Requires improvement

Humber NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV942	Mill View	Mill View Court	HU16 5JQ
RV934	Newbridges	Newbridges	HU9 2BH
RV933	Westlands	Westlands	HU3 5QE
RV945	Miranda House	Avondale	HU3 2RT
RV945	Miranda House	Psychiatric intensive care unit	HU3 2RT

This report describes our judgement of the quality of care provided within this core service by Humber NHS Foundation 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.

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement
Are services safe?	**Inadequate**
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

We rated acute and psychiatric intensive care wards as requires improvement because:

- All wards had ligature points. These were detailed on ligature audits. However, clear actions to mitigate against risk of ligature were not documented. Funding bids had been submitted to resolve some of the ligature risks, but not all of these had been approved.
- The trust's policy on rapid tranquilisation was out of date. Staff did not have a clear understanding of what constituted rapid tranquilisation. Rapid tranquilisation was being undertaken without the appropriate observations being carried out in line with trust policy and national guidance.
- The full range of emergency medicines were not available in line with trust policy. This included medicines, which may need to be administered following rapid tranquilisation. There were out of date medications and oxygen on some of the wards.
- The use of seclusion did not always follow the principles of the Mental Health Act Code of Practice. Patients did not have seclusion exit plans and seclusion was not always ended appropriately.
- Staffing levels meant that patients could not always have sufficient one to one time with staff. There was a high reliance on bank and agency staff to meet staffing shortfalls. Staff did not always receive regular management and clinical supervision in line with trust policy. Training in the Mental Health Act was not mandatory and compliance with Mental Capacity Act training was low.
- There was a lack of leadership from senior managers in the trust, leaving staff feeling unsupported. There was limited evidence of clinical audit being carried out. Learning from incidents and complaints was not robust and did not inform service delivery.
- Blanket restrictions were in place regarding the searching of patients bags on return from leave.
- Same sex guidance was not always adhered to.

However:

- Most of the ward environments, including clinic areas, were clean and well maintained.
- Staff treated patients with dignity and respect. Staff had an understanding of the needs of patients. Patient meetings were held regularly on the wards. Patients spoke positively about staff, although felt there were not always enough staff on the wards.
- Staff felt very well supported by managers on the wards. There was a good range of professionals working within multi-disciplinary teams on all the wards.
- Mental Health Act documentation for detained patients was in good order. Staff regularly read patients their rights under the Mental Health Act. All detained patients received an automatic referral to an independent mental health advocate.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- Ward layouts did not always allow staff to have clear observation of all parts of the ward.
- There were ligature points in all wards. Although these were detailed on the ward ligature audit, there was a lack of identified action to mitigate against the risk.
- There were not always sufficient staff of the wards to allow patients enough one to one time with their named nurse.
- Compliance with mandatory training was low at 58%.
- The trust had not reviewed or updated their Rapid Tranquilisation policy, therefore practice was did not follow current guidelines.
- Staff did not have a clear understanding of the definition of rapid tranquilisation and as a result, required physical checks and observations of patients were not being carried out.
- The range of emergency medicines was not available in line with trust policy
- Out of date medications and oxygen were found on some of the wards.
- Seclusion rooms were not being used in line with principles within the Mental Health Act Code of Practice.
- Blanket restrictions were in place regarding the searching of patients bags on return from leave
- Same sex guidance was not always adhered to on Mill View Court.

However:

- Clinic areas were clean and well maintained.
- Staff had a clear understanding and knowledge of safeguarding policies and procedures.
- Staff know how to report and record incidents on the ward

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Patients were not always involved in developing their care plan.
- Physical health monitoring was not in place for all patients.
- Training in the Mental Health Act was not mandatory and compliance with Mental Capacity Act training was low.
- Staff were not involved in clinical audits.
- Staff did not always receive management and clinical supervision in line with trust policy.

Summary of findings

- There was no risk assessment undertaken prior to Section 17 leave being taken.

However:

- There was a good range of staff working within a multi-disciplinary team.
- Paperwork for patients detained under the Mental Health Act was in place.
- Patients were regularly read their rights under the Mental Health Act.
- All detained patients received an automatic referral to the independent mental health advocate

Are services caring?

Good

We rated caring as good because:

- Patients told us that most staff were kind, caring and respectful.
- We observed interactions between staff and patients that were respectful and caring.
- Staff on the wards had a good understanding of the needs of patients.
- Patients meetings regularly took place on all of the wards.

However:

- Staff were sometimes too busy to respond too patients' requests for attention.
- Patients told us that there were no activities during weekends.
- Patients did not have keys to their bedrooms.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- There was no dedicated team or person responsible for bed management.
- Beds for patients who were on leave from the ward were used for new admissions.
- The psychiatric intensive care unit was closed to female admissions.
- Patients did not have keys to bedrooms.
- Complaints about the service did not result in changes to how services were delivered.

However:

- Patients had a good choice of hot and cold food, including healthy options.
- All of the wards provided access to spiritual support.

Summary of findings

- Patients told us they knew how to make a complaint.
- Staff knew how to handle complaints in line with the trust policy.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff did not have a good awareness of the trust's vision and values.
- Staff felt there was a 'blame culture' and that senior management were not supportive.
- There was a lack of clinical audit taking place across the service.
- Staff shortages were frequent which added to pressure felt by on staff on the wards.

However:

- Staff felt well supported by nurses managing the wards.
- Charge nurses were passionate about their jobs and the wards they managed

Summary of findings

Information about the service

Humber NHS Foundation provides inpatient acute and intensive care services for people of working age with mental health conditions. Services are provided for both patients admitted informally and those detained under the Mental Health Act 1983.

The trust has four acute wards for adults who require a hospital admission due to their mental health needs, for assessment and treatment.

These wards are:

Mill View Court, an acute assessment and treatment ward for both men and women with 10 beds. This ward is based on Castle Hill Hospital site. Mill View Court provides intensive hospital based care for East Riding residents who are in the most acute and vulnerable stages of mental illness and are unable to be supported at home.

Newbridges, an acute assessment and treatment wards for men and has 18 beds. Newbridges provides a flexible and comprehensive service to the male population of Hull who are experiencing an acute mental illness and crisis. The unit caters for males only and provides single bedroom accommodation on two floors, with an accessible bedroom provided on the ground floor.

Westlands, an acute assessment and treatment ward for women and has 18 beds. Westlands provides a flexible and comprehensive service to the female population of Hull who are experiencing an acute mental illness and crisis. Based in the west of the City the unit caters for females only.

Avondale, an acute assessment ward for men and women and has 14 beds. Avondale is based in Miranda House and provides an assessment and treatment service for up to seven days to adults who are experiencing acute episodes of mental ill health and cannot safely be treated in other settings. Patients requiring care for longer than seven days are transferred to Westlands unit for females and Newbridges unit for males.

There is also a psychiatric intensive care unit within Miranda house, for people who present higher levels of risk and require increased levels of observation and support. The psychiatric intensive care unit provides safe, secure and gender specific accommodation for both males and female patients. The unit provides intensive, multi-disciplinary, time limited treatment in a secure environment for mentally disordered patients who exhibit severe behavioural disturbance.

Care Quality Commission last inspected acute and psychiatric intensive care services in 2014, as part of the comprehensive inspection of Humber NHS Foundation Trust. We carried out a focused inspection on Newbridges in November 2015. There were no compliance actions identified.

Our inspection team

Chair: Dr Paul Gilluley, Head of Forensic services at East London Foundation Trust and CQC National Professional Adviser

Head of Inspection: Jenny Wilkes, Care Quality Commission.

Team Leader: Patti Boden, Inspection Manager (Mental Health) Care Quality Commission.

