Southern Health NHS Foundation Trust

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

Inspection report

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Ratings

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

Our findings

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

Requires Improvement 

We rated the acute wards for adults of working age and Psychiatric Intensive Care Units core service as requires improvement because:

- Some areas that required improvement at the last inspection in October 2021 still needed to be improved. The trust therefore needed to consider the effectiveness of its internal governance arrangements so that potential issues could be identified and addressed promptly in future.
- Patients at Antelope House did not always have their physical health monitored as frequently as it should have been. We reported this to senior leaders who took immediate action to ensure staff understood their responsibilities in relation to monitoring the physical health of patients.
- The process for safely managing controlled drugs was not always followed by staff on Cherry and Juniper wards at Parklands Hospital.
- Staff did not always complete the necessary enhanced patient observations at Elmleigh.
- Patients at Elmleigh were not always promptly reviewed by a doctor on admission to the service and did not therefore have timely access to their required medicines. This posed a risk of missed doses.
- Improvements were needed to ensure staff had received the necessary mandatory training to safely fulfil their roles. At Elmleigh, most staff had not recently completed training in prevention and management of incidents of violence and aggression, during which they learn how to use safe restraint techniques.
- Some blanket restrictions were in place that unnecessarily restricted the comfort, privacy and dignity of patients. These included patients not being able to lock their bedroom doors, not having access to their own private lockable space, not being able to control the viewing panels in their bedroom doors and sometimes relying on staff to locate cups for them to access drinking water.
- Staff did not always receive regular supervision. Supervision compliance was particularly low at Elmleigh, Antelope House and on Juniper ward at Parklands Hospital. This posed a risk that staff would not receive the support they needed to fulfil their roles safely and confidently. However, a new project group had been set up to improve supervision compliance and review the style of staff supervision.
- Staff sickness rates at Elmleigh were increasing. Staff turnover rates varied across the core service according to hospital location. Turnover was highest at Antelope House. These factors meant that patients were less likely to receive continuity of care from staff who knew them and understood their needs and preferences.
- Although there had been progress made in relation to staff recruitment since the last inspection, there was still a significant number of vacant posts that needed to be recruited to.
- There was significant demand for beds. Abbey ward, a 10-bed female Psychiatric Intensive Care Unit (PICU), was closed at the time of the inspection. However, the trust had commissioned additional PICU beds in the independent sector to help manage this demand.

However;

Our findings

- Staff now clearly recorded when clinical equipment was last cleaned at Elmleigh and Antelope House.
- The process for monitoring the physical health of patients receiving high doses of antipsychotic medicines had been strengthened.
- Patients now had their own copies of care plans and had been involved in developing their own care plans and risk assessments.
- Staff felt more able to speak up about their concerns without fear of retribution. They also knew how to escalate concerns using the trust's freedom to speak up guardian.
- Staff now managed patient safety incidents well and staff received appropriate support if they were involved in an incident.

Is the service safe?

Requires Improvement 

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

Safe and clean care environments

All ward environments were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. All wards that were inspected were single sex.

Staff knew about the potential ligature anchor points on each ward and proactively managed these risks to keep patients safe. Ligature 'heat maps' were present in staff areas alerting all staff to the presence of environmental risks that needed to be managed to keep patients safe from potential harm.

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

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Staff completed audits to help check that staff were correctly following infection, prevention and control measures. These included monthly hand hygiene audits where the lead member of staff would observe staff hand hygiene practice for a variety of care activities and identify any improvements that were then communicated back to the staff team.

Seclusion rooms

Our findings

Seclusion rooms allowed clear observation, two-way communication and patients could easily observe the time. Toilet and washing facilities were located within the seclusion room. The trust was in the initial stages of considering how best to consider the layout of these facilities in future to afford as much privacy and dignity to patients as possible.

