Good

Nottinghamshire Healthcare NHS Trust

Acute admission wards

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Bassetlaw Hospital	RHAAA	B2 ward	S81 0BD
Highbury Hospital	RHANM	Rowan 1 and Rowan 2 wards, and Redwood 1 and Redwood 2 wards	NG6 9DR
Queen's Medical Centre	RX1RA	A42 and A43 ward	NG7 2UH
Millbrook Mental Health Unit	RHABW	Orchid ward	NG17 4JL

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare 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 Nottinghamshire Healthcare NHS Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare 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 Adult admission wards (mental health)	Good
Are Adult admission wards (mental health) safe?	Requires Improvement
Are Adult admission wards (mental health) caring?	Good
Are Adult admission wards (mental health) effective?	Good
Are Adult admission wards (mental health) responsive?	Good
Are Adult admission wards (mental health) well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Overall, people received a good service from the adult admission wards. The service had a clear vision and staff were positive about working towards this. The quality of the service delivered was also monitored on an ongoing basis, where areas for development were identified, clear action plans were put in place and progress was monitored. Staff were generally supported in their roles and were supervised regularly. In addition, patients told us, and we observed, that staff were caring and compassionate.

There were some particular areas of good practice across the wards:

The skills of staff were being developed to meet the needs of patients. Across the wards staff were allocated link roles in specialty areas in order to support people appropriately.

The supervision structure. This helped staff to feel well supported and enabled lessons learnt to be shared.

Clear working practices across acute admission wards, and clear learning from incidents across the trust and within the adult admission service as a result.

There were good links with community care coordinators from the point of a people's admission. Staff described working to the least restrictive practice with patients and confirmed a low use of restraint was used as a result. Sometimes this was in order to prevent people harming themselves or when treatment was being provided. This way of working underpinned the adult mental health service line's recovery focus model. De-escalation techniques were used first with restraint used as a last resort. This practice was echoed throughout all of the adult inpatient services we visited.

However, we found that there were some areas where the service could make some improvements, including:

There were noted staffing level pressures on Redwood 1 and Redwood 2. For example on Redwood 2 there was one qualified member of staff on at night. Staff had reported challenges with this and it was felt that the cost improvement had a direct impact on these staffing pressures. We were told there had been increased staff sickness and patient complaints and a lot of pressures to complete ward related tasks on time. On Redwood 1 some staff we spoke with expressed feeling stressed on shift and felt that due to staffing level pressures on the ward this could impact on quality of time they spent with patients, and whether their leave was accommodated. We found that leave was usually accommodated however. Staff informed us that it was not always easy to fill the day shift and that a lot of ringing around was involved to get someone at short notice.

Across the adult admission wards staff confirmed that access to occupational therapy and psychology had been reduced.

There was an air of anxiety about the potential closures of A42 and A43 wards at the Queen's Medical Centre. The service director for these wards told us that this had not yet been confirmed, and that staff had been told about developments so far. Plans for moving services to a virtual ward in the community had been considered, but staff remained unclear where this left them in the trust.

The dispensing of medicines on Orchid Ward, Millbrook Mental Health Unit was not always carried out in line with the trust's medicines policy.

We found there was an area where the service must make some improvements. The trust had not adhered to national guidance on gender separation at Bassetlaw hospital (B2 ward) and Millbrook Mental Health Unit (Orchid ward).

Summary of findings

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

Are services safe?
Overall, people on the adult admission wards received safe care from the service. However, at Highbury Hospital there were staffing pressures on some wards. In addition, the trust had not adhered to national guidance on gender separation at Bassetlaw hospital (B2 ward) and Millbrook Mental Health Unit (Orchid ward).

Requires Improvement 

Are services effective?
Care was responsive and reflected the needs of patients. Staff used current best practice on critical physical care and reported monthly, in line with efficiency targets.

Good 

Are services caring?
Overall, we saw that staff were caring and responsive to people, and were skilled in the delivery of care.

Good 

Are services responsive to people's needs?
Services were generally responsive to people's needs, and we saw evidence of good follow-up care in people's records.

Good 

Are services well-led?
There were clear expectations and structures in place to support the teams to meet management's expectations.

Good 

Summary of findings

Background to the service

Nottinghamshire Healthcare NHS Trust mental health services for adult acute admissions, provide inpatient services for people aged 18 to 65 years.

The adult admission wards are based across on four hospital sites: Bassetlaw Hospital (B2 ward), Highbury hospital (Rowan 1 and Rowan 2 wards, and Redwood 1 and Redwood 2 wards), Millbrook Mental Health Unit (Orchid ward) and Queen's Medical Centre (A42 and A43 wards).

CQC inspected Highbury hospital in October 2013. At this inspection, we found that the hospital was not complying with the Regulations on care and welfare, consent, and medicines. Following this inspection, we issued compliance actions. The inspection of 29 April to 2 May looked at whether the hospital had made the changes need to meet the standards.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector (Lead for Mental Health), Care Quality Commission (CQC)

Team Leader: Jenny Wilkes, Head of Inspection (Mental Health), CQC

The team included CQC inspectors; a Mental Health Act commissioner looking at rights of patients sectioned under the Mental Health Act 1983; a variety of specialists including nurses, social workers, occupational therapists and a consultant psychiatrist; and Experts by Experience with experience of using mental health services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

We visited Nottinghamshire Healthcare NHS Trust's mental health adult admission wards between 29 April and 1 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff, such as nurses, doctors, and therapists. We also spoke with staff, including a service manager for acute admissions, doctors, nurses, ward managers, healthcare assistants and therapists. We observed ward rounds, and handover between shifts. We talked with people who use services, their carers and/or family members, and observed how people were being cared for and reviewed their care or treatment records.

Summary of findings

What people who use the provider's services say

People using the services, and their relatives, were positive about their experience of care at the trust. Most people told us that they found staff to be very caring and supportive. However, there was a mixed response about whether people felt involved in the development of their care planning.

Good practice

- The supervision structure helped staff to feel well supported and enabled lessons learnt to be shared.
- There was clear learning from incidents across the trust within the acute admission services.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- The trust must enure that national guidance on gender separation at Bassetlaw hospital (B2 ward) and Millbrook Mental Health Unit (Orchid ward) is adhered to.

Action the provider SHOULD take to improve:

- The trust should ensure that staff are consistently following the trust's medicine's policy on Orchid Ward, Millbrook Mental Health Unit.

Nottinghamshire Healthcare NHS Trust

Acute admission wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
B2 Ward	Bassetlaw Hospital
Rowan 1 and 2 wards and Redwood 1 and 2 wards	Highbury Hospital
A42 and A43 wards	Queen's Medical Centre
Orchid ward	Millbrook Mental Health unit

Mental Health Act responsibilities

All staff spoken with had undertaken training in the Mental Health Act and Mental Capacity Act and staff of all levels demonstrated a good understanding of these.

We reviewed people's records for people who were detained under the Mental Health Act. Mental health documentation reviewed was generally found to be compliant with the Act and the code of practice in the detained patients' files we examined.

At Millbrook mental health Unit, we reviewed the use of the Mental Health Act on Orchid Ward. We found that old section 17 leave forms had not been routinely crossed out or cancelled for one person, and one person had not been routinely informed and reminded of their rights under the Mental Health Act. We were unable to find entries regarding capacity assessment as per the code of practice.

There was an information board detailing information on how to access Independent Mental Health Advocates. However the feedback of people's understanding around advocacy was varied. Two of the three people we spoke with said they were not aware of advocacy services.

At Queen's medical centre on A43 ward, there was a mixed patient population on the ward and interpreters were often accessed for reviews, care planning, independent mental health advocates (IMHAs) and key working sessions. The ward had recently recruited two healthcare assistants of Polish decent, to reflect the flow of people coming through the service. Mental Health Act rights information was available in various languages.

