

Solent NHS 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) |
|-------------|---------------------------------|---------------------------------------|--------------------------------------|
| R1CF2       | The Orchards, St James Hospital | Maple ward                            | PO4 8LD                              |
| R1CF2       | The Orchards, St James Hospital | Hawthorn ward                         | PO4 8LD                              |

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

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as good because:

- Staff completed comprehensive and mostly person-centred assessments on admission. Physical health assessments took place on admission. There was good multidisciplinary team input in to patient care from a number of professionals across both wards.
- Mental Health Act documentation was complete across both wards. Staff adhered to the principles of the Code of Practice.
- Patients told us staff were caring. They had access to advocacy and information on their rights. We observed warm and professional actions on both wards despite the staff being under pressure.
- Patients could access information easily about treatment and support. Patients' needs were respected with regard to food, cultural and their spiritual needs. There was good access to interpreters

- Managers were available to staff. Despite the high acuity of patients and increased risks in previous months, staff had maintained fairly good morale and told us they felt supported by their leaders. The modern matron provided robust oversight of both wards and worked well with the ward managers.

However:

- We found potential ligature points in the enclosed gardens of both wards. These were not recorded on the ligature risk audit and were not always mitigated by staff.
- On Maple ward there was no clear segregation of male and female bedrooms. This was in breach of Department of Health guidance on mixed sex accommodation.
- Staff did not put a high priority on reporting safeguarding concerns on Maple ward (PICU). We saw examples of risks around safeguarding issues not transferred to care plans and found that there were not always clear management plans in place.

# Summary of findings

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

### Are services safe?

We rated safe as requires improvement because:

- There were potential ligature points not identified on the ligature risk assessment audit on both Hawthorn ward and Maple ward.
- On Maple ward there was no clear segregation of male and female bedrooms. This was in breach of Department of Health guidance on mixed sex accommodation. There were also issues regarding the privacy of females on Hawthorn.
- Staff on Maple ward were not care planning and managing risks around safeguarding vulnerable adults issues consistently or safely.
- Staff had not had the opportunity to complete mandatory training during periods when the wards had been unsettled recently.

However:

- Relational security in the ward environments was good.
- All patients had robust risk assessments which were reviewed regularly.
- There was safe storage and management of medicines. Staff followed appropriate best practice guidelines in administration of medicines. Staff regularly checked the emergency resuscitation equipment and monitored patient whereabouts.

Requires improvement



### Are services effective?

We rated effective as good because:

- Staff completed a comprehensive, person-centred assessment when each patient was admitted.
- Care plans were a good standard and contained some complex issues.
- There was good access to different professionals across both wards. Multidisciplinary meetings were held daily.
- Staff adhered to the Mental Health Act code of practice and its principles.

However:

- Actions from multidisciplinary meetings were not always clearly communicated to staff.

Good



# Summary of findings

## Are services caring?

We rated caring as good because:

- Staff were kind and spoke to patients with respect. They knew their individual needs well and despite ward pressures ensured their needs were met.
- Patients had access to an advocate if they needed one and information on rights was available.
- We observed warm interactions with patients. Staff demonstrated patience and professionalism.

However:

- not all care plans were created with the patient.

Good



## Are services responsive to people's needs?

We rated responsive as good because:

- Hawthorn ward had very good access to Maple ward in the event of needing to transfer a patient quickly to a psychiatric intensive care unit.
- Individual patient needs were respected around food, religious and their spiritual needs.
- There was a clear procedure so that patients could complain. Complaints were investigated and responded to appropriately.
- Patients had good access to ward activities on both wards.
- The wards were proactively addressing discharges which had previously been delayed prior to the appointment of permanent psychiatrists.

Good



## Are services well-led?

We rated well-led as good because:

- Morale on both wards was fairly high, despite recent levels of high risk and stress.
- Ward managers and senior managers were visible and staff told us they felt supported. Managers had been proactive in closing Maple ward during an intensely risky period.
- The staff teams on both wards were cohesive and provided mutual support. Staff appeared to treat each other with respect.

Good



# Summary of findings

## Information about the service

Solent NHS Trust has two wards, Hawthorn and Maple. Both of these are at The Orchards, St James' hospital in Portsmouth.