Clinic room and equipment

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

During the last inspection in October 2021 we identified that staff did not always record whether clinical equipment was kept clean at Elmleigh and Antelope House. At this inspection staff kept equipment clean and kept appropriate records to demonstrate when equipment was last cleaned.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

During the last inspection in October 2021 we identified that there were not always enough skilled and qualified staff rostered to work on each shift. At this inspection, the provider was continuing to take action to improve this. Across the wards that were inspected, 22% of registered nurse posts were vacant. The most significant registered nurse vacancies were on Juniper ward at Parklands hospital, where 53% of posts were vacant, and at Elmleigh, where 37% of posts were vacant. The provider was continuing to make progress with recruiting new staff to these posts and was working to recruit registered nurses in bulk from overseas. At the time of the inspection, 14 individuals had recently been appointed to work as registered nurses at Elmleigh. Once these staff came into post Elmleigh would have a surplus of registered nurses.

Seventeen percent of nursing support posts were vacant across the wards that were inspected. The provider was working hard to recruit permanent staff to these posts.

Vacant shifts were normally covered by regular agency staff, who worked frequently at the service and were familiar with systems, processes and the needs of individual patients. Between April and October 2022, 7710 registered nurse shifts across the wards that were inspected were covered by agency staff or staff doing additional bank shifts. There were 594 registered nurse shifts that went unfilled across the wards that were inspected. This challenge was most acute at Elmleigh and Cherry wards, where there were 156 and 103 unfilled registered nurse shifts respectively. Nine-thousand and sixty five nursing support worker shifts across the wards that were inspected were covered by agency staff or staff doing additional bank shifts, between April and October 2022. There were 1105 nursing support shifts that went unfilled across the wards that were inspected. This challenge was most acute at Elmleigh, where there had been 300 unfilled nursing support shifts during the same timeframe.

Bank and agency staff had a full induction and understood the service before starting their shift. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients also received regular one to one time with their named nurse. The service had enough staff on each shift to carry out physical interventions safely. Managers could adjust staffing levels according to the needs of patients.

Staff sickness rates across the wards we inspected averaged 7.4% between April and October 2022. There were no significant hotspots. However, sickness rates at Elmleigh had steadily increased from 6.4% in April 2022 to 11.7% in October 2022.

Our findings

Staff turnover rates varied according to hospital location. Turnover rates were highest at Antelope house, at an average of 27.3% between April and October 2022, followed by 16.6% at Parklands Hospital and 11.3% at Elmleigh during the same timeframe.

Medical staff

The service had appropriate medical cover during the day and out of hours and a doctor was always available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff kept up to date with their mandatory training. Training completion rates were above the provider's target in most locations for most courses and managers proactively alerted staff when they needed to update their training. The mandatory training programme was comprehensive and met the needs of patients and staff.

However, the number of staff eligible for immediate life support training had recently increased. This meant that lots of staff were booked to attend the training but had not yet completed it. Compliance for immediate life support training was below 70% on Cherry, Trinity and Saxon wards. Compliance for preventing and managing incidents of violence and aggression training, where staff learn how to use safe restraint techniques, was 35% at Elmleigh. On Juniper, Trinity and Saxon wards compliance was slightly below 70%. Leaders reported that additional sessions had been scheduled during the early part of 2023.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. **Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.**

Assessment of patient risk

During the last inspection in October 2021 we identified that patient risk assessments were not always kept up to date, particularly following risk events that patients had been involved in. At this inspection, all patients had a risk assessment in place that was reviewed regularly by staff. Initial risk assessments were completed promptly on admission to the service.

However, we identified one patient at Elmleigh who had an identified high risk of self-harm and had been given a bedroom with additional environmental risks compared with others on the ward. Although staff reported that a specific risk assessment around the use of this room had been completed, this could not be located by staff. We raised this at the time of the inspection and staff agreed to look into this promptly.

Management of patient risk

During the last inspection in October 2021 we identified that staff did not always follow the appropriate patient observation processes. At this inspection we identified that this still needed to be improved at Elmleigh because staff

did not always complete the agreed enhanced patient observations that had been agreed to help mitigate individual patient risks such as self-harm or suicide. We identified multiple occasions at Elmleigh where staff had not recorded that they had completed the required four observations per hour for patients whose risk management plan indicated that they needed to be observed by staff four times per hour to ensure they were safe.