In B2 ward in Bassetlaw Hospital, The trust was not promoting physical and sexual safety through the elimination of mixed sex accommodation as recommended in the Mental Health Act Code of Practice in order to promote sexual safety for females.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

People's capacity was discussed as routine in ward reviews and in nursing discharge planning meetings. There was a clear understanding of the Mental Capacity Act demonstrated by staff and documentation was completed by the multi-disciplinary team.

Requires improvement

Are services safe?

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

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

Summary of findings

Overall, people on the acute admission wards received safe care from the service. There were clear working practices across acute admission wards, and clear learning from incidents across the trust and within the adult admission service as a result. Staff described working to the least restrictive practice with patients and confirmed a low use of restraint was used as a result. Sometimes this was in order to prevent people harming themselves or when treatment was being provided. This way of working underpinned the adult mental health service line's recovery focus model. De-escalation techniques were used first with restraint used as a last resort. This practice was echoed throughout all of the adult inpatient services we visited.

However, at Highbury Hospital there were staffing pressures on some wards. In addition, the trust had not adhered to national guidance on gender separation at Bassetlaw hospital (B2 ward) and Millbrook Mental Health Unit (Orchid ward). The dispensing of medicines on Orchid Ward, Millbrook Mental Health Unit was not always carried out in line with the trust's medicines policy.

Our findings

B2 ward, Bassetlaw Hospital

Track record on safety

The ward had a system in place to capture safety performance. Staff we spoke with explained the process they used to report incidents through the reporting system. Management reviewed all incidents and identified potential learning and improvements. Appropriate changes were implemented to minimise the risk of incidents reoccurring. For example the ward had linked in with the trust's violence and minimisation group in the past. This group had undertaken a piece of work in health and safety which had been triggered from incidents involving the throwing of hot water on other wards. As a result changes had been implemented across services, including on B2 ward, with regards to how hot water was monitored. One person using the service we spoke with described an incident on the ward the day before our visit and said staff had responded appropriately and managed to calm the situation down. They said ''calm ward with no trouble.''

Learning from incidents and improving safety standards

There was a pharmacy link nurse on the ward who was responsible for keeping staff up to date on medication error updates, from across the trust, and changes that were implemented as a result to ensure people were kept safe. Discussion of changes implemented included drug key safety. Keys were now separated as this had been an issue in the trust before. Previously there had been a medication trolley on the ward but medication was now separated into individual boxes and stored safely in a cupboard in the ward's clinical room. We were told this had improved the process of administering people's medication.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff had completed training in safeguarding children and vulnerable adults and knew how to respond appropriately to any allegation of abuse. There were detailed policies and procedures in place in respect of safeguarding so staff could respond appropriately to concerns. Staff knew where to refer safeguarding concerns and obtain safeguarding advice if needed. People who used the service told us they felt safe on the wards. If staff raised a safeguarding alert they were responsible for following this through to completion. We were told this was to empower staff to take responsibility for the issues raised. There was a safeguarding lead on B2 ward.

Appropriate arrangements were in place for the management of medicines including a pharmacy link nurse on the ward. There were fridges for medicines requiring cold storage and records showed that the fridge temperatures were checked on a daily basis to ensure they were within the required range. Medicines were stored safely in locked cupboards, and the drugs fridge, and expiry dates for emergency and every day medicines were monitored electronically via computer, which also notified the team when they would need re-ordering. There was a

safety tag on the emergency equipment and if this was broken it would be checked and replaced. There was a designated person to check emergency equipment on each shift.

Assessing and monitoring safety and risk

All admissions to the service were reviewed weekly, by a bed panel, which ensured that the needs of the ward and all patients were considered before a new admission was accepted.

There were procedures in place to identify and manage risks to patients. We observed that staff discussed risks related to patients at the handover between shifts and in the multi-disciplinary ward round. People's safety was taken into account in the way care and treatment was planned and links to community teams were discussed.

We found that there were enough members of staff to care for people on B2 ward safely. On the day of our visit there were 24 people on the ward with an additional three on leave. If people on leave needed to return earlier they would have to be admitted to another location within the trust as they did not have allocated beds. Staffing levels were adjusted when changes in need were identified. The staffing levels were five staff during the day and four at night, with a minimum of two qualified staff at night. There were usually three qualified staff on the early shift during the week due to clinical activity. Regular bank staff were asked to fill shifts if there were gaps and this aided continuity of relationships for people using the service. If bank or agency staff were new to the ward they were given a general orientation and induction. We were told that escorted leave for people was usually accommodated but could be delayed due to pressures on the ward such as presenting risks or patients put on 1:1 observations. The community teams facilitated home leave. People we spoke with described being able to leave the ward when they wanted. For example one person told us of being able to go to the shops and away for weekends. One person expressed that although they had the option to leave the ward whenever they wanted to they preferred to have an escort.

Staff described working to the least restrictive practice with patients and confirmed a low use of restraint was used as a result. Sometimes this was in order to prevent people harming themselves or when treatment was being provided. This way of working underpinned the adult mental health service line's recovery focus model. De-escalation techniques were used first with restraint used as a last resort. This practice was echoed throughout all of the adult inpatient services we visited.

Foreseeable emergencies

The service had systems to deal with foreseeable emergencies. Most staff were trained in hospital life support techniques and dates were booked in for staff that had yet to complete this. Training records confirmed this and staff told us they felt confident in dealing with medical emergencies. We saw the emergency equipment was easily accessible and records showed it was checked regularly to ensure it was fit for purpose. There was an accident and emergencies department close to the ward.

Environment

Risks in the environment were generally managed on B2 ward and ensured appropriate levels of security were used while caring for people in the least restrictive way. A recent audit of ligature risks showed that improvements had been made to the safety of the environment. Potential ligature points were managed as part of both ward and individual risk assessments. Management staff informed us there remained some outstanding ligature risks which they were aware of and were managing. These ligatures were mainly populated in the public areas of the ward which staff would monitor. Violence and aggression and ligature risk audits were supposed to be completed yearly in line with service recommendations. However staff told us the last audit completed was 16 months ago. We discussed outstanding features of the action plan and were told that delays could occur due to the service level agreements the trust had in place.

Mixed-sex accommodation

B2 was a mixed-sex ward. Staff used 'fobs' to access the segregated female area on B2 ward. Nursing staff on duty allocated where people slept on the ward and we were told that risks to individuals were taken into account before they were placed in a particular area of the ward. Staff mostly adhered to keeping male and female sleeping areas separate. However on the day of the visit we were informed, and observed, that a female was placed in a single room within an all-male area of the ward. When raised with the managers on the ward they informed us that historically adult wards in the county area had been mixed wards. They had not raised this as an issue to their senior managers nor were they clear on why this decision

had been made in the first instance. However it was acknowledged that ideally a female would not be placed in a male area of the ward. Additionally, given the design of the ward, the female patient would have to walk through an area occupied by the male sex to reach the toilets or bathrooms in the female area of the ward. We were also told that the female patient would use the male toilet at night. Staff were not therefore effectively monitoring the use of gendered facilities.

In 2011 the Department of Health required all providers of NHS-funded care to confirm that they were compliant with the national definition "to eliminate mixed sex accommodation except where it is in the overall best interests of the patient or reflects the patient's choice".

With regards to mental health inpatient wards the Mental Health Act Code of Practice (revised in 2008) says:

"Separate facilities for men and women - 16.9 All sleeping areas (bedrooms and bed bays) must be segregated, and members of one sex should not have to walk through an area occupied by the other sex to reach toilets or bathrooms.''

The provider was therefore not promoting physical and sexual safety through the elimination of mixed sex accommodation as recommended in the Mental Health Act Code of Practice in order to promote sexual safety for females.

