stanley ward	Manor Hospital
Pembleton ward	Manor Hospital
Ferndale ward	St Michael's 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.

Twelve patients on Ferndale ward were detained under the terms of the Mental Health Act (MHA) (1983). Four patients were informal (meaning they could leave at will). Two were subject to Deprivation of Liberty Safeguards (DoLS).

Eight patients on Stanley ward were detained under the terms of the MHA, two were subject to DoLS and two were informal.

Eight patients on Pembleton ward were detained under the terms of the MHA and four were informal.

Patients had received their rights under section 132 of the Act and these were repeated at regular intervals. All sets of MHA legal documentation had been completed correctly were up to date and held securely. The MHA record keeping and scrutiny was satisfactory. The trust monitored the effectiveness of MHA record keeping. For example, the trust carried out regular monitoring audits.

Staff on duty confirmed they had received recent training in the MHA and displayed a good working knowledge of the Act.

Qualifying patients were not referred to support from an Independent Mental Health Act Advocate, in line with MHA code of practice. Section 17 forms did not indicate to whom a copy had been given in addition to the patient.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust offered mandatory training in the Mental Capacity Act. Staff attendance at this was 94% on Pembleton ward, 90% on Ferndale ward and 76% on Stanley ward. Staff on duty we spoke with had a working knowledge about the MCA and DOLS.

Posters were displayed informing patients of how to contact the independent mental health advocate.

Are services safe?

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

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

Our findings

Safe and clean environment

- All wards admitted both men and women, however female patients were sleeping in the male areas of the wards. Male patients were also sleeping in female areas of the wards. This meant that the wards did not comply with the Department of Health guidance on the need to provide same-sex accommodation and Mental Health Act 1983 code of practice.
- Staff could not observe all areas of the wards to maintain patient and staff safety. The trust had mitigated risk and promoted observation by installing some mirrors on Ferndale ward, Pembleton ward but Stanley ward did not have mirrors in place. All bedroom doors were solid wood and did not have privacy panels for staff to observe patients when needed
- We found multiple ligature points on all wards, these included window latches, taps and doors. Annual ligature risk assessments had been completed however individual patient risk assessments had not. This meant that patients with a known risk of self-harm had not been adequately assessed. Ligature cutters were kept in the emergency bag in the clinic room. This was behind a locked door and not easily accessible to staff as there was only one key which was kept with the medicines keys by the nurse in charge.
- Ward equipment was well maintained. Cleaning records were up to date and demonstrated that the environment was regularly cleaned. Practices were in place to ensure good infection control. Staff had access to protective personal equipment such as gloves and aprons.
- Clinic rooms were equipped with accessible resuscitation equipment with emergency drugs. Staff regularly checked equipment and kept a record of this.
- Clinic rooms did not have couches for examining patients.
- The wards were visibly clean, bright and airy and each patient had their own bedroom which had a sink.

Safe staffing

- There were sufficient numbers of staff on all wards. The wards worked on basic numbers of three trained nurses and three healthcare assistants (HCAs) working a long day. Two HCAs worked a twilight shift and two trained nurses and three HCAs worked at night.
- Each ward had two vacancies for trained nursing staff. Pembleton and Stanley wards had two vacancies, each for HCAs. Ferndale had seven vacancies which were in the process of being recruited to.
- Data provided by the trust showed 738 shifts in the past twelve months had been covered by bank or agency staff.
- One hundred and thirty out of 868 shifts had not been covered by bank or agency staff where there was sickness, absence or vacancies. moved from other wards where possible to cover the shortfall.
- Ward managers were able to adjust staffing levels daily to take into account increased clinical needs such as levels of observation or patient escort.
- Duty rotas over the last three months showed there was always a qualified, experienced member of staff on duty on each ward. Regular bank and agency staff were used to ensure that the correct number of staff were on duty.
- The training records demonstrated the majority of staff had completed their mandatory training. Staff that had not completed their mandatory training were scheduled to attend.

Assessing and managing risk to patients and staff

- None of the wards had a seclusion room. Staff told us that a link corridor between Pembleton and Stanley ward was used for de-escalation and the management of aggression this meant that agitated and aggressive patients were cared for in an area that was not suitable for that purpose. The link corridor was used to store equipment and furniture which posed a falls risk to patients. These incidents were recorded using the seclusion policy documentation.

Are services safe?

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

- Between 1 June and 30 November 2015 there had been 30 recorded incidents of restraint on 14 patients. Rapid tranquilisation had been used on four patients and followed National Institute for Health and Care Excellence (NICE) guidance.
- Individual risk assessments were complete in all the care records we inspected. Patients with a known risk of self harm did not have specific risk assessments when being nursed in areas with significant ligature points. Three out of 17 were out of date.
- Falls assessments had been completed and care plans were in place.
- Ninety-two per cent of staff had received annual training in prevention and management of violence and aggression.
- There was an effective medicines management system in place. Staff gave covert medicines (when a patient refuses to take medicine they need to prevent deterioration in their health) in line with trust policy and a record was kept with the prescription chart.
- Ninety percent of staff were trained in safeguarding. Three out of the 12 staff we spoke with knew how to make a safeguarding alert.
- Staff carried personal alarms to summon help when needed.