Hawthorn ward is an acute admissions ward for both men and women. There were 22 beds open at the time of inspection. Maple ward is a 10-bedded psychiatric intensive care unit (PICU) for both men and women.

The wards provide 24-hour care and have therapy services that deliver sessions and treatment from 9am to 5pm seven days a week.

The wards had previously been inspected on the 1 June 2014 and we had not issued any compliance actions for these wards.

## Our inspection team

The inspection was led by Joyce Frederick, head of hospital inspection, CQC.

The team comprised of two CQC Inspectors and two specialist advisors who were nurses with experience in working in these environments.

## Why we carried out this inspection

We inspected this core service as part of our on going 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 and sought feedback from patients, staff and carers.

During the inspection visit, the inspection team:

- Visited both of the wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients.

- Spoke with nine patients who were using the service.
- Spoke with the managers for each of the wards.
- Spoke with nine other staff members; including doctors, nurses and social workers
- Interviewed the modern matron with responsibility for these services.
- Spoke with the medical director responsible for these services.
- Attended and observed two hand-over meetings and two multi-disciplinary meetings.
- Looked at 25 care records of patients.
- Carried out a specific check of the medication management on Maple ward.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

# Summary of findings

## What people who use the provider's services say

We spoke with patients on both Hawthorn ward (acute) and Maple ward (PICU). Most gave us positive feedback

about their care and found the staff to be very caring and supportive. However, some also told us they felt the staff were too busy and didn't have enough time for regular one to one time with them.

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure potential ligature points in garden areas are on the ligature risk audit and mitigated safely.
- The provider must ensure patients with potential safeguarding issues are managed safely. There must be clear cohesive care plans reflecting these risks.
- The provider must ensure that the wards do not breach the Department of Health guidance on mixed sex accommodation.

### Action the provider **SHOULD** take to improve

- The provider should ensure the privacy of females in the corridor opposite the male lounge on Hawthorn ward.

- The provider should address known blind spots on the ward
- The provider should ensure actions are followed up to isolate heating in seclusion room from the central control.
- The provider should ensure security checks are thoroughly and consistently completed at all times.
- The provider should ensure all staff have the opportunity to complete mandatory training.
- The provider should ensure all patients are involved in decisions around their care and offered copies of their care plans.



Solent NHS 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 |
|---------------------------------------|---------------------------------|
| Maple ward                            | The Orchards, St James Hospital |
| Hawthorn ward                         | The Orchards, St James Hospital |

### Mental Health Act responsibilities

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

- Staff on both Hawthorn ward (acute) and Maple ward (PICU) adhered to the Mental Health Act (1983) and its code of practice.
- Staff we spoke with demonstrated a good understanding of the Mental Health Act and detention paperwork we looked at was of a very high standards.
- Staff ensured patients' rights under section 132 were read and repeated appropriately.

### Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff on both wards received mandatory Mental Capacity Act (MCA) training. However, we found staff we spoke with did not demonstrate a confident understanding of the MCA and its five statutory principles.
- There was a policy on the MCA and Deprivation of Liberty Safeguards that staff could access.
- MCA issues were generally discussed in the daily multidisciplinary meetings.