Highbury Hospital, Rowan 1 (male) and 2 (female) wards and Redwood (male) 1 and 2 (female) wards

We visited all four of the adult admission wards at Highbury; Rowan 1, Rowan 2, Redwood 1 and Redwood 2. Rowan 1 and 2 wards and Redwood 1 and 2 wards were each separated into male and female wards respectively. There was a system in place to increase / decrease the number of beds used between Rowan 1 and 2, for example if there were more women to men at that point.

Track record on safety

All four wards had a system in place to capture safety performance. Staff explained clearly the process they used to report incidents through the reporting system. Appropriate changes were implemented to minimise the risk of incidents reoccurring. For example on Rowan 1 ward staff discussed a recent example of verbal abuse that had been directed towards staff. An incident reporting form was completed and actions taken discussed with staff.

Learning from incidents and improving safety standards

Learning points from incidents were being identified and plans put in place to improve safety. Drug use on Redwood 1 had been identified as a priority area to address. The ward had employed strategies to mitigate the use of drugs on the ward through the use of drug dogs and environment checks. If a person was a known user, the challenges would be discussed with them, the drug and alcohol team accessed for advice and a drug and alcohol audit tool used to review people in general and identify high risk areas.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Appropriate arrangements were in place for the management of medicines. For example the wards had good links with the pharmacy and medicines were handled safely. The pharmacist attended the ward weekly and saw new admissions when required. Medicines were safely stored and locked away. Yearly medication audits were completed to identify gaps. On Redwood 1 staff discussed what they would do if they identified a medication error and how lessons would be learned from this. Pharmacy produced a lessons learned bulletin which covered the common medication themes across the trust. On Redwood 2 staff said there was a weekly medicine care review and the medicine management system had been improved as a result. Learning with staff had been disseminated around missed doses.

Staff on the wards had completed training in safeguarding children and vulnerable adults and knew how to respond appropriately to any allegation of abuse. There were detailed policies and procedures in place in respect of safeguarding supporting staff in responding appropriately to concerns. Staff knew where to refer safeguarding concerns and to obtain safeguarding advice if needed. On Rowan 2 ward staff said they had contacted the trust lead on the Deprivation of Liberty Safeguards in the past for advice. We saw one example on Redwood 1 where a safeguarding referral, which had been completed and diarised to raise on 28 April 2014, had not been sent when we visited the ward on 30 April 2014. This was raised with the ward manager due to the timeliness of when this alert should have been referred on.

Assessing and monitoring safety and risk

There were procedures in place to identify and manage risks to people who used the service. We saw that staff

discussed risks related to individuals at a handover between shifts and a multi-disciplinary ward round we sat in on. People's safety was taken into account in the way care and treatment was planned. Risks, community involvement, medication, safeguarding and their mental health were some of the elements discussed.

Understanding and management of foreseeable risks

Overall we found there were enough members of staff to support people across the four wards. However there were noted staffing level pressures on Redwood 1 and Redwood 2.

If people on leave needed to return earlier they had to be admitted to another location within the trust as they did not have allocated beds on the wards. Staffing levels were adjusted when changes in needs were identified. On Redwood 1 the staffing levels were planned at four staff during the day and three at night, with a minimum of two qualified staff during the day. Four nights of the week the ward manager informed us that there was one qualified member of staff at night. Regular bank staff were asked to fill shifts if there were gaps and this aided continuity of relationships for patients. If bank or agency staff were new to the ward they were given a general orientation and induction to the ward. Some staff we spoke with expressed feeling stressed on shift and felt that due to staffing level pressures on the ward this could impact on quality of time they spent with patients, and whether their leave was accommodated. We found that leave was usually accommodated however. Staff informed us that it was not always easy to fill the day shift and that a lot of ringing around was involved to get someone at short notice. If someone cancelled a shift at short notice some staff said this could have a knock on impact because they could not always get another qualified member of staff on shift. The ward manager had tried to get round this by introducing a middle shift gap between 1pm and 4pm.

On Redwood 2 there was one qualified member of staff on at night. Staff had reported challenges with this and it was felt that the cost improvement had a direct impact on these staffing pressures. We were told there had been increased staff sickness and patient complaints and a lot of pressures to complete ward related tasks on time. There were two vacancies for two staff nurses. We visited the ward across two consecutive days and reviewed the staffing off duty rota. There were two qualified and two non-qualified on the floor on 1 May 2014. They obtained temporary support from the neighbouring ward to assist with breakfast time that day. If leave was taken we saw this was recorded in patient records and progress notes. If leave was cancelled this was also recorded on the ward's electronic system. Band 3 staff could take people on leave and Band 2 staff had a choice in this, however this was not detailed in their job description. Each night shift was led by a single staff nurse, which presented its own challenges. For instance supporting a new admission or supporting patients with challenging behaviours. Staff members we spoke with, confirmed that an incident form would be filled in if staffing levels were low.

Queen's Medical Centre – A42 (male) and A43 (female) wards

Track record on safety

The wards had clear systems for the reporting of incidents. Staff we spoke with explained the process they used to report incidents through the electronic reporting system. They told us they felt confident in how and what they would report as an incident. All reported incidents went via management for approval.

Learning from incidents and improving safety standards

The trust encouraged learning and sharing from other service lines in the trust. From a recent visit by staff from secure services to ward A43, the ward was looking at newly identified ligature and security risks. For example catchers and doors for anti-barricade. The alarm system was also under review as this did not currently specify where the incident was taking place.

Risks were generally well managed across both wards. Staff discussed an environmental suicide and ligature point assessment tool dated 14 April 2014. None of these ligatures had been identified by A43 as high risk. However some remained outstanding. These were located within the public areas of the ward which staff informed us they were managing. However we did observe an exposed overflow pipe in one of the female toilet areas which had sharp edges around the rim of the pipe. Additionally self-harm trends had been identified as a risk area on this ward. We raised this with staff who confirmed this could be used as a ligature. There was also the potential for infection control growth within the pipe. Staff informed us that catchers on windows had been identified back in November 2012 from their ligature risk audit. In November 2013 all catches were

removed following a serious untoward incident. The timeliness of changes to the environment would depend on what the item was and who was responsible for its removal as both A42 and A43 were rented by the trust, but owned by Nottingham University Trust (NUT). The response by the staff team to the serious untoward incident in October 2013 was commended by both the emergency crash team on site in the hospital and the trust's resuscitation lead.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff had completed training in safeguarding children and vulnerable adults and knew how to respond appropriately to any allegation of abuse. There were detailed policies and procedures in place in respect of safeguarding to support staff in responding appropriately to concerns. Staff knew where to refer safeguarding concerns and how to obtain safeguarding advice if needed. On A42 safeguarding meetings were held at Highbury Hospital. There were leads for safeguarding on the wards and information displayed on local authority referral contacts.

The wards had clear systems in place for the management of medicines. Staff on shift were allocated to administer medication and controlled drugs were always administered by two qualified staff.

The wards were generally well maintained and safe. Corridors were clear and not being used for storage.

Assessing and monitoring safety and risk

We found that there were enough members of staff to care for patients safely on A42 and A43 wards. Staffing levels were adjusted when changes in needs were identified. Staff said there was a low use of bank staff and information was made available to agency staff who were new to the ward. Patient allocations on the ward were organised by risk. Individual rooms were given to people who were more physically or psychologically ill.

Understanding and management of foreseeable risks

The wards ensured appropriate levels of security while caring for people. All staff had access to alarms and keys with alarms available for visitors. In addition the nurses had access to emergency equipment and ligature cutters. Nurses had received training in first aid. On A42 there was a searching policy (with consent). Items deemed to be dangerous were removed and put into a property box. We saw a sign in one of the dormitories asking people not to keep prohibited items in their rooms. This reduced the risk of harm to people and others using the service.