Track record on safety

- In the last 12 months the service had reported five serious incidents. One following a patient's physical deterioration and admission to an acute hospital and four following a fall resulting in a fracture.

Reporting incidents and learning from when things go wrong

- Staff used the electronic system to report incidents and understood their role in the reporting process. Each ward had access to an online electronic system to report and record incidents and near misses.
- Ward managers told us they provided feedback in relation to learning from incidents to their teams in weekly team meetings and handovers. Meeting notes were kept in a folder in the ward office
- Debriefs were available to staff following incidents.

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

- Staff who undertook assessments and care planning had received training in dementia awareness. Care records for patients receiving care and treatment in the older person inpatient wards showed patient needs were assessed. Referral systems were in place to access the need for services such as podiatry, dentists and tissue viability nursing.
- 15 out of the 17 care plans we inspected were incomplete and were not personalised or holistic.
- Patient physical health needs were identified. Physical health examinations and assessments were documented by medical staff following the patient's admission to the wards. Ongoing monitoring of physical health care problems was taking place.
- All wards used paper care records. These were stored securely and available to staff when they needed them.
- Patients on enhanced observations did not have individual risk assessments completed.

Best practice in treatment and care

- Patients accessed a range of physical healthcare services including podiatrists, district nurses, tissue viability nurses and opticians.
- Staff used the 'Modified Early Warning Signs' (MEWS) tool on all wards. Staff recorded physical observations using the MEWS ratings to make a decision about further action they should take. Patient's nutrition and hydration need were met.
- There was a choice of food and drink prepared and served in ways that encouraged patients to eat and drink, including hot and cold finger food. Patients could access hot drinks on request. Patients were regularly weighed. Action was taken, for example nutritional supplements were offered, when concerns were identified.
- Outcomes for patients using the services were monitored and audited. The staff used health of the nation outcome scales (HONOS).

Skilled staff to deliver care

- Staff said that they received regular supervision. A record of this was kept in the ward office.
- Patients received care and treatment from a range of professionals including nurses, doctors, psychologists, activity coordinators, occupational therapists and pharmacists.
- Staff said that they had received a comprehensive induction to their role.
- Ward managers said that they had good support from human resources to manage poor performance.

Multi-disciplinary and inter-agency team work

- There was good multi-disciplinary team (MDT) input to the wards, including psychiatry, specialist nurses (including tissue viability nurses), physiotherapists, and dietician, pharmacy, and activity coordinators. Multi-disciplinary team meetings and ward rounds provided opportunities to assess whether the plan of care was meeting patient need.
- Staff worked closely with community colleagues. For example care coordinators attended MDT meetings whenever possible.

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

- Ninety-four percent of staff on Pembleton ward had received training in the Mental Health Act (MHA). Ninety percent of staff on Ferndale ward had received training in the MHA. Seventy six percent of staff had training in the MHA on Stanley ward.
- Qualifying patients were not being told of their right to support from an Independent Mental Health Act Advocate (IMHA). Those patients lacking capacity were not referred automatically in line with MHA code of practice.
- Some section 17 leave forms did not indicate to whom they had been given in addition to the patient.
- Staff read, explained and repeated at regular intervals patient rights (under section 132 of the MHA).
- There was a trust team that provided ward staff with administrative support and legal advice on implementation of the MHA and its 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.

Good practice in applying the Mental Capacity Act

- Ninety-four percent of staff on Pembleton ward had training in the Mental Capacity Act (MCA). Ninety percent of staff on Ferndale ward had training in the MCA. Seventy six percent of staff had training in the MCA on Stanley ward.
- Posters were displayed informing patients and carers how to contact the independent mental health advocate, the independent mental capacity advocate and the Care Quality Commission.

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 saw that nursing staff treated patients with care and respect and communicated in ways patients understood. However, one member of catering staff was inpatient when a patient was undecided in their choice of lunch.
- Staff knew of individual needs and concerns, and spoke respectfully about patients.
- We saw when staff helped patients with their personal care, this was done in private and patient dignity was maintained.

The involvement of people in the care that they receive

- Patient's views were sought wherever possible and families were actively involved from an early stage after admission. However some care plans did not reflect this.

- Staff on Ferndale and Pembleton wards organised weekly community meetings. Meeting notes recorded what had been discussed. Patients talked about menus, ward environment, activities and were asked for feedback.
- Patients views recorded in the 'this is me' document were not included in the care plan. Not all patients had a copy of their care plan.
- Patients were invited to the multi-disciplinary reviews along with their family where appropriate.
- Visiting hours were in operation and there was a separate room for patients to see their visitors. One carer told us that they were discouraged from visiting more than once a day.