# 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 were clean, well lit, airy and open. There was good access to outdoor space with secure gardens on both wards. On Maple ward (the psychiatric intensive care unit or PICU) the door to the enclosed garden was open throughout the day.
- Maple ward had an airlock in the entrance which meant two doors could not be opened at the same time. Hawthorn was an open acute ward which meant ordinarily the doors would not be locked, and patients would have a key pass to their rooms.
- The team on Hawthorn ward had temporarily implemented the locked door policy, which is used when risk is considered higher than usual and staff need to ensure a higher level of security throughout the ward, so access to the garden was more limited. Patients admitted informally had to ask staff to leave the building. There were clear signs about this on doors.
- Both wards had blind spots (area which cannot be seen by line of sight) in the main corridors, bedroom corridors and in an alcove where a telephone used to be. There were no concave mirrors to mitigate these. However, we saw that staff carried out regular observations which were based on patients' individual risks. Staff were present out on the wards and demonstrated good relational security.
- There were many potential ligature points. A ligature is a fixed item to which a person could tie something for the purpose of self-strangulation. Staff had identified ligature risks inside the buildings and made a complete risk assessment that was up to date. However, on both wards we identified potential ligature points in the outdoor areas which had not been identified, one being in a blind spot. We raised this with the modern matron and the trust immediately who gave assurances that action would be taken.
- The trust then confirmed that this was remedied. A full assessment of ligature risks of outside areas was completed following our visit after we raised the concern with the trust.
- Clinic rooms were clean and tidy. They had an examination couch and resuscitation equipment was present and checked regularly. We reviewed records relating to these checks and they were all in date. This included emergency drugs. However, we did find some gaps in recording of fridge temperatures between November 2015 and April 2016. The effectiveness of some medications rely on them being stored between a range of specific temperatures. Staff could not demonstrate they had ensured this.
- All bedrooms had en-suite facilities. On Hawthorn ward male and female sleeping areas were segregated, with a separate lounge for females. However, a male lounge overlooked a female corridor. There was no privacy screening in place in this area. On Maple ward there was no clear segregation of male and female bedrooms at the time of our visit due to the gender mix in the PICU at the time. This was in breach of Department of Health guidance on mixed sex accommodation. However, we saw they had separated gender as much as physically possible under the circumstances. There was a notice in the office to remind staff about Department of Health same sex accommodation guidelines. Two bathrooms had been put out of use to prevent patients passing bedrooms of opposite gender.
- On Maple ward (the PICU), the seclusion room was at the end of one bedroom corridor. There was an observation hatch installed, concave mirrors in place allowing sight of blind spots within the room and into the bathroom. Bedding was safe and appropriate for patients in seclusion. Staff communicated through the hatch in the door. The room also had toilet and washing facilities and a clock in the annex which could be seen from inside the seclusion room.
- Ventilation in the seclusion room was only available through the window. Heating was centrally controlled

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for the entire ward and not isolated. We raised this at the time and saw this was on the risk register. The trust had an action plan to isolate the heating within the seclusion room.

- Staff followed infection control principles and there were signs about handwashing on both wards. Infection control was included in mandatory training. Eighty-eight percent of Maples ward staff and 86% of Hawthorn ward staff had completed this training.
- Patient-led assessments of the care environment (PLACE) score for St James hospital wards was 98.5% for cleanliness.
- All staff on both wards carried personal alarms. We saw these were tested and checked regularly.
- Staff completed environmental risk assessments regularly. On both wards this was carried out by the member of staff who was monitoring patient whereabouts. We looked at these records and saw they were completed. However, we were told of an incident where a patient had managed to get into the cupboard where patient security items were stored. We raised this at the time of our inspection. Staff were reminded to be more vigilant.

## Safe staffing

- At the time of our inspection staffing levels had significantly improved from recruitment difficulties that the wards had experienced in the previous 12 months. On Maple ward there were no vacancies. On Hawthorn ward sickness levels had improved with only one member of staff on long term sick, and one 0.7 WTE registered nurse vacancy.
- The service had recently appointed permanent medical staff which had resolved a previous reliance on locums. There were two consultant psychiatrists (one was off work sick at the time of inspection) and three junior doctors including a general practitioner trainee across both wards. There was sufficient medical cover out of hours.
- Both ward managers were able to adjust staffing levels to take account of the acuity of the patients. Both told us they felt confident they would be supported by the trust if they needed more staff to ensure safety.

- Staff were able to carry out regular one to one sessions with their patients. However recently this, including some activities, had been affected. Both wards had been very unsettled and staff needed to focus on safety as a priority. We saw this had been resolved at the time of our inspection.
- Staff received mandatory training. Average mandatory training rate for staff on Maples ward (the PICU) was 82% and on Hawthorn ward (the acute admission ward) was 83% of staff completing their training. Mandatory training included information governance, appraisals, corporate induction, diversity, fire safety, health and safety, infection control, manual handling, resuscitation, safeguarding children, safeguarding adults and Mental Capacity Act. Maples ward had achieved a score of 75% and over in all but fire safety, health and safety, safeguarding adults and Mental Capacity Act. Hawthorn ward had achieved the benchmark score of 75% in all but fire safety, safeguarding children, safeguarding adults and Mental Capacity Act.
- Staff on both wards also received prevention and management of violence and aggression (PMVA) training. However, this was not mandatory. We looked at training records and saw all staff on both wards were appropriately trained in managing physical violence and aggression.
- We raised training issues with managers. The majority of the mandatory training is completed as an online course. The staff who had not been able to complete all their training told us this was due to prioritising safety on the wards rather than being in the office. We were assured that these staff would be given the time and opportunity to complete their mandatory training now that the wards were less unsettled.
- Hawthorn ward (the acute admission ward) did not practice seclusion. On Maple ward (the PICU) there had been five episodes of seclusion in the previous six months up to January 2016. None of these were long term. We requested up to date data from the trust however did not receive this.
- There was one person in seclusion at the time of our inspection. We found staff followed the seclusion policy and documented checks appropriately. We observed