Millbrook Mental Health Unit, Orchid Ward (mixed ward)

The ward had 25 beds for men and women. On the day we inspected the ward there were 26 people listed on the ward, one person was on leave, and their bed was being used for a new admission.

Understanding and management of foreseeable risk

The sleeping areas are divided into two wings one for men and one for women. Male areas consisted of three five bed bays. The women's wing had two four bed bays. There were two en suite bedrooms located on the male wing that could be used for men and women depending on the level of need.

On the day of our inspection the two single rooms were being used by women. We saw men walked throughout the male wing going about daily activities. Each bay area was divided by curtains that were not always drawn around beds. This posed a privacy and dignity risk for both men on the wing and the two women in the single rooms on the wing.

There was a women only lounge, but we saw it being used by men. However we were told that they would be asked to leave if requested by the women.

There were good systems for keeping people safe and safeguarded from abuse. All the staff we spoke to told us that they received safeguarding vulnerable adults and children training each year. They were able to tell us about their responsibility to refer any potential abusive situations they came across.

When safety alerts were issued by the central alerting system these were shared with staff through the monthly safety bulletin. They would also be e-mailed to the ward managers who had the responsibility to share they information with staff through their supervisions and team meetings.

Requires improvement

Are services safe?

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

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We found that the ward had reliable systems in place to reduce risks to patients. The ward was clean and tidy when we visited with cleaning schedules in place to ensure cleaning was undertaken.

When we checked the storage of medications we found they were being stored safely. Medicines were stored in the locked clinic room and all medicine cupboards and refrigerators were locked. The keys were kept by a nurse. Clinic room and fridge temperatures were being monitored and were within the guidelines on the dates we checked.

One person told us that medicines were dispensed into pot and then placed on medicine cards so when they arrived for their medicine the tablet was ready for them in the pot. The trust's Medicines policy states that dispensing in pots, and leaving them on medicine cards, is unacceptable practice due to the risk of the pot and medication card being separated or mixed up or the pot being knocked over. We discussed this practice concern with two staff who acknowledged that this practice did sometimes happen on the ward.

We informed the ward manager who was clear that it was unacceptable practice and would investigate immediately.

Are services effective?

Good

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

Summary of findings

Care was responsive and reflected people's needs. Staff used current best practice on critical physical care and reported monthly, in line with efficiency targets. The skills of staff were being developed to meet the needs of patients. Across the wards staff were allocated link roles in specialty areas in order to support people appropriately.

Across the acute admission wards, staff confirmed that access to occupational therapy and psychology had been reduced.

Our findings

Bassetlaw Hospital, B2 ward

Assessment and delivery of care and treatment

Staff discussed the early warning system they worked to known as the health information programme (HIPS). Areas involved in this system included medication requisition from GPs, blood testing and ensuring patients were examined by a doctor on admission. In addition staff informed us that physical observations were completed regularly during the day and we looked at a patient's care record which confirmed what staff told us. Patients we spoke with discussed receiving physical observation checks and one said if they felt unwell, staff would get a doctor to review them.

A number of audits were completed on the ward to monitor the risks and quality of the service. For example there was a system in place for staff from the acute admission wards from Millbrook to audit the care plans on B2 and vice versa. However the ward manager, who was new in post, was unaware of whether any changes had taken place from the last audit completed in February 2014 but said that if actions were identified these would be acted upon immediately.

Outcomes for people using services

The ward was often running at full, or over full, bed occupancy. Staff confirmed that bed managers monitored the re-admission rates of people and would look at triggers leading to their re-admission.

The length of stay for people using the acute admission wards was monitored and reviewed weekly by a multi-disciplinary team if it went over the 50 days. On the day of the visit we were informed that 10 people on B2 ward were currently delayed discharges or transfers. There were arrangements in place to minimise the duration they were to remain on the ward. For example one person's accommodation was not suitable for them to move to, so arrangements were in place to address this.

Staff, equipment and facilities

There was a broad mix of mental and physical health diagnoses on the ward. The ward manager told us that optional specialty training was on offer for staff but that there was a heavy reliance placed on the staff's previous experience to deliver in their role. Staff on the ward were assigned dedicated link roles including in areas of diabetes, self-harm and physical health. These roles involved staff attending speciality training and courses and bringing the learning back to the ward to inform staff understanding and clinical changes.

Staff received appropriate training, supervision and professional development. Staff told us they had undergone recent training appropriate to their role. Records showed that most staff were up to date with statutory and mandatory training requirements. For example in safeguarding and the Mental Health Act and Mental Capacity Act. Where training was outstanding staff were booked in for future dates. New staff undertook a period of induction and shadowed other staff before being included in the staffing numbers. This helped ensure staff were able to deliver care to the patients safely and to an appropriate standard. There were promotion opportunities for staff. One nurse had moved from a Band 5 to a Band 6 since starting on the ward. Staff told us that they received regular clinical and managerial supervision and this was monitored by the service manager to ensure this was being completed.

The care planning pathway was reviewed across all of the acute admission ward sites. Staff felt that the lack of training and placements on wards had had a knock on effect in that staff were unclear how to complete care plans. A roll out of new paperwork began recently to address these issues. However training has yet to be embedded for support staff in how to complete care plans and they relied on staff that were already writing care plans.

Are services effective?

Good

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.

Multi-disciplinary working

Staff worked to a recovery focused model. There were two activity coordinators who each worked four days a week to deliver the activities programme on the ward. Activities were nurse-led on the weekends.

We saw a music group taking place on the day of the inspection. People spoken with described the activities that book place on the ward. Occupational therapy input was accessed only through the community. There had been a psychologist on the ward however the post had not been filled since they had left.

Occasionally a person under the age of 18 was admitted to the ward. In these circumstances the ward had arrangements in place to facilitate their short stay. The young person would be put on 1:1 observation and an appropriate CAMHS (child and adolescent mental health services) professional would be contacted to move them to a more appropriate ward.

Mental Health Act (MHA)

All staff had undertaken training in the Mental Health Act and Mental Capacity Act and staff of all levels demonstrated a good understanding of these.

Highbury Hospital, Rowan 1 (male) and 2 (female) Wards and Redwood (male) 1 and 2 (female) Wards

Assessment and delivery of care and treatment

Physical healthcare checks were completed in the first 72 hours of a person being admitted. Where appropriate, referrals were made to specialist teams. This enhanced care for people using the service and supported the team with ensuring best practice was in place in regards to care plans.

Outcomes for people using services

Health of the Nation Outcome Scales (HONOS), were being used to assess people on Rowan 1. This meant that the service was aiming to admit people only when their level of need reached a level that would benefit from inpatient admission.

The trust was open to using models of care and reviewing other approaches in light of people's changing needs referred to and using the service. Rowan 1 was formally accredited nationally through the Royal College of Psychiatrists' accreditation network for inpatient wards up until February 2013. Identified areas for improvement included access to a pharmacy and a physical health team. Both were implemented as a result and the ward now had access to specialist input for tissue viability.

Staff, equipment and facilities

The skills of staff were being developed to meet people's needs. Across the wards, staff were allocated link roles in specialty areas in order to support people appropriately. These staff members were expected to attend speciality training and to disseminate learning back on the ward. For instance on Rowan 1 there was a link staff member for personality disorder. There was a resource file for staff with a section on coping strategies to support people who were diagnosed with a personality disorder.

Staff had group supervision with a psychologist. On Rowan 1 ward staff were able to bring issues they wanted to discuss. For example they had previously discussed a person with specific vulnerabilities and had been categorised with negotiable leave. Staff expressed that there was not sufficient access to psychology input. One male patient was discussed who a staff member felt would benefit from dialectical behavioural therapy (DBT). However we were informed that currently only women could access DBT in the trust but that this was under review. Staff on Rowan 1 told us that people did have input from psychology and that they were signposted appropriately for therapies such as cognitive behavioural therapy (CBT) and improving access to psychological therapies (IAPT), but this in itself would have a waiting time attached.