During the last inspection in October 2021 we identified that staff did not always monitor individual patient's physical health using the National Early Warning Sign tool as frequently as was outlined in their care plan. At this inspection this continued to be a challenge. At Elmleigh staff did not always check the physical health of some patients as frequently as had been decided by the doctor. On Cherry ward at Parklands Hospital staff did not closely monitor the food and fluid intake of a patient whose food and fluid needed to be monitored regularly as was detailed in their care plan. We escalated these concerns during the inspection and leaders took immediate action to ensure staff understood their responsibilities in relation to monitoring the physical health of individual patients.

During the last inspection in October 2021 we identified that patients who received high-dose antipsychotic medicines did not have their physical health checked as frequently as was necessary to mitigate the risks of physical health deterioration caused by the patient's medicine. At this inspection this had improved and patients who received high-dose antipsychotic medicines had their physical health checked in line with their care plans. This meant that staff would be able to take prompt action if a patient's physical health started to deteriorate.

Staff followed the trust's policy in relation to searching patients and their bedrooms when necessary to keep them safe.

Some patients had unnecessary blanket restrictions placed upon them, which deprived them of their freedom more than was necessary to keep them safe from potential harm. For example, patients were not able to routinely lock their own bedroom doors and there was no lockable space within patient bedrooms. This meant that patients relied on staff to support them to lock any valuable possessions away in a communal lockable space. Bedroom doors had viewing panels so staff could safely observe patients when necessary. However, patients could not control these panels themselves. This meant that patients relied on staff to act on their behalf if they decided they wanted to close their viewing panel. During the inspection, patients at Elmleigh needed to ask staff to get cups for them to drink water from the tap.

Use of restrictive interventions

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Between April and October 2022 there were 572 episodes of restraint experienced by patients across the wards that were inspected. One-hundred and eleven of these were in the prone position. There were 260 occasions where patients received rapid tranquilisation medicines by intramuscular injection.

Cherry ward at Parklands Hospital was an outlier in that the use of restrictive interventions on this ward was significantly higher than other wards. During the same timeframe 267 episodes of restraint were experienced by patients, 43 in the prone position. Of the 260 instances where patients received rapid tranquilisation medicines by intramuscular injection, 160 of these occurred on cherry ward. Leaders explained that this was because one patient regularly experienced restrictive interventions as a way of managing potential self-harm incidents and medicine administration, and that this process featured in their care plan.

Our findings

However, most staff at Elmleigh had not received recent training in preventing and managing incidents of violence and aggression. This meant that they may not be familiar with best practice in relation to using de-escalation to avoid the need for restrictive interventions, and the safe techniques that should be used if restraint is required.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. There were family visiting rooms that could be used to facilitate children visiting.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke to could explain how to report a safeguarding concern. There was support provided by the trust if staff wanted to discuss possible safeguarding concerns.

Some patients at Antelope House reported feeling that staff locked them out of their bedrooms as a punitive measure. We raised this concern with senior leaders during the inspection, who stated that some patients had access to their bedrooms restricted by a maximum of one hour to manage particular risk behaviours, and that these plans were detailed within the patient care plan. Trust senior leaders also reported that there had been one known incident when a patient was locked out of their bedroom for longer than planned, which was currently subject to an investigation. Staff were also considering how to better involve patients in decisions to limit bedroom access.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical record, which were stored electronically.

Patient notes were comprehensive, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely, including archived paper records.

Medicines management

Staff did not always follow these systems to ensure controlled drugs were managed safely on Cherry and Juniper wards at Parklands Hospital. or to ensure patients had access to the medicines they needed when they were first admitted to the service.