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staff across both sites used good de-escalation techniques if a patient became upset, agitated or if the patient displayed behaviour that could pose a risk to themselves or others.

- The trust reported that restraint was used on three occasions on Hawthorn ward in the period between August and January 2016. None of these were prone (face down) restraint. There were 17 uses of restraint on Maple ward in the same period. Three of these were prone restraint. We looked at these and saw correct restraint procedures had been followed and documented.

## Assessing and managing risk to patients and staff

- We looked at 25 care records during our inspection of Maple ward and Hawthorn ward.
- We found staff had completed thorough risk assessments for each patient on admission. These were updated regularly and the majority of care plans reflected the risks. However, we identified two records where risk assessments identified potential safeguarding and visitation risks. These were not carried over into the care plans and actions had not been taken. For example, referral to or discussion with the local authority safeguarding adults team. We raised this immediately with the trust who assured us this would be made a priority.
- Staff were supposed to have received mandatory training in safeguarding adults and children. However, safeguarding adults training compliance on Maple ward was 68% and we were concerned at a lack of good understanding of what constituted potential abuse. We saw procedural flowcharts clearly displayed in the staff office. However we were concerned that not all appropriate referrals were made in a timely manner on Maple ward.
- We found two examples of vulnerable adults on Maple ward where a referral to the safeguarding adults' team should have taken place. We raised this with the team at the time as it impacted on the current safety of a patient. In addition the care plan did not reflect this risk or clear actions to be taken on the ward to protect the individual.
- There were appropriate restrictions identified for individual patients. Where a behavioural plan had

identified the need for restrictions for one patient, this had been agreed with members of the multi-disciplinary team (in particular the psychologist) and documented in the care plan.

- Both wards had a list of property that was monitored and controlled. This included alcohol and illicit substances (including psycho-active substances known as legal highs), lighters or matches, stimulant drinks, weapons, glass, and razors. Patients were allowed mobile phones and cameras when staff were sure the patient understood expectations around the safe and confidential use of mobile phones with cameras and laptops.
- Staff ensured belongings were searched in their bedrooms on admission and following periods of leave. Any controlled items were placed in an allocated locker in the patient store cupboard.
- We looked at records of patients who had received rapid tranquilisation medication. We saw staff had followed appropriate guidance from the national institute for health and social care excellence.
- Staff managed medicines on Hawthorn ward well. Staff carried out clinic room and emergency equipment checks.
- On Maple ward medicines management was also good overall. The clinic room was a suitable size, was locked and had lockable cupboards. Emergency drugs, including adrenaline for anaphylaxis and naloxone were present, in date and checked three times a week. The medicines stock list was provided by the trust pharmacy at St Mary's hospital. Medicines were administered from the stable door of the medicines room, dependent on the patient situation.
- The controlled drug cupboard was small but adequate. Controlled drug requisitions were fully completed and the register matched the stock checks. Staff recorded illicit drugs in the controlled drugs register which were then either disposed of or removed by the police.
- A pharmacist and a technician visited Maple ward every day Monday to Friday to provide support.
- There were clear and safe procedures for visitors to the wards. Adults were not permitted in the ward areas

# Are services safe?

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without prior agreement with the staff. People under the age of 18 years were not allowed onto the wards. There were two family rooms in order to facilitate visitors of all ages, one for each ward.