Multi-disciplinary working

Assessments on wards were multi-disciplinary in approach, with involvement from medical, nursing and specialist teams. For example on Redwood 2 there had been a range of improvement work around facilitating timely discharges. Multi-disciplinary meetings now took place on Mondays with representation from consultants, the community, psychology and ward pharmacy.

There were good links to a police liaison officer on Rowan 1.

Are services effective?

Good

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.

Queen's Medical Centre – A42 (male) and A43 (female) wards

Assessment and delivery of care and treatment

Staff were aware of people's individual needs and were able to explain to us how they were supporting them. Staff handovers took place at the beginning of shifts.

Staff looked at the person's journey in a holistic way. One staff member discussed the way they worked with people and the importance of respecting people's boundaries. They said they would go through the recovery information booklet to make recovery a reality. On A43 information was displayed on boards around recovery and definitions of 'taking control over your life, sleep, hygiene and healthy eating boards'. For instance staff explained to us the impact sleep deprivation could have on a person's psychological well-being. On A43 women could be referred to dialectical behavioural therapy. There was limited access to psychology and staff felt more access would be beneficial to patients.

Outcomes for people using services

The length of stay for people using the acute admission wards was monitored and reviewed weekly by a multi-disciplinary team if it went over the 50 day mark. There were arrangements in place to minimise the duration they were to remain on the ward. For example, discharge planning commenced early in the admission process to avoid delays to a person being discharged from the wards.

Staff, equipment and facilities

The skills of staff were being developed to meet people's needs. Staff were mostly up to date with mandatory training and some staff we spoke with confirmed they could access further professional development opportunities, for example one unqualified staff member was undertaking their nurse training. Across the wards staff were allocated link roles in specialty areas in order to appropriately support people. These staff members were expected to attend speciality training and to disseminate learning back on the ward. For instance there were staff leads for pressure ulcers, one of the key priority areas of the trust. On A43 there was a lead for security and training and this staff member was also an instructor on the management of violence and aggression.

The wards were designed and decorated in an appropriate way to promote a therapeutic environment. Information was displayed in a clear way. On A43 the ward had a number of pictures, artwork, books and games to give it more of a comfortable feel.

Multi-disciplinary working

We observed a handover on A43 and saw evidence of staff's awareness of the process for the escalation of safeguarding issues. Staff had reported safeguarding concerns in line with their policy and took action to communicate that a patient was due weekend leave and to ensure safeguarding plans would be in place to protect people from potential abuse. There was good discussion of people's risks and actions required to minimise these risks that reflected their complex needs. Staff demonstrated by their interactions and behaviour a high level of care and compassion for their patients. On A43 the consultant said they attended meetings twice weekly where everyone would be discussed. They demonstrated good knowledge of discharge arrangements and knowledge of individuals.

On A43 a length of stay (LOS) was completed weekly for the LOS meeting. We discussed this with the staff member who monitored and attended these meetings. At the time of the visit there were four people whose discharge from hospital was delayed. This was mainly due to difficulty in moving people on to appropriate accommodation. The service had monthly meetings with commissioners to update them. We were told that across the trust's adult mental health services, 40% of inpatient stays went over the 50 days. Reasons for people being re-admitted were monitored through bed management meetings.

The occupational therapy (OT) service had been cut across both wards. There used to be an OT for each of the wards. Now one OT was shared across both wards. Since the OT input had been cut there was an increase in the use of healthcare assistants. A healthcare assistant was now used on the mid shift to support activities on the wards. A patient on A42 described a lack of access to structured and unstructured activities and a lack of access to psychological therapies. Another said there was not enough to do on the ward. One person felt there were sufficient activities on the ward.

Are services effective?

Good

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.

Millbrook Mental Health Unit, Orchid Ward (mixed ward)

All of the staff we spoke with told us they felt supported in their roles and had good access to training and supervision. Supervision is a meeting with line manager to discuss performance and identify training requirements.

People's admission pathway was effective overall and included a physical health care assessment, nutritional assessment, observation, and alcohol use assessment. A risk management assessment was completed and risks identified were managed through an agreed care plan between the person and the multidisciplinary team. (MDT). We reviewed six people's care notes including their care plans.

We reviewed the use of the Mental Health Act on Orchid Ward. We found that old section 17 leave forms was not routinely crossed out or had been cancelled for one person, and one person had not been routinely informed and reminded of their rights under the Mental Health Act. We were unable to find entries regarding capacity assessment as per the code of practice. Mental health documentation reviewed was generally found to be compliant with the Act and the code of practice in the detained patients' files we examined.

Staff told us that the majority of mandatory training was delivered by e-learning. The majority of the staff on

Orchid had completed most of the training.

Good

Are services caring?

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

Summary of findings

Overall, we saw that staff were caring and responsive to people, and were skilled in the delivery of care.

Our findings

Bassetlaw Hospital, B2 Ward

Kindness, dignity and respect

People using the service were generally positive about the attitude of staff and the support they had received. Comments included ''Staff are ok. They look after me and I feel confidence in them. Staff help me a lot and I like them'' and ''I feel it's a very good hospital with very good staff.''

We saw that the interaction between people who used the service and staff members was positive and that staff responded to people with patience, kindness and ensured that they were treated with dignity. We observed many examples of staff engaging with people in a kind and respectful manner on all of the wards. For example we saw there was a music group going on the day of the inspection. Patients appeared engaged and enjoying themselves. We also saw that people felt comfortable approaching the manager's office and we saw positive interactions between managers and people using the service.

The ward was a mixed sex ward but did not always promote physical and sexual safety as one female patient had been allocated a single room on the male area of the ward.

There was a quiet room on the ward which was clearly labelled and we saw that people using the service made use of this. Several patients described where they would go if they wanted space. They would access their room and one mentioned using the quiet room or garden area.

People using services involvement

There was a carers' board displayed on the ward with information on the Bassetlaw carer's support group. There was a carer champion on the ward and staff informed us that they would make a referral for a carer's assessment where necessary.

There was an information board detailing information on how to access Independent Mental Health Advocates.

However the feedback of people's understanding around advocacy was varied. Two of the three people we spoke with said they were not aware of advocacy services. One mentioned seeing the noticeboard for advocacy but said they had not really understood this. One person described their understanding of what advocacy was and that staff told them about this. Additionally some people said they would know how to raise a complaint with staff if required but one was not clear on how to do this.

Staff responded to people's requests. We saw that a list of times and people's names were displayed on the ward. Staff explained that they had requested for their information to be displayed in this way so that they knew of their ward round times.

Where English was not someone's first language, staff could access an interpreter through the Mental Health Act office. A staff member described an example where they had accessed an interpreter for one person for ward rounds and regularly invited their family members into the service.

Emotional support for care and treatment

People using the service described the activities undertaken on the ward. They said activities happened and were not usually cancelled. One expressed liking the ''staff led activities''; another discussed watching films and playing ball games.''

Highbury Hospital, Rowan 1 (male) and 2 (female) Wards and Redwood (male) 1 and 2 (female) Wards

Kindness, dignity and respect

We saw that the interaction between people who used the service and staff members was positive and that staff responded to people with patience, kindness and ensured that they were treated with dignity. We observed many examples of staff engaging with people in a kind and respectful manner on all of the wards. For example We observed one person who was being discharged on the day of our visit. Their relative appeared happy and thanked staff.

On Rowan 1and 2 there was an issue around people being able to talk on the phone in private. On Rowan 2 there was a lack of phones for private discussion in a quiet space. Staff allowed people to call relatives in the main office when required. The need for an extra phone had been raised. On Rowan 1 there was a phone for people to use in a communal area. However this did not allow anyone to make a call in private.

