Good

Tees, Esk and Wear Valleys NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXF3L	Roseberry Park	Bransdale Ward Bedale Ward Overdale Ward Stockdale Ward Bilsdale Ward	TS4 3BW
RX3NH	Sandwell Park	Lincoln Ward	TS24 8LL
RX3MM	West Park Hospital	Cedar Ward Elm Ward Maple Ward	DL2 2TS
RX3CL	Lanchester Road Hospital	Tunstall Ward Farnham Ward	DH1 5RD
RX3LK	Cross Lane Hospital	Danby Ward	YO12 6DN

Summary of findings

		Esk Ward	
RX3XX	Friarage Hospital Mental Health Unit	Ward 15	DL6 1JG
RX3YE	Briary Unit	Cedar Ward	HG2 7SX
RX34L	Peppermill Court	Ebor Ward Minster Ward	YO31 8SS

This report describes our judgement of the quality of care provided within this core service by Tees, Esk and Wear Valleys NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

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

Summary of findings

Ratings

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

Overall rating for the service	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

Contents

Summary of findings

Overall summary

We have rated acute inpatient wards and psychiatric intensive care units as good overall because:

- Following our inspection in January 2015, we rated the services as 'good' for Effective, Caring, Responsive and Well led. Since that inspection, we have received no information that would cause us to re-inspect these key questions or change the ratings.

However:

- Our rating of the Safe key question remains requires improvement. This was because staff did not always adhere to trust policy in documenting and monitoring the seclusion of patients. Staff did not always observe and monitor patients following rapid tranquilisation in line with trust policy. Some staff were not up to date with their mandatory training in life support and rapid tranquilisation. Staff did not consistently document their management of patients' risk. Six wards did not have a current environmental risk assessment survey in place. One ward was unable to control temperatures in certain areas and the environment of one ward did not enable staff to fully maintain the privacy and dignity of the patient.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The trust had not reviewed their environmental risk assessment surveys annually in line with their policy, on six of the wards we visited. Ligature risks and blind spots existed on all wards and not all staff could identify these, or identify how they mitigated for them.
- On some wards, staff secluded patients without documenting this as seclusion. This was not in line with trust policy or the Mental Health Act code of practice. Where staff had documented episodes of seclusion, nursing and medical reviews did not always take place at the required frequency and seclusion care plans were not always individualised.
- Staff did not always monitor and record physical observations of patients following the administration of rapid tranquilisation. Staff were not up to date with their training in rapid tranquilisation.
- Some staff were not up to date with their training in immediate life support. National guidance states that staff should be trained annually in immediate life support if they deliver or are involved in rapid tranquilisation, physical restraint, and seclusion.
- The staffing establishment levels on the psychiatric intensive care units did not meet national guidance requirements. Some of the acute wards did not routinely meet the trust's staffing establishment levels of two qualified staff per day shift.
- Staff did not always fully complete the patient's safety summary tool to reflect current risk. Patients did not always have an intervention plan in place to manage their identified risks. Where blanket restrictions were in place, the trust did not have a system for reviewing these.
- Staff were unable to control the temperature of the de-escalation room on Cedar Ward at the Briary Unit. The temperature could only be altered by logging a call with the maintenance provider's helpdesk. The limitations of the environment on Ward 15 at The Friarage Hospital mental health unit meant that staff could not always ensure patient's privacy and dignity was maintained.

However:

- All patients we spoke with reported they felt safe on the acute wards and psychiatric intensive care units.

Summary of findings

- The wards had good medicines management practices in place and staff worked closely with pharmacists to ensure prescribing was safe and in line with national guidance.
- Staff were trained in the management of violence and aggression. The wards were focussed on de-escalation techniques to minimise the number of incidents on the wards.
- The trust had procedures in place to investigate incidents and share lessons learned with staff. Staff could identify where changes in practice had been made following these reviews.

Are services effective?
Since the previous inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

Good

Are services caring?
Since the previous inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

Good

Are services responsive to people's needs?
Since the previous inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

Good

Are services well-led?
Since the previous inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

Good

Summary of findings

Information about the service

Tees, Esk and Wear Valleys NHS Foundation Trust describe themselves as a specialist mental health and learning disabilities trust. Their mission statement is to improve peoples' lives by minimising the impact of mental ill health or a learning disability. Their vision is to be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations. These services are provided for people who are admitted informally and patients who are detained under the Mental Health Act, along with those cared for in the community.

The trust is registered with the CQC to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury
- Accommodation for persons who require nursing or personal care
- Personal care
- Diagnostic and screening procedures

The trust has wards for adults of working age in four geographical areas; York and Selby; North Yorkshire; Teesside; Durham and Darlington. These services comprise 15 acute inpatient wards and two psychiatric intensive care units located in eight hospital locations:

Roseberry Park in Middlesbrough, Teesside:

- Bedale Ward is a 10 bed mixed gender psychiatric intensive care unit and had 10 patients at the time of inspection
- Bilsdale Ward is a 14 bed male acute inpatient ward and had seven patients at the time of inspection
- Bransdale Ward is a 14 bed female acute inpatient ward and had 14 patients at the time of inspection
- Overdale Ward is an 18 bed female acute inpatient ward and had 18 patients at the time of inspection
- Stockdale Ward is an 18 bed male acute inpatient ward and had 13 patients at the time of inspection

Sandwell Park in Hartlepool ,Teesside:

- Lincoln Ward is a 20 bed mixed gender acute inpatient ward and had 18 patients at the time of inspection

West Park Hospital in Darlington:

- Cedar Ward is a 10 bed mixed gender psychiatric intensive care unit and had 10 patients at the time of inspection
- Elm Ward is a 20 bed mixed gender acute inpatient ward and had 20 patients at the time of inspection
- Maple Ward is a 20 bed mixed gender acute inpatient ward and had 19 patients at the time of inspection

Lanchester Road Hospital in Durham:

- Farnham Ward is a 20 bed male acute inpatient ward and had 17 patients at the time of inspection
- Tunstall Ward is a 20 bed female acute inpatient ward and had 19 patients at the time of inspection

Cross Lane Hospital in Scarborough, North Yorkshire:

- Danby Ward is an 11 bed male acute inpatient ward and had eight patients at the time of inspection
- Esk Ward is an 11 bed female acute inpatient ward and had 11 patients at the time of inspection

Friarage Hospital Mental Health Unit in Northallerton, North Yorkshire:

- Ward 15 is a 14 bed mixed gender acute inpatient ward and had 12 patients at the time of inspection

The Briary Unit in Harrogate District Hospital, North Yorkshire:

- Cedar Ward is an 18 bed mixed gender acute inpatient ward and had 16 patients at the time of inspection

Peppermill Court in York:

- Ebor Ward is a 12 bed female acute inpatient ward and had 12 patients at the time of inspection

Summary of findings

- Minster Ward is a 12 bed male acute inpatient ward and had 11 patients at the time of inspection

Tees, Esk and Wear Valleys NHS Foundation Trust have been inspected on a number of occasions by the CQC since registration. The acute inpatient wards and psychiatric intensive care units have previously been inspected by the CQC at all locations, with the exception of Peppermill Court. Peppermill Court opened in October 2016 and this is the location's first inspection by the CQC.

We have also carried out regular Mental Health Act monitoring visits to the acute inpatient wards and psychiatric intensive care units at all locations, with the exception of Peppermill Court. Where we found issues relating to the application of the Mental Health Act on these monitoring visits, the trust has provided an action statement telling us how they would adhere to the Mental Health Act and the code of practice.

Our inspection team

Team Leader: Jayne Lightfoot, Inspector, Care Quality Commission.

The team that inspected acute wards for adults of working age and psychiatric intensive care units comprised eight inspectors, one inspection manager and four mental health nurses.

Why we carried out this inspection

We undertook this unannounced inspection to find out whether Tees, Esk and Wear Valleys NHS Foundation Trust had made improvements to their acute inpatient wards for adults of working age and psychiatric intensive care units since our last comprehensive inspection of the trust in January 2015.

When we last inspected the trust in January 2015, we rated acute wards for adults of working age and psychiatric intensive care units as good overall. We rated the core service as requires improvement for Safe, good for Effective, good for Caring, good for Responsive and good for Well-led.

Following this inspection we told the trust that it must take the following actions to improve acute inpatient wards for adults of working age and psychiatric intensive care units:

- The provider must ensure that current risks have an associated intervention plan which clearly outlines measures to manage the risk with the input of the patient.
- The provider must ensure that all staff on Ward 15 are given clear guidance on the management of ligature risks and current risks posed by patients and make the appropriate adjustment to observation levels.
- The provider must ensure an effective quality monitoring system is in place for joint working with partner NHS trusts where services are provided from.

We also told the trust that it should take the following actions to improve:

- The provider should ensure that privacy and dignity is maximised in the bed bays of ward 15 and Cedar at the Briary Unit.
- The provider should ensure that the recording of any episodes of seclusion are documented separately from daily notes and are comprehensive.
- The provider should review blanket restrictions across all acute and PICU to ensure that the risks are assessed on an individual basis.
- The provider should ensure that patients are involved in writing care plans and this is evidenced in PARIS.
- The provider should ensure systems are in place to capture the shortfalls in the Mental Health Act and Mental Capacity Act as identified by the MHA reviewers at Ward 15, Cedar at the Briary Unit, Overdale and Stockdale.

Summary of findings

- The provider should ensure that the patient survey on the Patient Experience Tracker (PET) can be understood and provide meaningful data.
- The provider should ensure that ward managers are aware of local risk registers and how to contribute to them.

We issued the trust with two requirement notices that affected acute wards for adults of working age and psychiatric intensive care units. These related to:

Regulation 9 (3) (a) HSCA (RA) Regulations 2014 Person-centred care.

Regulation 12 (2) (i) HSCA (RA) Regulations 2014 Safe care and treatment.

How we carried out this inspection

We asked the following question of the service:

- is it safe?

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

During the inspection visit, the inspection team:

- visited all 17 of the wards at the eight hospital sites and looked at the quality of the ward environment
- spoke with 41 patients who were using the service and 20 carers or families of patients
- spoke with the managers or acting managers for each of the wards
- spoke with 71 other staff members; including doctors and nurses, pharmacists and housekeepers
- attended and observed five report out meetings.
- looked at the treatment records of 78 patients
- looked at most patient's prescription charts
- looked at the records of five episodes of seclusion and the enhanced observation records of eight patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients reported they felt safe on the acute wards and psychiatric intensive care units. They felt staff treated them with respect, helped them, and were caring towards them. Patients reported the environments were clean and well maintained. Patients reported they found the trust's no smoking policy difficult, but that staff offered them smoking cessation and support. Patients reported they could access staff when they needed to.

Carers we spoke to said that staff were helpful and supportive. They reported feeling involved in the patient's care and being invited to meetings. Staff were friendly and welcoming when they visited the ward and they felt safe on their visits. Carers stated the wards were always clean and well maintained.

Good practice

As part of the Tees, Esk and Wear Valleys NHS Foundation Trust quality improvement system the acute wards and psychiatric intensive care units followed the principles of the 'Virginia Mason Production System', an evidence based way of working originating from Seattle USA. Part of this included a meeting on each ward called a 'report out'. This was attended by staff in the morning on a daily basis where each patient was discussed using a visual control board looking at current care and risk factors and tasks were set for staff for the day. We attended five 'report out' meetings and found these to be an effective system for ensuring care was patient focussed, therapeutic and informed by risk.

Summary of findings

The trust operated a psychiatric intensive care unit pathway called a 'PICU pyramid'. There was an admission flow chart in place based around the principles of a care planning approach to engage patients in the management of their behaviours. This aimed to ensure admission to the psychiatric intensive care unit was a last resort. The plans incorporated measures to proactively encourage patients to move back to the acute ward even before transfer had taken place.

The trust had also adopted the "safe wards" model, which recommended techniques that staff could use to achieve a calm environment and reduce the use of restraint, rapid tranquilisation, and seclusion.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that each ward has a suicide prevention environmental survey reviewed annually in line with their policy. Staff must be aware of ligature risks and blind spots on the wards and be able to identify how they mitigate for these.
- The provider must ensure that all staff are up to date with their mandatory training in immediate life support as a minimum standard for staff that deliver, or are involved in, rapid tranquilisation, physical restraint, and seclusion.
- The provider must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with trust policy. The provider must ensure staff are trained in rapid tranquilisation.
- The provider must ensure that staff recognise when patients are being secluded in rooms other than a seclusion room in line with their policy. Staff must record this as seclusion and ensure patients are afforded the procedural safeguards of the Mental Health Act code of practice in these instances. The provider should ensure that the recording of any episodes of seclusion is in line with trust policy and complies with the Mental Health Act code of practice.

Action the provider SHOULD take to improve

- The provider should ensure that all equipment in the resuscitation bags is in date and ready to use in an emergency.
- The provider should ensure that staffing establishment levels on the psychiatric intensive care units comply with national guidance.
- The provider should ensure that the wards meet their agreed staffing establishment levels of qualified staff
- The provider should ensure that staff are trained in the use of the safety summary tool and that it reflects current patient risk. Staff should ensure intervention plans are in place and fully documented to manage identified risks and are individual to each patient.
- The provider should ensure there is a clear process in place to review blanket restrictions.
- The provider should ensure they maximise the privacy and dignity of patients on Ward 15 at The Friarage Hospital mental health unit.
- The provider should ensure they are able to control the temperature in the de-escalation room on Cedar Ward at The Briary Unit.

Tees, Esk and Wear Valleys NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Roseberry Park	Bransdale Ward Bedale Ward Overdale Ward Stockdale Ward Bilsdale Ward
Sandwell Park	Lincoln Ward
West Park Hospital	Cedar Ward Elm Ward Maple Ward
Lanchester Road Hospital	Tunstall Ward Farnham Ward
Cross Lane Hospital	Danby Ward Esk Ward
Friarage Hospital Mental Health Unit	Ward 15
Briary Unit	Cedar Ward
Peppermill Court	Ebor Ward Minster Ward

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983.

We did not inspect the provider's compliance in relation to the Mental Health Act as part of this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not inspect the provider's compliance in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards as part of this inspection.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

The inspection team undertook a tour of each of the 17 ward environments. The wards were modern and purpose built, with the exception of Cedar Ward at the Briary Unit and Ward 15 at the Friarage Hospital mental health unit. These wards were located in older medical wards on acute hospital sites and consequently the environments had limitations. At the time of the previous inspection, the trust had plans in place to relocate these wards, but this had not yet happened. During the previous inspection, the height of the fence in the courtyard on Cedar ward at West Park Hospital did not comply with the requirements for a psychiatric intensive care unit. The trust had corrected this to the required standard in May 2016. The trust had deemed the seclusion room on Cedar ward at West Park Hospital not fit for purpose. They had de-commissioned it so it was no longer in use. The staff would transfer any patients requiring seclusion to Roseberry Park.

We found each ward to be clean, with furnishings in good order and evidence of maintenance work being carried out when required. The majority of patient bedrooms were ensuite. Housekeeping staff had cleaning schedules and documented the completion of these daily. Staff kept cleaning equipment in a locked cupboard and used a cleaning trolley when on the wards. We observed staff on every ward adhering to infection control principles, including handwashing. Clinical staff conducted audits of cleanliness and infection control and prevention to ensure that people who used the service and staff were protected against the risks of infection.

The patient led assessment of the care environment scores for condition, appearance and maintenance and cleanliness in 2016 were as follows:

- Roseberry Park scored for 92% condition, appearance and maintenance and 98% for cleanliness
- Sandwell Park scored 93% for condition, appearance and maintenance and 99% for cleanliness
- West Park Hospital scored 92% for condition, appearance and maintenance and 99% for cleanliness
- Lanchester Road Hospital scored 93% for condition, appearance and maintenance and94% for cleanliness
- Cross Lane Hospital scored 95% for condition, appearance and maintenance and 97% for cleanliness
- Friarage Hospital Mental Health Unit scored 86% for condition, appearance and maintenance and 97% for cleanliness

Ligature points and blind spots were evident at each location we visited. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. In the previous inspection in 2015, we found that the beds on Ward 15 and Cedar Ward at the Briary Unit were a ligature risk. These had since been replaced with static anti-ligature beds. A blind spot prevented staff from observing all parts of the ward clearly and mirrors had been installed in some wards where observation was restricted. Closed circuit television was in use in most wards in the communal areas only.

The majority of staff could identify what mitigating factors the ward had in place to ensure the safety of patients. These included the use of risk assessments, staff engagement with, and observation of patients and the position of staff on the ward. However, on Bransdale ward, not all staff we spoke with could identify the observation blind spots and not all staff on Esk ward could explain how they mitigated for ligature points.

In the previous inspection in 2015, we stated that the provider must ensure that all staff on Ward 15 are given clear guidance on the management of ligature risks and current risks posed by patients and make the appropriate adjustment to observation levels. We also raised concerns that suspended ceilings on Ward 15 at the Friarage Hospital mental health unit could pose a ligature risk. Suspended ceilings were still in place in some areas of the ward. These were identified on the environmental audit. However, this had been due for review on 18 June 2016 and had not been reviewed at the time of inspection. Staff we spoke with did not identify ligature risks on the ward other than a handrail in one bathroom.

Requires improvement

Are services safe?

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

The trust undertook annual suicide prevention environmental surveys. At the time of inspection, evidence provided by the trust showed these were out of date on seven wards as follows:

- Bedale Ward due for review April 2015
- Cedar Ward at the Briary Unit due for review January 2016
- Danby Ward due for review May 2016
- Esk Ward due for review May 2016
- Bransdale Ward due for review May 2016
- Ward 15 at the Friarage Hospital mental health unit due for review June 2016
- Elm Ward due for review August 2016

Following the inspection, the trust stated that the environmental survey had been conducted on Elm Ward in July 2016 and was therefore in date.

The trust had five mixed sex acute wards and two mixed sex psychiatric intensive care units. Each of these complied with the guidance on same sex accommodation. All sleeping and bathroom areas were segregated, and patients did not have to walk through an area occupied by another sex to reach toilets or bathrooms. The wards provided separate male and female toilets and bathrooms and women-only day rooms. Some of the mixed gender wards had 'swing beds' which allowed gender segregated areas to be opened up if there were more males or females admitted. These were managed well and allowed an effective system for managing admissions.

In the previous inspection in 2015, we recommended that the provider should ensure that privacy and dignity is maximised in the bed bays of Ward 15 and Cedar Ward at the Briary Unit. At the time of this inspection, Ward 15 still had two single sex bedrooms, each of which contained bed bays for four patients. The ward also had two single bedrooms. Cedar Ward had a bay for four patients, a bay for three patients and two single rooms on both the male and female areas of the ward. The bedrooms were clearly marked with the gender of the patient; however, this was not ideal to ensure the privacy and dignity of the patients. The trust had made changes to the environment on Ward 15 by partitioning beds to provide extra privacy to patients in the shared bays. The old curtains had been removed and replaced with curtains that were thicker and hung from anti-ligature tracks. An issue remained that the bay bedroom windows did not provide reflective glass to ensure patients privacy from the outside where other acute hospital wards and offices were located. Curtains were in place across the windows however; these were thin and did not always obscure the view into the ward bedrooms.

We inspected the clinic room on each ward and found all of them to be clean, tidy and in good order. Staff had access to equipment for physical health monitoring, including weight scales and blood pressure machines. Where examination couches were in place they were clean and ready for use. Staff cleaned and checked the clinic equipment routinely and ensured it was calibrated in line with manufacturer's recommendations, with stickers in place to evidence this. Staff checked and documented fridge temperatures daily. However, on Bransdale Ward between the 1 August and 1 September 2016, staff had failed to record fridge temperatures on five days.

On all wards, staff undertook and documented the required checks of emergency drugs and resuscitation equipment. However, at Peppermill Court some of the stock in the resuscitation bag was out of date or missing. The forceps had been missing since 26 October, the red and green disposable nasopharyngeal airway tubes were not sealed and had expired on 17 October and the oxygen was only ¼ full.

The trust had a seclusion room on Bedale Ward at Roseberry Park, Ward 15 at the Friarage Hospital mental health unit in Northallerton, and one shared by Danby Ward and Esk Ward at Cross Lane Hospital. At the time of the previous inspection in 2015, the seclusion room on Ward 15 was found to contain blind spots where patients could remain out of sight of observing staff. The trust had since moved the seclusion facilities to a different room. All three seclusion rooms were fit for purpose and complied with the requirements set out within the Mental Health Act code of practice. The seclusion rooms allowed clear observation of patients and two-way communication between staff and patients. The rooms provided patients with access to toilet facilities and a clock to orient themselves to day and time. The seclusion rooms that were not occupied were clean and ready for use in an emergency.

The trust had a de-escalation room on Cedar Ward at West Park hospital, Cedar Ward at the Briary unit, on Ward 15 at the Friarage Hospital mental health unit, and one shared by

Requires improvement

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Danby Ward and Esk Ward at Cross Lane Hospital. These low stimulus rooms were used to enable a patient to enter an area where they could de-escalate from their current emotional state, in a safe place to reduce the chance of physical injury to both themselves and others around them.

In the previous inspection, we found that on Cedar Ward at the Briary Unit the temperatures were variable with some rooms being very warm and others very cold. At the time of this inspection, the de-escalation room on Cedar Ward at the Briary Unit was very warm. Staff were unable to control the temperature as the radiator and controls were covered by wooden casings. The manager stated they were aware of this issue and that temperature control was an issue with the age of the building. On the day of inspection at Peppermill court, the wards were very cold. The heating system was not working correctly and this was being repaired while we were there. When we returned the following week, this was working.

All wards had alarm systems in place. Staff wore personal alarms that sounded if assistance was needed and either the alarm or panels in the corridors identified the location of the incident. At each location, staff were designated as responders on each shift. Staff reported no concerns about the alarm system. The majority of wards also had patient call systems in non-communal areas, such as patient bedrooms and shared bathrooms.

Safe staffing

The trust did not use a recognised tool to establish staffing levels on the wards. All acute wards had an expected staffing establishment level of two qualified and two unqualified staff during the day, and two qualified and one unqualified staff during the night. Some wards operated two twelve hour shifts from 7:30 – 8:00, while others also had a combination of twilight shits and middle shifts with varying start and finish times. Lincoln Ward at Sandwell Park did have the budget for an additional staff member every day above the staffing establishment. This ward had twenty beds and was in a small hospital with only one other ward. The manager felt the additional staff member was crucial to maintaining the safety of staff and patients on the ward, and senior managers supported this.

If a ward had placed one patient on enhanced observation levels, it was expected the staff would absorb that within their current staffing establishment. If the ward placed any additional patients on enhanced observation levels, one additional staff member would be sought for every additional patient. Some staff did report they felt the staffing establishment levels were too low, particularly if all beds on the ward were occupied and patients support needs were high.

Managers felt supported to increase staffing levels as required. At Roseberry Park, a duty manager had oversight of the staffing levels each day and met with the ward managers daily to review the needs of each ward and allocate staff as required. Staff from wards at Roseberry Park could be allocated to support Lincoln Ward at Sandwell Park if required. A similar meeting took place daily at West Park Hospital where managers from each ward met to review staffing, patient risk and bed availability.

Bedale Ward, the psychiatric intensive care unit at Roseberry Park had the same staffing establishment as the acute wards. Cedar Ward, the psychiatric intensive care unit at West Park had two qualified and three unqualified during the day, and one qualified and four unqualified during the night. The National Association of Psychiatric and Intensive Care and Low Secure Units stated that staffing levels should be at least one third higher on psychiatric intensive care units and a third of the nursing staff on each shift should be qualified.

The trust had undertaken a trust wide review of psychiatric intensive care units and seclusion facilities in August 2016. The paper that was produced recommended that staffing establishments in both trust psychiatric intensive care units should be increased to meet guidance. This was not in place at the time of inspection. Staff on the psychiatric intensive care units stated that they always operated at above establishment levels due to the complex nature of the patient group and those on enhanced observations. We reviewed the previous three weeks rota and found that all shifts were above staffing establishment levels.

The wards rarely used agency staff but did use bank staff and overtime to respond to planned and unplanned staff absence. Agency staff were being used at Peppermill Court whilst recruitment of permanent staff was ongoing. The service had been open five weeks at the time of inspection. Staff reported agency staff were fully inducted to the ward and they aimed for consistency in using the same people.

Managers felt they could access bank staff easily when planning ahead, but found it harder to respond to

Requires improvement

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absences at short notice. Managers aimed for consistency in using regular bank staff and often used staff from their own ward who also worked bank shifts. All bank staff underwent a trust induction checklist on the ward and a shadow shift before they were allocated shifts. Staff had a safe staffing escalation process to follow if they had concerns about staffing levels on their ward. Staff and patients reported no concerns about the use of bank staff on most of the wards across the trust.

We reviewed staffing rotas for each ward and found that shifts were rarely short on staff numbers. However, at Roseberry Park not all shifts met the staffing establishment levels of two qualified staff during the day. Between 5 September and 30 October, wards had used an unqualified staff member in place of a qualified staff member for four shifts on Bilsdale Ward, five on Overdale Ward, 11 shifts on Stockdale Ward, and 27 shifts on Bransdale Ward. Staff reported this was also an issue at times on Ward 15 at the Friarage Hospital mental health unit and on Esk Ward at Cross Lane Hospital.

The manager on Bransdale Ward reported that the staffing issues during this period had been escalated to senior managers and placed on the risk register. The ward had a number of staff absent, some on longer-term absence, and four unqualified staff had left in the previous four months. The manager was using permanent and experienced unqualified staff to supplement the required qualified staff member.

Staff at Cross Lane Hospital reported that recruitment and retention of qualified staff had been difficult. The central bank was based at Roseberry Park, so many qualified staff were not local to the area. They had recently created their own bank and had recruited eight qualified nurses for this. The trust did have a rolling recruitment advert for nurses in York. In the week following inspection, a recruitment event was held in York and interviews were held in Middlesbrough, both of which resulted in a number of qualified nurses being recruited. Managers reported that the trust responded quickly to vacancies and they were supported to access bank staff to fill gaps in staffing levels.

Absence levels varied across the wards. The trust monitored this through the production of weekly purposeful and productive inpatient services reports against a target of 4.5%. As at 31 October, absence levels ranged from 0% on Danby Ward to 10% on Overdale Ward and Stockdale Ward.

Staff were available to assist in the event of an incident such as restraint, where a minimum of three staff would be required, arrangements were in place with neighbouring wards to provide an alarm call response to assist. At Roseberry Park, we observed staff across the hospital site respond to incidents when the alarm was activated. Patients reported they felt safe on the acute wards.

All wards followed the trust supportive engagement and observations policy and patients reported they could usually access support from staff when required. Staff on most wards reported that patient leave from hospital was rarely cancelled due to staffing. Staff discussed patients leave status in the morning report out meetings. Some wards had access to support time recovery workers who would assist in facilitating escorted leave. However, staff on Elm Ward and Maple Ward did state that cancellation of leave could be an issue at times due to staffing levels.

All of the acute wards and psychiatric intensive care units had good access to medical cover. Each ward had at least one consultant and one junior doctor allocated for their patients, with most wards having more than this. The doctors worked closely with the other staff on the ward and were involved in the daily report out meeting. An out of hours rota was in place at each hospital site. At Roseberry Park, the junior doctor on call was resident on site and staff did not raise any concerns about access to medical cover out of hours. In some of the more remote areas, the trust paid for doctors to stay in accommodation close to the hospital when they were on call. At West Park Hospital, some staff said it could sometimes take up to an hour for the on call doctor to attend, although others said the response time was usually within 20 minutes. At Lanchester Road Hospital, staff reported no concerns in accessing medical staff out of hours.

The trust had seven core mandatory training courses that staff were required to attend. These included equality and diversity, fire, infection control, health and safety and information governance. Compliance levels with these seven courses ranged from 95% on Lincoln Ward to 80% on Farnham Ward. The trust had a target for attendance at mandatory training of 95%, however, the majority of wards were meeting the standard national training target for the NHS of 75%. The only wards below this were Ebor Ward and Minster Ward, which was attributed to the unit being open five weeks and a number of the staff undertaking their induction and training at the time of inspection.

Requires improvement

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Staff were supported by managers to access training. The trust monitored compliance with mandatory training via an electronic staff record. This was discussed in monthly management meetings and in supervision with staff.

Staff had additional training depending on their role. The compliance rates for qualified nurses being trained in management of violence and aggression were all above the NHS standard of 75%. The compliance rates for medicines management were below this standard on two wards, Cedar Ward with 60% and Ward 15 with 63%. The majority of wards were 100% complaint with care programme approach training.

Training was available for staff in basic and immediate life support. At the time of inspection, compliance with resuscitation training per ward was as follows:

- Roseberry Park Hospital – Bedale Ward 39%, Overdale Ward 55%, Stockdale Ward 53%, Bilsdale Ward 60%, Bransdale Ward 29%
- Sandwell Park Hospital – Lincoln ward 60%
- West Park Hospital – Cedar Ward 54%, Elm Ward 44%, Maple Ward 59%
- Lanchester Road Hospital – Tunstall Ward 85%, Farnham Ward 65%
- Cross Lane Hospital – Esk Ward 14%, Danby Ward 38%
- Friarage Hospital mental health unit – Ward 15 35%
- Cedar Ward at the Briary unit – 62%
- Peppermill Court – Ebor Ward 76%, Minster Ward 76%

The Resuscitation Council (UK) stated that staff had to attend this training annually and recommended immediate life support as a minimum standard for staff that deliver or are involved in rapid tranquilisation, physical restraint, and seclusion. The trust had recognised that the number of staff who required this training did not correlate with the availability of training courses they were able to access. Compliance levels with this training were decreasing each month. At the clinical leaders and operational directors meeting in June 2016, they identified that only 50% of staff across the trust were in date with their resus training. This was placed on the trust risk register. An agreed action was to match the training to job plans and identify three groups of staff; those that required cardio-pulmonary resuscitation training, those, which required basic life support training, and those, which required immediate life support training. The trust had planned 96 training courses to run between November 2016 and March 2017, with 1140 available spaces for staff.

Assessing and managing risk to patients and staff

Staff were required to complete an initial assessment on each patient following admission, which incorporated a care plan and a risk assessment. Tees, Esk and Wear Valleys NHS Foundation Trust used a two stage narrative risk assessment tool that was developed within the trust, called a safety summary. Stage one was a summary of past and present safety issues and stage two identified safety and harm minimisation plans for the patient. Following admission, staff would complete the safety summary narrative risk assessment. This would be reviewed following the 72 hour formulation meeting, and then at weekly intervals for each patient or following any change in behaviour or presentation. Staff stated they used intervention plans to record how they were managing patient risk.

The safety summary tool had recently been updated and staff were unsure of which parts they were required to complete and when. The majority of staff we spoke to had not yet received training in the completion of the updated document, however guidance was available for staff on the trust internal system.

We reviewed the care records of 78 patients. All records had a safety summary in place, with evidence of reviews taking place. However, some of the reviews in the safety summary document were not dated, making it difficult to ascertain whether the frequency of reviews was in line with the trust policy. Lack of dates was also an issue in identifying how soon after admission each patient's risk assessment had been completed. Staff did not complete the safety summary in a consistent format across the wards. We found that information on the safety summary was not always reflected in the intervention plans.

In the previous inspection in 2015, we reported that there were not always intervention plans in place for patients identified risks. We reviewed intervention plans during this inspection and found that this was still a concern. Although all patients had intervention plans, these were often generic and did not always reflect the individual risk and need of the patient. We saw a document that contained a number of generic intervention plans that staff were to personalise for patients. However, this did not always

Requires improvement

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happen. Staff stated intervention plans were written for the patient, not in conjunction with them, but they would show them to the patient and amend if required following discussion.

All wards had a named nurse audit that staff on night shift would complete. This included a review of risk assessments and intervention plans. On Lincoln Ward at Sandwell Park, the managers had developed an additional audit tool. We reviewed recent audits of 15 files over the two months prior to inspection. The risk assessment was up to date in 13 of the files. However, the audit had identified that only one of those had evidence that the intervention plan had been developed collaboratively with the patient. In six files, staff had not developed separate intervention plans for separate risks, and in seven of those files, the risk summary did not inform the intervention plan.

We found that risk information was not always updated following incidents. On Bedale Ward, all five records we reviewed had completed stage one and stage two safety summaries. However, three of those did not reflect incidents that had occurred on the ward or detail in the intervention plans how those risks were being managed. These included patients who had assaulted other patients and patients who had absconded.

We saw that some patients had positive behaviour support plans in place. These had often been compiled with psychology staff and were done collaboratively with the patient. Where these plans were in place, they clearly detailed the individual risks and needs of the patient and plans to manage these risks.

We observed staff discussing patient risk in detail in all five report out meetings that we attended. Staff then documented these discussions about risk in patient case notes. Staff on the wards knew the risks of their patients and the plans in place to manage them. However, it was not clear to see this from every patient's risk assessment or intervention plan.

All wards ensured informal patients were aware of their rights to leave. Staff would assess the presentation of patients prior to them leaving the ward for their own safety, and some patients had leave intervention plans. Notices were in place at exit doors and the informal patients we spoke to were aware of their rights. Staff did not routinely search patients or their rooms on any of the acute wards. Staff reported searching would only take place in response to concerns about the safety of the patients and if they suspected risk items had been brought onto the ward. If staff completed a room search, they submitted an incident report on this through the electronic reporting system. Staff understood the supportive engagement and observation policy. We reviewed the records of eight patients on enhanced observation levels. The records showed that staff were documenting the correct observation levels for these patients and recording observations at the required intervals.

There were some blanket restrictions in place across the acute wards and psychiatric intensive care units. A blanket restriction is a rule laid down by mental health services, which applies to everybody, or to all detained patients, regardless of their particular needs and circumstances. All locations had a list of items that patients and visitors were not allowed to bring on to the wards. These items were large amounts of cash, razors, lighters and matches, alcohol and illicit substances and sharp objects and glass articles. In the previous inspection in 2015, we reported that blanket restrictions were in place about mobile phones and internet access. At the time of this inspection, access to mobile phone and the internet was risk assessed on an individual basis.

Some wards had rooms that were only to be accessed with staff supervision and were therefore locked to patients at all other times, regardless of individual risk. These varied across each ward and hospital site. On Maple Ward at West Park, this included the assisted bathroom and the activities of daily living kitchen. The laundry room remained open on Maple Ward, however on Tunstall Ward at Lanchester Road Hospital the laundry room remained locked. This was also the case on a number of other wards across the hospital locations, such as Danby Ward at Cross Lane Hospital. Staff we spoke with were unaware of any trust review process for blanket restrictions. They were therefore not undertaking regular reviews of blanket restrictions in place on their wards.

Access to outdoor space had to be supervised on some wards. On Cedar Ward at West Park, this was because the height of the fence did not meet the required standards and this was detailed on the risk register. The trust had plans to replace this fence. In the previous inspection in 2015, we identified that the gates to the garden at The Friarage Hospital mental health unit were not locked and this had resulted in a number of patients going absent

Requires improvement

Are services safe?

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without leave through the garden area. At the time of this inspection, the gates were locked and there had been no recent incidents of this nature. Patients only had access to the outside area on Ward 15 at the Friarage and Cedar Ward at the Briary unit with staff supervision, as it was away from the ward itself.

All wards had access to rooms off the main ward area that could enable children to visit patients. Staff were required to attend mandatory training in safeguarding children level one and safeguarding adults. Compliance rates with this training varied across the wards and the majority were achieving the trust target of 95%, or at least the NHS standard of 75%. A safeguarding policy was available on the trust intranet for staff to follow if they had a safeguarding concern. Staff had a good knowledge of what constitutes abuse and how they would raise a safeguarding alert. We saw evidence that staff raised safeguarding concerns in response to identified risks. Staff reported good links with the trust safeguarding team and the local authorities.

Across the acute wards and psychiatric intensive care units there had been 93 incidents of restraint in August, 16 of which had been in the prone position and 24 in the supine position. Prone restraint means that the patient is laid in the face-down position, while supine restraint means that the patient is laid in the face-up position. There had been 123 incidents of restraint in September, 23 of which had been in the prone position and 24 in the supine position. The psychiatric intensive care unit, Bedale Ward had the most incidents of restraint, with a total of 30 in August and 33 in September.

All staff were trained in the management of violence and aggression, which encouraged verbal de-escalation with physical restraint to be used only if other techniques had failed. Staff used a 'talking tips' method to provide reassurance to patients and de-escalate situations. Some wards also had a grounding box, which provided a number of sensory items that could be used to distract patients and calm down a potentially aggressive situation. Where patients had positive behaviour support plans in place, they clearly identified primary, secondary, and tertiary strategies for managing behaviour that challenged. On Bedale Ward, all patients were required to have an intervention plan that detailed how staff would manage violent and aggressive behaviour, and these were in place in the records we reviewed.

The trust had a policy in place on the use of rapid tranquilisation. The administration of medicines using the parenteral route (usually intramuscular), possibly under restraint, to maintain safety is termed rapid tranquillisation. Where medication was prescribed for this purpose, it was done so in line with National Institute for Health and Care Excellence Guidance. The trust reported 68 instances of rapid tranquilisation across the 17 acute wards and psychiatric intensive care units between September and October 2016. The highest levels of use were on the psychiatric intensive care units, with Bedale Ward reporting 12 instances and Cedar Ward at West Park Hospital reporting 15 instances. The compliance rates for qualified nurses in rapid tranquilisation ranged from 0% on Cedar Ward at the Briary Unit to 64% on Elm Ward. The only ward meeting the NHS standard target and the trust target was Stockdale Ward with 100%.

We observed staff encouraging patients to take their medication orally and staff explained they would always try this option first. When staff had administered rapid tranquilisation, there were clear guidelines within the trust policy to be followed about the post administration monitoring of the patient. Staff used the early warning score system to observe and monitor patients' vital physiological signs. A score is allocated based on the results of these measurements, which determines the frequency with which the patient needs to be monitored. We reviewed the early warning score and case notes of seven instances when patients had been administered intramuscular rapid tranquilisation in the previous month, across four of the wards. In four of those instances, which involved one patient on Stockdale Ward and one patient on Bedale Ward, staff had not completed the required observations.

The trust had completed a recent audit of rapid tranquilisation at Roseberry Park. This found that the early warning score had not been calculated as required. In 33 instances reviewed, only 21% of electronic records included a full set of baseline physiological observations or valid reasons why this was not the case. Only 24% of electronic records included a full set of post rapid tranquilisation physiological observations or valid reasons why this was not the case. The audit also found that only 30% of patients had baseline respiration rate recorded in their electronic record; and only 27% had the same documented in their electronic record post rapid tranquilisation. In response to this, the heads of nursing

had completed a root cause analysis. Following this, the trust had developed an action plan which involved reviewing the rapid tranquilisation and early warning scores policies and procedures. The trust also planned to provide staff with additional training, produce a quick reference guide to the use of rapid tranquilisation, and to develop a poster to promote the use of the early warning scores.

The trust had a policy on seclusion and segregation. Seclusion is defined as 'the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.' (Paragraph 26.103 Mental Health Act code of practice 2015). The policy states that 'if a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded. It is essential that they are afforded the procedural safeguards of the code.'

The trust did not have an effective system in place for monitoring the recording of all episodes of seclusion. We found that where wards had access to a de-escalation room, patients could be taken there in restraint and prevented from leaving. On Danby Ward and Esk Ward at Cross Lane Hospital, staff we spoke with stated that some patients chose to go to the de-escalation room while others were taken there by staff. Staff reported patients were not shut in the room and could use the ensuite bathroom. We were told patients would have a member of staff with them and if they wanted to leave, they would need to be assessed by a qualified nurse prior to leaving. This was to determine whether the patient was safe to return to the ward. One staff member said there was not a lot of difference between seclusion in the seclusion room and de-escalation in the de-escalation room. However, this was not documented as seclusion and therefore patients were not afforded the procedural safeguards of the code in these instances.

On Ward 15 at the Friarage Hospital mental health unit, people we spoke with identified that the de-escalation room was used as therapeutic intervention where staff would engage with patients. The trust policy stated that 'in contrast to seclusion and segregation, there are methods of managing challenging behaviour such as "de-escalation in a low stimulus environment," and these methods should be used as part of a therapeutic management/treatment plan.' However, some staff also identified that there were episodes where patients were being encouraged to go to or were taken to this room and prevented from leaving. Staff stated they would judge the situation if patients asked to leave. Again, this was not being recorded as seclusion.

For the months of September and October 2016, there had been 13 episodes of seclusion on Bedale ward that involved six patients. There were two episodes of seclusion involving two patients on Danby Ward and Esk Ward. There had been no episodes of seclusion on Ward 15 at the Friarage Hospital mental health unit. The trust had one seclusion room on Bedale Ward at Roseberry Park that was to be used by all 15 acute wards and the other psychiatric intensive care unit. If this seclusion room were in use, patients would be secluded in one of the seclusion rooms on the forensic inpatient wards at Roseberry Park. Peppermill Court in York did not have a de-escalation room or a seclusion room. If a patient required seclusion, they would need to be transferred 50 miles to Roseberry Park. Staff raised this as a concern. Peppermill Court had been open five weeks at the time of inspection and the trust were considering the need for de-escalation facilities at this location. Between 6 May and 27 October 2016, there had been no recorded instances of patients being transferred from another hospital location for seclusion at Roseberry Park. The trust were undertaking a review of the seclusion facilities at the time of inspection and a proposal had been made for seclusion facilities at West Park Hospital. The paper also recommended the trust consider the development of a formal extra care area on each inpatient site.

We reviewed the records of five episodes of seclusion. In the previous inspection in 2015, we recommended that the provider should ensure that the recording of any episodes of seclusion are documented separately from daily notes and are comprehensive. We found this had improved at the time of this inspection. Staff were able to have seclusion records open for one episode of seclusion at the same time, to enable the medical reviews and 15 minutes observations to be documented simultaneously.

In all records on Bedale Ward we found that staff had documented the start time and reasons for seclusion, along with 15 minute observations. Staff documented that all patients had been offered food and drink. Seclusion care plans were in place for each episode, although they

were generic and did not meet the requirements of the Mental Health Act code of practice. We found gaps in the documenting of nursing and medical reviews in seclusion records. In one record, we found no evidence that the patient had been reviewed by an independent multi-disciplinary team despite the episode being ongoing over four consecutive days. This should have occurred after 8 consecutive hours in seclusion or 12 intermittent hours in seclusion. Staff noted the date and time that seclusion ended and the decision was undertaken following a multi-disciplinary team review.

Appropriate arrangements were in place for the management of medicines on all of the wards we visited. Nursing and pharmacy staff carried out regular checks on medicine prescription and administration records to make sure that these were accurate and fully completed and to identify any medicine omissions. The pharmacists reconciled all patients' medicines on admission and assessed the suitability of patients' own medicines for use where necessary. Pharmacists were supported by pharmacy technicians. They were fully integrated into the wards and attended the daily report out meetings. The wards undertook a weekly review in this meeting of as needed medication and high dose antipsychotics. The use of high dose antipsychotic treatment was closely monitored and pharmacists alerted the clinical team when monitoring tests or medication reviews were due to reduce the risk of any adverse effects. We saw high dose monitoring forms with prescription charts. We also saw consent to treatment forms and the required Mental Health Act documentation with prescription charts.

Pharmacy staff carried out a full clinical check of all prescription and administration records and alerted clinical staff if patient safety monitoring checks were due or if a person's medication required a review. They monitored medicine omissions and ensured that these were investigated and reported via the electronic incident reporting system where appropriate. The staff had access to a medications safety officer and they ensured any information about incidents with medication were shared across the trust.

Nursing staff told us that they had access to medication information and that a pharmacist would discuss medicines with individual patients if this was requested. Patients and their carers were provided with information about their medicines and a pharmacist was available to support this and meet with them directly if required. The clinic rooms used to dispense medication were clean and tidy and medicines were stored safely. The pharmacists we spoke to had a detailed knowledge of the controlled drugs policy and undertook a controlled drugs audit every three months.

Track record on safety

Between 1 September and 31 October 2016, there were 616 incidents reported through the trust's electronic incident reporting system. Of these, 98 were incidents of self-harm and 45 were incidents of patients going absent without leave. The highest number of incidents occurred on the two psychiatric intensive care units, Cedar Ward with 62 and Bedale Ward with 86. The lowest number of incidents were reported on Tunstall Ward with four and Bilsdale Ward with 10.

Two adverse events had happened on Cedar Ward at the Briary unit in recent months. We reviewed both incident investigations and found they were detailed, thorough, and clearly identified recommendations with action plans in place to improve patient safety.

Reporting incidents and learning from when things go wrong

Staff we spoke with on all acute wards knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the trust's patient safety team, who maintained oversight. The system ensured that senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.

Since October 2015, staff across the trust had received a monthly learning lessons bulletin. The aim of the bulletin was to share the lessons to be learned from both positive practice and areas for improvement to reduce risk and improve quality of care. This included learning from other trusts or national reviews. The trust also provided staff with a patient safety bulletin that highlighted themes from recent serious incident reviews across the trust. In addition, there was a draft learning lessons framework in place, which was being refined through the learning lessons project. This was focused on learning lessons from serious incidents, safeguarding and medicines management.

Staff were involved in reviewing incidents using the format of situation, background, assessment, recommendation, and decision. These completed reports were then shared

Requires improvement

Are services safe?

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with staff across the trust. We saw discussions about lessons learned in the meeting minutes of managers and individual staff teams. Staff reported they had access to de-brief sessions and were provided with feedback on the investigation of incidents. Staff had access to counselling through the employee assist scheme if required.

Staff across the trust could identify changes that had been made because of lessons learned from incidents and complaints. An example of this was a complaint that was raised by a patient's family who felt they were unable to get consistent feedback on the patient's progress over the phone from the ward staff. Ward managers were now asked to contact a patient's family if appropriate following admission to introduce themselves and ensure the family had a point of contact on the ward. Staff also took part in rapid process improvement workshops to affect change in practice and procedure where they had identified something was not working. An example of this was the involvement of the community team staff in the report out meetings each week to ensure a smooth transition from hospital to community for the patient.

The trust had a duty of candour policy and staff knew where to access this. All managers and most of the staff that we spoke to could explain their responsibilities under the duty of candour. One manager identified that when a medication error had occurred for a patient, they ensured both the patient and their family were aware of this and apologised for the error. Another manager reported that they had responded to a complaint with a written apology to the patient and the offer of a de-brief to discuss the situation and lessons learned.

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

Since the previous inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

Good

Are services caring?

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

Our findings

Since the previous inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

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

Since the previous inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

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

Since the previous inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that each ward has a suicide prevention environmental survey reviewed annually in line with their policy. Staff must be aware of ligature risks and blind spots on the wards and be able to identify how they mitigate for these. This is a breach of Regulation 12 (2) (d) The provider must ensure that all staff are up to date with their mandatory training in immediate life support as a minimum standard for staff that deliver or are involved in rapid tranquilisation, physical restraint, and seclusion. This is a breach of Regulation 12 (2) (c) The provider must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with trust policy. The provider must ensure that staff are trained in rapid tranquilisation. This is a breach of Regulation 12 (1)

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 The provider must ensure that there is an effective system in place to record and monitor when patients are being secluded in rooms other than a seclusion room, in line with their policy. Staff must record this as seclusion and ensure patients are afforded the procedural safeguards of the Mental Health Act Code of Practice in

This section is primarily information for the provider

Requirement notices

these instances. The provider should ensure that the recording of any episodes of seclusion is in line with trust policy and complies with the Mental Health Act Code of Practice.

This is a breach of Regulation 17 (2) (c)

This section is primarily information for the provider

Enforcement actions

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.