Our findings

The process for safely managing controlled drugs on Juniper and Cherry wards at Parklands hospital needed to be strengthened. We identified four doses of controlled drugs that had been administered but not countersigned as required by guidance issued by the National Institute for Health and Care Excellence. The trust had reported having strengthened its controlled drugs management process following the previous inspection in October 2021, when we identified similar concerns in relation to the safe management of controlled drugs at Melbury Lodge.

We identified an incident at Elmleigh where a patient was not administered a dose of their medicine as required. Following the inspection, the trust commenced an investigation into this incident, which had arisen because the patient had been transferred to Elmleigh from another hospital without their medicine. There had been a delay to the clerking in process at Elmleigh and the patient had therefore missed a dose of their medicine.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence guidance. This had improved since the last inspection in October 2021, when we identified that patients who received high-doses of antipsychotic medicines did not always have the necessary enhanced physical health monitoring paperwork in place.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

During the last inspection in October 2021 we identified that serious incident investigation reports were not sufficiently detailed to help support staff to manage risks and learn from incidents to help prevent them re-occurring. During this inspection, we identified that the service managed patient safety incidents well. Staff recognised and reported incidents appropriately and managers investigated these, identifying appropriate lessons that could be learnt. We also identified that staff now felt better supported following serious incidents and had the opportunity to attend debrief sessions.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service. Managers told staff about learning from incidents in team meetings and supervision. Staff also shared learning from incidents at handovers.

Psychologists were working closely with ward staff on Trinity ward at Antelope House to upskill them in psychological intervention techniques to help manage future incidents. This was in response to staff reporting that they found it challenging to manage the frequency of self-harm incidents on the ward.

Our findings

Is the service effective?

Good 

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient and reviewed these assessments at regular intervals.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the wards.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery orientated. However, we identified that not all care plans were up to date at Antelope House.

Best practice in treatment and care

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

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

During the last inspection in October 2021 we identified that staff did not always review patients' physical health often enough. At this inspection, we told senior leaders at Antelope House about some incidents where patients had not been subject to physical health checks at the frequencies detailed in their care plans. Staff took immediate action to ensure each patients' physical health was monitored by staff at appropriate frequencies suitable to their individual physical health needs.

Improvements were made to the way staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Leaders took immediate action during the inspection to implement a new food and fluid recording template. This was because we identified a patient on Cherry ward at Parklands hospital whose food and fluid intake was not being monitored at the appropriate frequencies that had been documented in their care plan.

Staff made sure patients had access to physical health care, including specialists as required.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patient care plans included information about following a good diet and practicing good sleep hygiene.

Our findings

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Clinical outcomes were audited by ward managers each month. Staff used quality improvement methodology to make improvements to services at a local level. For example, 'snapshot' documents detailing each patient's key background information and interests had been developed to help temporary staff learn about each patient and tailor their support.

Skilled staff to deliver care

The ward teams included the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. We identified that patients could routinely access support from Occupational Therapists who supported them to develop their daily living skills in readiness for discharge. Occupational Therapists tailored their support to patients depending on how acutely unwell they were at the time and used things like music groups to start to engage patients in their programme of support. At Antelope House we identified that every patient received a psychology formulation and either received tailored one to one support or was able to access a range of different psychology focussed groups to help aid their recovery.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Staff reported feeling well supported through routine managerial supervision and annual appraisals. Seventy-five percent of all staff working across the wards that were inspected had received an appraisal during the last 12 months. There were some challenges in ensuring all staff had received monthly supervision. Below 70% of staff at Elmleigh, Antelope House and Juniper ward at Parklands Hospital had completed all their supervision sessions in the last 12 months, However, the trust did not currently capture accurate data on whether staff had received their required supervision and appraisal. A project group was in place which aimed to change the style of supervision staff received. The Head of Clinical Improvement led this project group and was ensuring training in resilience based clinical supervision was rolled out.

Managers made sure staff attended regular team meetings and ensured key information was made available to those who could not attend. Staff also met each day during safety huddle meetings.

Managers identified staff training needs and sourced specialist training courses.

Managers supported staff through periods of poor individual performance using goals and objectives and received support from trust human resource staff if needed.