Good

Are services caring?

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

Across the four wards there was a whiteboard in the nursing offices with patient names and details displayed about their leave status. As part of their action plan from the previous inspection we saw these were covered when not in use to preserve patient's privacy around their personal details.

On Rowan 2 there is a culture link nurse and a form to identify what patients' needs were on admission. We noted that one patient who had been admitted to the ward the night before was Muslim. Staff were not aware of their cultural needs and this had not been documented in their care notes. This was then raised with staff which was subsequently acted on.

People using services involvement

Where English was not someone's first language, staff could access an interpreter. On Redwood 2 there was a DVD available with different language rights leaflets.

Across the wards people using the service discussed what and how they were supported by staff. One person on Redwood 2 said staff were friendly, accommodating, knowledgeable and caring. This was reflected in the interactions we observed on this ward between staff and people using the service. On Rowan 1 we looked at a care plan and discussed this with a staff member. We saw that the patient's rights had been discussed and information was detailed in respect of the psychological and physical sections. Staff were aware of the risks to the person. In addition the recovery plan was written from the patient's perspective. Staff discussed the issues they had to try to get people to sign their care plans and how they employed strategies to overcome this. On Redwood 1 we saw someone had written their own recovery. There was a clear cross over between this and the care plan. However they appeared confused over how their recovery plan was being used. The patient and nursing staff then discussed the plan and how it would work. We looked through four other care plans at random, two of which were written and signed by patients.

On Rowan 2 several people we spoke with complained of the poor quality and amount of food offered. One felt that their physical health suffered due to a lack of being offered healthy alternatives. They expressed not being involved in the development of their care plans and were not clear on their rights being read to them. When raised with staff they said that a lot of keyworker sessions were held and that if detained, patients were given rights about their detention under the Mental Health Act. Staff told us there were good links to advocates.

Staff were responsive to concerns raised by people. One example involved a person who felt they were being neglected on Redwood 2. As a result the ward manager re-introduced the named nurse system. The ward manager was the complaints lead and expressed having an open door policy.

Emotional support for care and treatment

There were lead staff members for carers. On Rowan 2 this member of staff ran a meeting group with carers. They offered carers a lead key worker contact. They used these groups to find out more about patients and what was important to them. Examples were provided on how they could support carers in a practical sense.

On Redwood 2 there was a welcome inpatient pack detailing information about inpatient stay on the ward and what to expect. There was comprehensive information on how to complain, community meetings and the occupational therapy timetable. The logo used on the front of the welcome pack was based on a patient's design.

We observed a dialectical behavioural group session on Rowan 2 and saw people's needs were considered and that people were engaged and taking part in the group.

Queen's Medical Centre – A42 (male) and A43 (female) wards

Kindness, dignity and respect

People were supported to maintain their independence where possible. On A42 people could access food and drinks in the beverage area and were able to cook their own breakfast in the occupational therapy kitchen. There was a smoking balcony for those that were restricted.

There was lockable storage in rooms for people to store their valuables securely.

People were allowed to keep their mobile phones on the ward unless a risk assessment stated otherwise.

People using services involvement

Where English was not someone's first language, staff could access an interpreter. On A43 there was a mixed patient population on the ward and interpreters were often accessed for reviews, care planning, independent mental health advocates (IMHAs) and key working sessions. The

Good

Are services caring?

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

ward had recently recruited two healthcare assistants of Polish decent, to reflect the flow of people coming through the service. Mental Health Act rights information was available in various languages.

People we spoke with across both wards gave mixed responses around their involvement in their care plans. Some people said their care plan had been offered to them but they had not been involved. One person felt it happened around them, not with them. One person said that they had felt involved in the development of their care plan. Another confirmed knowing of their discharge arrangements. All were positive about staff and felt they were caring. One said the ward was very well staffed and staff were clear on their responsibilities. One person told us that they met with their consultant regularly and that the ward manager was approachable. They felt there was good access to independent mental health advocates (IMHA) and some had accessed these in the past. One said they had been given information about their rights under the Mental Health Act and these were repeated if they felt unwell. One person said that their faith needs were respected and that they were able to go to church.

We saw from a care record that specialist input was obtained from psychology and a person was offered an acute care wellness and recovery plan. It had been recorded when their rights had been read to them and reviewed. We followed up with a discussion with the patient and they confirmed that when they raised a medical issue on one particular occasion this was responded to. They said they had been allocated a key worker and medical team and reviewed by the consultant or doctor at least once per week.

Emotional support for care and treatment

We saw that staff demonstrated a high level of emotional support to patients on the ward at an individual level and took time to explain and support patients in a sensitive manner. There were health and well-being and recovery groups on the wards.

Staff referred relatives onto carer groups.

Millbrook Mental Health Unit, Orchid Ward (mixed ward)

All of the people we spoke with were very positive about the attitude of the staff and the support they had received.

We saw that the interaction between people who used the service, and staff members, was positive and that staff responded to people with patience and kindness. We observed many examples of staff engaging with people in a kind and respectful manner on the ward.

When we spoke with patients and their carer's, most they told us they had a high level of involvement in their care and had issues clearly explained to them. One person told us that their care was very good, that people were asked their opinion and given an opportunity to give their views. They said they were always listened to. Another person told us, "I can always get one to one time with staff when I want it.''

People we spoke with said when there were incidents on the ward. staff responded by making sure a member of the team was always allocated to be with the other people on the ward to reassure them.

When we spoke with relatives of people and they all told us they felt that communication with staff was good and they were kept informed by staff. They told us they were invited to weekly reviews and felt involved in the care.

Are services responsive to people's needs?

Good

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

Summary of findings

Services were generally responsive to people's needs, and we saw evidence of good follow-up care in people's records. There were good links with community care coordinators from the point of a people's admission.

Our findings

Bassetlaw Hospital, B2 Ward

Right care at the right time

Care was being delivered on B2 ward by a multi-disciplinary team (MDT). In addition, there was input from specialist teams, such as physical healthcare, when required. Staff confirmed that access to occupational therapy and psychology had been reduced. We saw from a care plan that a range of appropriate options had been discussed for the patient's discharge. Risks were identified and physical health checks had been carried out. We looked at notes for another patient and followed up on a discussion with them. They were clear that most of the areas discussed in their notes had been discussed during the MDT round.

During a ward round we observed that staff discussed a range of areas pertinent to a patient's care and welfare. This included what they had been up to in a day, appointments off the ward, referrals to community teams, current issues, for example if drug related, mood state, observation levels, discharge arrangements, family involvement and behaviours. Outside of the ward round staff discussed the type of specialty input they could access around substance misuse and improving access to psychological therapies (IAPT).

Whether admissions were planned or unplanned, patients always received a full assessment including using pre-admission information. This involved undertaking a range of mental and physical health checks. Where a risk was identified plans were put in place to support the patient. For instance if there were previously identified safeguarding issues staff would link in with staff in the community teams to look at the historical, and present risks, which would then inform how a patient was supported on the ward.

Care Pathway

Pre-admission information was obtained from the community, in advance of an admission where possible, to ensure staff knew of the risk areas to a patient and how they could best support them during their stay. The service was aiming to care for more patients within community settings, where this was more appropriate. As a result targets had been set to reduce the length of stay to 50 days and discharge arrangements began at the point of admission to limit the amount of time they were an inpatient. Care coordinators were brought in early to a patient's care to help facilitate their arrangements for discharge.

Learning from concerns and complaints

There were issues raised in a community meeting we observed about the temperature and late delivery of meals on the ward. There was discussion about the food being colder than it should be. The problems seemed to be around the porters getting to the ward and leaving the kitchen on time. This had been raised with the catering manager through the trust's service level agreement meeting with Bassetlaw hospital.