## Track record on safety

- The trust reported two serious incidents requiring investigation (SIRI), both in 2015. They involved unexpected death and an incident involving a family member. The latter issue was around discharge arrangements and safeguarding.
- We looked at the root cause analysis investigation (RCA) and it clearly outlined the actions taken and lessons to be learned. They also identified that duty of candour had been fulfilled by the trust.
- Solent NHS trust commissioned an independent review of its incidents and serious incidents process in February 2016. It found overall the trust to be committed to creating an open culture and shared learning.

## Reporting incidents and learning from when things go wrong

- The trust had an electronic incident reporting system. Staff we spoke with knew how to report incidents. All staff had access to the system.
- There were a total of 60 incidents reported over the previous six months. Maples ward reported 25 incidents and Hawthorn ward reported 35 incidents.

- We reviewed a sample of incident records across the two wards and found that information was correct and up to date, that incidents were reviewed and actions carried out. For example self-harm, security and violence and aggression incidents were all clearly documented.
- Incidents were discussed at team meetings and actions agreed. We looked at a sample of team meeting minutes and saw incidents were discussed and learning needs addressed.
- On Hawthorn ward learning points from incidents were displayed on posters in the staff area each month. For example, in January and April there were prompts to remember to follow the standard format for clinical assessment before a patient took section 17 leave. There was also a prompt to remind staff to ensure consent to share information with carers was sought and documented, and a reminder for staff to request medical reviews of physical wellbeing. These posters also identified and congratulated staff on improvements made following learning from incidents. For example, audits demonstrated an improvement in risk assessments and reviews.
- There had been a number of incidents of violence and aggression in the two weeks before the inspection, as both wards were under pressure. We saw staff received debriefing and support following these incidents. Staff told us they felt supported and able to discuss incidents with their peers and manager.

# Are services effective?

Good 

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

## Our findings

### Assessment of needs and planning of care

- There were 18 patients on Hawthorn ward (out of 24 beds) and seven on Maple ward (out of 10 beds) at the time of our inspection. We reviewed all 25 care records and found that assessment processes were comprehensive and carried out in a timely manner.
- We saw care plans were of a good standard, were holistic and recovery orientated and included some complex interventions. However, not all care plans contained identified risks around safeguarding, or had been completed with the patient. We were assured work was in progress with regard to this.
- Both wards undertook physical health assessments of all patients on admission. If physical health issues changed this was documented and a review took place. This was led by nursing staff.
- All records were held electronically. All staff had access to his with the exception of agency staff. All access to the system was password protected.

### Best practice in treatment and care

- Care plans across both wards reflected use of guidance from the national institute for health and social care excellence. We saw also that prescribing of medication followed the appropriate guidelines.
- All care records we looked at across both sites had up to date health of the nation outcome scales (HoNOS) scores in place. We were told that HoNOS information was reviewed in the multidisciplinary meetings. We observed a multidisciplinary meeting which showed this was the case.
- Patients across both wards had access to good activities through a therapy team. Both wards had an activities co-ordinator. Patients also had access to evidence based psychological therapies.

### Skilled staff to deliver care

- Both wards had access to the same multidisciplinary team. This included healthcare support workers, psychologists, occupational therapists, consultant psychiatrists, staff grade doctors, staff nurses and activity co-ordinators. There had been a long period

where the wards did not have consistent medical cover and relied on several locum doctors who were not familiar with the ward. However, the multidisciplinary team was almost fully staffed at the time of our visit.

- From January 2016 supervision was offered on both wards and completed on a monthly basis. Staff told us they were happy with the support and supervision offered, however it had been difficult to attend formal supervision over the previous two months due to heightened acuity and busyness of the wards.
- Most of the staff on both wards had received annual appraisals before our inspection. These were usually carried out at the beginning of the year. At the time of our inspection 85% of Maple ward staff had completed appraisals compared to 97% of Hawthorn ward. All remaining staff appraisals were planned and booked.

### Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings took place daily. They consisted of staff from both wards, and included the modern matron, consultant psychiatrist, bed manager, staff nurse. These meetings also included a benefits advisor, substance misuse lead and occupational therapist. The meetings lasted for an hour each day.
- Individual patients were discussed and actions taken from the meeting. This could have been around family interactions, barriers to discharge, patient diagnosis, benefits issues and risks.
- We observed that there were some disagreements and challenges from individual professionals about elements of patient care and treatment during this meeting. We were concerned that we could not see clear actions being transferred back to the respective wards following the meeting. However, when we looked at the meeting notes and handover documentation this information was consistent.
- Staff carried out three handovers per day to ensure all relevant patient information was communicated effectively to the team. We observed two of these and saw good discussion of risks and individual actions.
- We saw that there was a range of activities available. These included coffee mornings, use of the gym, relaxation, art, mindfulness and distress tolerance. There was an activities board opposite the main nursing office.



# Are services effective?

Good 

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

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

- Staff we spoke with had a good understanding of the Mental Health Act, code of Practice and its guiding principles.
- All of the seven patients on Maple ward (PICU) were detained under the Mental Health Act. All paperwork relating to their detention was stored safely and completed correctly. Staff had presented their section 132 rights and re-presented as appropriate.
- On Hawthorn ward 14 out of 18 patients were detained under the Mental Health Act. We specifically looked at the records for seven of the detained patients and found good quality recording of their detention paperwork.
- Section 17 leave had clear review dates and conditions for leave. Copies of the forms had been given to the patients. Risk assessments were completed and documented on electronic records.
- All consent to treatment was completed with clear expiry dates. There was appropriate use of Section 62 (emergency treatment) and there was good evidence of discussion between patient and their responsible clinician.

- There was good evidence of managers meetings and Mental Health Act tribunal hearings happening and we saw clear and concise tribunal reports.
- Patients had access to independent Mental Health Act advocacy, and there was an automatic referral made unless the patient refused.

## Good practice in applying the Mental Capacity Act

- Staff we spoke with on Maple ward were not confident in the Mental Capacity Act and its five principles and they were not able to demonstrate a good understanding of the principles.
- On Hawthorn ward, staff were more confident in describing the Mental Capacity Act and its principles. However, they told us they still lacked confidence in carrying out specific assessments. If a Mental capacity Act assessment needed to take place this would be discussed through the multidisciplinary team.
- We found that all patients had their capacity to consent to treatment assessed and documented clearly in their care records.

# 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

- Staff were caring and supportive towards patients. We witnessed good interactions between staff and patients that were kind and professional.
- Staff and managers that we spoke with demonstrated a good knowledge of the patients they were caring for.
- Patients that we spoke with told us they generally felt respected and listened to, and that staff were kind to them. Some patients told us they would like to have more time with staff but they appear to be busy all the time on the ward. They also told us they had been offered advocacy on admission and knew how to access advocacy services. One patient told us they could not access advocacy services through the ward as they were informal.
- Staff held community meetings on the wards each morning. This gave patients opportunity to discuss concerns and request items or activities.

### The involvement of people in the care that they receive

- Staff told us they provided welcome packs for both wards were provided to patients when they were admitted. These packs were informative and easy to read, with information around admission, information sharing and confidentiality, visiting the wards, property management, assessments, medication times, staff roles and responsibilities, mealtimes and ward activities. There was also clear information about patients' rights regarding treatment, contact with friends and family, involvement of friends and family in their care and treatment and details on carer support. However, two patients told us they had not received a welcome pack until two weeks prior to our inspection.
- We saw that staff had documented patient participation in their care planning and risk assessment process in most of the records. The patients we spoke with told us they knew what was in their care plan. However we could not see evidence that all care plans had been discussed with the patient, or that they had been offered a copy.



# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

- The average bed occupancy between August and January 2016 was 80% on Maple ward (the psychiatric intensive care unit or PICU) and 72% on Hawthorn ward (the acute admission ward). However, over the previous three months this had increased to an average of 95% occupancy for both wards.
- Although Hawthorn ward had 24 beds, the trust had closed four beds to admissions due to the increased acuity of patients being admitted and staff recruitment problems. However, increased pressure on beds had resulted in the need to reopen two more beds. At the time of our inspection there were 18 patients admitted, two of whom were on home leave.
- Maple ward had also been closed to admissions for the week before our inspection, because of risk management issues. The ward was very busy and there had been several incidents of violence and aggression. However, at the time of our inspection this had been resolved.
- We saw that there was always a bed available for when patients returned from leave.
- Maple ward and Hawthorn ward were within the same building and directly accessible by adjoining corridors. This meant patients who required transfer to the PICU could easily and safely transferred.
- Between January and June 2016 there had been seven delayed discharges from Maple ward. On Hawthorn ward the number of delayed discharges was much higher. There had been 69 delayed discharges on Hawthorn ward. The reasons for this, were in part were patients being made homeless during admission and care co-ordinators needed to find accommodation. However, the main reason was the lack of consistent medical cover. During this period, patient progress was delayed thereby delaying discharge planning. Since the appointment of permanent psychiatrists, the wards were actively addressing the discharge process and remaining delayed discharges.

### The facilities promote recovery, comfort, dignity and confidentiality

- We saw staff had good access to interpreters. Staff gave us several examples of where an interpreter had been required, and had been quickly accessed for both patient and family member.
- There was good access to outside space. Both wards had enclosed gardens and informal patients could leave the ward at any time. The enclosed garden on Maple ward was open at all times. However, Hawthorn ward had implemented their locked door policy temporarily, which meant patients could access the garden for a limited period of time each hour.
- Patients had access to hot drinks and snacks 24 hours a day.

### Meeting the needs of all people who use the service

- Both wards had good disabled access. There were two disabled bedrooms (one male and one female). Both wards had ample space for wheelchair access.
- There was access to information leaflets about treatment and advice. These were available if requested in different languages and formats.
- Both wards also had visible information about local services, patient's rights and complaints procedures.
- Patients told us the food was of good quality and menus were varied. Individual needs were respected regarding food, religious and spiritual requirements.

### Listening to and learning from concerns and complaints

- All staff we spoke with were able to tell us how they would handle complaints made by patients and visitors.
- All patients we spoke with knew how to complain. The complaints process was displayed on the wards.
- The service had received 23 complaints in total. All complaints were investigated and complainant responded by chief executive officer with the outcome. Twelve out of the 23 complaints related to clinical treatment and delay.

# Are services responsive to people's needs?

Good 

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

- Complaints were discussed in team meetings and we saw discussions had taken place about improvements to be made, particularly around the process of discharging patients.

# Are services well-led?

Good 

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

## Our findings

### Vision and values

- Staff were able to tell us the trust's values and vision. There were posters around both wards to ensure the trusts values and visions were kept in staff's awareness.
- Staff knew who the senior managers were and we were told they had recently visited the ward and spoken to staff.

### Good governance

- Systems to ensure that staff received mandatory training were mostly robust. However the majority of staff training was e-learning. This meant that staff were required to leave the ward environment to complete the training. Both wards had been unsettled so staff had not achieved completion in all mandatory training.
- Despite how busy the ward was, staff had completed appraisals and told us they were happy with the level of supervision they received. Where formal supervision had not been possible, informal support was available.
- Systems were mostly good for ensuring that environmental risks were assessed and mitigated. However, we found that in some areas this had not been fully completed.
- Staff participated in ward based clinical audits. For example care records, care plans and the clinic room.

- Data on performance was regularly collected through a range of audits. Ward managers completed 72 hour audits on key performance indicators regarding patients' admissions.

### Leadership, morale and staff engagement

- Both Maple ward ( the psychiatric intensive care unit) and Hawthorn ward (the acute admission ward) had experienced and knowledgeable managers. Staff we spoke with told us they were supportive and listened when a concern was raised.
- There was a modern matron responsible for both wards. They demonstrated good knowledge and understanding of the wards and acted quickly when we raised concerns about the environment and safeguarding issues. Staff told us the matron was supportive and available for them to speak to.
- Managers had acted to ensure that the ward was as safe as possible during a risky time. They had closed Maple ward to admissions to support the staff and to provided a period of time for the ward to settle.
- We had a good sense of team working and mutual support within the staff. They spoke of each other with respect and warmth.

### Commitment to quality improvement and innovation

- We were not given any examples of quality improvement and innovation by the trust during our inspection.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulation

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

Potential ligature points in the outside area of both Maple ward and Hawthorn ward had not been identified or acted upon.

Staff were not ensuring patients with potential or actual safeguarding issues were managed safely in the ward environment. Care plans around these risks were not cohesive.

This is a breach of regulation 12 (1) (2) (b) (d)

#### Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

On Maple ward there was no clear segregation of male and female bedrooms in one corridor. This was in breach of Department of Health guidance on mixed sex accommodation.

This is a breach of regulation 10 (2) (a)