Cathy Winn, Inspection Manager (Acute) Care Quality Commission

The team inspecting the acute wards for adults of working age and psychiatric intensive care wards consisted of one inspector, one consultant psychiatrist, two registered mental health nurses, one Mental Health Act reviewer, one social worker and one occupational therapist.

Summary of findings

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, asked a range of other organisations for information and sought feedback from patients and carers at focus groups. We visited five wards between 12-14 April 2016. This included a seclusion review on Newbridges on 14 April 2016. We visited Mill View Court and Newbridges again on 21 and 22 April 2016.

During the inspection visit, the team:

- Visited all five inpatient wards, looked at the quality of the environment and observed how staff were caring for patients.
- We carried out a review of the seclusion room and records on Newbridges.
- Spoke with 21 patients who were using the service, and reviewed feedback from 19 patients who completed comments cards.
- Spoke with two carers.
- Spoke with the managers of each ward.
- Spoke with 16 other staff members; including consultant psychiatrists, junior doctors, modern matrons, psychologists, nurses, healthcare assistants, occupational therapists and activity coordinators.
- Attended and observed one patient meeting, three patient activity groups, one care programme approach meeting, three staff handovers and two clinical review meetings.
- Reviewed patient prescription charts.
- Carried out a specific check of the medication management on the wards.
- Reviewed 21 treatment records of patients, including Mental Health Act documentation of detained patients and 23 seclusion 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

Patients were given the opportunity to provide feedback on the service they received prior to our inspection via comment cards left on all wards. We received 19 completed comments cards from patients on Westlands, Newbridges, Mill View Court and Avondale. Thirteen of the comments were positive. Patients commented that staff were kind and helpful, and that they treated patients with respect. Negative comments related to there not being enough staff to run activities and enable patients to take leave. One comment referred to a member of staff who was rude.

We spoke with 21 patients across all five acute and psychiatric intensive care wards about the care and treatment they received. Overall, patients spoke very positively about the staff on all of the wards. Patients

Summary of findings

recognised that the wards were frequently short staffed and told us this impacted negatively on care. Not all patients felt they had enough one to one time with nursing staff.

We spoke to two patients who did not know if they had a care plan. Others could not tell us if they had been involved in the development of the care plan.

Two carers of patients using the service attended a focus group. Carers felt communication between the acute wards and families was not good.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is an up to date rapid tranquilisation policy and that staff have a comprehensive understanding of what constitutes rapid tranquilisation.
- The provider must ensure that appropriate observations are carried out following any episodes of rapid tranquilisation, in line with national guidance.
- The provider must ensure that seclusion is undertaken in line with Mental Health Act Code of Practice principles.
- The provider must ensure that all patients are actively involved in the development of care plans.
- The provider must ensure that same sex guidance contained within the Mental Health Act Code of Practice is adhered to.

Action the provider SHOULD take to improve

- The provider should ensure that there are effective controls in place to mitigate against ligature risks. These should be clearly documented.
- The provider should ensure that there are sufficient staff to ensure patients are able to have sufficient one to one time with nursing staff.
- The provider should ensure that appropriate levels of physical health monitoring are in place for all patients, including those with long-term conditions.
- The provider should ensure that there is dedicated, female only space on Mill View Court, that is available at all times for female patients.
- The provider should ensure that refrigeration temperatures are checked daily on all wards, in line with Trust policy and national guidance.
- The provider should ensure that appropriate medicines management systems are in place on all wards, in line with Trust policy.
- The provider should ensure that there are appropriate systems in place to enable patients to summon assistance of staff, including in patient bedrooms.
- The trust should ensure that all discharged patient who require treatment and support from community care teams have a care package in place prior to discharge.
- The provider should ensure that staff receive the full range of mandatory training, including Mental Capacity Act training and that staff receive supervision and appraisals in line with trust policy.
- The provider should ensure that capacity assessments are completed for patients.
- The provider should review restrictive practices and blanket restrictions on the wards, including access to bedroom keys and mobile telephone chargers.
- The provider should ensure that bed occupancy levels are maintained at such a level that allows patients on leave to return to the ward.
- The provider should ensure that there are robust processes in place to review and learn from incidents and complaints.
- The provider should ensure that staff feel appropriately supported by senior management within the organisation.

Humber NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Avondale	Miranda House
Psychiatric intensive care unit	Miranda House
Newbridges	Newbridges
Mill View Court	Mill View
Westlands	Westlands

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.

Training in the Mental Health Act was not mandatory for staff. Staff had not received training on the revised Mental Health Act Code of Practice.

Mental Health Act documentation for detained patients was in place and completed correctly. Patients appeared to be detained under the correct legal authority. The Trust had a central Mental Health Act office who reviewed all detention paperwork. All detained patients had an automatic referral to an independent mental health advocate.

Patients had not signed Section 17 leave forms. It was not documented in all cases that patients had been given a copy.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a trust policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were aware of this policy, but had limited understanding of the principles of Mental Capacity Act. Training in Mental Capacity Act was mandatory, but only 37% of staff had completed this training.

Staff were unaware of any processes within the trust to monitor adherence to Mental Capacity Act

Inadequate

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

The ward environments at Westlands, Mill View Court and Miranda House (psychiatric intensive care unit and Avondale) were visibly clean and well maintained. Bathrooms and shower facilities at Westlands had recently been refurbished. Cleaning staff were on duty in all the wards we visited. At Newbridges, the ward décor looked tired, with graffiti on the walls in a number of areas. We saw that a toilet opposite the downstairs lounge had a blocked sink and toilet. At the time of the inspection, there was building work being undertaken at Newbridges, following a serious fire on the ward in March 2016. Because of the fire, one bedroom was out of use.

Patient-led assessments of the care environment surveys are the national system for assessing the quality of the patient environment. Newbridges and Westlands had both scored below the national average for condition, appearance and maintenance in the patient-led assessments of the care environment assessment. Newbridges had also scored below the national average for privacy and dignity.

Newbridges had experienced particular issues around detained patients absconding from the ward. Incident data was reviewed for October 2015 to March 2016. During this time, 36 patients had absconded. Fifteen of these incidents had involved patients climbing over or under the garden wall or fence. Building work taking place at the premises at the time of the inspection included the construction of a new perimeter fence.

The layout of the wards did not always allow staff to have clear observation of all parts of the ward. Risk had been minimised by the use of mirrors to aid observation. However, there were some blind spots on the wards, which meant staff were unable to observe all areas.

Patients on all wards had individual bedrooms. Mill View Court was the only ward where all bedrooms had en-suite facilities and nurse call systems. All wards had communal bathrooms, which provided access to shower and bathing facilities for patients.

There were ligature points on all of the wards, including in patient bedrooms. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves. All wards had completed ligature audits. The audit did not identify actions to show how these risks were being mitigated. Staff told us that capital bids had been submitted to secure funding to allow remedial work to be undertaken to remove some ligature points. We saw a copy of the trust's capital funding application log, dated April 2016. The funding application to replace window handles at Mill View Court had been approved. However, applications to replace windows on the psychiatric intensive care unit and Avondale had no decision reached. Staff said that patients would be individually risk assessed in relation to self-harm and risk of ligature. We saw one care record at Mill View Court where a male patient had been identified at high risk of suicide due to three previous suicide attempts. One of these was an attempted suicide by hanging. This risk was not included in the patient's safety plan and we saw no evidence of environmental ligature risks being considered or specifically mitigated against for this patient. On Avondale, there were bars across the windows overlooking the garden to prevent the windows fully opening. These could have been used to tie a ligature. Patients had unsupervised access to the garden. We raised this with staff and they were unaware of this ligature point. This was not identified on the ward ligature audit.