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Access and discharge

- The bed occupancy rate from 1 June 2015 to 30 November 2015 was 102% on Pembleton ward, 95% on Ferndale ward and 111% on Stanley ward. The average length of stay on Pembleton ward was 81 days, Ferndale ward length of stay was 139 days and Stanley ward was 110 days.
- Bed numbers on Ferndale had increased from 16 beds to 19 over the Easter period due to increased demand. There were 18 patients on the ward on the day we inspected.
- Staff told us that when patients went on leave their bed was always used for another admission. If the leave was unsuccessful a bed would be found on another ward.
- There were two delayed discharges on Stanley ward, one patient was awaiting funding and another was awaiting a suitable community placement.
- Key performance information was displayed on ward notice boards. This included length of stay and readmissions within 30 days of discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- All wards had a range of rooms and equipment to support treatment and care. There were quiet areas on each ward. There was a room set aside on each ward where patients could meet visitors.
- Each ward had access to an activity coordinator and occupational therapist. Activity programmes were displayed which included creative crafts, quizzes and gardening.
- Staff unlocked doors on the main entrances to allow informal patients to leave the ward on request. There was a poster on the door telling informal patients what to do if they wished to leave the ward.
- Staff assisted patient to use the ward phone on request and patients were able to use their own mobile phones. There was a patient telephone in a corridor on each ward.

- Wards had access to garden areas leading off from the lounge. This provided a spacious area for patients to be able to walk, share time with carers and to enjoy fresh air.
- Patients had access to cold drinks in the day room 24 hours a day. Hot drinks were prepared by staff throughout the day.
- On Pembleton ward patients' full names were displayed on bedroom doors. This was a potential breach of confidentiality which was brought to the attention of the ward manager, who immediately rectified it.

Meeting the needs of all people who use the service

- Wards were accessible for patients with disabilities. Each ward had a disabled toilet and bathroom.
- There were a number of leaflets available telling patients how to make a complaint, how to get in touch with advocacy services, local carer groups and about individual treatments.
- Trust wide interpretation services were available if required.
- Patients were able to order food in line with spiritual and specific dietary needs, hot and cold finger food was available.
- There was access to spiritual support through the provider chaplaincy service.

Listening to and learning from concerns and complaints

- Staff knew how to help patients make a complaint. Both wards used the trust's complaints system. Information about the complaints process was available on notice boards.
- There was one complaint relating to Ferndale ward between November 2014 and November 2015. The complaint was partially upheld and appropriately investigated by the trust.
- 'Thank you' cards and letters from patients and carers were displayed on the notice boards.
- Feedback from complaints and compliments were discussed at team meetings. Notes of the meetings were kept in a file in the ward office.

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 told us they were aware of the trust's vision and values.
- There were vision and values statement posters unique to each service displayed.
- Ward managers said that the chief executive had visited their wards and the trust chair had work a shift on Pembleton ward.

Good governance

- Three out of 12 staff interviewed were able to describe how to raise a safeguard.
- Ligature cutters were kept locked in the clinic room and were not easily accessible to staff.
- Full patient names were displayed on bedroom doors.
- Patients with a known risk of self-harm had not been adequately risk assessed.
- Patients on enhanced observations did not have individual risk assessments completed.
- Ward managers said they had sufficient authority and felt able to carry out their role effectively.
- Incidents were reported through the trust's electronic incident reporting system. Each incident was reviewed by the ward manager and learning shared at the monthly ward meeting.

- The trust had a dedicated MHA team to help with any legal or administrative issues.
- Managers staffed shifts to the agreed safe level of nurses; they often used bank staff to achieve this.
- All staff had received mandatory training and all had completed an induction to their job role. There was six weekly supervision and an annual appraisal process.
- Monthly medication, MHA and handwashing audits were taking place.

Leadership, morale and staff engagement

- Staff knew how to use whistle-blowing process and felt able to raise concerns without fear of victimisation.
- Ward managers said that they felt supported by senior managers, and they had sufficient authority to make changes to the ward staffing levels when needed.
- Staff said that there were opportunities for personal development and training for example a trust wide leadership programme.
- Staff sickness and absence was managed by ward managers with human resource support.

Commitment to quality improvement and innovation

- Wards had taken part in the 'productive ward – releasing time to care' initiative. This initiative encouraged staff to maximise time spent with 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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- Wards and courtyard areas had potential ligature points that had not been fully managed, mitigated, or addressed.
- Ligature cutters were kept in the clinic room which meant they were not always easily accessible.
- Some wards had poor lines of sight. Staff could not easily observe patients.
- A corridor was used as a seclusion area.

This was a breach of Regulation 12 (1)(2) (a)(b)(d)(e)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Section 17 leave forms did not indicate to whom they had been given in addition to the patient

This was a breach of regulation 17 (2) (c)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Qualifying patients were not referred to support from an Independent Mental Health Act Advocate (IMHA), as required by MHA code of practice

This was a breach of regulation 9 (3) (c) (d)