Multi-disciplinary and interagency teamwork

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

Our findings

Staff held regular multidisciplinary meetings to discuss patients and improve their care and staff reported that they worked well together as a team.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Teams had excellent working relationships with teams external to the organisation. This included colleagues working in residential and community services, who staff worked closely with when planning patients' discharge. Staff from community mental health teams were invited to ward rounds and discharge planning meetings. We also observed that staff working in services that patients were planning to be discharged to were invited to spend significant time on the wards getting to know the patient and learning about their needs from trust staff ahead of their discharge.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act (MHA) and the MHA Code of Practice, and could describe the Code of Practice guiding principles. Ninety-six percent of staff had completed their training in the MHA across the wards that were inspected.

Staff had access to support and advice on implementing the MHA Code of Practice. Staff knew who their MHA administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity to consent to their treatment were automatically referred to the service. We saw posters on the ward advertising advocacy and staff told us that they would visit and speak to patients.

Staff explained to each patient their rights under the MHA in a way that they could understand and repeated this regularly. We saw that this was recorded in patients' records.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

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

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

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Our findings

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 (MCA) and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

During the last inspection in October 2021 we identified that reasons why patients lacked capacity to make particular decisions about their care and treatment were not routinely recorded. At this inspection this had improved. Where patients had been assessed as lacking capacity to make specific decisions about their care and treatment, the reasons why it was deemed they lacked capacity were clearly recorded. However, we identified one patient at Elmleigh who did not have a capacity assessment for a decision to impose dietary restrictions that was made in the patient's best interests. We escalated this during the inspection and immediate action was taken to assess the patient's capacity to make this decision.

Staff did not receive training in the MCA as part of the mandatory training programme run by the trust. However, staff we spoke with had a good understanding of the five principles of the Mental Capacity Act.

There was a clear policy on the MCA and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff told us they could speak to the MHA administrators for advice if they needed it.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Patients we spoke with were generally positive about their relationships with staff, and staff spoke about patients in a kind and compassionate way. They had a good understanding of the individual needs of patients and explained how they were working to meet these needs.

Our findings

Staff supported patients to understand and manage their own care treatment or condition. They directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff followed policy to keep patient information confidential.

The trust was currently considering whether its seclusion facilities afforded patients as much privacy and dignity as possible. Discussions amongst senior leaders were ongoing about potential adaptations that could be made to seclusion rooms to promote patients' privacy when they needed to use the toilet.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff would show patients around the ward and introduce them to the staff and other patients.

During the last inspection in October 2021 we identified that patients did not always have access to their care plans. At this inspection, this had improved. Patients now had copies of their own care plans and had been involved in developing their care plans and risk assessments.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Staff involved patients in decisions about the service when appropriate. For example, patients supported staff by joining staff recruitment interview panels.

Staff supported patients to make advanced decisions about their care and staff also signposted patients to advocates for support as and when needed.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff gave support to families or carers. Patients told us they could choose who was involved in their care and staff made sure any family members who patients wanted to be involved were kept up to date and involved in discussions about their care and treatment.

Staff helped families to give feedback on the service. There was a carers forum that allowed carers to share their experiences and give feedback to the trust.

Staff gave carers information on how to find the carer's assessment.

Our findings

Is the service responsive?

Requires Improvement 

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

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

During the last inspection in October 2021 we identified that there was significant pressure on the adult acute mental health inpatient pathway. At this inspection this continued to be a significant challenge for the service. The wards continued to operate at near maximum capacity and staff were under significant pressure to admit patients to the wards because of high demand.

During the last inspection in October 2021 there was only a small number of Psychiatric Intensive Care Unit (PICU) beds available across the trust, and staff reported that this meant patients receiving treatment on the acute wards were more acutely unwell than had been the case historically. At this inspection staff reported feeling that patients on the wards continued to be very acutely unwell and that there were still not many PICU beds available, which meant that staff needed to manage significant individual patient risks on the wards. For example, staff at Trinity ward at Antelope House in particular, reported finding their work environment incredibly challenging. Abbey ward at Antelope House, which is a female PICU ward, was closed at the time of the inspection. Staff on Trinity ward reported that this meant they needed to manage a significant number of patient self-harm incidents.