Mill View Court, Avondale and the psychiatric intensive care unit provided accommodation for male and female patients. At the time of the inspection, there were no female patients on the psychiatric intensive care unit. This was due to a male patient who was in long-term segregation in the female bedroom area. On Avondale, male and female sleeping areas were on separate corridors. Three rooms on the female corridor were 'swing beds' which meant these could be used for male patients. Although not all rooms in Avondale had en-suite facilities, the bedrooms on this corridor did. This meant that although females would have to walk past male bedrooms, they had access to separate shower and toilet facilities. There were separate male and female sleeping areas at Mill View Court. These were open access, meaning patients could freely move between both areas. There had been

occasions when male patients had been sleeping in the female bedroom area. Staff had recorded this on the incident recording system. There was a designated female only lounge. However, both staff and patients told us that this was frequently used as a mixed lounge for both male and female patients. The Mental Health Act Code of Practice (paragraphs 8.25-6)3 states that: "All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse." Mill View court did not meet the standard for same sex accommodation as described in the Mental Health Act Code of Practice. Female patients told us there were unhappy that there was no specific space on ward for them. At the time of the inspection, there were eight male and two female patients. Female patients on the ward told us they felt 'outnumbered' by males.

On Avondale, there was one bedroom with poor visibility of the bed from the privacy window on the door. This meant that staff had to enter the room to be able to observe the patient. This included during the night, when staff had to use a torch to see the patient.

There were clinic rooms on all the wards. These were clean and well maintained. Medicines were stored securely and the nurse in charge held the keys. We checked the arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and found they were stored securely. However, we found discrepancies, which had not been investigated or reported on Westlands. We saw evidence of some medication checks on the wards, although these were not performed weekly in accordance with the Trust policy. Medicines requiring refrigeration were stored appropriately and temperatures were monitored using data loggers. However, on all wards we found temperatures were not checked every day as per the Trust policy and national guidance.

All wards had seclusion facilities. The seclusion rooms were almost identical in terms of layout. Clocks were visible to enable patients to see the time. The seclusion room at Mill View Court had no natural light into the room. There were no blinds on the viewing panels of the seclusion rooms.. Staff provided patients with bowls via the door hatch to use for toileting. Once used, patients would pass these bowls containing urine and faeces back to staff through the hatch. The same hatch was used to pass food and drink to patients. Anti-ligature bedding was in all seclusion rooms.

Staff adhered to most infection control principles including hand washing. There were hand gel dispensers at the entrance to all the wards. We reviewed the health and safety files on all wards. We found that risk assessments for the environment were updated regularly and reviewed.

Nurse call alarms, to attract the attention of staff, were present in all bedrooms at Mill View Court. Most bedrooms on the other wards did not have a nurse call system installed. Staff carried security alarms whilst working on the wards.

Safe staffing

The trust provided data on the total number of substantive staff working on each of the wards;

Avondale 23.29 whole time equivalent

Mill View Court 27.40 whole time equivalent

Psychiatric intensive care unit 29.21 whole time equivalent

Newbridges 30.60 whole time equivalent

Westlands 30.40 whole time equivalent

Data showed that all five wards were above the trust average vacancy rate of 8.70%. The vacancy rate on the psychiatric intensive care unit was 25.56%, Newbridges was 19.66%, Westlands was 14.12%, Avondale was 12.71% and Mill View Court was 10.06%.

There were 80.81 whole time equivalent qualified nurses and 74 whole time equivalent healthcare assistants working across acute wards and the psychiatric intensive care unit. Staffing levels for each ward were;

Avondale – 14.8 whole time equivalent qualified nurses and 13.6 whole time equivalent healthcare assistants

Westlands – 17 whole time equivalent qualified nurses and 14.4 whole time equivalent healthcare assistants

Psychiatric intensive care unit – 18.21 whole time equivalent qualified nurses and 16 whole time equivalent healthcare assistants

Inadequate

Are services safe?

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

Newbridges – 17 whole time equivalent qualified nurses and 14.6 whole time equivalent healthcare assistants

Mill View Court – 13.8 whole time equivalent qualified nurses and 15.4 whole time equivalent healthcare assistants

At the time of the inspection, 11.8 whole time equivalent nursing posts were vacant and 10 healthcare assistant posts were vacant.

The psychiatric intensive care unit carried the highest rate of qualified nursing vacancies at 32.95%, followed by Avondale at 12.16% with Westlands and Newbridges both at 11.76%.

Newbridges had the highest incidence of staff sickness with 12% between December 2014 to November 2015. Westlands had a permanent staff sickness rate of 6.91% during the same period. These were both higher than the NHS average of 4.7%.

All wards had a charge nurse, who provided management and leadership on the wards. They were supported by one or two deputy charge nurses. Charge nurses told us they did not know how staffing establishments had been calculated. All wards had undergone a recent 'optimisation' process to review staffing levels. This involved reviewing existing staffing levels against demands on the service. Charge nurses on Mill View Court and Newbridges said that as a result of this exercise they had been identified as being under establishment. However, it was not clear how this would affect the number of staff available within the team.

Mill View Court, Newbridges and Westlands operated a three-shift system.

- Early shift 07:00 – 15:00
- Late shift 12:00 – 20:00
- Night shift 19:30 – 07:30

Minimum staffing numbers for each shift on these wards was;

Mill View Court

Early Shift 2 qualified Nurses, 2 healthcare assistants

Late Shift 2 qualified Nurses, 3 healthcare assistants

Night Shift 1 qualified nurses 3 healthcare assistants

Newbridges

Early Shift 2 qualified nurses, 3 healthcare assistants

Late shift 2 qualified nurses, 3 healthcare assistants

Night shift 2 qualified nurses, 2 healthcare assistants

Avondale

Early Shift 2 qualified nurses, 3 healthcare assistants

Late shift 2 qualified nurses, 3 healthcare assistants

Night shift 2 qualified nurses,2 healthcare assistants

Staff at Miranda House on the psychiatric intensive care unit worked long day shifts, starting at 06:40 and ending at 19:20. Minimum staffing numbers on day shift were two qualified nurses and three healthcare assistants. Night shift started at 18:40 until 07:20. Minimum staffing on night shift were two qualified nurses and two healthcare assistants.

All of the staff we spoke highlighted issues with staff shortages. Wards frequently relied on bank and agency staff to meet minimum staffing levels. We saw staff rotas, which confirmed a reliance on bank and agency staff. We saw staffing shortages recorded on Datix, the trust's incident reporting system. Between October 2105 and March 2016, Newbridges had 14 incidents recorded as 'staffing level shortage', Mill View Court had seven incidences, Westlands had four, Newbridges had three and Avondale had two. Staffing shortages on the psychiatric intensive care unit had resulted two qualified nurses not always being on duty. This had a significant impact on the ward. Qualified nurses would prioritise administering medication, undertaking physical observations and health checks for patients. This left little time to undertake other tasks including key working and updating care records.

The trust provided data on the number of shifts covered by bank or agency staff as of December 2015. Avondale had the highest use of bank or agency staff. Newbridges had the most shifts that had not been covered with bank/agency staff.

Ward

Avondale

Number of shifts covered by bank/agency staff 278

Number of shifts not covered by bank/agency staff 18

Mill View Court

Number of shifts covered by bank/agency staff 215

Inadequate

Are services safe?

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

Number of shifts not covered by bank/agency staff 25

Psychiatric intensive care unit

Number of shifts covered by bank/agency staff 206

Number of shifts not covered by bank/agency staff 29

Newbridges

Number of shifts covered by bank/agency staff 206

Number of shifts not covered by bank/agency staff 29

Westlands

Number of shifts covered by bank/agency staff 168

Number of shifts not covered by bank/agency staff 13

Charge nurses tried to use bank staff that were familiar with the wards and patients. An e-rostering team coordinated advance requests for bank and agency staff. Agency staff were used when bank staff were unavailable. Staff told us that this was difficult to manage, as agency workers were unfamiliar with the wards and patients. Staff felt that agency staff 'made the numbers up' but could not fulfil all the responsibilities required when working on the wards.

Avondale and the psychiatric intensive care unit had highlighted staffing issues as a significant risk. We saw copies of risk register insertion forms completed in November 2015 and January 2016 respectively. The outcome of these issues being escalated to senior management was unclear.

All patients had a named keyworker nurse and associate keyworker. Patients also had a named member of staff allocated each day from the available staff on duty. Staff and patients told us that it was not always possible for patients to spend regular time with their named nurse.

Section 17 leave was rarely cancelled due to staffing shortages. Often leave was planned between the hours of 12:00 and 15:00 when there were more staff on duty on the wards, however three patients told us they had leave cancelled or cut short due to staffing issues.

Out of hours medical cover was provided after 17:00 and over the weekend by on-call consultants and junior doctors. Staff did not have any concerns regarding access to medical cover.

All staff were required to undertake a suite of mandatory training. The average mandatory training rate for staff across the acute wards and the psychiatric intensive care unit was 58%. This was below the trust compliance target of 75%. Mill View Court had the highest percentage of trained staff with an overall training rate of 78%. The psychiatric intensive care unit had the lowest rate of training at 35%

Health & Safety training had the highest rate of completion with 87%. Control of Substances Hazardous to Health Awareness training followed this with 86%. Equality & Diversity had the lowest rate at 22%. Mental Capacity Act closely followed this with 36%.

Assessing and managing risk to patients and staff

Staff used the Galatean Risk and Safety Tool to assess risks. This was in line with the Department of Health best practice in managing risk guidance (2007). Staff carried out Galatean Risk and Safety Tool assessments upon admission and updated regularly. We reviewed 21 patient care records. We found that completed Galatean Risk and Safety Tool assessments in all but one record we reviewed.

The trust had a supportive engagement policy. This policy had replaced the previous observation policy and seemed to have been implemented on different wards at different times. For example, at Mill View Court, staff told us the engagement policy had been in place for around ten months. At Newbridges, the engagement policy had only been adopted the week prior to the inspection taking place. In line with the supportive engagement policy, all patients had a safety plan. This plan included identified patient risks, triggers, strategies to respond to risk and the agreed level of engagement. Members of the multi-disciplinary team agreed the level of engagement, based on risk. Qualified nursing staff could change the level of engagement within agreed parameters determined by multi-disciplinary team and specified within the safety plan.

All of the wards had ligature points, including in patient bedrooms. Ligature audits were in place for all wards. However, there were no actions identified on the audit to mitigate risk of ligature. Staff told us that risks were managed on an individual basis, using appropriate levels of engagement to mitigate risk. A patient at Mill View Court had been assessed on the Galatean Risk and Safety Tool as high risk of suicide, with one previous suicide attempt by hanging. This was not reflected in the patient's safety plan and there was no evidence that for this patient, his risk of ligature had been effectively mitigated.

Inadequate

Are services safe?

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

New admissions on the wards were on the highest level of engagement, whilst baseline assessments were being carried out.

The trust had a policy for searching patients. Staff would search patients' bags following episodes of leave from the ward. If there were any items of concern, staff would discuss this with patients. The psychiatric intensive care unit had a body scanner that would be used alongside a 'pat down' of patients following episodes of unescorted leave. Staff would only search patients' rooms if there were reason to suspect that there were items in the rooms that could cause harm to the patient or others.

The trust provided data on the use of restraint and seclusion. Between 1 November 2015 and 31 March 2016, there were 72 uses of restraint on 48 different service users. The highest number of restraints occurred on Westlands (26% of all restraints), followed by Mill View Court and the psychiatric intensive care unit (25% of all restraints). The data provided by the trust prior to our inspection indicated that none of these resulted in the use of prone restraint or rapid tranquilisation.

However, staff on all of the wards told us that prone restraint was sometimes used. We reviewed care records and found that prone restraint had been used. Staff had clearly documented this in patient notes, along with other techniques that had been used before prone restraint was initiated.

Data from the trust indicated there were no circumstances in which long-term segregation had been used. Between 1 November 2015 and 31 March 2016, there were 47 uses of seclusion. Of these 13 occurred on the psychiatric intensive care unit, 13 on Newbridges, nine on Westlands, seven on Mill View Court and five on Avondale.

The trust had a policy providing guidance on the use of rapid tranquilisation. This policy had been due for review in February 2016. The policy did not appear to have been reviewed and updated. The trust defined rapid tranquilisation as 'the administration of any medication to calm or sedate agitated aggressive service users as quickly as is safely possible'. We found that rapid tranquilisation was being used. Staff did not appear to have a clear understanding of what constituted rapid tranquilisation. As a result, appropriate monitoring and observations were not recorded following the administration of rapid tranquilisation as per national guidance and trust policy.

The trust policy stated that after rapid tranquilisation, observations (blood pressure, pulse and respiration rate) following both intra-muscular and oral medication should be made every 15 minutes unless more frequent observation is indicated. At the end of the first hour following administration of medication a medical review must take place'. On Newbridges, Westlands and Avondale, six prescription charts indicated the use of rapid tranquilisation. In four of these records, we found no observations had been recorded at all. We found a seclusion record on Newbridges, which detailed a patient had been restrained using prone restraint, and rapid tranquilisation can been carried out. Again, there was no evidence that physical observations as outlined in the trust policy had been undertaken.

We were concerned that for some incidents, which involved the rapid tranquilisation of patients, there was no clear rationale for this in the patient records. In three care records we reviewed, we found that rapid tranquilisation had been used. One patient had been given intra-muscular medication on three separate occasions over a three-week period. None of the entries on the care record acknowledged this as rapid tranquilisation. Nor was there any rationale for the administering of this. There was no evidence that physical health monitoring had been undertaken after rapid tranquilisation had taken place.

We reviewed 23 seclusion records. This included a seclusion review, which was undertaken at Newbridges as part of the inspection. We found that in seven of the seclusion episodes, patients were observed as being 'settled' for significant periods of time. However, the seclusion was not ended. We found no evidence of exit plans when seclusion was commenced. We found some basic plans for seclusion. These did not detail what the patient needed to do for seclusion to end or what behaviour or settled period was required to end seclusion. There was no recorded evidence that this was discussed with the patient. This was not in line with the Mental Health Act Code of Practice. Staff observed patients at 15-minute intervals and documented these in seclusion records. Nursing reviews took place, however in a number of records one nurse and one healthcare assistant had undertaken these. Mental Health Act Code of Practice requires two qualified nurses to undertake these reviews. Physical health monitoring did not appear to be carried out whilst patients were in seclusion. We could find no evidence of physical health monitoring in records.

Inadequate

Are services safe?

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

Patients in seclusion were sometimes denied the use of toileting facilities, even when they were displaying settled behaviour. One seclusion record indicated that a patient had been denied use of the toilet due to 'lack of staff'. A female patient was denied access to the toilet to change sanitary products. The seclusion record indicated that sanitary products had been provided to the patient via the hatch in the seclusion room door.

One male patient on the psychiatric intensive care unit was in in long-term segregation. This episode started as seclusion at the end of January 2015 and the patient was moved into long term segregation on the 09 April 2016. This patient was located in the female sleeping area of the ward. This meant that the ward was closed to female admissions. There was a seclusion care plan in place and regular reviews of this patient were being undertaken including physical health monitoring.

All of the wards had a contraband items list. This included mobile phone chargers. Staff explained this was due to the potential for chargers to be used as ligatures. There had been no individual assessment of risk around the use of mobile phone chargers. This appeared to be a blanket restriction.

Most patients were detained under the Mental Health Act 1983. Mill View Court had two informal patients. These patients were able to leave the ward at their own free will. Staff told us that a qualified nurse would speak to informal patients prior to them leaving the ward. This was to review risks relating to those patients. We spoke to two informal patients. One patient told us that they had not been allowed to leave the ward as staff had said they were concerned for his safety.

Staff had a good understanding and knowledge of safeguarding policies and procedures. Safeguarding training compliance on all wards was above the trust target of 75%. On Newbridges, 100% of staff had completed safeguarding training. Westlands and Avondale had 75% compliance; the psychiatric intensive care unit was 80% and Mill View Court 75%. Staff were able to describe situations that would lead to a safeguarding referral. Staff knew the internal lead for safeguarding as well as the local authority safeguarding hub.

We looked at the systems in place for medicines management. We reviewed 21 prescription records and spoke with nursing staff where were responsible for medicines.

Administration records were not always completed fully. We saw gaps in eight of the 21 prescription records we checked; staff had not signed or recorded a reason why medicines had not been given. On Mill View Court, staff had recently implemented an audit to check prescription and administration records were fully completed. However, this was still in its infancy.

There were adequate supplies of emergency equipment, oxygen and defibrillators. Staff had signed to say medicine and equipment checks had been completed, however we saw this had not been done every day on Newbridges, as per the trust policy. On Westlands and the psychiatric intensive care unit, we found oxygen had expired. Stocks of emergency medicines varied from ward to ward. None of the wards we visited held the essential stock stated in the trust resuscitation policy. This included medicines which should be immediately available when rapid tranquilisation is used. We raised our concerns regarding the lack of some essential and emergency medications with the trust senior management on 14 April 2016. The trust responded and advised an immediate pharmacy audit would be carried out to review medicines stock across all the wards. We returned to Newbridges and Mill View Court on 22nd April 2016. We found that one of the emergency medicines on Newbridges had expired in January 2016. One of the essential medicines detailed in the trust resuscitation policy was not present on Mill View Court.

There was a lack of information to guide nursing staff when administering 'when required' medicines. It was not always clear what maximum dose the prescriber had intended. We found two prescriptions on Avondale which were unclear and nursing staff were unable to tell us what the medicine was for or what the maximum dose was.

Track record on safety

There had been five recorded serious incidents on the acute wards and psychiatric intensive care unit between April 2015 and March 2016. Three of these related to the avoidable or unexpected death of a patient. One related to a detained patient who had absconded from the ward.

Inadequate

Are services safe?

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

Staff on one of the wards made us aware of a serious incident that had occurred in September 2015. This involved a serious assault on a member of staff by a patient. This incident was not included in the serious incident data provided by the trust. Following this incident, the trust had reviewed the protocol for staff transporting patients in vehicles. Changes had been made to ensure that two members of staff sat in the back of vehicles, either side of the patient.

We noted that from October 2015 to March 2016, 36 patients had absconded from Newbridges. Staff had recorded these on electronic incident recording system. One of these incidents had also been recorded as a serious incident.

Reporting incidents and learning from when things go wrong

Staff were aware of the incident reporting and recording policy. Staff logged all incidents on Datix, the trust's electronic system. All staff, with the exception of agency workers, had access to this system.

Staff described the type of things that would be regarded as a reportable incident. These included physical and verbal aggression by patients, absconding, restraints and seclusion. Staff told us that incidents occurred daily, with varying degrees of severity. We were told that verbal aggression was rarely recorded on Datix, as this happened so frequently they would 'spend all day' recording these.

Charge nurses had oversight of all incidents reporting for their wards. They conducted a review or investigation of the issue as necessary. Datix would then be updated to reflect any actions taken following the incident. An operational risk management group met to discuss incidents. This group used to provide data on incidents to the lead nurse meeting, but we were told this no longer happened. We saw a copy of the monthly incident report for Newbridges and Westlands. This was a graph detailing the types of incidents and day/time of the week incidents occurred. The graph was very difficult to read. Charge nurses told us they did not find the information useful presented in this way. There was no apparent trend analysis of incident data taking place.

Following incidents, charge nurses would provide support to staff on the ward. One charge nurse told us that the trust did not recognise or use effective debriefing after incidents. There did not appear to be a clear structure or process for debrief. We spoke to one member of staff who had been involved in a serious incident who had received support from occupational therapy following an assault by a patient. Staff told us that patients were sometimes debriefed following an incident. Where this took place, this would be recorded in patient care record. We did not see any entries in the care records we reviewed.

Staff had varying levels of understanding of duty of candour. Most staff could explain that there was a process in place for apologising to patients when things went wrong. Staff knew there was a section on the Datix recording system that asked about duty of candour. Staff could not think of any recent incidents when duty of candour had been applied.

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 carried out comprehensive assessments of patients' needs upon admission. This assessment included a review of clinical needs as well as mental and physical health needs.

We looked at 21 patient records. All patients had a recovery star care plan. However, we found two of these plans were only partially completed. The quality of the care plans varied. We found no evidence of patient involvement in ten of the care plans we reviewed. Patients on the psychiatric intensive care unit had a recovery star care plan and an additional care plan. The format and content of the psychiatric intensive care unit specific care plan was comprehensive in all four of the records we reviewed. Six of the patients we spoke to said they had not been involved in developing their care plans.

Staff used the recovery star to undertake reviews of the patient's progress towards identified treatment goals. Some staff felt that the recovery star tool was not an appropriate care planning tool. This had been raised within the charge nurse meeting and escalated to the acute services care group. Staff were unclear if these concerns had been taken on board.

Patient care records were paper based. The Galatean Risk and Safety Tool was completed electronically and a copy printed off and retained file. At the time of the inspection, the trust was experiencing some technical difficulties with the electronic record. As a result, staff were not using the Galatean Risk and Safety Tool to review risk. Staff told us they were using the patient's safety plan as a means of monitoring risk whilst Galatean Risk and Safety Tool was unavailable. Some safety plans did not include all the risks on the Galatean Risk and Safety Tool. This was therefore not a robust method of assessing ongoing risk whilst the Galatean Risk and Safety Tool was unavailable for use.

Physical health monitoring was not in place for all patients. We found three records where no physical health assessment had been complete upon admission. In 12 of the care records we reviewed, we found no evidence of ongoing physical health monitoring. This included a lack of appropriate physical health monitoring for patients with long-term conditions like diabetes, heart disease and thyroid problems. One patient had been assessed as having hearing difficulties in their initial assessment. However, the care plan stated there were no physical health issues. We spoke with this patient who told us they did have difficulty hearing, which sometimes caused them problems with their understanding. Another patient with hepatitis C had no information in their care record as to how this would be managed. Three patients told us that their physical health needs had not been assessed.

Care records were paper-based and were stored securely in the nursing office on all the wards. Documents were not always stored in the correct section of the patient file making it difficult to find information at times.

Best practice in treatment and care

We reviewed 21 prescription records in detail and spoke to nursing staff who were responsible for medicines. Medical staff stated they adhered to national guidance from the national institute for health and clinical excellence (NICE) when prescribing and administering medication. However we found evidence that guidance was not followed in relation to rapid tranquilisation.

Staff were aware of a range of national institute for health and clinical excellence guidance including self-harm, depression, schizophrenia and dealing with violence and aggression. Each ward had a standard operating procedure, which detailed a suite of national guidance, which guided staff in the delivery of treatment and care.

Patients had access to psychologists. There was 2.83 whole time equivalent psychology staff working across the service. Staff told us that there was not enough capacity within the psychology team to meet patient needs. The charge nurse at Newbridges told us that an additional assistant psychologist was being recruited. This was a temporary post for six months. At Westlands and Mill View Court, psychology delivered group sessions, including a 'managing emotions' group. Staff at Avondale told us that psychological therapies were also available at Victoria House, and patients could sometimes be referred there.

Staff were not clear which outcome monitoring tools were being used. Patients were assessed using the mental health clustering tool on admission. This was developed in partnership between the Department of Health, the Royal College of Psychiatrists Centre for Advanced Learning and Conferences and the Care Pathways and Packages Project as a means of allocating clients to care clusters, which in turn supports care. The mental health clustering tool

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incorporates the Health of the Nation Outcome Scale. The Health of the Nation Outcome Scale is the most widely used routine clinical outcome measure used by mental health services in England.

The Beck Depression Inventory is a 21-question multiple-choice self-report inventory, one of the most widely used psychometric tests for measuring the severity of depression. We found this had been completed in one of the care records we reviewed.

Another care record contained a completed Hospital Anxiety and Depression Scale. This is commonly used by doctors to determine the levels of anxiety and depression that a patient is experiencing.

We could find no other evidence of outcome monitoring for patients being routinely used on the wards.

There was limited evidence of staff involvement in clinical audit. Staff told us that there had been case file and length of stay audits undertaken. On Avondale, staff said that five care records per month were reviewed and that had resulted in improvements to practice. We did not see any documentation for either of these audits. We asked the trust to provide information on any clinical audits undertaken specifically within the acute wards and psychiatric intensive care unit. No information was provided.

Skilled staff to deliver care

All wards had a charge nurse who was the senior nurse responsible for the management of the ward. Deputy charge nurses, registered mental health nurses and healthcare assistants worked on all wards. There was access to staff from a wide range of mental health disciplines. This included consultant psychiatrists, psychologists, dual diagnosis nurses, junior doctors, occupational therapists and activities coordinators. The consultant psychiatrists, psychologists and dual diagnosis staff worked across all the acute wards and the psychiatric intensive care unit. A pharmacist visited each ward one day per week.

The trust policy on rapid tranquilisation stated that 'all qualified registered mental health nurses working in areas who may be required to administer rapid tranquillisation must include as part of their mandatory training: immediate life support, including the use of oxygen, suction, defibrillation and anaphylaxis'. Some qualified staff had completed training in immediate life skills. On Avondale, two qualified staff had completed this training, eight qualified staff on Mill View Court, eight qualified staff on Westlands, nine qualified staff on the psychiatric intensive care unit and one qualified staff on Newbridges.

Charge nurses identified some gaps in competencies in relation to personality disorder, dialectical behaviour therapy and formulation. Data from the trust indicated that just two staff at Avondale, one at Mill View Court and one at Westlands had completed formulation training.

At Newbridges, mandatory training for all staff was being prioritised, so no other training was available to staff until mandatory training had reached the trust compliance level of 75%.

The trust policy on supervision stated that all staff should receive management and clinical supervision every four to six weeks. Data provided from the trust indicated that clinical supervision rates were 80% for Avondale, 60% for the psychiatric intensive care unit, Newbridges and Westlands and 40% for Mill View Court. Staff acknowledged that, due to staffing pressures, supervision sessions did not always happen. The trust policy stated that supervision logs should be completed within supervision or where supervision has been scheduled and cancelled, indicating the reason for cancellation. However, data on the number of supervisions that had been planned and cancelled was not available.

Appraisal rates across wards varied. Mill View Court had the highest level of staff completing appraisals at 70%. On Avondale, 67% of staff had completed appraisals, 65% of staff on Westlands, and 44% of staff on the psychiatric intensive care unit. Newbridges had the lowest number of staff who had completed appraisals at 29%. This meant that in total, 67 staff working on acute wards and the psychiatric intensive care unit had not had a performance and development review in the twelve months prior to inspection.

Multi-disciplinary and inter-agency team work

Multi-disciplinary team meetings took place weekly on all the wards. This gave professionals involved in patient care the opportunity to discuss the treatment being provided and any possible changes. We were unable to observe any multi-disciplinary meetings. However, we did see documentation that was completed at these meetings. These showed that the meetings were well attended by a range of professionals. This included the consultant

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psychiatrist, clinical psychologist, doctor, occupational therapist, pharmacist, dual diagnosis nurse, mental health nurse and charge nurse. We saw that the views of patients and in some cases, family members had been taken into account in the formulation of decisions about treatment. Patients signed the notes from the multi-disciplinary team meeting. A summary of the decisions made at the meeting were documented in patient care records.

We observed three staff handovers, which included everyone coming on duty for that shift. The staff member leading the handover provided an overview of all patients on the ward. This included a summary of the patient's general presentation, any leave or activities planned and issues with medication. Staff discussed new admissions onto the ward. The handover on Avondale took place in a busy office, with people entering and leaving and telephones ringing.

We observed two clinical review meetings. These were daily meetings attended by clinical staff. On the psychiatric intensive care unit, the modern matron, speciality doctor, consultant psychiatrist and deputy charge nurse attended this meeting. On Mill View Court, the consultant psychiatrist, junior doctor, staff nurse, occupational therapist and a GP trainee attended the meeting. The meetings were informal, with staff in attendance discussing patients on the ward in terms of their diagnosis and presentation.

Charge nurses and other staff told us there were effective relationships in place with local safeguarding teams. Staff told us of varying levels of contact with community care co-ordinators. Not all patients were allocated a care co-ordinator from community mental health teams. Patients sometimes had to wait for long periods for community care co-ordinators to be allocated.

Crisis teams in the local area were short staffed, so had little involvement in discharge planning. Staff from the acute wards contacted discharged patients with a seven-day follow-up telephone call. Staff told us that occasionally patients were discharged without a robust community care package in place, onto the waiting list of community teams.

Patients were supported using a Care Programme Approach. This is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. We observed a Care Programme Approach meeting involving the patient, consultant psychiatrist, mental health nurse and social worker

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

Training in the Mental Health Act was not mandatory for staff at the trust. Data provided indicated very low numbers of staff completed Mental Health Act training. Only five staff from acute wards and the psychiatric intensive care unit had completed this. Training in the revised Mental Health Act Code of Practice had not been delivered. Staff told us there was a central office within the trust, for advice on any issues relating to Mental Health Act.

Mental Health Act monitoring visits had taken place on three wards between March 2015 and March 2016. In total, 16 issues had been identified, seven on the psychiatric intensive care unit, three on Mill View Court and six on Westlands. Most issues were in the category of purpose, respect, participation and least restriction with seven issues. During previous Mental Health Act monitoring visits the following issues had been highlighted:

- Lack of staff available to address patient needs
- No evidence that patients had been given copies of their care plans
- Patients did not have keys to their bedrooms, which was identified as a blanket restriction
- Section 17 leave forms were not signed by patients

All of these issues were still evident at the time of our inspection.

We looked at 21 care records and we reviewed three sets of detention paperwork in detail. We found in all cases that detention records were in order. At the time of the inspection all patients detained appeared to be under the appropriate legal authority. We saw that patients had been given their rights under the Mental Health Act upon admission and at regular intervals thereafter. Two patients told us they were regularly read their rights and staff asked patients to confirm their understanding of what they were being told.

Patients did not sign section 17 leave forms and there was no evidence that patients had been given a copy. There did not appear to be any assessment of risk taking

Are services effective?

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place prior to leave being granted. We could see no evidence that any discussion took place directly after leave with patients to assess how the leave had gone. One patient had two section 17 leave forms on file, which specified different length of time for the leave. It was unclear which form staff were using to grant leave in this case.

Staff told us that all detained patients had an automatic referral to the independent mental health advocate. Five patients we spoke to confirmed they were in contact with the independent mental health advocate. Staff were concerned that there was no advocacy service for informal patients. This service was no longer available due to funding cuts.

We found that in most records we reviewed, consent to treatment had been given. In four records, we could find no evidence that patients had consented to treatment.

There had been no Deprivation of Liberty Safeguards applications made for any of the wards in the six months prior to the inspection.

Staff told us that all original copies of Mental Health Act paperwork were held in the central Mental Health Act office, where documentation was reviewed. This was subject to audit by a scrutiny panel. We did not see the findings from Mental Health Act audits that had taken place.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was part of the mandatory training set. Only 37% of staff on acute wards and the psychiatric intensive care unit had completed Mental Capacity Act training. Staff were aware of the trust's policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff appeared to have a limited understanding of the principles of Mental Capacity Act. Staff told us that capacity was always assumed, unless there was a reason to challenge this. There was a form to assess patient capacity; however, staff could not remember the last time this had been used. Staff said they had held best interest meetings for patients. However, as this had not been a recent event, there was no paperwork on the ward to enable the inspection team to review this.

Staff were unaware of any processes within the trust to monitor adherence to Mental Capacity Act.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spoke with 21 patients receiving care and treatment. Interactions between staff and patient were observed throughout our inspection. Staff spoke to patients in a kind and caring way. Patients told us that most staff were kind, caring and respectful. Staff always knocked before entering bedrooms for example.

Patients told us that staff were often too busy to respond quickly when patients asked to speak to them. We did observe staff telling patients to wait or speak to another member of staff whilst we were on the wards.

We observed two incidents where patients were becoming aggressive and shouting on the wards. Staff responded to these situations very quickly, using verbal de-escalation techniques. These incidents were managed calmly and with respect for patients.

Twelve of the patients we spoke to told us that they did not think there were always enough staff on duty. This was also reflected on two of the comments cards we received. Patients told us that this meant they did not get to spend enough one to one time with staff.

Patients did not have keys to their bedrooms. This meant that patients had to request access to their rooms by staff. Patients told us staff were not always available to respond to requests to open bedroom doors.

We observed a health promotion group and smoking cessation group on the psychiatric intensive care unit. The activity coordinator facilitated these, supported by two healthcare assistants. Four service users attended. The group was very relaxed and welcoming, giving patients the opportunity to speak freely about health related issues. Drinks were available to patients. Staff were very caring and allowed patients to put their views across, whilst keeping the conversation focused.

One patient on Westlands was concerned that the garden was the only outdoor space available, but this was where other patients went to smoke. This was not pleasant for those patients who did not smoke.

Staff on the wards seemed to have a good understanding of the needs of patients. Patient's meetings were held each morning on the ward, facilitated by a member of the nursing team. This gave patients the opportunity to raise any issues they had.

The involvement of people in the care that they receive

All of the wards had a clear admission process which including orientating new patients onto the ward. We saw copies of the welcome pack for new patients on Westlands, Mill View Court and Newbridges.

We saw information boards on the wards, and at Westlands, there was a staffing 'tree' diagram at the front of the ward. This had a photograph of all staff on it so that patients could clearly see who worked on the ward and what their roles were.

We reviewed 21 care records and found these varied in quality, Ten care plans did not appear to have any patient involvement. Six patients we spoke to did not know if they had a care plan, and could not remember if they had been involved in making decisions about their care.

All detained patients had access to an independent mental health advocate. The central Mental Health Act administration office in the trust made an automatic referral to the independent mental health advocate. Most of the detained patients we spoke to confirmed that they had seen and spoken to an advocate.

Patient meetings took place regularly on the wards. This provided patients with an opportunity to raise and discuss issues. We observed a patient meeting on Avondale. Six patients and two members of staff attended this. Staff led the meeting. The meeting content included a reminder of the smoking policy, visiting hours and what patients were allowed to bring onto the ward. Staff asked patients what activities they would like to do. The ward had a 'comfort box' and this was brought into the meeting. This contained items that might be used by patients to help calm them when they were feeling anxious or agitated.

We saw on multi-disciplinary team records that some family members had been involved in discussions.

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 average bed occupancy rate between April 2015 to March 2016 was 97.4%. Bed occupancy rates varied between the wards:

- Avondale 89%
- Newbridges 102%
- Westlands 101%
- Mill View Court 105%
- Psychiatric intensive care unit 89%

Charge nurses told us of the challenges they faced due to pressures on available in-patient beds. Staff felt under pressure to admit new patients into leave beds. There had been occasions when patients who were away from the ward on leave had been unable to return to the ward, as their bed had been allocated to a new patient.

At the time of our inspection, there was no dedicated role overseeing bed management for the trust. As a result, this was being covered by the mental health crisis team two days per week and three of the charge nurses from the acute wards one day per week each. This was in addition to their usual day-to-day duties.

The trust reported that there were no out of area placements during the period 1 September 2015 and 29 February 2016

Patient length of stays varied across the wards. The average length of stay for patients as of 29 February 2016 was:

- Mill view court 51 days
- Avondale 7 days
- Psychiatric intensive care unit 106 days
- Newbridges 29 days
- Westlands 43 days

Staff described a clear pathway for referral and transfers of patients to psychiatric intensive care units when their needs could not be managed on acute wards. However, due to a male patient being in long-term segregation in the female sleeping area, the psychiatric intensive care unit was closed to female admissions. Staff at Westlands told us there was a female patient who was exhibiting escalating behaviours. Staff were awaiting a psychiatric intensive care unit assessment, but were unable to transfer this patient. The only option would be to consider an out of area unit.

The trust provided data on delayed discharges. Between 1 September 2015 and 29 February 2016, Mill View Court had a delayed discharge rate of 6%, Westlands was 5% and Newbridges was 2%. Staff told us that the main reason for delayed discharges was due to securing funding for placements. Access to beds in specialist treatment units was also highlighted as an issue. For example, one patient on Newbridges had a head injury and was awaiting a bed in a neuro-rehabilitation unit.

There had been a total of 104 readmissions within 30 days between the period 1 September 2015 to 29 February 2016 across the wards:

- Mill View Court 9
- Psychiatric intensive care unit 1
- Avondale 70
- Westlands 24

The facilities promote recovery, comfort, dignity and confidentiality

The range of facilities varied significantly across the wards. All wards had a clinic room to examine patients. Most wards had a suitable range of rooms for patients to have one to one time with staff and meet with visitors. At Newbridges, due to ongoing building work, staff told us there were not enough rooms. Staff used the faith room for visits, Care Programme Approach meetings and other meetings.

Patients on all wards with the exception of the psychiatric intensive care unit could use their own mobile phones. No patients had access to mobile phone chargers, as these were on the contraband items list. There was no specific risk assessment relating to the use of phone chargers, we considered this a blanket restriction. There was access to a telephone on the wards for those patients who did not have a mobile phone.

Patients had access to their bedrooms during the day. Bedrooms were locked and staff would open at patient request. However, some patients we spoke to said they were often kept waiting to get access to their rooms as staff were so busy. We considered this to be restrictive practice.

Are services responsive to people's needs?

Requires improvement

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

Patients at Mill View Court and Westlands said they would prefer their own bedroom keys. Patients on all wards were able to secure personal or valuable possessions in a lockable unit in their rooms.

All wards had outdoor space, which patients could access. On the psychiatric intensive care unit, the door to the outside area was kept locked. Staff would open this at patient request. Staff supervised patients using the outside area on this ward.

We saw copies of weekly activity schedules on all the wards. Patients at Mill View Court told us that the activity schedule had only been produced the week prior to our inspection. Most of the activities were organised during Monday to Friday. There was limited access to structured activities during the weekend, patients told us there was almost nothing to do at weekends.This was due to the availability of staff to facilitate these sessions. All wards had an activity coordinator. The activity coordinators worked weekdays only, with the exception of Westlands. Patients told us that weekends were 'the most boring time'.

Patients did say that sometimes ward activities and escorted leave were cancelled due to staff shortages. They told us they found this frustrating.

All wards had locks on the main entrances with entry and exit controlled by staff. Staff provided informal patients with information about their rights to leave the ward. We spoke to one informal patient to confirm they were aware they could leave the ward at will. One patient who was informal patient told us they had not been allowed to leave the ward on one occasion.

Most of the patients we spoke to said there was a good choice of food and they quality was good. The only negative comment about food was that the portions were sometimes too small.

Patients could access drinks and snacks whenever they wanted. On Newbridges and the psychiatric intensive care unit, patients had to ask staff to make hot drinks

Meeting the needs of all people who use the service

All of the wards provided some facilities for patients with physical disabilities. On Newbridges and Westlands, patient bedrooms were on the first floor. There was a lift on both of the wards to give first floor access. Newbridges had an adapted room on the ground floor that could be used for patients with physical disabilities.

We saw a wide range of information leaflets on the wards. This included information on how patients could complain if they were not happy with the service. These were all printed in English. Staff told us they could access translation services and interpreter through the local authority as and when required.

We observed a Care Programme Approach meeting where the patient had requested an interpreter, who had attended the meeting to facilitate translation.

Patients had a good choice of hot and cold food. This included healthier options, gluten free and vegetarian choices. We did not see any specific foods that took into account cultural needs of patients. Staff told us that this would be discussed individually as required with patients and suitable food options would be provided.

All of the wards provided access to spiritual support. Not all wards had specific faith rooms. Some patients had used section 17 leave to access local faith services

Listening to and learning from concerns and complaints

There was information displayed on the ward, informing patients of the complaints process. Information on complaints was also contained in the ward welcome packs. Patients told us they know how to make a complaint. However, two patients said that although they understood the process, they would not feel comfortable about making a complaint about the ward. One patient had a negative experience after making a complaint. The patient raised an issue about member of staff with the charge nurse. The charge nurse had brought the member of staff into the room to be confronted by the patient. This had made the patient uncomfortable.

Staff knew how to handle complaints appropriately and in line with the trust policy.

The trust received 32 formal complaints relating to acute wards and the psychiatric intensive care unit between January 2015 to March 2016. One of these was fully upheld

Are services responsive to people's needs?

Requires improvement

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

and seven were partially upheld. During the same period, ten compliments on the service had been received. We saw no evidence of complaints from patients resulting in changes to how services or treatment was delivered.

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

The trust vision was to be caring, compassionate and committed. The trust values were; putting the needs of others first, acting with compassion and care at all times, continuously seeking improvement, aspiring to excellence, and valuing each other and teamwork. Most staff on the wards could not tell us the trust vision and values. However, staff did say that they worked in a way the promoted good care and acted with professionalism. Staff interactions with patients were compassionate and kind. Staff spoke very strongly about good team working on the wards. Charge nurses on all the wards were identified as being supportive and effective leaders.

Each ward had a statement of purpose that set down the purpose and identified objectives for the service. The statement of purpose did not refer to the trust vision and values.

Some staff told us there was no link between corporate vision and values to team and individual objectives.

Senior management were not viewed in a positive way by staff. Staff told us of a 'blame culture' and felt that outside of ward level managers, more senior managers were not supportive.

Newbridges had been visited by the chief operating officer from the trust following a serious fire on the ward and had been supportive to staff. The chief executive had recently visited Mill View Court. The chief operating officer had also visited following an incident. Staff at Westlands said they had been visited by senior managers as part of a quality visit within the last twelve months, but could not recall who had visited. The psychiatric intensive care unit had been visited by the chief executive and trust chairman as part of an infection control 'walk around'

Good governance

Across all wards, we found that mandatory training was below the trust compliance target. Staff were not always receiving regular supervision and appraisals. We found staffing issues on almost all wards, with vacancy and absence rates above trust and national averages. Wards were often short staffed and there was a heavy reliance on bank and agency staff. Activities for patients on almost all of the wards were limited to weekdays.

We found evidence that the trust had not reviewed or updated the rapid tranquilisation policy. Staff understanding of what constituted rapid tranquilisation appeared limited. As a result, rapid tranquilisation was being undertaken, but the appropriate physical checks of patients were not being carried out.

There was limited evidence of review and learning from incidents.

Mental Health Act documentation was in order and staff knew that the central office for the Mental Health Act reviewed these. We did find that section 17 leave records were not signed by patients in most cases. We could not find documented evidence of risk assessments being undertaken prior to leave being granted.

There was a lack of clinical audit taking place across the service. Aside from monthly case file reviews on some wards, staff were unable to describe any other clinical audit.

Wards were monitored on a range of measures, including staffing levels, training, supervision and appraisals, bed occupancy, delayed discharges. We saw copies of performance reports, with areas of performance rated red, amber or green. There were a number of areas rated red and amber, indicating they were not in line with targets. We saw no actions identified to resolve performance issues.

There was an item on the organisational risk register in relation to staffing for acute adult mental health wards and the psychiatric intensive care unit. However, other risks, for example, the risk of patients absconding from Newbridges, were not on the organisational risk register. Charge nurses provided an overview of the process of escalating risk within the trust. Issues would be discussed within the operational risk management group. Staff were not assured that items escalated to operational risk management group were appropriately considered or actioned. There did not appear to be an effective process of communication in place after operational risk management group had met. We saw copies of two risk forms for Newbridges and Avondale. Both related to staffing issues. The outcome of these was unknown.

Leadership, morale and staff engagement

Sickness rates varied between wards. All wards with the exception of Avondale had sickness rates higher than the

Are services well-led?

Requires improvement

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trust and NHS average. Sickness levels were highest on Newbridges, at 14%, on Westlands 7%, on Mill View Court 6%, on the psychiatric intensive care unit 5% and Avondale 3%.

Staff told us that staff shortages impacted negatively in many ways. This included quality of patient care, high stress levels and low morale. Twelve patients we spoke to told us that they were aware that the wards were often short staffed and that this meant that they could not spend enough one to one time with staff.

Ward staff spoke very positively about the support and leadership of charge nurses on the wards. Charge nurses were passionate about their jobs and the wards they managed. They told us of feeling that they were 'micro-managed' in some elements of their job and that paperwork and report writing was sometimes prioritised over patient care. An example of this was the briefing reports that were required for any incidents with patients going absent without leave from the wards. Based on the current reporting procedure, a report is required within 24 hours of a patient going absent. Charge nurses were required to complete detailed reports for all episodes, including absences of only a few minutes. One report was requested for an informal patient who had not returned to the ward following home leave for Christmas. This was felt to be overly bureaucratic, to provide reassurance to senior managers, rather than allowing ward managers to make informed decisions based on risk and their level of experience.

Charge nurses told us they felt confident to raise issues with more senior managers, although things did not always change as a result.

Overall, staff reported that they felt well supported within their teams on the ward. Support from senior management was not perceived as being strong or effective.

Staff observed that there had been a lot of organisational change in the trust. This was perceived as being the creation of more senior management roles whilst staff in operational roles continued to struggle with low staffing numbers.

Commitment to quality improvement and innovation

At the time of the inspection, only one ward was fully accredited through the Royal College of Psychiatrists' accreditation for inpatient mental health services programme. Accreditation for inpatient mental health services programme is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Avondale was accredited until February 2019. Mill View court, Newbridges, Westlands and the psychiatric intensive care unit all had their accreditation for inpatient mental health services programme deferred.

All of the wards were participating in the 'safe wards' initiative.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Seclusion records documented extended periods of seclusion continuing, when observations indicated patients were settled Patients in seclusion were not allowed access to toilet facilities, including for personal hygiene needs. This was a breach of regulation 13 (4) (b) (c)

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients were not always involved in the development of their care plans. This was a breach of regulation 9 (2) (b)

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was a lack of physical health monitoring of patients, including during episodes of seclusion and after rapid tranquilisation. Essential medicines, including those for administration for resuscitation and after rapid tranquilisation were not present on all wards

This section is primarily information for the provider

Requirement notices

There were out of date medicines and oxygen on some of the wards.

This was a breach of regulation 12 (2) (a) (f) (g)