Highbury Hospital, Rowan 1 (male) and 2 (female) wards and Redwood (male) 1 and 2 (female) wards

Vision and strategy

The trust had a clear vision for the adult admission service line, involving increasing the community provision and working to the least restrictive way of working with patients through the use of de-escalation which underpinned their recovery model. These strategies for the service were clearly evident and staff had a good understanding and knowledge of these.

Responsible governance

At a previous inspection conducted by the CQC in October 2013, at Highbury Hospital, the service had failed to meet some of the standards. This was because the trust did not always act in accordance with legal requirements with regard to a person's capacity to consent and/or care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare, and the trust did not have appropriate arrangements in place to manage medicines. In response to this, the trust had developed an action plan to improve the safety of the service and ensure they were meeting the standards. We found that the learning from this had been shared across the hospital. For example, one area of concern had been

Are services responsive to people's needs?

Good

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

staff understanding of the Mental Capacity Act 2005 (MCA). During our visit staff demonstrated a good understanding of, and the requirements of, the MCA 2005. As well as sharing the results centrally, individual feedback was given to staff through supervision sessions. When we visited all four wards we saw this learning had been shared there.

Leadership and culture

Staff we spoke with told us they felt that the management of the team was good and they felt supported by their team manager. They felt they had good access to training and development opportunities. Managers and staff we spoke with told us they had a good interface with the trust. However there was a mixed response from staff around the visibility of senior management on wards. One staff member did not feel there was a higher trust level presence on the ward. Issues were further raised about the lack of development for Band 2 staff.

Engagement

The views of staff were collected through supervision sessions. Wards also had team meetings where concerns could be raised. Staff we spoke with told us they felt they would be able to raise concerns.

Performance improvement

The trust had clear safety related goals that the wards were working towards. Reports were used to identify early warning signs and risks that could affect the quality of care and treatment provided, including staff sickness levels, patients obtaining discharge summaries on time and mandatory training compliance. Each ward collected a range of performance indicators monthly, which was reported centrally. Where performance did not meet the expected standard it was risk flagged and the reason was investigated. On Redwood 1 indicators being collected included MDT delivery, which we saw indicated positive results where the number of patients had been followed up on within seven days. From the period July–December 2013 there were a number of inpatients who were still on the ward after four months and we saw this had improved, moving from red to green in January–February 2014. However there was poor performance noted for the number of patients who were not given their discharge letters in a timely manner. A lot of the time the summaries were provided following discharge. As the wards were in the process of transitioning from paper to an electronic system the limited access to computers was having an impact on getting the summaries to patients on time.

Additionally all four wards had clearly identified risk priority areas specific to their patient population. For example on Rowan 1 Ward there was a suicide prevention strategy in place. There were clear protocols in place to mitigate risks to patients. For instance there was a sharps policy in place and staff monitored risks to patients on an individual basis, including those who were at a high risk of accidental death. Other identified priorities across the wards included physical health and absconding.

Queen's Medical Centre – A42 (male) and A43 (female) wards

Planning and delivering services

Single sex accommodation was maintained on all the wards, which was in line with national guidance.

Right care at the right time

During a ward round we observed that staff discussed a range of areas relevant to patients care and welfare. On A42 we were told that all patients were discussed three times a week. Following this tasks were allocated following review. Any risk areas were discussed and there was clear evidence of liaising with general medical teams about medical problems and with other specialist teams such as rehabilitation and continuing mental health teams. There was also discussion of discharge planning, accommodation and follow up. There was also evidence of an individualised approach to patients. One example involved a patient being granted section 17 leave so they could attend a club. Overall the doctor appeared to have good knowledge of the patients. On A43 discharge summaries were given to patients in a timely manner.

We found good evidence from care records that physical health was monitored effectively and that staff were responsive to patient needs. We reviewed assessment and care planning records for five patients on A43 which we saw were reviewed from handover. There were specific care plans for patients with complex needs and physical health concerns. In one example a patient's medication had been changed and as a result they had not been eating sufficiently. A nutritional assessment (MUST) had been undertaken and the safety care plan reflected recent medication changes and recording and observation of food intake. In another example a patient had been identified as a choking risk. There was evidence of a care plan in place to observe patients during meal times. A patient had been

Are services responsive to people's needs?

Good

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

assessed by a speech and language therapist and their recommendations were reflected in the care plans. All others checked reflected that the staff team had been responsive to patient needs.

Care Pathway

There was a clear system in place that supported the safe admission to the service. On A43, referrals for new admissions came in from the city, county or outside of these. All patients come through the bed crisis team. People coming onto this were either new or were known to services within the last 18 months. The ward also took in respite placements. An assessment was completed on admission and the patient was placed on initial observations and allocated a primary nurse within the first 24 hours of their stay. Pre-admission information was gathered, prior to the admission of the patient where possible, to inform care plans and risk assessments. Staff said that most admissions were out of hours but that they always undertook an assessment regardless of the level of information they had at point of admission. We were told that discharge planning, around accommodation, was an issue and that previously there was no system of escalation around this. The new associate medical director was currently addressing this.

Learning from concerns and complaints

Patients were aware of how to raise complaints and some told us they were aware of the patient advice and liaison services (PALS) and advocacy if they wanted to raise a complaint. On A43 this was apparently low. One theme came from carers around the sharing of information. Staff made clear with patient that they would not disclose information about them to carers unless they gave their consent.

Millbrook Mental Health Unit, Orchid Ward (mixed ward)

The staff, who worked within crisis services, worked alongside inpatient staff to ensure people did not have unnecessarily long hospital stays. Staff told us that if a person's mental health improved they could be discharged to the care of the crisis team. A discharge coordinator attended the ward to meet people and worked with the MDT to support people's move back home into their community.

We saw that people were encouraged to make recovery plans which were people's personal care plans, written by them, describing the help they needed to recover from their illness. The plans were focussed on leaving hospital and resuming their lives. These plans formed part of the inpatient care plans that staff referred for working with people.

There were no blanket rules or restricted practices applied on Orchid Ward. People were allowed to keep their mobile telephones and chargers. We saw them with hair straighteners and hair dryers. If there was any risk of self-harm people were assessed to determine the level of risk from the articles they had brought to hospital.

There was an activity programme on display. One person told us they enjoyed the activities because it stopped them getting bored when on the ward and later that morning they would be attending a poetry group led by the occupational therapist.

People had access to drinks facilities so they could make tea, coffee or have cold drinks when they wanted, without restrictions.

Are services well-led?

Good

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

Summary of findings

There were clear expectations and structures in place to support the teams to meet management's expectations.

There was an air of anxiety about the potential closures of A42 and A43 wards at the Queen's Medical Centre. The service director for these wards told us that this had not yet been confirmed, and that staff had been told about developments so far. Plans for moving services to a virtual ward in the community had been considered, but staff remained unclear where this left them in the trust.

Our findings

Bassetlaw Hospital, B2 Ward

Vision and strategy

The trust had a clear vision for the service, involving increasing the community provision and working to the least restrictive way of working with patients, through the use of de-escalation which underpinned their recovery model. These strategies for the service were clearly evident and staff had a good understanding and knowledge of these.

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication, from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust. Staff on B2 Ward had implemented many of the nine priorities of the trust, including working to reduce medication errors, improving the number of staff having quality appraisal and supervision and learning from incidents.

All staff on the ward were up to date with equality and diversity training and from patients we spoke with, and observations on the day, we saw that patients were treated with respect and dignity on the ward. One patient said ''when I have a one to one staff listen to me. They help me to express my feelings.'' Another patient expressed feeling confident in how staff supported them and felt they would do this whether it fell within their realm of health issues or outside of it.

Responsible governance

Within the trust's ''Professional Guide to Quality'' booklet dated February 2014 importance was placed on leading teams ''if you lead a team (big or small, clinical or non-clinical) you have a responsibility to lead the quality agenda for that group of people.'' We were told that the adult admission wards at Bassetlaw and Millbrook had remained mixed sex wards historically. However management staff were unaware of how or why this decision had been made and had therefore not been part of the service redesign process. Decisions were clinically led on the ward. Staff informed us that they did not have much involvement in the service design and governance structure. Therefore transparency in communication and engagement in decision making from the trust, to ward level in respect of service design, was not apparent.

Management staff on the ward attended a number of forums for updates in the trust and disseminated this information at ward level. For example in staff team meetings.

Leadership and culture

Staff we spoke with told us they felt that the management of the team was good, they felt supported by their team manager and had good access to training and development opportunities. Managers and staff we spoke with told us they had a good interface with the trust.

Engagement

The views of staff were collected through supervision sessions. Wards also had team meetings where concerns could be raised. Staff we spoke with told us they felt they would be able to raise concerns.

Performance Improvement

The wards had clear objectives, which all staff were working towards as part of their performance development. Regular and structured supervision sessions were being undertaken, which included individual feedback.

The trust had clear safety related goals that the ward were working towards. Reports were used to identify early warning signs and risks that could affect the quality of care and treatment provided, including staff sickness levels, relationships within the staff team and mandatory training compliance. Where performance did not meet the expected the standard it was risk flagged and the reason was investigated.

Are services well-led?

Good

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

Additionally B2 ward had identified key priority areas in service for example in relation to people who had absconded from the ward. Staff found the controlled access to the area of the ward was not secure. In response staff now fobbed people in and out of the ward and recorded the times they came in and out.

Highbury Hospital, Rowan 1 (male) and 2 (female) Wards and Redwood (male) 1 and 2 (female) Wards

Vision and strategy

The trust had a clear vision for the adult admission service line, involving increasing the community provision and working to the least restrictive way of working with patients through the use of de-escalation, which underpinned their recovery model. These strategies for the service were clearly evident and staff had a good understanding and knowledge of these.

Responsible governance

At a previous inspection, conducted by the CQC in October 2013 at Highbury Hospital, the service had failed to meet some of the standards. This was because the trust did not always act in accordance with legal requirements with regard to a person's capacity to consent; care and treatment had not always been planned and delivered in a way that was intended to ensure people's safety and welfare and the trust did not have appropriate arrangements in place to manage medicines. In response to this, the trust had developed an action plan to improve the safety of the service and ensure they were meeting the standards. We found that the learning from this had been shared across the hospital. For example, one area of concern had been staff understanding of the Mental Capacity Act 2005 (MCA). During our visit staff demonstrated a good understanding of and the requirements of the MCA 2005. As well as sharing the results centrally, individual feedback was given to staff through supervision sessions. When we visited all four wards we saw this learning had been shared in each one.

Leadership and culture

Staff we spoke with told us they felt that the management of the team was good and were supported by their team manager. They felt they had good access to training and development opportunities. Managers and staff we spoke with told us they had a good interface with the trust. However there was a mixed response from staff around the visibility of senior management on wards. One staff member did not feel there was a higher trust level presence on the ward. Issues were further raised about the lack of development for Band 2 staff.

Engagement

The views of staff were collected through supervision sessions. Wards also had team meetings where concerns could be raised. Staff we spoke with told us they felt able to raise concerns.

Performance improvement

The trust had clear safety related goals that the wards were working towards. Reports were used to identify early warning signs and risks that could affect the quality of care and treatment provided, including staff sickness levels, patients obtaining discharge summaries on time and mandatory training compliance. Each ward collected a range of performance indicators monthly, which were reported centrally. Where performance did not meet the expected standard it was risk flagged and the reason investigated. On Redwood 1 indicators were being collected, including MDT delivery, which we saw indicated positive results where the number of patients had been followed up on within seven days. From the period July – December 2013 there were a number of inpatients who were still on the ward after four months and we saw this had improved moving from red to green in January – February 2014. However there was poor performance noted for the number of patients who were not given their discharge letters in a timely manner. A lot of the time the summaries were provided following discharge. As the ward was in the process of transitioning from a paper to electronic system, and there was limited access to computers, this was having an impact on getting the summaries to patients on time.

Additionally all four wards had clearly identified risk priority areas specific to their patient population. For example on Rowan 1 Ward there was a suicide prevention strategy in place. There were clear protocols in place to mitigate risks to patients. For instance there was a sharps policy in place and staff monitored risks to patients on an individual basis including those who were at a high risk of accidental death. Other identified priorities across the wards included physical health and people who absconded from the ward.

Are services well-led?

Good

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

Queen's Medical Centre – A42 (male) and A43 (female) Wards

Vision and strategy

The trust had a clear vision for the acute admission service line, involving increasing the community provision and working to the least restrictive way of working with patients through the use of de-escalation which underpinned their recovery model. These strategies for the service were clearly evident and staff had a good understanding and knowledge of these.

However on talking with staff on the wards there was an air of anxiety over the potential closures of both wards. The service director for the wards confirmed this had not been confirmed yet and there had been communication with staff on the developments so far. High level plans had been considered to move to a virtual ward in the community. However at present staff remained unclear where this left them in the trust.

Responsible governance

There had been a serious untoward incident on A43 reported back in October 2013. The manager and service manager for the ward confirmed that the final findings of the internal investigation had not been completed and that they were unaware when this was going to happen. Initial root cause findings had been completed and immediate actions had been taken to remove all catchers from all the windows on both A42 and A43 wards. However the final conclusions and learning from the investigation were staff at the time of the inspection despite the investigation being conducted internally in the trust.

Leadership and culture

Staff we spoke with told us they felt that the management of the team was good. On A42 the matron visited bi-weekly. Staff said they had good access to training and development opportunities, however there was a mixed response from staff around the visibility of senior management on wards. One staff member said they had received a visit by the director of nursing but felt more visibility may encourage confidence in management, another said above a certain level very senior managers did not come on the ward.

Engagement

The views of staff were collected through supervision sessions. Wards also had team meetings where concerns could be raised. Staff we spoke with told us they felt they would be able to raise concerns.

Performance improvement

The wards had clear objectives, which all staff were working towards as part of their performance development. Regular and structured supervision sessions were being undertaken, which included individual feedback.

Millbrook Mental Health Unit, Orchid Ward (mixed ward)

Vision and strategy

The trust's vision and strategies were evident and staff had a good knowledge and understanding of these.

Responsible governance

There were clear structures in place to ensure that learning following incidents was shared and practice changed to reduce risks to people who used the service.

Staffs were aware of the management structure and where to seek support. When we asked staff about safeguarding processes they told us if they needed extra support they would seek advice from the trust's safeguarding team.

Engagement

The ward manager was visible and staff told us they felt supported. The staff had received appraisals and regular supervisions. Staff we spoke with understood the tasks they faced in the ward, but almost all told us they felt they were in a good team and that they felt they were delivering good care.

Performance improvement

Data was collected on performance regularly. Each ward completed a balanced scorecard, which recorded their performance against a range of indicators. Where performance did not meet the expected standard it was risk flagged and the reason was investigated.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person had not taken proper steps to ensure that people were protected against the risk of receiving inappropriate or unsafe care. **How the Regulation was not being met** A female patient, on B2 ward at Bassetlaw Hospital, was placed in a single room within an all male area of the ward. The design of the ward meant, the female patient would have to walk through an area occupied by men to reach the toilets or bathrooms in the female area of the ward. We were also told that the female patient would use the male toilet at night. Staff were not therefore effectively implementing and monitoring the use of gendered facilities. Regulation 9 (1) (b) (ii)