However, staff reviewed the length of stay and progress of patients to ensure they did not stay at the service longer than they needed to. Staff started planning patients' discharge from the point of admission to help minimise the occurrence of delayed discharge.

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

When patients went on leave there was always a bed available when they returned.

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

At Antelope House we observed good practice in relation to patients who required short periods of informal hospital stay to help stabilise them before discharge back to the community. Staff were sensitive to the fact some patients benefited from this type of admission and tried their hardest to facilitate these types of admission where appropriate.

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

Our findings

Discharge and transfers of care

Forty patients had experienced a delay to their discharge from the service between April and October 2022. This meant that leaders may not be ready to take action to reduce instances where patients remained in hospital longer than they needed to.

However, staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff supported patients when they were referred or transferred between services. Leaders reported that most known cases where transfers of care were delayed were caused by challenges in finding community residential placements for patients to be discharged to.

Facilities that promote comfort, dignity and privacy

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

Some blanket restrictions were in place that compromised patients' privacy, dignity and comfort. Patients were not routinely able to lock their own bedroom doors and there was no lockable space within patient bedrooms. This meant that patients relied on staff to support them to lock any valuable possessions away in a communal lockable space. Bedroom doors had viewing panels so staff could safely observe patients when necessary. However, patients could not control these panels themselves. This meant that patients relied on staff to act on their behalf if they decided they wanted to close their viewing panel. During the inspection, patients at Elmleigh needed to ask staff to get cups for them to drink water from the tap.

The trust was in the process of considering how to improve the privacy and dignity of patients who needed to be treated in seclusion rooms. Toilet and washing facilities were located within the main sleeping area of the seclusion rooms, which meant that patients were more openly exposed to staff observing that they remained safe whilst in seclusion. This also meant that floor areas often became wet and slippery.

Each patient had their own bedroom, which they could personalise.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

Each ward had an outside space that patients could access easily.

Patients' engagement with the wider community

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

Patients told us that there were activities on the wards, but they were not always supported off the ward due to staff shortages. This meant work and education opportunities in the community were limited.

Staff helped patients to stay in contact with families and carers. Staff supported patients to visit relatives and they could

use video call technology.

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

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. All wards were fully accessible to people with mobility needs.

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

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

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

Patients had access to spiritual, religious and cultural support. Multi-faith rooms were available on each hospital site and each ward was visited by a chaplain, who could access other religious leaders for patients as needed.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. All formal complaints that were made about the service between April and October 2022 were partially upheld. During this timeframe, all complaints were resolved within the trust and none were referred to the Parliamentary Health Service Ombudsman.

The service clearly displayed information about how to raise a concern in patient areas and staff knew how to handle complaints.

Patients received feedback from managers after the investigation into their complaint. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Requires Improvement ➔➔

Our rating of well-led stayed the same. We rated it as requires improvement.

Our findings

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They were visible in the service and approachable for patients and staff.

Staff reported feeling that leaders were now more approachable and receptive to receiving feedback about the service.

However, trust leaders reported feeling assured that the necessary improvements had been made to the service since the last inspection and that internal assurance processes were in place to help ensure improvements were sustained. Although some improvements had been made since the last inspection, we identified other areas that continued to require improvement that leaders had not been made aware of.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff we spoke with understood the trust's values and said that they felt the teams they worked in demonstrated these values in their day to day work. Staff told us they formed part of the trusts appraisal process and were used for setting team objectives.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

During the last inspection in October 2021 we identified that some staff did not feel confident to raise concerns because they worried managers might bully them. They also reported feeling that leaders would not act on any feedback they had. At this inspection we identified that this had improved, and that staff did feel more able to speak up about any concerns they had. Staff were also familiar with the trust's freedom to speak up arrangements if they wanted to raise concerns anonymously.

Governance

The trust had not successfully embedded and sustained all the improvements it planned to make following the last inspection of the Acute and PICU core service inspection in October 2021. Some of these areas that required improvement continued to put patients at risk of receiving unsafe care. For example, the gaps in staff completing physical health observations for patients, staff not correctly following safe controlled drugs management procedures on Cherry and Juniper wards at Parklands Hospital, gaps in ensuring patients capacity to consent to particular decisions had been assessed and challenges in delivering care and treatment to patients on acute wards who were particularly acutely unwell were all areas that had previously been identified as requiring improvement in October 2021, and continued to require improvement at this inspection. These issues featured on a trust action plan that senior leaders used for their own assurance and reported to the CQC that the necessary improvements had already been made.

Although these areas requiring improvement had not been flagged by the trust's own governance systems, a governance structure was in place that helped ensure key performance issues were fed up to trust senior leaders and vice versa through a series of clinical governance meetings. All staff attended team meetings where key learning and changes to practice were discussed.

Management of risk, issues and performance

Teams did not have access to all the information they needed to provide safe and effective care.

Our findings

Leaders were not able to access reliable data to demonstrate whether staff had received their required supervision and appraisal. This meant that leaders were not assured that all staff were receiving the necessary support to carry out their roles effectively. A supervision improvement project group was in place, which aimed to improve both the recording of supervision and appraisal compliance and the quality of supervision that was provided.

However, some other management information such as staff training compliance and safe staffing data was easily accessible to leaders. Ward managers told us they could submit items to the trust risk register. Items on the risk register and their action plans were discussed at governance meetings.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff told us that systems in place to collect and analyse data were efficient and did not add to their workload. The information collected was easily available to staff so they could understand their team's performance.

Staff told us that the current workload was due to staff shortages and current high acuity on the wards which meant they needed to manage and prevent significant incidents, was reducing the time they had available to develop quality improvement initiatives.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Ward managers engaged with other teams. Ward managers encouraged staff from community teams and other health and social care organisations to join relevant meetings and they could do this via video conferencing.

Learning, continuous improvement and innovation

The wards at Parklands had the Accreditation for Inpatient Mental Health Services (AIMS) which

recognises high standards of organisation and care. For a service to be given an AIMS, teams must meet national requirements from NICE and the Department of Health.

The trust has signed up to the national Mental Health Safety Improvement Programme (MHSIP) which has three aims, improving sexual safety, reducing restrictive practices and reducing self-harm and suicide.

Our findings

Areas for improvement

MUSTS

- The trust must ensure staff know how to follow the correct procedures for safely managing controlled drugs. **Regulation 12 (1) (2) (f)**
- The trust must ensure patients at Elmleigh are promptly reviewed by a doctor when they are admitted so they have access to their required medicines to minimise the risk of missed doses. **Regulation 12 (1) (2) (g)**
- The trust must ensure staff at Elmleigh complete observations of patients to mitigate their identified risks as outlined in each patient's care plan. **Regulation 12 (1) (2) (b)**
- The trust must reduce blanket restrictions that unnecessarily restrict the comfort, privacy and dignity of patients. **Regulation 13 (1) (2)**
- The trust must improve its governance assurance processes so that improvements can be embedded and sustained. **Regulation 17 (1) (2) (a)**
- The trust must ensure all staff can access appropriate support via regular supervision. **Regulation 18 (1) (2) (a)**

SHOULDS

- The trust should continue to ensure staff monitor patients' physical health and food and fluid intake at the frequencies recorded in their care plan.
- The trust should ensure staff continue to fulfil their responsibilities in relation to monitoring the physical health of patients as directed by doctors.
- The trust should continue with its work to recruit to staff vacancies to help ensure patients are always cared for by people with the appropriate skills and experience to meet their needs.
- The trust should continue its efforts to ensure all eligible staff are up to date with their training in preventing and managing incidents of violence and aggression, and immediate life support training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment